Worcestershire Acute Hospitals NHS Trust

Kidderminster Hospital and Treatment Centre

Quality Report

Kidderminster Hospital and Treatment Centre
Bewdley Road
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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
Minor injuries unit	Inadequate
Medical care (including older people's care)	Requires improvement
Surgery	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
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 at Kidderminster Hospital on 8 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 Kidderminster Hospital and Treatment Centre as inadequate, with one of the five key questions we always ask being judged as inadequate.

Our key findings were as follows:

- Managers did not have clear oversight of mixed sex breaches or the need to report them in line with national guidance
- 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.
- Not all staff had had undertaken the mandatory training required, including safeguarding children's training, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and insulin management.
- Appropriate systems were in not in place for the management of controlled drugs within the endoscopy unit.
- Resuscitation equipment was not fit for purpose in an emergency situation. In the MIU we found an empty oxygen cylinder and out of date paediatric airway masks.
- Pain in children attending the MIU was not always managed effectively. We found children were not always assessed for pain and associated pain scores were not always documented.
- Medical notes were not always locked away safely.
- Medicines were not always stored safely. For example: medication fridge temperatures in the MIU were above the recommended temperatures for storing medicines and vaccines.
- Limited use of local audit meant that some outcomes with regards to patient safety, care and effectiveness were not fully understood.
- The NHS Friends and Family Test (FFT) had been suspended in children's clinics since the service reconfiguration. Patients' feedback could not be used to monitor and improve services.
- Nursing staff competency assessment records in the children's clinic were all out of date.
- Examination protocols for standard x-ray examinations were not routinely reviewed and not subject to document control. Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses and/or treatment.

Summary of findings

- There was a lack of radiation protection infrastructure.
- Examination protocols for standard x-ray examinations were not routinely reviewed and not subject to document control. Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses and/or treatment.
- Staff were caring and respectful towards patients. Patients' privacy and dignity was protected and staff adapted their approach to meet the individual needs of patients
- There was an on-site Resident Medical Officer to cover services seven-days a week.
- 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.
- Establish female genital mutilation and child sexual exploitation training that is to be completed by all staff working in children and young people's services.
- Ensure administration of controlled drugs are always documented contemporaneously with signature as appropriate.
- Ensure that medicines are always stored within the recommended temperature ranges to ensure their efficacy or safety.
- Ensure all equipment is in date and used, stored and maintained in line with manufacturers' instructions.
- Ensure that resuscitation equipment is readily available for use when required without posing a risk.
- Ensure that there is an effective system in place to ensure that all electrical equipment has safety checks as recommended by the manufacturer.
- Ensure that equipment is checked as per policy.
- 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 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.
- Ensure there is a strategy in place for diagnostic and imaging services that staff are aware of.
- Develop a clear strategy for surgical services which includes a review of arrangements for county wide management of emergency surgery.
- Ensure there is a process for collecting data regarding the effectiveness of the children's outpatients department to recognise and plan where improvements can be made.
- Ensure mixed sex breaches are reported as required.
- Ensure patient notes are stored securely and safely.
- Increase staff awareness of the trust's incident reporting procedures and risk matrix tool.
- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets trust target of 90%.
- Ensure all staff receive an annual appraisal.
- Ensure staff receive appropriate clinical supervision.

In addition, the trust should:

- Ensure there is a clear consistent approach to streaming patients in the minor injuries unit at all times, to ensure patients with the most urgent needs are prioritised.
- Ensure every child has a pain assessment and pain scores are documented.
- Ensure pain relief given to children is audited in the minor injuries unit.
- Ensure that guidelines are in date and are in line with national best practice guidance.

Summary of findings

- Ensure patient outcomes are collected, monitored, analysed and used to drive service improvements.
- Ensure there is a clear minor injuries unit strategy.
- Consider developing a formal clinical audit plan, including regular, local audit of documentation, environment, equipment and hand hygiene. Then share the results with staff to improve patient care.
- Ensure all additional training identified is completed by staff.
- Ensure that World Health Organisations' Five Steps to Safer Surgery checklists is reviewed and completed appropriately.
- Review the systems in place to ensure staff feel safe, respected and valued within the workplace.
- Ensure staff have knowledge of the key objectives within the service.
- Consider involving staff in strategic plans and developments within surgical services.
- Review the number of cancelled operations in line with the national average of 6%.
- Review the choices offered to patients about where they are discharged too for continuing care.
- Record templates should be developed that clearly identify where information should be recorded.
- Record meetings where performance in the children's clinic is discussed.
- Ensure there are appropriate and child friendly waiting areas for children and young people and provide appropriate environments for them, including room temperatures.
- Take action to address the 'did not attend' appointment rate for new children and young people's clinic appointments.
- Ensure complaints are investigated within the timescales stated in the trust's complaints policy.
- Ensure there is a clear flow of information from the children's clinic to the board via effective governance processes.
- Ensure there is senior oversight of the minor injury unit.
- Ensure there are suitable arrangements for the maintenance, renewal and replacement of equipment and medical consumables.
- Ensure that risks are identified, escalated and acted on without delay.
- Ensure that processes are in place to assess, monitor and mitigate risks relating to service users.
- Ensure that systems and processes are operated effectively.
- Ensure that records and information in relation to equipment is accurate, analysed and reviewed by people with the appropriate skills and competence to understand its significance.
- Ensure effective governance measures are in place to ensure staff adhere to trust policies and processes.

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?
Minor injuries unit	Inadequate 	We rated the MIU as inadequate because:

- Resuscitation equipment was not fit for purpose in an emergency situation. We found an empty oxygen cylinder and out of date paediatric airway masks. This was escalated to senior nursing staff and rectified during our inspection.
- There was out of date equipment across the unit including wound dressings and airway management equipment. Senior nursing staff were aware of this issue prior to our inspection and were in the process of removing out of date equipment.
- Staff did not always adhere to trust policies. For example, medication fridge temperatures were above the recommended temperatures for storing medicines and vaccines. However, this had not been escalated to the pharmacy department.
- Risks were not always identified and there was a lack of oversight relating to risks in the MIU. There was no risk register for the MIU.
- There was a significant disconnect between the MIU and the divisional leadership team. The MIU rarely featured at divisional meetings and we were not assured that performance, quality, and incidents were discussed with divisional leads. Divisional leaders were not visible within the MIU.
- Whilst we saw an improvement in security arrangements since our last inspection in July 2015, there had been a rise in the number of incidents of 'non-physical assault' on staff, such as patients being verbally aggressive towards staff.
- There was no clear or consistent approach to triage and streaming in place to ensure that patients with more urgent needs were prioritised at all times in line with national guidance.
- Some guidelines were out of date. Patient outcomes were not routinely collected or monitored. There was a significant lack of audits

Summary of findings

within the MIU. We saw evidence of only one audit and there was no formal audit plan for the unit. This was identified during our July 2015 inspection and there had been no improvement.
- Pain in children was not always managed effectively. We found children were not always assessed for pain and associated pain scores were not always documented. There were no audits in relation to pain relief given to children.
- The MIU did not have a strategy and there were no plans to develop one for the unit.

However:

- Action had been taken to improve security in the MIU. There were security arrangements in place and risks related to security had been addressed and documented since our last inspection in July 2015.
- Patients were seen and treated within a timely manner.
- There was clear guidance for the management of deteriorating patients and staff were knowledgeable about how to care for a deteriorating patient.
- There were infection prevention and control processes in place and the environment and equipment was clean. Cleaning schedules were completed and all staff took responsibility for cleaning within the MIU.
- Medicines were stored securely and administered appropriately with the use of patient group directives.
- Staff were caring and respectful towards patients. Patients' privacy and dignity was protected and staff adapted their approach to meet the individual needs of patients.
- There was a dedicated children's waiting area available separated from the main waiting room.

Medical care (including older people's care) — **Requires improvement**

We rated medical care as requiring improvement because:

- Appropriate systems were in not in place for the management of controlled drugs within the endoscopy unit.

Summary of findings

- Not all staff had had the mandatory training required, including safeguarding children's training, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and insulin management.
- Safeguarding children training was below the trust target.
- Medical staffing levels did not meet the required levels which could place patients at risk.
- Although the trust assessed and responded to patient risk there were shortfalls in the completion of the World Health Organisations' Five Steps to Safer Surgery checklists.
- Not all staff had received an appraisal to evaluate their performance in delivering effective care and treatment.
- The leadership, governance and culture did not promote the delivery of high quality person-centred care.
- Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust
- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally.
- The environment was well maintained and there were reliable systems in place to prevent and protect people from a healthcare associated infection.
- Patient records were written and managed in a way that kept patients safe. Records seen were legible, and up to date.
- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Staff reviewed and assessed the patient's pain control, nutrition and hydration needs to ensure they met the individual's requirements.
- Services within the hospital were planned and delivered to meet the needs of local people.
- People were supported, treated with dignity and respect and received compassionate care.

Summary of findings

- Patients told us that staff were caring, kind and respected their wishes. We saw that staff interactions with people were person-centred and unhurried.
- Patients could access interpreters when required and information leaflets were available in braille or as audio tapes.
- The service had mechanisms in place which provided patients with additional support due to their complex needs.
- Concerns and complaints procedures were established. Information was available for patients regarding how to make a complaint.
- Nursing and medical staff were positive about the teams they worked in and the services they provided.

Surgery

Requires improvement

We rated surgery services as requiring improvement because:

- Patient outcomes were generally below the England average and not all staff were aware of patient outcomes relating to national audits or performance measures.
- Medical notes were not always locked away safely.
- There was a high number of medical and nursing vacancies; 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) for the trust was consistently below the England average of 80%.
- The number of cancellations of operations was higher than the national average.
- Mixed sex accommodation breaches had not been reported.
- Managers did not have clear oversight of mixed sex breaches or the need to report them in line with national guidance.
- Patient 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.

Summary of findings

- Staff reported the executive team were not visible in their areas.
- Staff survey results indicated deterioration from the previous year.

However:

- There was a positive culture of incident reporting and staff said they received feedback and learning from serious incidents.
- Medical staffing was appropriate. There was an on-site Resident Medical Officer to cover services seven-days a week.
- 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.
- The was a good consent process.
- 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 also available.
- Staff were caring, kind and compassionate to patients' needs. Patients spoke very highly of the care they had received.
- Patient's pain, nutrition and hydration was appropriately managed.
- The governance framework had improved since our last inspection.
- There were regular staff meetings at all levels and information was shared with staff.
- There was evidence of patient and public engagement.

Maternity and gynaecology

Requires improvement

We rated maternity and gynaecology as requiring improvement because:

- Environmental checks were inconsistent. Systems for monitoring equipment safety were not robust.

Summary of findings

- Limited use of local audit meant that some outcomes with regards to patient safety, care and effectiveness were not fully understood. This was especially noticeable with regards to documentation and assessment.
- Compliance with mandatory training modules remained below the trusts target of 90%.
- Multiple sets of patient notes led to gaps in information in some records that we saw.
- Senior leaders were not always visible and some had limited capacity due to multiple roles.
- New pathways were not dated or referenced with up to date evidence.
- Staff had a poor understanding of female genital mutilation, child sexual exploitation, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Leaders had told us that all staff had been trained in these areas.
- Medical staff vacancy rates in obstetrics and gynaecology were above the national average, leading to cancellation of clinics.
- There was no awareness, amongst staff, of major incident plans or roles that individuals would take should there be a major incident.
- Midwives were not rotated to different areas, potentially resulting in loss of some skills.

However:

- All staff considered patients' needs, were respectful and caring in their interactions.
- Staff were valued and respected. There was open and honest communication between staff and managers. Local leaders were visible and approachable.
- Divisional leaders had a clear vision and strategy for maternity services.
- Incident, comments and complaints processes were thorough; lessons were learned and disseminated well. However, the target to complete these was often missed.
- Nursing and midwifery leaders were always available on the telephone or email.

Summary of findings

Services for children and young people

Requires improvement

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

- Staff were not aware of any guidance to support them in identifying what incidents should be reported. This created a risk of under reporting of incidents.
- Incident reports did not always identify learning. This meant there was a risk of both the service and staff not learning from incidents.
- Record templates were not always clear and did not contain columns on documents that clearly identified where height and weight should be recorded.
- 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.
- Level three safeguarding children's training was not always face to face and was not updated annually; this was not compliant with the guidance on safeguarding training.
- The operating theatres sometimes had young people on theatre lists. Staff in the main theatres were not trained to level three in safeguarding. In addition, staff were not trained in paediatric immediate life support (PILS).
- The safeguarding supervision policy stated on the intranet, that it was 'in development'. There were though, some policies relating to safeguarding children that were not available on the trust intranet, including a 'no allegations policy'; and a 'managing celebrity visits' policy.
- There was no clinical audit plan for the children's clinic. There was little evidence that continual improvement of the service and compliance with best practice was identified or actions taken to address shortfalls.
- The women and children's division had introduced a performance dashboard to monitor patients' outcomes. There was little evidence that performance in the children's clinic was discussed.

Summary of findings

- We viewed nursing staff competency assessment records and found these were all out of date. This meant the hospital could not be sure that staff were competent in all the skills required for their role.
- There had been no training for nursing staff to enable them to recognise sepsis.
- There was no formal clinical supervision for nursing staff. Supervision was provided by an outpatient's manager via telephone as they worked at another location. However, the manager also worked in WRH as an advanced nurse practitioner and could only offer staff telephone support when there were quiet periods at WRH.
- The NHS Friends and Family Test (FFT) had been suspended in children's clinics since the service reconfiguration. Patients' feedback could not be used to monitor and improve services.
- The 'did not attend' (DNA) appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%.
- The allergy service had a waiting time of up to 14 weeks due to the service only having one consultant.
- As a result of the emergency service reconfiguration which took place during the spring of 2016, the children's service did not have a clear vision, and did not have a long-term strategy. Staff were unaware of the vision and values for the children's outpatients' service as these were not defined.
- The governance framework was not effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings.
- Monthly divisional governance meetings were not consistently adhering to their terms of reference. This included: not focusing on themes and trends from incidents; safeguarding training performance, being reported as mandatory training, and not broken down to include compliance with level three safeguarding training. Discussions in regards to the divisional risk register focused on the number of risks

recorded rather than how they were being managed. There had been little discussion around how the children's services transitional period was being managed.
- The outpatients manager had not been allocated any contracted hours for service leadership and they were fitting this in with their ANP role at WRH. This meant it was likely that staff would not receive timely supervision and advice.

However:

- The environment was observed to be visibility clean and staff followed correct protocols.
- Medicine cupboards and treatment rooms were sufficiently secure to prevent unauthorised access.
- Overall, care records were generally written and managed well. However, record templates were not always clear, and did not contain columns on documents to clearly identify where height and weight should be recorded.
- Medical and nursing staffing levels were planned and reviewed in advance, based on an agreed number of staff per shift.
- The trust had a major incident plan in place. However, staff were not aware of a local formal business continuity plan.
- The trust's 95% target for referral to treatment time (RTT) for non-admitted children and young people receiving an appointment within 18 weeks was regularly met.
- Staff who worked in the children's clinic 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.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts including privacy and about care and treatment and staff friendliness.
- Staff communicated with children, young people and their families in a way that they could

understand their care and treatment. Staff understood the impact that a patients care, treatment and condition had on them and those close to them.
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of information available on the children's clinic.
- Services in the children's clinic took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- There was good teamwork and committed staff in the children's clinic.

Outpatients and diagnostic imaging

Inadequate

We rated outpatients and diagnostic imaging as inadequate because:

- There was a lack of radiation protection infrastructure.
- Examination protocols for standard x-ray examinations were not routinely reviewed and not subject to document control. Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses and/or treatment
- The trust did not consistently meet all cancer targets for referral to treatment times.
- Staff we spoke with were unaware of any patient harm reviews undertaken to mitigate risks to patients who had breached the RTT / cancer waits.
- We could not ensure that all equipment was suitable for purpose. We saw a blood pressure monitoring machine had not been calibrated. Aging and unsafe equipment across the trust that was being inadequately risk rated with a lack of capital rolling replacement programmes in place.

Summary of findings

- 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.
- Not all nursing and medical staff had had appropriate levels of children's safeguarding training.
- Compliance with mandatory training had improved since the last inspection. Training figures showed training compliance met the trust's target of 90%.
- There were moderate to high level of clinic cancellations with less than six weeks' notice across particular specialties.
- Hand hygiene and arms bare below the elbow audits were not regularly carried out with only one weekly audit carried out so far in the current financial year.
- There was a shortage of medical staff across all specialities. This meant there could be a delay in patients being seen for new or follow-up appointments.
- We were not assured that all complaints were dealt with in a timely manner and in accordance with trust policy.
- We could not be assured the service had a robust, realistic strategy for achieving the priorities and delivering good quality care.

However:

- Staff were dedicated and caring staff. 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 good.
- There were effective systems in place regarding the handling of medicines.
- FP10 prescription pads were stored securely.

Summary of findings

- Patient's medical records were accurate, complete, legible, up to date and stored securely.
- Leadership within the outpatient's team was visible however, the management of risk was insufficiently robust and further improvements were necessary.
- 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.

Kidderminster Hospital and Treatment Centre

Detailed findings

Services we looked at
Minor injuries unit; Medical care (including older people's care); Surgery; Maternity and Gynaecology; Services for children and young people; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Kidderminster Hospital and Treatment Centre

Kidderminster Hospital and Treatment Centre offers clinical facilities and patient accommodation for a wide range of day case, short stay and inpatient procedures. The nurse-led minor injuries service is open 24 hours a day and treats more than 24,000 patients every year. There are approximately 600 staff based at the hospital and treatment centre, 70 of which are consultants.

Other facilities at the Kidderminster site include a full range of outpatient clinics, including outpatient cancer treatment in the Millbrook Suite, MRI and CT scanners and a renal dialysis unit.

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 Kidderminster Hospital and Treatment Centre was rated as requires improvement 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, outpatients, and general medicine; accident and emergency 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?
- Is it responsive of people's needs?

Detailed findings

- 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 Kidderminster Hospital and Treatment Centre

Kidderminster Hospital and Treatment Centre is part of Worcestershire Acute Hospitals NHS Trust.

In 2015/16, the trust had:

- 120,278 urgent and emergency 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:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Requires improvement	Inadequate	Good	Good	Inadequate	Inadequate
Medical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Inadequate	Inadequate	Inadequate
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Detailed findings

Notes

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

Minor injuries unit

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

Information about the service

The minor injuries unit (MIU) at Kidderminster Hospital and Treatment Centre is open 24 hours a day, seven days a week.

From November 2015 to October 2016 there were 20,211 attendances at the MIU. Of those, 5,755 (28%) were aged between 0 and 17 years old. The percentage of patients attending the unit had decreased by 22% since our last inspection of the MIU in July 2015.

The MIU is staffed by emergency nurse practitioners and health care support workers. It provides care and treatment for patients with minor injuries such as wounds, sprains, minor head injuries and broken bones.

Patients generally present to the MIU by walking into the reception area and booking in. Patients who attend should expect to be assessed and admitted, transferred or discharged within a four hour period in line with the national target for all accident and emergency and unscheduled care facilities.

The unit consists of five consulting rooms and a triage room including a plaster room and an ophthalmic room.

We carried out an announced inspection of the MIU on 24 and 25 November 2016. During our inspection we spoke with four members of staff, four patients and we looked at 11 sets of patient records.

Urgent and emergency services provided by this trust were located on three hospital sites, the others being Worcestershire Royal Hospital and Alexandra Hospital. 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.

Minor injuries unit

Summary of findings

We rated the minor injuries unit (MIU) as good for caring and responsive. We rated safe as required improvement, and effective and well-led as inadequate. Overall, we rated the MIU as inadequate because:

- Resuscitation equipment was not fit for purpose in an emergency situation. We found an empty oxygen cylinder and out of date paediatric airway masks. This was escalated to senior nursing staff and rectified during our inspection.
- There was out of date equipment across the unit including wound dressings and airway management equipment. Senior nursing staff were aware of this issue prior to our inspection and were in the process of removing out of date equipment.
- Staff did not always adhere to trust policies. For example, medication fridge temperatures were above the recommended temperatures for storing medicines and vaccines. However, this had not been escalated to the pharmacy department.
- Risks were not always identified and there was a lack of oversight relating to risks in the MIU. There was no risk register for the MIU.
- There was a significant disconnect between the MIU and the divisional leadership team. The MIU rarely featured at divisional meetings and we were not assured that performance, quality, and incidents were discussed with divisional leads. Divisional leaders were not visible within the MIU.
- Whilst we saw an improvement in security arrangements since our last inspection in July 2015, there had been a rise in the number of incidents of 'non-physical assault' on staff, such as patients being verbally aggressive towards staff.
- There was no clear or consistent approach to triage and streaming in place to ensure that patients with more urgent needs were prioritised at all times in line with national guidance.
- Some guidelines were out of date. Patient outcomes were not routinely collected or monitored. There was a significant lack of audits within the MIU. We saw evidence of only one audit and there was no formal audit plan for the unit. This was identified during our July 2015 inspection and there had been no improvement.
- Pain in children was not always managed effectively. We found children were not always assessed for pain and associated pain scores were not always documented. There were no audits in relation to pain relief given to children.
- The MIU did not have a strategy and there were no plans to develop one for the unit.

However:

- Action had been taken to improve security in the MIU. There were security arrangements in place and risks related to security had been addressed and documented since our last inspection in July 2015.
- Patients were seen and treated within a timely manner.
- There was clear guidance for the management of deteriorating patients and staff were knowledgeable about how to care for a deteriorating patient.
- There were infection prevention and control processes in place and the environment and equipment was clean. Cleaning schedules were completed and all staff took responsibility for cleaning within the MIU.
- Medicines were stored securely and administered appropriately with the use of patient group directives.
- Staff were caring and respectful towards patients. Patients' privacy and dignity was protected and staff adapted their approach to meet the individual needs of patients.
- There was a dedicated children's waiting area available separated from the main waiting room.

Minor injuries unit

Are minor injuries unit services safe?

Requires improvement

We rated safe as requires improvement because:

- Resuscitation equipment was not fit for purpose. There was an empty oxygen cylinder on the adult resuscitation trolley and we found out of date paediatric resuscitation equipment, despite daily checks being carried out. This was escalated and immediately rectified.
- There were numerous items out of date in the minor injuries unit (MIU) store room including dressings and caster tape.
- The temperature of the medicine fridge in the MIU repeatedly exceeded the maximum recommended temperature as per trust policy from August to November 2016, which meant there was a risk that vaccines stored in the fridge were ineffective. Staff did not always adhere to the trust's medicines policy and issues with the safety of medication storage were not identified and had not been escalated to pharmacy.
- Since our last inspection in July 2015 there had been a rise in the number of incidents of 'non-physical assault' on staff, such as patients being verbally aggressive towards staff.
- Safeguarding training compliance rates for adults and children did not meet the trust target of 95%.
- There was no clear or consistent approach to triage and streaming in place to ensure that patients with more urgent needs were prioritised at all times in line with national guidance.
- There was no dedicated triage nurse. Each day an ENP took on the role of triage which meant there were less ENPs to treat patients. There was no consistent process in place to ensure that patients with red flag symptoms and children received an initial clinical assessment within 15 minutes. Patients were only triaged between 9am and 5pm. There were plans in place to introduce streaming by a health care support worker which meant that patients would no longer be triaged by an emergency nurse practitioner (ENP) as of January 2017.

However:

- Appropriate actions had been taken to mitigate security issues found on our last inspection in July 2015 and out of hour's security was provided by porters. All staff carried personal attack alarms, CCTV was in operation and staff had received training in conflict management and personal safety.
- Patients were generally seen and treated within a timely manner.
- Staff were encouraged to report incidents and always received feedback from incidents.
- Staff adhered to the infection prevention and control policy, the MIU and equipment within the unit was visibly clean.
- There were clear processes in place to identify and manage children and adults at risk of abuse.

Incidents

- Staff told us they were encouraged to complete incident reports via the electronic reporting system. Staff said they received feedback either in writing or verbally. Staff we spoke with knew how to report incidents.
- There were no "never events" reported from September 2015 to August 2016. A never event is described as a wholly preventable incident, where 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.
- The MIU had reported two serious incidents between January and December 2016. One incident was a medication error and we saw evidence of a comprehensive investigation report and action plan. All actions had been completed and learning had been implemented. For example, storage of medication fluids had been re-evaluated and separated and all MIU staff had revisited the trust's intravenous medication policy. The most recent incident was a report of a missed fracture, however, the trust were unable to provide us with assurance that they had carried out a full root cause analysis.
- We were unsure if all incidents were reported. For example, out of date equipment found in the department had not been reported as an incident.

Minor injuries unit

- There had been 41 incidents reported from September 2015 to August 2016. One resulted in moderate harm, eight resulted in minor harm and 32 resulted in no harm.
- There were seven incidents reported of visitors using the toilets in the department to take illegal drugs. Learning from these incidents had been implemented and actions taken included removal of a payphone, locking toilets out of hours and alterations of the CCTV angles.
- There had been 15 incidents of 'non-physical assault' on staff, such as patients being verbally aggressive towards staff. This was added to the divisional risk register in July 2015 following our inspection.
- Security arrangements had improved since our last inspection in July 2015. Staff told us that actions had been taken in order to improve staff and patient security. For example, porters had undertaken security training that enabled them to provide out of hours security to the department and all staff had received or were booked on to training in conflict resolution and personal safety.
- During our July 2015 inspection staff told us they left treatment doors open when treating patients following an incident where staff could not be alerted when difficulties arose whilst reviewing a patient. Upon inspection, we found all treatment room doors closed and all staff had been provided with personal attack alarms to raise alerts if required.
- We saw no evidence of MIU incidents being discussed at divisional meetings. Staff told us incidents were discussed at departmental meetings.
- 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 we spoke with could explain the importance of being open and honest with patients, and how this related to 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 them.

Cleanliness, infection control and hygiene

- Infection control practices within MIU were in line with the trust policy. Staff had access to personal protective equipment, such as gloves and aprons. We observed ENPs utilising the appropriate equipment when required.
- Handwashing facilities and alcohol gel was available at regular points within the MIU. We observed clinical staff washing hands between patient contact.
- We observed staff in the department adhering to the trust's 'arms bare below the elbow' policy.
- The MIU was visibly clean. We observed domestic staff carrying out cleaning tasks throughout our inspection. Cleaning schedules were in place to ensure domestic staff knew what was required and we also saw cleaning schedules for MIU clinical staff.
- Equipment was visibly clean across the MIU. Some equipment had decontamination status labels that identified when a piece of equipment was last cleaned.
- Staff told us they used the triage room if patients with an infection needed to be isolated to minimise the risk of spreading infections. For example, patients with chickenpox.
- The MIU carried out mini patient-led assessments of the care environment (PLACE) audits. PLACE audits focus on the environment in which care is provided, as well as supporting non-clinical services, such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. In May 2016 the result was 96% which was about the same as the England average of 98%.

Environment and equipment

- The resuscitation trolley was centrally located and daily checks had been documented which suggested that it was fit for purpose in an emergency. However, we found the oxygen cylinder was empty and two paediatric airways were out of date. This was highlighted to a staff member who took immediate action to replace the cylinder and remove out of date resuscitation equipment. We were assured that the oxygen cylinder had been replaced before leaving the department however we were not assured that out of date resuscitation equipment had been replaced. The trolley was cleaned weekly.
- The MIU store room was secure and could only be accessed by MIU staff. Items were stored neatly and the room was not overstocked. We found numerous items in the storeroom and plaster room that had exceeded their

expiry date, including dressings, caster tape rolls and airways. Senior nursing staff advised us they were aware of out of date equipment and there was ongoing progress to remove this equipment from the MIU. However, we did not see any evidence of a robust system in place to monitor equipment and their expiry dates and out of date equipment had not been reported as an incident.

- Equipment was in working order with the exception of the medication fridge. Items were labelled with the date they were last serviced and when their next service was due. All equipment had received appropriate electrical equipment testing where required.
- There had been a number of incidents reported in the MIU regarding intravenous illegal drug use by visitors in the MIU visitor toilet facilities. This had been an on-going issue at the hospital and meant there was a risk of staff and visitors coming into contact with needles. In an attempt to reduce this, blue lights had been installed in the toilet that was available for visitors to use 24 hours a day. Blue lights fitted in toilets were used to prevent veins from showing up on the body to deter drug users. Staff told us that the second toilet with white lights in the MIU reception was locked from 8pm to 8am, as this was when incidents of illegal drug use occurred most. Staff we spoke with said when incidents like this occurred they were encouraged to complete an incident report and would call the police if necessary.
- There was a separate waiting room for paediatric patients opposite the reception desk in line with the Royal College of Paediatrics and Child Health (RCPCH) recommendations in Standards for Children and Young People in Emergency Care Settings, 2012. An alarm had been fitted to alert help if required. We were told that new thermal blinds had been purchased to prevent the room from getting cold, however; they had not yet been fitted. We were told by staff that children generally waited in the main waiting area where there was also a provision of toys.

Medicines

- The MIU had appropriate systems in place regarding the safe handling and administration of medicines. However, we found that these processes were not always followed.
- Records showed fridge temperature checks had been completed daily. However, we found the maximum fridge temperatures recorded had exceeded eight degrees Celsius on a total of 60 days between August and November 2016. There was a risk that tetanus and hepatitis B vaccines, stored in the fridge, were less effective or ineffective as they had not been stored at the recommended temperature. Staff were not aware of this risk and had not escalated high temperatures to pharmacy in line with the trust's medicines policy. Staff told us that pharmacy staff regularly visited the MIU and inspected the place of storage in line with the medicines policy. However, the fridge temperatures had not been highlighted. Following our inspection the trust told us "the fridge is operating at a temperature within acceptable parameters and no medications had been affected." The trust also informed us that an investigation had been carried out by the deputy director of pharmacy and the deputy director of nursing. We were told the fridge temperature thermometer had been reset and medicines that had been affected were destroyed as a precautionary measure. The information provided was contradictory and there was no assurance that patients who had been treated prior to the investigation were not harmed.
- Medicines were stored in locked facilities and all medication we looked at was in date. Medication storage keys were colour coded and had an alarm attached to alert the key holder that another member of staff required them.
- Medicines that contained penicillin were stored securely on a separate marked shelf to remind staff that those particular medicines could not be administered to patients that had a penicillin allergy.
- Controlled drugs were stored securely in cabinets that met the secure storage arrangements for controlled drugs.
- ENPs had access to patient group directives (PGDs). PGDs are documents which permit the supply of prescription only medicines to groups of patients without individual patient prescriptions. PGDs were stored in an easily accessible folder behind the nurse's station. Staff had all completed the necessary competency checks for PGDs.

Records

- Records were stored behind the nurse's station and were out of reach of patients and visitors.

- We looked at a total of 11 patient records. Most required information had been documented and recorded in legible handwriting with the exception of child pain scores. Patient arrival times, description of injury or illness and observations were recorded.
- Allergies were clearly documented on the records we looked at.
- Staff printed a clinical assessment system card for each patient on arrival. Records were then scanned on to the electronic system once a patient had been discharged from the MIU and hard copies were destroyed.
- Staff had access to patient's previous attendances via the electronic system.
- Staff had access to specific forms, such as for patients with head or eye injuries.

Safeguarding

- There were some processes in place to identify and manage children and adults at risk of abuse. Staff we spoke with were aware of what to do if they had a safeguarding concern and knew how to contact the safeguarding team when they required support.
- Staff told us every child that attended the MIU was checked against the child protection list which also included names of children who had been reported missing. The list was kept in a folder situated in the triage room and was updated weekly.
- A list of children that attended the MIU was sent electronically on a daily basis to the trust's safeguarding team along with a copy of their discharge summary. We were told this was usually done by the health care support worker on the night shift.
- Not all MIU staff had received the appropriate level of training for safeguarding children. This included safeguarding levels one, two and three for children in line with the intercollegiate document 'Safeguarding children – roles and competencies for healthcare staff' published by the RCPCH 2014. This guidance 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.
- Staff compliance with safeguarding training for children level one was 68% (15). 14% (3) of staff had completed children's level two training and 57% (12) had completed children's level three training. This did not meet the trust target of 95% compliance. We saw evidence of three staff members booked onto safeguarding children's level three training within the next three months however, this still would not have met the trust's compliance target.
- 82% of staff had received adult safeguarding training level one. 67% (14) of staff had completed adult safeguarding training level two and 20% (1) of staff required to undertake adult safeguarding level three had completed it.
- Some staff had attended child sexual exploitation and female genital mutilation training courses.

Mandatory training

- Mandatory training covered conflict resolution, equality and diversity, fire, health and safety, infection control, information governance, manual handling, personal development review, and resuscitation. Compliance with mandatory training overall was 90%. This did not meet the trust target of 95%.
- The trust did not provide information in relation to life support training for MIU staff therefore we could not be assured that staff were trained to the appropriate level.
- Only 55% of staff had completed equality and diversity training. However, we were told that compliance figures for this element of mandatory training were low across each department due to a recent change in how often staff were required to complete the training.
- Conflict resolution training was intended to provide staff with the skills to protect themselves from patients and visitors that become aggressive or violent which was an issue in the department. Compliance with conflict resolution training was 86%.

Assessing and responding to patient risk

- Patients who presented to the MIU were required to report to reception. The reception was staffed by health care support workers. The health care support worker on reception directed patients to the waiting area. Health care support workers told us they had a list of red flag symptoms, including chest pain, signs of a stroke and difficulty in breathing, that they would escalate concerns immediately to the triage nurse. This was in line with guidance issued by the Royal College of Emergency Medicine's (triage position statement stated April 2011).

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- There was no consistent process in place to ensure that patients with red flag symptoms and children received an initial clinical assessment within 15 minutes. Patients identified with red flag symptoms and children should be seen within 15 minutes of arrival as recommended by Department of Health and Royal College of Paediatric Child Health guidance. This should be a face-to-face encounter with the patient within 15 minutes of arrival and the assessment should be undertaken by a trained clinician.
- On our previous inspection in July 2015, there was no dedicated triage nurse. However, we were told that a business case for a temporary six-month band 5 triage nurse had been approved. From January 2016 to October 2016 there was no clear triage process in place.
- There was a dedicated triage room. During this inspection, between 9am and 5pm an emergency nurse practitioner (ENP) on shift triaged patients. This meant that the number of staff that were able to treat patients was reduced and staff told us this was not sustainable. This was a trial and had been in place for six weeks prior to our inspection.
- We were told that a new business case had been developed for a band 5 dedicated triage nurse; however, this had not been approved. A business case had been developed to recruit a band 3 health care assistant to carry out streaming from January 2017 to replace the triage process. Streaming is the process of allocation of patients to specific patient groups and/or physical areas of a department.
- There are no nationally set targets for the time in which patients should be seen from arrival to initial assessment in an MIU facility. However, the MIU had set their own target of 95% of patients should receive triage within 15 minutes of arrival.
- In October 2016, 65% of patients were triaged within 15 minutes. Day by day time to triage data was displayed in the staff break room and staff told us this was updated monthly.
- The average time from arrival to initial assessment from April to October 2016 was 26 minutes.
- All patients were seen and discharged or transferred within four hours from April to October 2016.
- The average time from arrival to treatment from April to October 2016 was 33 minutes.
- On observation, as part of the trialled triage process, we found staff were undertaking an initial clinical assessment. The initial clinical assessment included measuring of vital signs, brief history and immediate plan of care. This process allowed the clinician to start any immediate treatment required and to order relevant investigations prior to the definitive clinician assessment. During our inspection we observed waiting times of 30 minutes. The waiting time was correctly displayed on the reception desk and staff told us they updated it if the time differed by more than 15 minutes. Patients who required emergency treatment were transferred to Worcestershire Royal Hospital or Alexandra Hospital. In emergencies, patients would be transferred by ambulance. Less than 1% (55) of attendances were transferred to emergency departments between April and October 2016.
- There were care pathways in place for patients that presented with head or eye injuries. Staff we spoke with were familiar with different pathways and could show us the associated documentation and proforma used.
- Patients had access to diagnostic facilities on site, such as x-rays between the hours of 9am and 6pm Monday to Thursday; 9am to 5pm Friday, and 9:30am to 5pm on weekends and bank holidays. Staff told us that patients who required an x-ray out of hours would be signposted to Worcestershire Royal Hospital or asked to return the following day if it was safe to do so.
- Staff knew where paediatric and adult emergency equipment was kept within the MIU and were able to describe what actions they would take if a patient's condition deteriorated within the department. There was a deteriorating patient policy available to staff.
- There was guidance to aid ENPs provide safe and accessible care for critically ill paediatrics who presented to MIU. The guidelines were based on a five-tier system produced by the Manchester Triage Group (2006, the guidance from the national Advanced Life Support Group 'APLS' manual (2011) and the Resuscitation Council UK, Guidelines for Resuscitation (2010)).
- A National Early Warning Score (NEWS) was used in the MIU and a paediatric early warning system (PEWS) was used for paediatric patients in line with the National Institute for Health and Care Excellence guidelines (CG50 Acute, illness recognising and responding to the deteriorating patient). We saw that NEWS was recorded at initial assessment.

Minor injuries unit

- The MIU used Sepsis Six (this is six steps to managing patients suspected of having severe sepsis, neutropenic sepsis or sepsis shock). Staff we spoke with described the initial steps they followed if a patient presented with suspected sepsis.

Nursing staffing

- The number of ENPs on shift met the planned establishment at the time of inspection. We were told that the unit did not use agency staff however; there were several members of staff with zero hour contracts. We requested the MIU's agency usage data from the trust however we did not receive the information.
- At night the MIU was staffed by one ENP and one health care support worker which met patient demand during this time.
- The nurse in charge completed a handover at the end of their shift with the next nurse in charge. A handover sheet enabled the nurse in charge to communicate and document staffing level concerns, patients expected from the emergency department, safety checks that were completed such as resuscitation trolley checks and medicine fridge checks. Both nurses signed the handover sheet to confirm it had taken place.
- There were no vacancies in the MIU at the time of inspection. However, we were told that a member of staff was due to go on maternity leave shortly after inspection and the recruitment process had begun to recruit a new ENP. We saw robust interim arrangements to ensure the unit was covered during the recruitment process.
- One staff member we spoke with told us the induction process for new ENPs included clinical supervision, classroom based learning and e-learning. New staff remained supernumerary for their first two weeks. We were told this was to allow time for familiarity with the demands of the department.
- The MIU used an electronic tool to ensure planned staffing levels were adequate. The tool showed the required number of staff for each shift and the staff members that were available to work.
- The nurse in charge was easily identified by wearing a red badge.
- A senior nurse told us there were three adult nurses in the MIU that had attended university training to acquire paediatric competencies. We requested evidence of this; however the trust did not provide it.
- We were not assured that there was a registered children's nurse on shift at all times within the MIU.

Medical staffing

- There was a consultant two days each week on shift, specialising in soft tissue reviews. There were no other doctors on duty at the MIU as it was a nurse-led service.
- There was an on-call ophthalmologist available for advice and there were arrangements in place with a local ophthalmology specialist care centre if patients required out of hours specialist ophthalmic care.
- There was an external GP service co-located within MIU. Staff told us working relationships were good and they could provide support to the MIU.

Major incident awareness and training

- The trust had an up to date major incident policy in place. Most staff we spoke with had an understanding of the role the department would play if a major incident arose.
- Porters had undertaken security training and held Security Industry Authority licenses that enabled them to provide out of hours security to the department. In addition to out of hour's security provided by the porters, the MIU also had off-site security that could be contacted 24 hours a day. If necessary the police were called where security were unavailable or unable to resolve a situation.
- There was a panic button in the reception area linked to the switchboard and CCTV was in operation.

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

Inadequate

We rated effective as inadequate because:

- During the last inspection in July 2015, we reported that there was no formal clinical audit programme for the minor injuries unit (MIU). During this inspection, we found there was still no local clinical audit programme in place and there were no plans in place to undertake any new audits.

- Patient outcomes were not routinely collected and therefore outcomes were not monitored. There was no systematic programme of audit used to monitor quality and to identify where improvements were required.
- Pain in children was not always assessed and associated pain scores were not always documented. Pain relief given to children was not audited in line with national guidance.
- We could not be assured that there was all nurses had paediatric competencies to care for children.
- Most guidelines were developed in line with national best practice guidance; however, some were out of date

However:

- Senior nursing staff had been involved in the development of guidelines based on best practice guidance.
- Staff regularly received one-to-ones. They worked shifts in the emergency department (ED) at Worcestershire Royal Hospital to maintain their nursing competencies and gain skills within a busy ED.
- Information was easily accessible to staff and staff knew where to find local and trust wide information.
- Staff within the MIU demonstrated a good knowledge of consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were clear on their responsibilities in relation these areas and could describe the processes in place.
- The MIU provided a service 24 hours a day, seven days a week.

Evidence-based care and treatment

- We saw evidence that guidelines were based on national best practice guidance from the National Institute for Health and Care Excellence (NICE); however, some guidelines were out of date. For example, the trusts ENP Clinical Presentation Guidelines, 2013 was due to be updated in July 2015.
- Staff told us care and treatment was based on the trusts 'ENP Clinical Presentation Guidelines', July 2013, which was developed in accordance with a five-tier system produced by the Manchester Triage Group, 1996. The guidelines were out of date and were due to be reviewed in July 2015. The guidelines were adhered to by the nursing staff in the MIU.
- Staff managed patients with suspected sepsis in line with NICE guidance 'Sepsis – recognition, diagnosis and early management', 2016. Staff within the MIU would begin the Sepsis Six tool and then the patient with suspected sepsis would be transferred to the emergency department at Worcestershire Royal or Alexandra Hospital.
- The MIU met some of the minimum requirements in accordance with those set out by the Royal College of Emergency Medicine (RCEM) document 'Unscheduled care facilities', 2009. These related to staffing levels, demographic data keeping and appropriate procedures in place with local ambulance trusts.
- During the July 2015 inspection we found there was no formal clinical audit plan. During this inspection, we found there was still no formal clinical audit plan.
- Senior nursing staff were often involved in writing and reviewing guidelines for the MIU.

Pain relief

- Pain in adults was assessed by an ENP during a patient's initial assessment.
- Pain relief medication was administered when required using Patient Group Directives.
- Staff told us there were pain charts available in several languages to help staff communicate with patients who did not speak English.
- Staff did not always record pain assessments and pain scores. As there were no children in the MIU during our inspection, we looked at four sets of paediatric notes for patients that had previously used the service. Three out of four sets of paediatric notes we looked at did not have a recorded pain score. Therefore we were not assured that pain in children was always being assessed.
- RCEM management of Pain in Children (revised July 2013) recommends that all children should be offered pain relief within 20 minutes of arrival and those in severe pain be reassessed every hour, also that an annual audit is conducted. We did not see any evidence of a process in place to meet these recommendations.
- None of the patients we spoke with reported being in pain.

Nutrition and hydration

- Staff we spoke with knew how to recognise signs of malnutrition and dehydration. However, they did not routinely monitor nutrition and hydration needs because patients were not in the unit long enough.

Minor injuries unit

Patient outcomes

- Patient outcomes were not routinely collected and monitored. There was no formal clinical audit plan and we only saw evidence of one completed audit. This meant that staff were unable to use information to improve care, treatment and patient outcomes. We saw no evidence that there were plans to conduct any audits for the remainder of 2016/17 with the exception of re-auditing weighing paediatric patients.
- In February 2016 the MIU participated in an audit of weighing paediatric patients. The aim was to ensure that all children under the age of 12 were weighed in accordance with Royal College of Nursing guidance 'Standards for the weighing of infants, children and young people in the acute health care setting', published in November 2013.
- The MIU audited a total of 209 sets of paediatric records and found that 49% had a recorded child's weight. This was re-audited in June 2016; however, it was unclear exactly how many records were audited during the one-week audit period and it was a shorter audit period than the initial audit period which took place over one month. In June 2016, the audit results showed 69% of children under 12 were weighed; however, this did not meet the trusts 90% compliance target. An action plan had been developed as a result of the audit and included re-auditing in 12 months, reminding staff to weigh children under 12 and the introduction of triage. The audit concluded that staff compliance with weighing children was usually low when the unit was busy. We were not assured the action plan fully addressed non-compliance and there was no process in place to regularly review staff compliance before the next audit in 12 months.
- A senior staff member we spoke with had attended an audit meeting. We were told that audit results and action plans from the one audit we saw were discussed at the MIU team meeting.
- We requested evidence of the unplanned re-attendance rates however this was not provided by the trust.

Competent staff

- Nursing competencies included taking a clinical history, examinations and assessing chest pain. Some competencies were required to be completed within two weeks of working in a department and others were required to be completed within six months. All other competency timescales were agreed with a manager.
- Staff told us they occasionally worked a shift in the emergency department at Worcestershire Royal Hospital to gain experience in a different setting and maintain their skills as part of their clinical supervision programme. One staff member told us they found this opportunity useful as they were able to discuss care and treatment with doctors.
- There was no formal supervision process for specifically for MIU staff.
- Staff told us they were able to access funding and time to attend training courses and were encouraged by managers to do so.
- There were several link nurses at the MIU with particular interests for example, sepsis and medication. Staff told us link nurses attended specialist training and shared resources and learning with their colleagues.
- Staff told us they received regular one to ones. 95% of staff had received an annual appraisal. This met the trust target of 85%. All staff that that had worked in the MIU for longer than 12 months had received an appraisal.
- There were arrangements in place for direct access to a registered children's nurse however we could not be assured that there was a nurse with paediatric competencies on shift in the MIU at all times including through the night. Evidence was requested to support this however this was not provided by the trust.

Multidisciplinary working

- Nurses and healthcare support workers reported a good working relationship with each other. Staff told us they felt supported by their colleagues and worked collaboratively when required to provide care and treatment.
- Staff worked well with other teams such as the radiography department based at the same site. Staff also told us they had a good working relationship with the external co-located GP service.
- Staff we spoke with reported a good working relationship with a local ambulance trust most of the time.
- There was no substance misuse or mental health service at the hospital however, staff were aware of how to refer

patients to services at Worcestershire Royal and Alexandra Hospital. They also had the telephone number for a community recovery service if patients wished to self-refer.
- Link nurses attended meetings in relation to their area of interest with staff from different departments.

Seven-day services

- The MIU was open 24 hours a day, seven days a week.
- On-site radiology services were available between 9am and 6pm Monday to Thursday and 9am to 5pm Friday, Saturday, Sunday and bank holidays.
- Patients were referred to alternative sites if they required an urgent x-ray out of hours or they were asked to return the next day if it was safe to do so.

Access to information

- Information required by staff to deliver effective care and treatment was accessible in a timely manner.
- Staff could access clinical guidelines, pathways and policies on the trust's internal website.
- Staff were able to access radiology reports.
- Patient information was available to all relevant staff on an electronic system. Staff could access previous attendances to the MIU and other trust sites.
- A discharge summary was sent electronically to each patient's GP when they were discharged from the MIU with the exception of patients' that lived outside of the region. They were sent to the patient's GP by post.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff within the MIU demonstrated a good knowledge of consent and Mental Capacity Act 2005 and how this related to their practice.
- We saw staff obtained verbal consent before they carried out interventions and consent to treatment was documented in patient records.
- Staff were able to describe how and when they would carry out a mental capacity assessment.
- Staff we spoke with knew how to make an application under Deprivation of Liberty Safeguards (DoLS) but said they had not needed to since working in the MIU and patients that required a DoLS assessment were discussed with medical staff at Worcestershire Royal Hospital.

Are minor injuries unit services caring?

Good

We rated caring as good because:

- Patients' were treated with respect and kindness. They were spoken to in a way that they could understand and were able to ask questions about their treatment.
- Patient's privacy and dignity was protected.
- Patients' spoke highly of the care and treatment provided by the staff in the minor injuries unit.

Compassionate care

- We observed staff speaking to patients in a polite, kind and respectful manner.
- Patients were treated with dignity and respect. Patient's privacy was respected. Treatment and consultation room doors were closed at all times. We observed staff knocking on doors before entering and using door signs to display when rooms were in use.
- All patients and relatives we spoke with said staff were friendly and caring.
- The trust used the Friends and Family Test to capture patient feedback. The average response rate between May and October 2016 was less than 1%. This did not meet the trust target of 20%. 78% of respondents between May and October 2016 said they would recommend the service to friends and family. This was worse than the England average of 88%.

Understanding and involvement of patients and those close to them

- Staff explained treatment they were providing in a way that patients could understand.
- We observed staff asking patients if they had any questions before they were discharged.
- We observed a healthcare support worker clearly explain the triage process and waiting times to a patient.

Emotional support

- We observed staff providing emotional support to patients and relatives.
- Staff we spoke with were aware of the impact that a person's treatment, care, or condition could affect them both emotionally and socially.

Minor injuries unit

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

Good

We rated responsive as good because:

- The service provided in the minor injuries unit (MIU) was planned and delivered with stakeholders to meet the needs of local people.
- Staff adapted their approach to meet people's individual needs including children, patients living with dementia and patients that did not speak English.
- There was a wide range of literature about minor injuries and after care available to patients.
- Patients were aware of waiting times within the MIU and could also access waiting times on the internet prior to attending the unit.
- There was a dedicated children's waiting area available separated from the main waiting room.
- The MIU received a low number of formal complaints. All complaints were acknowledged within three days. Most complaints were responded to within 25 days.
- The MIU saw, treated and discharged or transferred patients within four hours.

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 MIU.
- The service was working with the local ambulance service to develop pathways and ensure suitable patients were transported to the MIU.
- There was adequate seating and space available for patients that were waiting to be seen.

Meeting people's individual needs

- Staff could describe how they adapted their approach to practice and communication when caring for patients living with dementia or a learning disability. Staff had developed skills from dementia training courses they had attended.
- Dementia friendly signs were displayed around the MIU waiting area. For example, toilet and café signs.
- There was a waiting room specifically for children separate to the main waiting area. There was a large playhouse for children in the main waiting area. Staff told us that when appropriate, this had been used for minor assessments for anxious children.
- A translation service and flash cards were available for patients that did not speak English. Staff knew how to access the translation service if they were required to use it.
- There was a wide range of information leaflets on minor injuries, management of symptoms and after care, such head injuries, sprains and strains, wound care, and fitness to drive. Leaflets were displayed in English; however, the trust did produce some leaflets in other languages.
- The MIU was accessible for wheelchair users as it was all on one level with wide doors and we saw that there was designated disabled parking bays on site. There were clear signposts at the front of the hospital and throughout directing patients to the unit.
- There was a telephone in the reception area that could be used to call local taxi companies free of charge.

Access and flow

- The Department of Health target for minor injuries units is to admit, transfer or discharge 95% of patients within four hours of arrival at the unit. From January to December 2016 the MIU consistently exceeded this target and achieved an average of 99.9% overall for that period.
- The average time from arrival to treatment from April to October 2016 was 33 minutes.
- There were systems and processes in place to monitor the time from arrival to initial assessment and this information was displayed in the staff break room.
- We saw no evidence that the MIU was incorporated in trust plans to improve patient flow. However, patients that presented with a minor injury to emergency departments at the Alexandra Hospital and Worcestershire Royal Hospital were informed at times when they may well be seen quicker at the MIU.

Minor injuries unit

- There were posters, leaflets and information on the trust's public website encouraging the public to think about attending the MIU for injuries that could be treated at the unit rather than attending an emergency department.
- The trust was promoting a local media campaign which was developed by a local clinical commissioning group. The campaign provided the public with a free guide to local health services, which was available in hard copy, on the internet and in the form of an 'app' for smartphone users. The aim was to help the public make an informed decision as to which local health service could best treat a patient's injury or illness in an attempt to ensure that patients who required urgent care were treated quicker.
- From November 2015 to October 2016 the average percentage of patients that left the department without being seen was less than 1%.
- Patients were kept up to date with waiting times. Waiting times were displayed in the reception desk and were regularly updated by staff in the reception area.
- MIU waiting times were also displayed on the internet which showed the public how many patients were in the department, how many patients were waiting to be seen and how many minutes' patients could expect to wait before they were seen by a nurse.

Learning from complaints and concerns

- The trust had an up to date complaints policy. From October 2015 to September 2016 the MIU received nine formal complaints. Five of the complaints related to general care, two related to delays and waiting times within the department, two related to staff attitude, and there was one complaint that related to poor communication. We saw details of the outcome of each complaint and the actions that followed. Staff we spoke with were also aware of the formal complaints made that related to the MIU.
- All complaints were acknowledged within three days. We found seven of the nine complaints were investigated and responded to within 25 days of receipt.
- There was clear guidance on display in the MIU for those using the service to make a complaint or express their concerns. Staff we spoke with knew what steps to take should a patient or relative ask them how to make a complaint.
- Senior nursing staff told us that if a patient made a verbal complaint to them they would try and resolve the concern at the time and recorded the details on an informal complaints log. There were seven informal complaints recorded on the log from July 2016 to January 2017. All of which were resolved at the time.

Are minor injuries unit services well-led?

Inadequate

We rated well-led as inadequate because:

- There was a significant disconnect between the minor injuries unit (MIU) and the divisional leadership team.
- There was a lack of discussion around performance, quality and incidents within MIU at divisional meetings.
- There was a lack of effective governance measures in place to ensure staff adhered to trust policies and procedures.
- Effective systems were not in place to measure quality and consistently identify areas for improvement or best practice. Therefore risks were not always identified and escalated and there was a lack of oversight relating to risks.
- There was no written strategy for the urgent care division or the MIU and there were no plans to develop a strategy for the unit.
- There were no processes in place to continuously seek to improve care, for example the MIU did not carry out local audits regularly.
- There was a lack of oversight, leadership and visibility from divisional leaders.

However:

- There was an open, honest and supportive culture amongst staff in the MIU. There was strong sense of teamwork and staff worked well together.
- Matrons and MIU senior nursing staff were visible and approachable within the MIU and were very much part of the team.

Leadership of service

- The MIU was led by a matron and managed by a senior sister.
- At the time of inspection, the MIU matron was not present and this role was being temporarily covered by a band 7 sister and ward manager from a different department within the Kidderminster Hospital and Treatment Centre.

Minor injuries unit

- The MIU was part of the trust's medical division. We were not aware of regular meetings with divisional directors and there were inconsistencies in the visibility of the divisional leadership team. Staff told us they felt this was as a result of the two emergency departments on other hospital sites taking priority over the MIU.
- From discussions with staff it was clear that local leaders, such as the matron and the senior sister in the MIU, were visible within the clinical environment and dealt with complex situations when they arose. However, divisional and executive leaders were not visible within the MIU and some staff were unaware of who their divisional leaders were.
- We could not be assured that staff were able to escalate issues, risks and ideas to the divisional leadership team or that the divisional team were accessible to MIU staff.
- The senior sister regularly attended county wide MIU meetings which meant that learning was shared with MIUs across the county.

Vision and strategy for this service

- Staff we spoke with were aware and committed to delivering the trust's vision, values and focus.
- There was no documented strategy for urgent and emergency care across the trust.
- There was no strategy in place for the MIU and staff we spoke with were not aware of any plans to develop an MIU strategy.
- Staff we spoke with were aware of a regional reconfiguration plan within urgent and emergency care however, they were uncertain if this would have any impact on the MIU.
- We reviewed a copy of the trust's patient care improvement plan for emergency and urgent care. This was developed in 2015 with the aim of ensuring safe and responsive care and treatment. There were six work streams however, only one was applicable to MIU. This was in relation to ensuring that 95% of patients received an initial assessment or triage within 15 minutes. The progress report dated November 2016 showed that none of the work streams had completely achieved the improvements in safety and responsiveness that had been planned.
- Staff told us that as of January 2017, the MIU would not triage patients and instead patients would be streamed by a band 3 health care support worker. However, we did not see any documentation of discussions about this in divisional meetings and a risk assessment had not been completed.
- We saw evidence of a robust succession plan for the next band 7 post along with an information folder of how to complete daily, weekly and monthly tasks.

Governance, risk management and quality measurement

- We did not see evidence of performance monitoring, quality measures or incidents being discussed relating to the MIU in any divisional meetings. Whilst senior nursing staff in the MIU understood some quality measures, we were not assured that there was oversight at a divisional level.
- Management meetings and mandatory training usually took place at Worcestershire Royal Hospital. On our previous inspection in July 2015, we found there to be an element of disengagement between the trust and the MIU. From discussions with staff we were not assured that this issue had been addressed. Staff we spoke with told us they felt they were the 'poor relation' to Worcestershire Royal Hospital and there was not always an MIU representative present at management meetings.
- There were very few formal processes in place to monitor and review aspects of performance to identify areas of good practice and areas for improvement, such as time to initial assessment. However, effective governance and performance management had not yet been established. For example, there was a lack of oversight and visibility of divisional managers and we saw no evidence of performance being discussed at divisional meetings.
- Staff we spoke with were aware of where to find up to date information on the unit's performance and this was usually displayed in the staff break room. However, we found there was a lack of monitoring of compliance to protocols, such as escalation processes. For example, senior staff in MIU had not identified and escalated issues, such as fridge temperatures and out of date equipment.
- The MIU did not have a local risk register. There was a divisional risk register for the medicine division where emergency medicine risks were recorded. Staff were aware of the one risk that related to the MIU on the risk register associated with the security of the department.

The unit had identified there was a risk that aggressive and violent service users may result in patients and staff being abused and/or harmed. Actions had been taken by the MIU manager to mitigate the risk and security had improved since the unit was last inspected in July 2015.

- There was a lack of understanding and oversight of the risks that could impact on the delivery of good quality care. Additional risks we found on inspection had not been identified by senior nursing staff in the MIU. Therefore, not all risks had been recorded on the risk register and consequently, mitigating actions had not been implemented. For example, oversight of medicines and equipment management within the unit had not been reported as a risk on the register or escalated to appropriate staff.
- There was no formal programme for clinical or internal audits to measure patient outcomes. Lack of clinical audits was highlighted on the July 2015 inspection and we did not see any improvements. This meant that there was no systematic programme of clinical and internal audit used to monitor quality and to identify where improvements were required. We found this impacted on patient care, for example, children were not always assessed for pain and associated pain scores were not always documented. There were no audits in relation to pain relief given to children.
- Some guidelines were out of date. For example, ENP clinical presentation guidelines. Senior staff in the MIU were responsible for updating and implementing local guidelines and policies. There was no formal process to inform senior MIU staff when a guideline or policy was due to be reviewed and updated.

Culture within the service

- Staff were proud to work in the MIU and they valued and respected each other and their work. One ENP said "I love it here (MIU). Everyone works hard and it does not go unnoticed (by MIU local managers)".
- Staff we spoke with said they were able to raise concerns with their nursing managers and felt confident enough to do so.
- Staff raised concerns with their colleagues and senior staff within the MIU about abusive behaviour and were encouraged to report episodes of verbal and physical abuse towards staff as an incident.
- There was a strong sense of teamwork which encouraged candour, openness and honesty.
- Staff felt they had ownership within the unit as each member of staff was responsible for part of the running of the service. For example, one member of staff led on privacy and dignity, and another led on dementia. Staff members were able to attend meetings and events relating to their area of interest and then shared information with their colleagues.
- On our previous inspection in July 2015 we found some staff at all levels felt they were the 'poor relative' of the other two hospitals. Two members of staff we spoke with still felt there was disconnect between the MIU and the two other hospitals despite some staff working shifts in the emergency department on other sites.
- Senior staff told us the average registered nurse sickness rate was less than 1%. We formally requested evidence of this for the MIU however we did not receive it. The sister told us that the MIU staff were extremely proud of their low sickness rates.
- New members of staff felt welcomed and engaged in the unit.

Public Engagement

- Staff in the unit kept copies of patient feedback and compliments and displayed these on a staff notice board. The senior sister kept a record of informal complaints to understand themes and trends.
- The trust's website displayed live waiting time figures for the emergency departments and neighbouring MIUs. This meant that people knew how long they would have to wait if they attended and also if there were any alternatives to the emergency department.
- The trust had patient and carer involvement in a range of committees and forums. There was a patient and public forum which was tasked with completing PLACE (Patient-led assessment of the care environment) visits, involved in quality review visits and tested and commented upon information available to patients.

Staff Engagement

- The MIU staff attended team meetings but meetings were irregular. Staff discussed a range of topics such as medicines management, x-ray reports, staffing shift patterns and vacancies.
- On our previous inspection, we saw evidence of MIU staff developing a monthly newsletter however this was no longer in place. During inspection, we saw evidence

of weekly trust newsletters and bulletins detailing key information about the medical service. Examples included details of staffing changes, updates on complaints and incidents and learning opportunities.
- We were told that staff morale across the service was very good even when there were occasions when work pressure was high. We observed good interactions amongst the team and observed health care support workers providing effective support to ENPs.

Innovation, Improvement and Sustainability

- The MIU had recently started using an 'on the spot' tetanus immunity test. The test provided results of tetanus immunity within 10 minutes. This meant that staff could provide the most appropriate wound management according to the patient's immunity status.
- Since our previous inspection in July 2015, we saw some improvements. Improvements in the MIU included security arrangements and out of hour's security presence in the unit. Compliance with mandatory training had increased by 4% but still did not meet the trust target. Patient confidentiality had improved and treatment room doors were kept closed at all times during our inspection.
- Some elements of care had not been maintained since our July 2015 inspection. For example, resuscitation equipment was not fit for purpose, fridge temperatures were not within the correct range and some guidelines were out of date.
- We found there was still no formal clinical audit plan in place and no efforts had been made to improve the disconnect between the MIU and the trusts emergency department and to prevent MIU staff from feeling as though they were the poor relation as highlighted in our previous report.

Medical care (including older people's care)

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

Information about the service

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 serves 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.

We carried out a comprehensive inspection of Worcestershire Acute Hospitals NHS Trust from 22nd to 25th November 2016 as well as an unannounced inspection at Kidderminster Hospital and Treatment Centre on 8th December 2016.

At Kidderminster Hospital and Treatment Centre we inspected the Millbrook Suite, the renal dialysis unit and the endoscopy unit. The service had been previously inspected in July 2015 and had been found good for safe, effective, good, responsive and well-led. The hospital does not have any medical ward facilities.

We spoke with 16 members of staff including nurses, doctors, pharmacists, therapists, administrators, and housekeepers. We spoke with seven patients and relatives. We observed interactions between patients and staff, considered the environment and looked at eight care records. We also reviewed the trust's medical performance data.

Medical care (including older people's care)

Summary of findings

Overall we rated the service as requiring improvement for safety, effective and well-led. We rated the service as good for caring and responsiveness.

- Appropriate systems were in not in place for the management of controlled drugs within the endoscopy unit.
- Not all staff had had the mandatory training required, including safeguarding children's training, Mental Capacity Act 2005, Deprivation of Liberty Safeguards and insulin management.
- Safeguarding children training was below the trust target.
- Medical staffing levels did not meet the required levels which could place patients at risk.
- Although the trust assessed and responded to patient risk there were shortfalls in the completion of the World Health Organisations' Five Steps to Safer Surgery checklists.
- Not all staff had received an appraisal to evaluate their performance in delivering effective care and treatment.
- The leadership, governance and culture did not promote the delivery of high quality person-centred care.
- Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust
- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally.
- The environment was well maintained and there were reliable systems in place to prevent and protect people from a healthcare associated infection.
- Patient records were written and managed in a way that kept patients safe. Records seen were legible, and up to date.
- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Staff reviewed and assessed the patient's pain control, nutrition and hydration needs to ensure they met the individual's requirements.
- Services within the hospital were planned and delivered to meet the needs of local people.
- People were supported, treated with dignity and 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.
- Patients could access interpreters when required and information leaflets were available in braille or as audio tapes.
- The service had mechanisms in place which provided patients with additional support due to their complex needs.
- Concerns and complaints procedures were established. Information was available for patients regarding how to make a complaint.
- Nursing and medical staff were positive about the teams they worked in and the services they provided.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Overall, we rated safe as requires improvement because:

- Staff did not sign for each controlled drug after its administration. This contravened the "Safer Management of Controlled Drugs" which states that a record of administration should be made on the appropriate chart immediately by the administered person.
- Staff confirmed they did not see children at the hospital. However, the children's safeguarding training data for medical staff and nursing staff was below the trust target of 90% at 11% and 30% (level 2) respectively.
- The trust had set a target of 90% for completion of mandatory training. However, the records showed that medical staff had not reached its target with the exception of manual handling. This meant that medical staff may not the appropriate training to meet the needs of patients using the service.
- Nursing staff had not achieved the trust target of 90% for medicine management (27%). This meant that staff may not have the relevant qualification to manage the administration of medicines that met patients' needs.
- The endoscopy service were trialling the World Health Organisations' (WHO) 5 Steps to Safer Surgery checklists we found inconsistencies in three of the six records reviewed.
- There were high numbers of medical vacancies.
- There were not appropriate facilities for patients attending the endoscopy department to change comfortably as the changing room was dual purpose as a staff toilet.

However:

- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally.
- Safety thermometer audit results were shared with teams and reviewed by service leads to identify areas of poor compliance or areas in need of improvement.
- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from healthcare associated infection.
- The design of most areas and the maintenance of the facilities and electrical equipment ensured the safety of patients.
- All areas were visibly clean and tidy. Cleanliness was audited regularly and action plans devised to address any areas of concern.
- We found that patient's individual care records were written and managed in a way that kept patients safe. Records seen were legible, and up to date. Patient records were maintained in accordance with trust policy.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally. For example, the trust's policy and procures was used by staff when reporting incidents. These were completed through the trust's electronic reporting system.
- Staff understood their roles and responsibilities in the management and reporting of incidents. Staff said they were encouraged to complete incident reports on the trust's electronic reporting system. Nursing staff reported that they used reflective accounts to consolidate learning from incidents and were able to give accounts where this had happened.
- Staff used the trusts policy and procedures when reporting incidents. These were completed through the trust's electronic reporting system.
- Staff on the oncology suite confirmed they now received better feedback from external wards' meeting minutes regarding incidents.
- Incidents were discussed at staff meetings so shared learning could take place which was confirmed by staff we spoke with. Staff explained how two drug charts had been incorporated into one across the hospital as a result of lessons learnt from an incident. They confirmed the changes were discussed at team meetings and daily huddles.
- The trust reported no never events in medical services at Kidderminster Hospital and Treatment Centre from July 2015 to June 2016.Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systematic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- In accordance with the Serious Incident Framework 2015, medical care services reported 38 serious incidents (SIs) across the trust which met the reporting criteria, set by NHS England, from July 2015 to August 2016. The trust did not provided a breakdown of the SIs attributed to Kidderminster Hospital and Treatment Centre.
- 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. We saw guidance within the service, which staff could refer to.
- Staff understood their roles and responsibilities in relation to duty of candour. Nursing staff said they could openly discuss incidents and learning with patients when required.

Safety thermometer

- The service used the NHS Safety Thermometer (which is a national improvement tool for measuring, monitoring and analysing harm to patient's and 'harm-free' care). Monthly data was collected and displayed locally. Nursing staff spoken with were aware of these audits and how results were used to make improvements.
- Safety thermometer audit results within the endoscopy suite were shared with the team and reviewed by service leads to identify areas of poor compliance or areas in need of improvement.
- Staff described the content of the safety thermometer, its locations, how often it was updated and how it was used to improve the service.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection. For example, we observed all areas within the Millbrook suite to be clean and tidy.
- Staff adhered to the infection control policy and procedures and had access to sufficient personal protective equipment, such as gloves and aprons. For example; we saw hand gel was available at each bed space within the Millbrook suite.
- Senior staff for the areas visited confirmed that any patient with a potential infection were, if required, treated in a side room. There were processes in place for areas to be deep cleaned by the infection prevention control (IPC) team.
- 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.
- All staff involved in decontamination had access to and wore the appropriate personal protective equipment including aprons and gloves.
- Cytostatic medicines requiring incineration and contaminated cytotoxic waste, a bi-product of chemotherapy and radiotherapy treatment, was disposed of in accordance with trust policy in purple bags. Used needles and syringes following administration of chemotherapy were disposed of appropriately in purple lidded sharps boxes.
- The hospital participated in the "saving lives" audit which reviews infection prevention and control in the workplace. The results showed the hospital had achieved 90% compliance.
- We observed staff complying with 'arms bare below the elbow' policy across the services visited.
- We saw that "I am clean" stickers were used across all areas visited to inform staff and patients that equipment was appropriately clean for use. Equipment seen was labelled and dated for the day of inspection, signifying that all equipment had been cleaned.
- Patient led assessments of the environment (PLACE) in 2016 showed a standard of 97% in the Kidderminster Hospital and Treatment Centre for cleanliness which was slightly below the England average of 98%.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. 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 45-50 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.
- There were processes and procedures in place for tracking each endoscope which had been used; decontamination records were filed in the relevant patient notes to ensure that equipment could be traced including details of the staff members who were responsible for operating and decontaminating them.
- Patients attending endoscopy appointments identified as having suspected communicable infections were placed at the end of treatment lists to allow additional cleaning times between patients.

Environment and equipment

- The design of most areas and the maintenance of the facilities and electrical equipment ensured the safety of patients. There were systems and arrangements in place to review and check equipment.
- The Millbrook Suite's environmental audit for September 2016 had an overall score of 90%. They scored 91% for cleanliness, 85% for condition/ appearance of the environment and 100% for equipment cleanliness, safety and temperature of the environment. The area identified as a concern was the ventilation grilles within the toilets. We saw this concern had been reported. However, we were unclear if this had been addressed as there was no evidence of any outcomes identified within the action plan. We observed the waiting area within the Millbrook suite was clean, tidy and free from dust and clutter.
- Systems, processes and practices essential to keep people safe were identified, put in place and communicated to staff. For example, portable electric equipment had been service tested regularly to ensure it was safe for use and had clear dates for the next test date on them.
- Assessment had been carried out by the security lead and recommendations made which included a new security contract that had been agreed and commenced at the hospital in October 2016. Staff confirmed they were happy with the security arrangements at the hospital.
- The changing room for patients within the endoscopy suite was cramped and they had to change within a clinical room which doubled up as a staff toilet. This meant that it was constantly in use and staff often had to wait if they wished to use the facilities. Senior staff confirmed a business plan had been submitted for the restructuring of the endoscopy area environment. However, there was no date as to when this would be reviewed by the executive team.
- Nursing staff said there was adequate supply of equipment to meet the needs of the patients. All equipment we checked was labelled as being suitable for use.
- The endoscopy unit was well maintained with separate male and female recovery areas.
- Equipment used for endoscopy procedures was tracked through the cleaning and sterilisation phases, and stored in line with best practice.
- Within the endoscopy unit there was:
  - Designated and dedicated decontamination areas
  - Separate entry and exit points
  - Separate dirty, clean and storage areas
  - One-way flow for equipment
- Weekly cleaning audits were completed effectively within the endoscopy unit. No anomalies were noted.
- Endoscopes were stored so that residual fluid did not remain in the channels and they were protected from the risk of environmental contamination.
- All equipment we checked was labelled as being suitable for use. Nursing staff said there was adequate supply of equipment to meet the needs of the patients.
- Appropriate coloured disposal bags were used for clinical areas. General waste and recycling facilities were available to staff, patients and visitors.
- In order to maintain the security of patients, visitors were required to use the intercom system outside for example; Millbrook suite to identify themselves on arrival before they were able to access the area. Staff had the appropriate access codes.
- There were systems in place to ensure resuscitation equipment was checked and ready for use on a daily basis. Records indicated that daily checks of the equipment had taken place on all of the areas visited.

Medicines

- There were arrangements for managing medicines in most areas to keep people safe. However, within the endoscopy unit there were no clear processes or procedures for the management of controlled drugs.
- Within the endoscopy unit controlled drugs (CD) were located within the clinical rooms. Controlled drugs are prescription medicines which are controlled under the

Misuse of Drugs legislation. The drugs cupboard contained sedative agents and opioid pain medicines. On checking the CD register we found two patients who had received an opioid medicine within the last two hours did not have an administration or witness signature. One other patient had received a sedative agent and also had no administration or witness signature within the CD book. Staff confirmed they signed as witnesses once the consultant had administered the medicines. Both the senior clinical staff and the nurse in charge confirmed they only signed the CD book when their patient list had been completed. One senior medical staff confirmed this was not considered to be best practice but stated that due to the patient list it was easier to sign the list at the end of the clinic session. The department of health (DoH) "Safer Management of Controlled Drugs" states that: A record of administration should be made on the appropriate chart immediately after administration by the person who administered the CD. This should include the identity of the person, the dose administered and the time of administration. This was escalated to the matron who confirmed they were in discussions with pharmacy to establish when CD drugs should be signed out on the drugs register.

- There were two medicines fridges located within the Millbrook Suite. One was specified for chemotherapy usage which was kept locked. We found the chemotherapy fridge to be neat and clean with no issues or concerns identified. The fridge temperatures had been monitored daily and were within the recommended average temperature of between 2-8º Celsius.
- Within the clinical room all supplies were neatly stored and within date. All intravenous fluids were within date and correctly stored. The clinical room also had two basins, one for handwashing and the other for cleaning equipment such as drug administration trays. Both had soap and a paper towel dispenser.
- Emergency medicines for resuscitation were stored on dedicated trolleys which were available for immediate use. This included for example; a defibrillator in working order, an oxygen cylinder identified as being full, and a reusable resuscitator, all of which were in date. All other equipment was in date and per the checklist which had been completed and signed daily.
- The Millbrook Suite did not have any controlled drugs.
- We observed that all Intravenous fluids were stored securely.
- 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 any drugs.
- We looked at six patient drug charts. Arrangements were in place for recording administration of drugs and a coding system was used to explain any reasons why they were not administered.

Records

- We found that patient's individual care records were written and managed in a way that kept patients safe. Records seen were legible, and up to date. Patient records were maintained in accordance with trust policy.
- Systems, processes and practices that are essential to keep people safe were identified, put in place and communicated to staff.
- The oncology department had their own computerised medical record software package. However, this was not linked to any other computer system within the trust and any information such as doctor's letters had to be printed off and sent to the relevant source. Staff said they found this element of the system frustrating and time consuming. Staff also reported that the system failed most afternoons but they had systems in place to mitigate any risks. For example; pharmacy faxed prescriptions should there be a system failure.
- All services inspected had locked medical notes trolleys, which were located either at the nurse's station or at the entrance to the medical bays. This meant that patient's medical records were stored securely.
- All computer terminals were secure and locked to prevent non-authorised persons accessing patient information.

Safeguarding

- Staff understood their responsibilities and knew how to identify potential abuse and report safeguarding concerns. Health care assistants explained how they provided one-to-one care for patients who may require support during their visit to the hospital.

- Staff completed training on safeguarding through electronic learning and had a good understanding of their responsibilities in relation to the safeguarding of vulnerable adults.
- Safeguarding adults 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%.
- The medical service at Kidderminster Hospital and Treatment Centre confirmed they did not see children but said staff had completed their children's safeguarding awareness training. However, the data provided showed the safeguarding children level 2 completion rates were 11% which was below the trust target. We saw the hospital had implemented a rolling training programme in safeguarding for all medical staff. This meant that medical staff may not have the relevant qualification to meet the needs of other patients should they be relocated to other hospitals within the trust.
- Nursing staff had a training completion rate of 99% for Safeguarding Adults. However only 30% off staff had completed safeguarding children level two training. Senior staff confirmed they did not see children but were aware of the shortfall and we saw arrangements in place for staff to attend safeguarding e-learning. This was identified on the staff notice board and confirmed by staff spoken with.
- There were clear systems, processes and practises in place to keep patients safe. Staff knew who the named safeguarding lead for the service was and how to contact them for support. For example; safeguarding information, including contact numbers were on display on staff notice boards and staff knew how to access the trust policy on the intranet.
- The adult safeguarding lead confirmed that female genital mutilation (FGM) training formed part of the safeguarding children and safeguarding adults training at all levels. All new staff received FMG as part of their safeguarding level 1 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 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%. Medicine management had the lowest training completion rate of 27% 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.
- Health care assistants had personal folders with all of their mandatory training requirements within.
- Training levels were not recorded on the risk register but was being tracked through the trust patient care improvement plan (PCIP). 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.
- Training timetables were on display for example; on the endoscopy unit staff could clearly see what training was out of date. The matron confirmed they followed up staff members who had failed to complete their training, or were having difficulties.
- Staff spoken with said they felt training had much improved since the last inspection which included female genital mutilation (FGM) training.
- Unit 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

- Although the endoscopy service assessed and responded to patient risk there were inconsistencies in the completion of the World Health Organisations' (WHO) 5 Steps to Safer Surgery checklists.
- Staff within the endoscopy team confirmed they were trialling the WHO checklist. Although the trust had implemented the WHO checklist, there were inconsistences in how they are doing this. We reviewed six records and found inconsistencies in the completion of three records which included incomplete assessments. This was brought to the attention of senior management who confirmed they would address our

concerns at their staff meeting and daily huddles. This meant we could not be assured there were systems and processes in place to prevent avoidable mistakes which may place patient's welfare at risk.

- The services visited had appropriate systems and process in place to identify, assess and respond to deteriorating patients' needs as required. Comprehensive risk management plans were developed in line with national guidance. The service used the National Early Warning Score (NEWS) system for identifying and escalating deteriorating patients. We reviewed four NEWS charts and found these were completed appropriately.
- All staff confirmed that should a patient's clinical condition significantly deteriorate they would either call the 999 emergency services or the internal 2222 crash team. This meant that staff were aware of the processes should a patient deteriorate whilst at the hospital.
- We saw copies of the control of substances hazardous to health (COSHH) risk assessments within the endoscopy unit 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.
- We reviewed eight sets of patients' notes and found there was a robust system in place for clerking new patients. When appropriate, clinical treatment pathways were in use, and the templates included relevant assessments.
- Although the service did not have Joint Advisory Group accreditation, they took into account the British Society of Gastroenterology's quality and safety indicators for endoscopic procedures when assessing and responding to patient risk.
- Staff knew how to access the management of violence and aggression policy and confirmed they had received training in conflict resolution and personal safety.

Nursing staffing

- The trust utilised the safer care nursing tool for their staffing levels and dependency reviews alongside the National Institute for Health and Care Excellence staffing guidelines which helped the hospital to support safe staffing acuity levels based on the patients' needs.
- Actual staffing levels were comparable to the planned levels for the services visited. The units displayed their planned and actual staffing numbers at its' entrance. Senior staff confirmed these were changed regularly to reflect the actual number of staff on duty. We observed previous duty rosters, which confirmed staffing levels were appropriate to clinical need.
- As of August 2016, Kidderminster Hospital and Treatment Centre reported a vacancy rate of 9% in medical care.
- The hospital turnover rate as of August 2016 was 9% within the medical service. Millbrook Suite reported the highest turnover rate of 24%. A turnover rate of 0% was reported for dermatology and the pain services.
- For the period April 2015 to March 2016, Kidderminster Hospital and Treatment Centre reported a sickness rate of 8% in medical care. This was greater than the trust rate of 5%. Dermatology and Millbrook suite had an absence rate of 14% and 10% respectively. The pain services had a sickness rate of 1%.
- From September 2015 to August 2016, Kidderminster Hospital and Treatment Centre reported an overall bank and agency usage rate of 1% in medical services which was lower than the trust target of 6%. The highest agency and bank usage was on the Millbrook suite (3%).
- The records seen showed agency staff were correctly inducted to the units to ensure they were aware of layout and team working and were supernumerary during this time. Checklists were used to ensure that the induction had been completed appropriately.

Medical staffing

- The records showed that staffing levels and skill mix had been planned and reviewed to ensure patients received safe care and treatment at all times. This was in line with relevant tools and guidance where available.
- As at September 2016, Kidderminster Hospital and Treatment Centre reported a vacancy rate of 38% in medical staffing which was higher than the trust target of 32%. The turnover rate of 50% in medical staffing which was higher than the trust target of 28%.
- From April 2015 to March 2016 the Kidderminster Hospital and Treatment Centre reported a sickness rate of 0%.
- From September 2015 to August 2016, the hospital reported a bank and locum usage rate of 41%. This was higher than the trust average usage of 27%.
- The proportion of consultants (42%) reported to be working at the trust was higher than the England

average (37%). Middle career (5%) and registrar doctors (28%) was lower than the England average of 6% and 35% respectively. Junior doctors (25%) working across the trust was higher than the England average of 21%.
- The service had a recruitment and retention strategy to review their staffing requirements. Senior medical staff confirmed they were actively recruiting to the vacant positions.

Major incident awareness and training

- The trust's winter plan for 2016/2017 summarised how the trust would provide an integrated approach to the delivery of 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 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.
- There were procedures for managing major incidents, winter pressures and fire safety incidents on the trusts' intranet which staff could easily access.
- Staff on the renal and endoscopy units described what they would do if they had to undertake a fire emergency evacuation of patients.

Are medical care services effective?

Requires improvement

Overall, we rated effective as requires improvement because:

- The hospital did not participate in any clinical outcome audits to support how the medical services were performing against trust with similar services.
- We saw no evidence to confirm dialysis staff had received the appropriate training and had the relevant competencies to attend to these patients.
- Not all staff had received an appraisal to evaluate their performance in delivering effective care and treatment.
- No nursing staff had undertaken additional insulin training as a result of the never event that occurred at the Alexandra Hospital. This meant that should any nursing staff be transferred to another hospital within the trust they may not have the relevant qualification.
- Only 41% of staff within the medical service had completed their Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. This was not in line with the trust target of 90%.

However:

- Patient's care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- Pain control was effectively managed with referrals to specialist advisors for additional support and treatment plans.
- Staff reviewed and assessed the patients' nutrition and hydration needs to ensure they met the patient's individual requirements.
- There was evidence of effective multidisciplinary team working within the service.
- Ad-hoc weekend service was provided by the endoscopy unit to manage the waiting list initiative.
- Staff had access to all information required to review patient's conditions and plan safe care and treatment.

Evidence-based care and treatment

- Policies were relevant and provided evidence-based guidance, based on current national standards, best practice recommendations and legislation and could be accessed by all staff via the trust's intranet system. These were used to develop how services, care and treatment were delivered. This included guidance such as National Institute for Health and Care Excellence (NICE).
- Assessments for patients were comprehensive, covering all health needs for example; clinical, mental health, physical health, and social care needs. Patient's care and treatment was planned and delivered in line with evidence-based guidelines.
- We saw evidence that all patients were reviewed by consultants. Medical and nursing records supported assessments and treatment plans devised during consultant reviews.

- All staff demonstrated awareness of trust policies and guidelines, which were available on the intranet. We saw within the renal unit different folders for different conditions which were based on NICE guidelines.
- 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 WHO checklist.
- We saw effective treatment planning recorded in nursing and medical notes for the implementation of care and treatments in line with national guidance. For example, we reviewed eight patients' records from the chemotherapy and endoscopy unit and found that the information captured and treatment implemented was in line with national guidelines.
- Patients who had received chemotherapy were provided with a telephone contact number as well as advice regarding any side effects or any signs or symptoms post chemotherapy.

Pain relief

- Staff confirmed they assessed, managed and recorded the patient's pain levels. Pain management commenced in the pre-assessment clinic where actions to deal with pain management were discussed. The effectiveness of pain relief was by using the pain scale within the National Early Warning Score (NEWS) charts.
- The patient's records showed that pain had been assessed and appropriate medicines prescribed and the effect of analgesia, if required, individually evaluated.
- Staff said that any concerns with pain control were referred to the consultant who re-assessed the patient and amended the medicine as required.
- Patient controlled analgesia (pain relief) used for some patients post-operatively was available. Staff said they had sufficient quantities to meet the needs of the patients.
- Staff had access and contacted the pain team as required. Staff confirmed the pain team were supported and provided advice.
- During our inspection, we observed staff asking patients about their pain. Three patients said they had been offered pain relief and felt their pain was being managed appropriately.

Nutrition and hydration

- Staff reviewed and assessed the patients' nutrition and hydration needs to ensure they met the patient's individual requirements.
- There were processes in place to identify and support patients that needed assistance with eating and drinking. Where applicable patient's nutrition and hydration intake had been recorded. Patients were offered drinks to promote hydration.
- We saw that oral fluids and sandwiches were offered to patients undertaking treatment at the Millbrook suite. Patients had access to tea, coffee and a cold drink throughout the day.
- Patients on the endoscopy unit were provided with a cup of tea or coffee and a biscuit after their procedure to aid recovery.

Patient outcomes

- The hospital did not participate in any national clinical audits or be involved with any research.
- We were given no evidence to demonstrate the trust participated in UK Renal Registry (UKRR) outcomes which analyses and reports on data from renal centres across the United Kingdom which would provide guidance to the trust so that they are able to benchmark their findings against other renal centres.
- The hospital carried out a "saving lives" audit which reviewed infection prevention and control in the workplace. The results showed the hospital had achieved 90% compliance.
- We saw the renal department had key performance indicators which were based on the renal association guidelines (accredited by the NICE). These outcomes included; water testing, machine testing, looking at blood trends, the recommended time on dialysis and how long a patient was on dialysis. The results were overseen by the renal consultants and discussed at the monthly quality meetings. We found no issues or concerns highlighted.
- The trust participated in the National Cancer Patient Experience Survey 2015, which was published in July 2016. Patients were asked to rate their care on a scale of zero (very poor) to 10(very good). The trust achieved a rating of 8.7. For example; Between October 2015 and March 2016, 1,278 eligible patients from the trust were sent the survey, and 888 questionnaires were returned completed. This represented a response rate of 70%, which was better than the national rate of 66%. For example; 86% (496) patients said they were always

treated with dignity and respect and 87% (841) patients said they were given the name of a clinical nurse specialist who would support them through their treatment.
- The hospital did not have Joint Advisory Group (JAG) on Gastro Intestinal (GI) endoscopy accreditation. However, senior staff within the unit stated that they were aiming to gain accreditation in 2017 and were looking at how they were going to monitor their outcomes in line with the guidelines set out by JAG.

Competent staff

- Staff had the appropriate qualifications, skills, knowledge and experience to deliver effective care and treatment. However, not all staff had received an appraisal to evaluate their performance in delivering effective care and treatment.
- From April 2016 and August 2016, 79% of staff within the medical service across the trust had received an appraisal compared to a trust target of 85%. Appraisal rates for medical staff had declined from 83% in April 2015 to 75% in March 2016. However, appraisal rates for non-medical staff had improved from 76% to 82% during the same period.
- Senior staff said they were aware of the shortfall in staff appraisals and were currently developing a programme to manage this. All staff spoken with confirmed they had received their annual appraisals.
- We saw no evidence to confirm dialysis staff had received the appropriate training and had the relevant competencies to attend to these patients.
- There was a rolling programme for the management of sepsis training. The records showed most staff at the hospital had completed their training in September 2016.
- Following a never event that occurred at the Alexandra Hospital additional training in the administration of insulin was rolled across the services. The Kidderminster Hospital and Treatment Centre did not have any medical wards and the records showed that from December 2015 to November 2016 no nursing staff had undertaken this training. However, 91% of senior staff had completed their training which included; sister/ charge nurses 100%), specialist nurse practitioners (100%) and staff nurses (88%). This meant that should nursing staff be transferred to provide care at another hospital within the trust they may not have the relevant qualification to meet the needs of patients.
- All chemotherapy staff within the hospital had completed their competencies which included the knowledge of cytotoxic therapy such as chemotherapy and radiotherapy, the safe management and administration of cytotoxic drugs within the clinical area, and the treatment of clinical symptoms.
- All staff within the Millbrook suite had completed their Immediate Life Support (ILS) training.
- All health care assistants at the Millbrook suite had completed their "taking blood" training.
- All new staff attended a trust induction programme that covered topics such as the trust values, information governance and clinical skills such as basic life support. We saw evidence that the medical induction training included topics such as infection control, values and behaviours and clinical informatics. Staff we spoke with confirmed they received adequate inductions.
- We saw that nursing staff within specialist clinical areas had additional competencies to ensure they were able to manage patients safely. For example, nursing staff within the Millbrook suite had competencies in the administration of cytotoxic drugs and the management of intra-peritoneal (thin tissue that lines the abdominal cavity and surrounds your abdominal organs) catheters.
- Within the trust, nurses had been offered planned study sessions and open drop in sessions arranged by the trust professional development nurse. They attended local team meetings as requested by staff. The trust also had an intranet page which provided further information and links to the Nursing and Midwifery Council (NMC).

Multidisciplinary working

- All necessary staff, including those in different teams and services, assessed planned and implemented patient care. Medical records detailed an admission treatment plan and were amended according to clinical findings and patient condition.
- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team working practices that delivered coordinated care to patients.
- There was an escalation policy for patients who required immediate review.
- The renal department conducted monthly multidisciplinary meetings which included consultants, names nurses and a dietitian, to discuss patients and any identified concerns.

- Staff reported good multidisciplinary team working, with effective links to specialist services such as tissue viability, infection control and diabetes specialist nurses. Nursing staff told us that they knew how to contact specialists and felt supported by them.
- Nursing staff told us that relationships with medical staff and other professionals were inclusive, positive and promoted multidisciplinary working. The matrons reported that the working relationship with the speciality consultants was very good.

Seven-day services

- The chemotherapy and renal unit provided a weekday service from 9am to 5pm. There was no plan to increase the service to seven days a week.
- Staff within the endoscopy unit confirmed they conducted ad-hoc weekend clinics in order to reduce the number of patients on the waiting lists. This was in line with the waiting list initiative. Senior staff confirmed all additional clinics were run through the goodwill of the nursing team as they did not use agency staff.

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.
- Patients' records were kept in similar locations in each clinical area. The records were stored in locked trolleys within the units.
- All clinical staff had access to hospital computers, which were password protected. During inspection, we observed that all computers were locked when not in use and no patient identifiable information was left unattended.
- Staff accessed diagnostic results such as blood results and imaging to support them to care safely for patients when required.
- 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.
- Patients' records included the endoscopy equipment used during clinical procedures alongside details of the staff which completed the procedures. This meant that all equipment was traceable.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood consent and how patients were supported to make decision as required by legislation and guidance, including the Mental Capacity Act (2005).
- The hospital had a consent policy that staff were familiar with.
- Staff confirmed awareness of the Mental Capacity Act 2005 (MCA) which they said was relevant should a patient attend any of their clinics with reduced capacity or a diagnosis of for example dementia.
- Most staff understood the concept of Deprivation of Liberty Safeguards (DoLS) and could give examples of where the safeguards should be applied or considered. Staff said they would seek advice from a senior member of nursing staff should a formal assessment require completing.
- However only 41% of staff had completed MCA and DoLS training. There was a rolling programme which was evident on the training schedule within the staff rooms
- Staff understood consent, decision making requirements and guidance. The hospital had four nationally recognised consent forms in use. Staff said they would seek advice from a senior member of nursing staff should a formal assessment of mental capacity require completing. 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 and another for procedures under a local anaesthetic. During our visit to the chemotherapy garden suite we observed staff obtaining and completing consent form 1 (patient agreement to investigation or treatment).
- Staff understood when to use the forms and whether the consent being 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 are read a verbal version of a consent form such as an information sheet and give their verbal consent rather than a written consent.
- Staff within the endoscopy unit confirmed they uploaded patient consent electronically prior to their procedure. This was confirmed in the records viewed.

Medical care (including older people's care)

- 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 were consented by the consultant using consent form four prior to any endoscopic procedures.
- We saw the appropriate consent forms completed within the endoscopy unit.

Are medical care services caring?

Good

Overall we found the service good for caring because:

- Patients and their relatives were treated with kindness, dignity, respect and compassion whilst they received care and treatment.
- Patients and relatives were included in decision-making and were assisted to make informed decisions about care and treatments.
- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them both emotionally and socially.

However:

- The Friend and Family Test (FFT) response rate for medical care at the hospital was 23%, which was worse than the England average of 26% between August 2015 and July 2016.

Compassionate care

- Patients were treated with kindness, dignity, respect and compassion whilst they received care and treatment.
- The Friend and Family Test (FFT) response rate for medical care at the hospital was 23%, which was worse than the England average of 26% between August 2015 and July 2016.
- We saw that staff respected their patients, their individual preferences, habits, culture, faith and background. During a visit to the oncology suite we observed good rapport between staff, the patient and their relative when explaining what they were doing.
- We observed staff being courteous over the telephone and when discussing patients between staff members.
- Patients reported that staff asked how they preferred to be addressed, and spoke to them appropriately. We observed staff using the "hello my name is" campaign. The aim of the campaign is to improve compassion in care and the patient experience within the hospital.
- We saw staff speaking with patients in a respectful way, engaging and laughing with patients.
- We saw that staff closed curtains and doors, where appropriate, to protect patients privacy. Patients told us that staff always respected their privacy and dignity.
- Nursing and administration staff ensured patient confidentiality was maintained at all times and were observed asking patients permission to share information with family members, seeking quiet rooms to hold conversations and covering medical records to prevent them being read by unauthorised persons.
- Most patients and carers we spoke with told us that they were happy with the care they received. One relative commented, "The nurses are lovely"; another said, "staff are friendly and always happy."

Understanding and involvement of patients and those close to them

- Patients and relatives said they were involved and understood their care, treatment and condition.
- Patients told us they had been given opportunities to discuss their treatment and the risks and benefits involved with their consultant, and felt actively involved in decision-making.
- Patients were involved in making choices around their care within their pathway. For example, a patient told us that staff talked to them about the treatment options available and supported them in their decision. Another patient told us that they had felt very anxious about their procedure and they were not sure if they wanted to proceed. Staff took time to have a further discussion with them going over the options for treatment ensuring they fully understood what was involved.
- Staff communicated in a way that patients could understand and was appropriate and respectful. Staff ensured that patients fully understood plans, taking time to explain treatment processes and what to expect. This enabled patients to be involved with making choices and informed decisions about their care and treatment.

- We saw evidence that families were involved in patient care. Those relatives we spoke with confirmed that they understood the treatment plans of their loved ones and had been included in decision-making.
- Patients described how informative both medical and nursing were. They confirmed they were able to ask questions and had been told how their illness or injury might improve or progress. Patients said that they had everything "explained" to them and "what to expect both after and during the treatment."

Emotional support

- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them both emotionally and socially.
- Patients at the Millbrook suite confirmed they were happy with the service provided especially as their relative could attend with them for support.
- Patients reported caring and attentive staff that were respectful and showed kindness
- We observed how staff appeared to understand and show how they supported the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital. Staff knew how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- Patients and their relatives told us the clinical staff were approachable and had "no complaints about the care" received.
- Staff confirmed patients who required support for conditions such as depression were offered counselling and could make referrals to counsellors to support each individual patient's needs.

Are medical care services responsive?

Good

Overall we found the service requires improvement for responsive because:

- Services within the hospital were planned and delivered to meet the needs of local people.
- There were systems in place which enabled patients to have timely access to initial assessments, diagnosis or urgent treatment.
- The service had mechanisms in place which provided patients with additional support due to their complex needs.
- Patients could access interpreters when required.
- Information leaflets could be made available in different languages, audible tapes or braille as required.
- Additional waiting lists were organised across the service to ensure patients received timely treatment.
- Patients within the oncology service had access to a 24 hour service helpline to support their needs.
- The hospital had systems in place to ensure that patients, relative and/or their representative knew how to make a complaint or raise concerns.

However:

- Patient complaints were not responded to in line with Trust policy.

Service planning and delivery to meet the needs of local people

- Services within the hospital were planned and delivered to meet the needs of local people.
- The services provided reflected the needs of the population. For example; the Millbrook Suite provided patients with a positive experience in relaxed and comfortable surroundings.
- The hospital did not have Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation. We saw a copy of the business plan to be presented which would meet the JAG 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. This meant the service had recognised the need of the local people and were looking to upgrade the facilities and premises which would be appropriate for the services that were planned and delivered.
- Patients at the Millbrook Suite said they felt all their needs were being met by the service. Relatives

confirmed the service was flexible and their relatives were provided with choice. This meant the service had reviewed the continuity of care which best met the needs of the patient.

Access and flow

- There were systems in place which enabled patients to have timely access to initial assessments, diagnosis or urgent treatment.
- Across the trust there were a significant number of patients waiting for a colonoscopy (a test that allows the examination of the inner lining of your large intestine (rectum and colon). The trust had a waiting list initiative to manage the risk which included additional clinics occurring at weekends. Staff confirmed they were aware of these and had participated in weekend working as appropriate. Three patients spoken with said they had not waited very long for an appointment, only a few weeks and could not fault the system.
- Patients attending the chemotherapy clinics had access to a 24 hour helpline to support patients with any issues or concerns which was provided by the acute oncology service. This helpline was based on the haematology ward at Worcestershire Royal Hospital. We observed patients being provided with leaflets outlining this service.
- Senior staff confirmed all patients were reviewed and treatments for patients with most urgent needs were prioritised. Patients at the Millbrook suite and the endoscopy service said they had waited only a short time for appointments. One patient said they had been seen within three weeks.
- Patients confirmed their appointments had been flexible to suit with their day to day lives and their accompanying relative.
- None of the patients spoken with had had their treatment cancelled. Senior staff confirmed cancelled treatment rarely happened as all clinics were prearranged with the appropriate cover.
- We saw the staff in the reception area at the Millbrook Suite kept patients informed of any delays to the service running time. We observed staff notifying patients of any delays on their visit to the service.

Meeting people's individual needs

- Services at Kidderminster Hospital and Treatment Centre were planned to take into account the needs of different patients.
- We observed that disabled patients could easily access the hospitals. Additional wheelchairs could be obtained if required to support the patient on their journey to their appointment. All clinical areas were accessible for wheelchair users and disabled toilets were available in public areas.
- Patients who required additional support to be involved in their care and treatment had access to language interpreters, sign language interpreters, specialist advisors and/or advocates as required. Staff knew how to access an interpreting service and said they were usually ordered in advance due to having prior knowledge of the patient's appointment.
- Patient leaflets could be translated into different languages which also included audible tapes and braille.
- Patients who visited the chemotherapy unit and oncology unit had access to refreshments and magazines whilst undertaking their treatment.
- Patients on the Millbrook Suite said they were able to order a snack such as a sandwich during their appointments. Staff confirmed they would obtain the snack to meet the cultural needs of their patients when required.
- Patients requiring additional support due to their complex needs for example, those living with dementia or learning difficulties were given extra time for their appointments.
- Patients had access to a chapel and multi faith room on site.

Learning from complaints and concerns

- The hospital had systems in place to ensure that patients, relative and/or their representative knew how to make a complaint or raise concerns.
- From September 2015 to August 2016 there were 19 complaints about medical care services at the hospital and it took an average of 35 days to investigate and close complaints. This was not in line with their complaints policy, which states that 90% of complaints should be closed within 25 days. Waiting times accounted for 32% of all complaints received whilst clinical treatment and access to treatment or drugs accounted for 26% and 16% respectively. However, the records showed that as at the end of August 2016, there were two complaints still open, one in July and another in August 2016.

Medical care (including older people's care)

- We saw literature within the services visiting outlining how people could make a complaint. Posters on display referred complaints to the patient advice and liaison service (PALS).
- Staff knew how to raise concerns about a wrongdoing in their workplace and demonstrated how they could access the whistleblowing policy on the trust's intranet.
- Patients spoken with were aware of the complaints process and knew how to raise concerns. All said they were more than happy with the service provided and had no issues or complaints.
- We saw many complimentary letters and thank you cards on display within the services inspected.

Are medical care services well-led?

Requires improvement

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

- Staff reported that senior management and the executive team rarely visited the service and that communication from them was not always timely.
- Staff were unaware as to how key objectives would be achieved within the service.
- Nursing staff, although aware of the risk register, had no knowledge of the content or how to access the information.
- Staff within the service did not feel respected and valued.

However:

- Local leaders had the necessary skills, knowledge, experience and integrity needed to manage the services.
- All staff delivered good, safe and compassionate care and were proud to work for the trust.
- Most staff knew of the trust's values and strategy for the service.
- Staff worked collaboratively, and supervising staff provided support and advice.
- The trust gathered the views of patients and used this to shape and improve the service.

Leadership of Service

- Local leaders were visible and approachable and managers understood some of the challenges at a local level within the medical service.
- Staff said they felt that local leadership had the necessary skills, knowledge, experience and integrity needed to manage the service.
- Nursing staff reported that the local clinical leads encouraged development and took ownership of the services provided.
- Staff said that more input from senior management would be beneficial and felt they rarely visited the service. Staff also had very little awareness of who the senior nursing team was within the trust.
- 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 the course had enabled them to learn from each other's experience and share ideas on how they should be managing clinical areas.
- Local senior staff understood the challenges to good quality care and could identify the actions needed to address them which included the recruitment of additional doctors.
- Nursing staff reported that clinical leads within specialities were visible and easily accessible. Nurses said that doctors were responsive to their needs and always available to help with patients care.
- Clinical leads and matrons told us that they were proud of their teams and recognised that staff worked hard within their roles.
- Staff reported that communication from the trust executive team was not always timely although they felt this had improved since the implementation of new management.
- Staff felt they had good training and development opportunities and found their managers friendly and supportive.
- We observed staff working well together and supporting each other. They told us that they were proud to work for the trust.
- Recruitment events had been planned for the next 12 months rotating around the trusts' three sites. The trust said they were working alongside NHS professionals (NHSP) regarding targeting increase of staff numbers on their books. Fortnightly recruitment events around the trust had been planned.

- We were told that buddy trust arrangements were in place with some nearby trusts and this had helped strengthen governance.
- Staff confirmed the managers supported them in their role. During our inspection, we found matrons available in various clinical areas communicating with both staff and patients.
- Staff on the Millbrook suite had quarterly team meetings with minutes sent to all absent staff.

Vision and strategy for this service

- The trust had a clear vision and a set of values which placed patients at the centre of their care.
- The trust's values were based on PRIDE which were:
  - Patients at the centre
  - Respect for everyone
  - Improve and innovate
  - Dependable
  - Empower
- Most staff showed awareness of the trust's values and were able to direct us to posters within the hospital.
- The service had clear aims and objectives for their continued development which included the redevelopment of the endoscopy area in order to obtain Joint Advisory Group (JAG) accreditation.
- Medical services had key objectives to support the overall trust operation plan. However, staff confirmed they did not know how these objectives would be achieved. This meant that communication was not effective and had not been disseminated to the staff team.
- Governance, risk management and quality measurement
- The trust had a governance structure, which included 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 observed minutes from these meetings during 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, the incorrect recordings of administered controlled drugs. This meant the trust did not have adequate systems in place to monitor these issues.
- The trust had a risk management strategy to ensure it complied with its statutory and NHS duties. This ensured the service delivered was safe and as effective as possible to manage the risks identified. However, we found no evidence the strategy had been disseminated to staff at team meetings.
- There was an inconsistent approach to governance and risk management within the medical specialities. We found poor oversight of outcome measures and audits.
- The divisional risk register highlighted risks across medical services and actions were in place to address concerns for example failure to meet National Institute for Health and Care Excellence guidelines. We saw the divisional risk register identified key areas for the service such as staffing levels. Staff across the service acknowledged that recruitment of qualified and experienced medical staff was a risk.
- Senior staff knew there was a risk register but had limited knowledge of the content or how to access the information.
- 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, staff spoken were unaware of these and felt information had not been cascaded to them.
- Each speciality group 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. Areas reviewed included; incidents, infection control, key performance indicators and patient feedback.
- Staff had a clear understanding of their roles and understood what they were accountable for and to whom.

Culture within the service

- Staff within the service said they did not feel respected and valued. Most staff stated they felt they were treated as "second class" as opposed to the other hospitals within the trust and did not feel supported by senior management.
- There was evidence of collaborative working across the units visited and a shared responsibility to deliver good patient centred care.
- All staff spoke positively about the clinical areas they worked in. This included clinical and non-clinical staff.

- Teams were observed working collaboratively, with support and advice being given when necessary. Nursing staff supporting new staff members. We observed staff being supervised completing tasks. Time was taken by supervising staff to explain processes and procedures to ensure they were fully understood.
- There was an open and transparent culture within the service where staff were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.
- Nursing staff were very positive about the contributions they made to patients' health and wellbeing. This was particularly evident in their care of elderly patients visiting the endoscopy and chemotherapy units.
- There was effective multidisciplinary working within the service, which involved patients, relatives, therapists, and nursing staff working together to achieve good outcomes for patients.
- Patients acknowledged a positive and caring culture within the services and were happy with their care.
- 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.

Public engagement

- Staff within the endoscopy and chemotherapy services recognised the importance of gathering the views of patients and actively sought comments and feedback on the services provided.
- The trust had recently embarked on a plan to co-produce a refreshed patient and public engagement strategy. The aim of the programme is to build a stronger and more dynamic collaboration with patients, and public by developing the way the trust works and communicates with the communities and partners it serves. However, staff said they were unaware of the strategy or of its implementation.
- The trust informed us they supported patient and carer involvement in a range of committees and forums. We saw the public forum was tasked with completing the patient-led assessments of the care environment visits which involved; quality review visits and test and commenting on patient information.
- The trust worked alongside a range of voluntary agencies including; Age UK, Worcestershire Health and Care Trust and Healthwatch. The trust actively gathered and acted on the feedback provided from these stakeholders in order to shape and improve the services and culture.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received

Staff engagement

- 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.
- We saw effective team working across all clinical areas. The links between administration staff, nursing staff and the unit nurses in charge were observed to be very strong, with staff offering support to each other regularly. Nursing staff reported that individuals performed beyond the requirements for their role.
- All nursing and medical staff told us that clinical leads were dedicated to their roles and the development of the service.
- During inspection, we observed evidence of regular team meetings and weekly trust newsletters and bulletins detailing key information about the service. Examples included details of staffing changes, updates on complaints and incidents and learning opportunities.
- We were told that staff morale across the service was very good even when there were occasions when work pressure was high. We observed good interaction and camaraderie amongst the teams.

Innovation, improvement and sustainability

- Staff within medical services recognised the importance of gathering the views of patients and actively sought comments and feedback on the services provided.
- The trust had recruitment events planned for the next 12 months rotating around the trusts' three sites. The trust said they were working alongside NHS professionals (NHSP) regarding targeting increase of staff numbers on their books.

Medical care (including older people's care)

- A dedicated helpline was available for haematology and cancer treatment patients.
- Following the last inspection the trust had made improvements in the following:
  - The reporting of incidents to ensure lessons learnt were cascaded to staff
  - The responding of complaints within the agreed timeframe
  - The use of the risk register as a tool to identify and monitor emergency and existing risks
  - Support mechanisms for senior nurses, including a development programme
  - Responding to patient complaints in a timely manner
- The trust had made some progress with the following:
  - The recruitment and retention of nursing staff in order to maintain patient safety
  - The compliance with mandatory training
  - The management of the administration of medicines
  - Ensuring that staff received annual appraisals

Surgery

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

Information about the service

Surgery services provided by Worcestershire Acute Hospitals NHS Trust are located on four sites; Worcestershire Royal Hospital is the main site, with Alexandra Hospital, Kidderminster Hospital and Treatment Centre and Evesham Community Hospital as additional sites.

Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre were visited as part of the inspection process and each location has a separate report. However, services on all four hospital sites are run by one management team. They are regarded 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 in the reports.

Kidderminster Hospital and Treatment Centre had four theatres and two treatment rooms. The surgical ward had 12 individual rooms for patients, although had the capacity for 18 patients if ever this was required. There was a separate theatre admission area and second stage recovery area for day case patients.

From April 2015 to March 2016 there were 15,700 admissions; with over 90% of these were day case surgery. There were no emergency cases carried out at Kidderminster Hospital and Treatment Centre. The main specialities covered at Kidderminster Hospital and Treatment Centre were, trauma and orthopaedic, ophthalmology, general surgery, ear, nose and throat (ENT), oral and maxillofacial, vascular, breast, urology, paediatric surgery, and surgical dermatology.

We visited all surgical services at Kidderminster Hospital and Treatment Centre as part of this inspection, and spoke with 20 staff on the ward, day surgery and in theatres including nurses, health care assistants, doctors, consultants, therapists and department managers. We spoke with four patients, and reviewed four 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 good for caring, and requires improvement for safe, effective, responsive and well-led because:

- Patient outcomes were generally below the England average and not all staff were aware of patient outcomes relating to national audits or performance measures.
- Medical notes were not always locked away safely.
- There were a number of medical and nursing vacancies; 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) for the trust was consistently below the England average of 80%.
- The number of cancellations of operations was higher than the national average across the trust.
- Mixed sex accommodation breaches had not been reported.
- Patients were not always offered a choice about where they were discharged to, for continuing care.
- Managers did not have clear oversight of mixed sex breaches or the need to report them in line with national guidance at the time of the inspection.
- Staff reported the executive team were not visible in their areas.
- Staff survey results indicated deterioration from the previous year.

However, we found:

- There was a positive culture of incident reporting and staff said they received feedback and learning from serious incidents.
- Medical staffing was appropriate. There was an on-site Resident Medical Officer to cover services seven-days a week.
- 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.
- The was a good consent process.
- The service had an effective complaints system in place and learning was evident.
- There was support for people with learning disability and reasonable adjustments were made to the service. An interpreting service was also available.
- Staff were caring, kind and compassionate to patients' needs. Patients spoke very highly of the care they had received.
- Patient's pain, nutrition and hydration were appropriately managed.
- The governance framework had improved since our last inspection.
- 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 number of vacancies for nursing staff in surgery. Safe staffing levels were being achieved by the use of bank and agency staff.
- Patient medical notes were not always locked away securely.
- 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.
- Not all staff had completed mandatory training.
- Safeguarding children training was very low and below the trusts target.

However, we found:

- 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.
- Staff followed the trust policy on infection prevention and control.
- 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 new pressure ulcers, 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 clean with an 'I'm Clean' sticker placed on to it.

Incidents

- Staff understood their responsibilities to raise concerns, 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 was one serious incident reported via the Strategic Executive Information System (STEIS), from October 2015 to September 2016. The serious incident reported related to out of date surgical screws used during a surgical procedure. A full investigation had taken place and the company confirmed the screws were still suitable to be used. Staff were able to describe changes that were made as a result of learning from incidents to prevent reoccurrence, these included monthly stock rotations and monthly stock checks.
- There were no never events reported at Kidderminster Hospital and Treatment Centre 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.
- During the last inspection, it was reported that from April 2014 to May 2015 there had been 18 grade three pressure ulcers. During this inspection, nine pressure ulcers grade had been reported by the surgical division 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.
- 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

were told that duty of candour had been applied following the implementation of some surgical screws that were out of date, the patient had been informed by the consultant and a letter had also been sent to confirm the conversations and action taken by the trust.
- We saw that each surgical speciality held regular mortality and morbidity meetings. Individual cases were discussed and lessons learned, such as checking discharge medication, ensuring blood test 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 patient 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, which included Kidderminster Hospital and Treatment Centre, that there were nine pressure ulcers, nine patient falls, and 13 reported urinary catheter related infections. There were no new MRSA infections in the past year.
- Venous thromboembolism (VTE) assessments were recorded. This was compliant with guidance from the National Institute of Health and Care Excellence (NICE 2010) for reducing the risk of VTE in adults.

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. For September 2016, we saw that 85% of nursing staff had completed their training in infection prevention and control against a trust target of 90%.
- There were specific cleaning schedules in place. Cleaning staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor.
- We observed staff followed the trust's policy regarding infection prevention and control. This included being 'arms bare below the elbow' and staff were compliant with hand washing.
- Hand hygiene gels were available throughout the ward and theatres. We observed all staff using alcohol hand gel when entering and exiting the wards.
- Personal protective equipment, such as gloves and aprons were available in sufficient quantities and used appropriately.
- 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 97%. Actions taken included, treatment of lime scale on taps and ensuring cleaning wipes were available for mobile computers.
- There were 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 or Clostridium difficile on the surgical ward.

Environment and equipment

- The ward, day surgery areas and theatres were spacious and well-lit and corridors were free from obstruction to allow prompt access. Some areas had stickers on the floor to indicate the correct place to store equipment.
- 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 available 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 had stickers with dates to show this had taken place.
- The airflow systems in theatres were revalidated regularly by an external organisation and met standards set out in the national guidance, Health Technical Memorandum (HTM) 03-01: Specialised Ventilation for Healthcare Premises. Data provided by the trust showed theatre ventilation validation and maintenance had taken place in November 2016 and was fully compliant.
- Sterile services for theatre equipment was provided by Alexandra Hospital. Staff told us they received a good service and had enough equipment.
- 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

- Daily pharmacy support was supplied by the Alexandra Hospital pharmacy team, with an out of hour's on-call pharmacist service.
- The pharmacy team visited the ward weekly 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.
- During the last inspection, it was reported that medication in one theatre had been drawn up for a patient and left in the anaesthetic room. During this inspection we did not find any drugs left unattended and found that medication was managed safely.
- Medicines were stored in a secure temperature controlled area near the nurse's station. We saw records of the daily checks of ambient temperatures in the medicines storage area 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 one occasion the fridge temperature was higher than the acceptable temperature range and all drugs were replaced.
- 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 kept 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 drugs 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.
- 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.

Records

- Medical notes were in good order and information was easy to access.
- We reviewed four sets of nursing and medical records and found they were legible, accurate, and up to date.
- Records included details of the patient's admission, risk assessments, treatment plans, and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- On the ward, the nursing and medical notes were stored in a locked trolley to ensure patient confidentiality and was easy for staff to quickly access.
- In the second stage recovery area, notes were left on shelves unattended at times. Therefore we were not assured of the security of the notes and that patient confidentiality was maintained 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 patients 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 of the safety of the notes and 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 accessible 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 prevention and control, fire, moving and handling and health and safety. Some training was delivered via face-to-face sessions and others were available electronically.
- There was an induction programme for all new staff.
- The trust's 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% compliant from August 2015 to August 2016. Observational audits had also been carried out, which highlighted the need to improve staff engagement with this process and that all theatre staff involved in the surgical procedure should be present at team brief. We observed the five steps to safer surgery being used correctly.
- Patients for elective surgery attended a preoperative assessment clinic where 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.
- 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.
- Patients were checked at regular intervals using an 'Intentional rounding' tool, which enabled staff to manage individual care needs, such as ensuring the had access to drinks. The checks included the use of a Waterlow risk assessment tool to estimate risk for the development of a pressure ulcer.
- The National Early Warning Score (NEWS) was used to identify deteriorating patients in accordance with NICE clinical guidance CG50.
- Staff used the NEWS in accordance with NICE clinical guidance CG50, 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 four sets of patients' notes and found NEWS charts were being used to record patients' vital signs and staff were aware 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.
- Staff told us they were aware of the trust sepsis policy and some had recently attended sepsis awareness training.
- There was a resident medical officer (RMO) on site 24 hours a day who was available for advice and support. There was also an on-call consultant for surgery who could be contacted for support. There were no emergency theatres available out of hours; patients would be transferred to either the Alexandra Hospital or the Worcestershire Royal Hospital if required. From May

2016 to November 2016 there had been one patient that required transferring to Worcestershire Royal Hospital and returned to surgery, this was reported as an incident.

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.
- There was a 7% vacancy rate within the surgical division at Kidderminster Hospital and Treatment Centre.
- The planned and actual staffing numbers were displayed on the ward. 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. Two agency staff had worked in theatre in the last 12 months and the use of agency staff was rare on the ward. Staff were able to work in all inpatient areas and would cover if there was shortage of staff to ensure patient safety. The ward manager or sister in charge was supernumerary and could also help with unfilled shifts.
- Theatre staff had been trained in different techniques which enabled them to provide cover for absences. Staff were trained to work in a variety of areas within theatres such as scrub roles, recovery roles and anaesthesia roles; some were able to work in all three areas.

Surgical staffing

- In September 2016, the trust reported a 10% consultant vacancy rate and a 27% vacancy rate for other medical staff grades. Medical staffing vacancies were on the surgical risk register and 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 was higher than the England average of 44%.
- There was a RMO on site 24 hours a day and an on call consultant for surgery who could be contacted for support.
- 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 services within the trust including surgical services.
- Staff gave examples of when the major incident policy would be used, for example loss of services or in the event of fire.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- 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.
- Local audits were not carried out to monitor patient outcomes.
- Not all staff had received an annual appraisal.

However:

- The trust participated in some national audits, for example the Patient Reported Outcome Measures which overall showed the trust was similar to the England average 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 was consultant-led and the resident medical officer was on site 24 hours a day.
- 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). Patient's 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. However, there were limited local audits undertaken which measured patient outcomes.
- 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 trust followed the NICE 2010 for reducing the risk of venous thromboembolism in adults. Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based. From July 2015 to July 2016, VTE compliance was 96%.
- The pre-operative assessment clinic assessed and screened patients in accordance with NICE guidance: Routine preoperative tests for elective surgery (NG45) 2016. For example MRSA screening and essential blood tests.

Pain relief

- Our observation of practice, 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.
- Patients we spoke with told us that their pain was managed effectively and staff had taken time to discuss pain and offer medication if required.
- There was a 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 who were available for advice. Staff told us they could access the acute pain service for advice.

Nutrition and hydration

- Patient's nutrition and hydration status was assessed and recorded using the Malnutrition Universal Screening Tool (MUST). During the last inspection it was reported that this was not consistently completed. During this inspection, we found up-to-date MUST assessments completed 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.
- We reviewed four sets of notes and we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- Day surgery patients were offered drinks and snacks post operatively.
- Depending on the type of surgery they were undergoing, some patients were given a pre-operative drink. The purpose of this drink was to aid the patient's recovery following their operation.

Patient outcomes

- Surgical procedures undertaken at Kidderminster Hospital and Treatment Centre were all elective with 90% being day case surgery. No emergency surgery was undertaken at Kidderminster Hospital and Treatment Centre.
- During the last inspection, there was no evidence on how information was cascaded and shared at all levels of the organization to improve care, treatment and people's outcomes. During this inspection, we found staff were still unaware of patient outcome results following audits and this information was not shared with staff.
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROM) programme and the National Joint Registry. However there was no local audit programme to measure patient outcomes.
- 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.
- From March 2015 to February 2016, patients at the trust had a lower expected risk of readmission for elective admissions.

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. 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 felt well supported and adequately trained within their departments.
- Newly qualified nurses were supported through a preceptorship programme, which offered role specific training and support. Nursing and theatre staff were offered opportunities to rotate within the surgical departments to improve their skills and knowledge.
- Junior doctors within surgery reported good surgical supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- During the last inspection, it was reported that appraisal rates were below the trusts target of 85%. During this inspection, we found appraisal rates were 80% and below the trust target for staff working within the surgical division at July 2016.
- 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 worked collaboratively to understand and meet the range and complexity of people's needs.
- The staff who worked in theatres, the ward and day surgery recently commenced a daily huddle at the beginning of the theatre lists to ensure effective communication, staff would raise any concerns about patient care, equipment, medication and cancelled cases. We observed the daily huddle which was quick, efficient and relevant information was shared between the teams. Staff told us they felt supported and that their contribution to overall patient care was valued.
- Patient care on the ward was supported by teams from a variety of disciplines including physiotherapists, pain team and pharmacists.
- We observed a good working relationship between nursing staff and doctors.

Seven-day services

- Consultant presence at Kidderminster Hospital and Treatment Centre ended when the theatre lists had been completed. Although ward staff were able to contact consultants if there were any issues with their patients.
- There was a Resident Medical Officer for the hospital on site 24 hours a day and visited the ward daily.
- Theatres operated on week days generally between 8am and 6pm, although lists often went beyond this time. There were booked Saturday and occasional Sunday lists to help with patient waiting times.
- Pharmacy, pain teams and physiotherapy services were available at weekends on an on call service out of hours.
- Physiotherapist would work at the weekend if required and when booked theatre list were planned.
- Imaging services were not available out of hours, if patients required urgent x-rays or scans out of hours they would be transferred to Worcestershire Royal Hospital or Alexandra Hospital.

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 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 the surgical division, 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. Staff on the ward told us they would refer the patient to the ward manager or resident medical officer to carry out any assessments. This was confirmed by the ward manager.
- Consent to care and treatment was obtained in line with legislation and guidance, including the MCA.
- 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/procedure and they were completed in full (they contained details of the operation/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.

Are surgery services caring?

Good

We rated caring as good because:

- Staff were caring and compassionate to patients. 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 provided 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 trolley space and doors were closed to patients' rooms. Patients we spoke with told us that staff treated them with respect. However patient privacy and dignity was not always maintained in the theatre admissions area. Patient that were undressed in theatre gowns and dressing gowns waiting for surgery could be seen by other people and those of the opposite sex and by patients and visitors in the waiting area.
- Staff responded promptly to patients' needs such as pain, discomfort, and emotional distress in a timely and appropriate way.
- Patients told us that they had managed to rest and sleep.
- Comfort rounds (where nursing staff regularly check on patients every few hours) were undertaken and recorded.
- From September 2015 to August 2016, the Friends and Family Test had a 22% response rate, which was lower than the England average of 29%. Over 90% of patient would recommend the hospital to friends and family.
- We received positive comments from the patients and relatives we spoke with about their care. Examples of their comments included 'this is an excellent hospital I always choose to come here', 'you can trust the staff, they are always friendly' and 'I was feeling anxious, but the staff have talked to me and explained everything, so I feel better now'.

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 been to see them following their surgery and explained their diagnosis. 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 nurses, doctors and therapists introducing themselves to patients and explaining to patients and their relatives about the care and treatment options.
- Relatives were encouraged to sit with their loved ones in the second stage recovery area to listen to the discharge information.

Emotional support

- 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 patient's needs. They often came onto the ward to speak with patients.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The admitted referral to treatment time (RTT) was consistently below the England average of 80%, in all specialities at 68% apart from ophthalmology which was 86%.
- The number of operations cancelled across the trust and not treated within 28 days was 14%. This was higher than the national average which was 6%.
- Theatre utilisation was 61%.
- Mixed sex accommodation breaches had not been reported.
- Patient were not always offered a choice about where they were discharged to for continuing care.
- Not all information leaflets and consent forms were available in other languages.

However:

- Service planning met the needs of the local people and the community.
- The average 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.
- There was a dedicated theatre list for people with learning disabilities.
- Arrangements were in place to support patients living with a dementia.
- Patients received a 24 hour post discharge telephone call.
- An interpreting service was available and used.
- Complaints systems were effective.

Service planning and delivery to meet the needs of local people

- The service 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.
- Patients admitted for surgical procedures at Kidderminster Hospital and Treatment Centre had to meet a certain criteria and be relatively fit and well. Patients needed a body mass index (BMI) under 40 and an ASA score no higher than ASA two. ASA scores are assessed by anaesthetists following the American Society of Anaesthesiologists (ASA) physical status classification system. ASA scores range from one to six. ASA one is a normal healthy patient; health and wellbeing reduce as the ASA number increases.
- 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 2015 to August 2016 was 61%: staff told us there was capacity to undertake more surgery.

Access and flow

- During the last inspection, it was reported that some patients were not able to access services for assessment, diagnosis or treatment when they needed to. There were frequent delays and cancellations. In 2015, the number of surgical patients trust wide whose operation was cancelled on the day of surgery and were not rebooked to be treated within 28 days was 20%. During this inspection there were 14% of patients whose operation was cancelled at the last minute across the trust which was worse than 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 apart from daily monitoring.
- 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.
- The ward was staffed to manage 12 beds. However, up to 18 patients could be accommodated if required. During our inspection we saw that five patients would be staying overnight, staff told us these low numbers were not unusual.
- 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 requiring emergency surgery out of hours would be transferred to either the Alexandra Hospital or Worcestershire Royal Hospital. Consultants in each speciality were on call at night and weekends and facilitated any emergency procedures as necessary. Staff told us they did not have any concerns with accessing the on call teams to transfer patients. From May 2016 to November 2016 there had been one patient that required transferring to Worcestershire Royal Hospital and returned to surgery, this was reported as an incident.
- Patient privacy and dignity was not always maintained in the theatre admissions area, where we observed mixed sex accommodation breaches. Patients that were undressed in theatre gowns and dressing gowns waiting for surgery could be seen by other people, those of the opposite sex and by patients and visitors in the waiting area. We raised this with the senior managers at the time of the inspection, who told us there were plans to redesign the area to ensure privacy and dignity was maintained and to prevent mixed sex breaches. However, they were unsure of when the redesign would commence. From 1 December 2010, NHS organisations are required to submit data on the number of occurrences of unjustified mixing in relation to sleeping accommodation. Sleeping accommodation includes areas where patients are admitted and cared for even where they do not stay overnight. It therefore includes all admissions and assessment units. This was not on the trusts risk register. The trust had not reported these as mixed sex accommodation breaches.
- The average length of stay (LOS) for elective treatment for the trust was similar to the England average LOS.

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 learning disabilities. 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 patients would be offered longer pre-operative assessment appointments and carers could stay with the patient longer on the wards.
- The hospital had a dedicated theatre list for patients with learning disabilities requiring dental treatments. There was a specialist nurse present and carers could stay with the patient throughout their journey.
- Theatre staff arranged for carers to accompany the patient to theatre when they had specific needs such as a learning or sensory disability.
- Day case patients would receive a post discharge 24 hour follow up telephone call from nursing staff, to check the patients wellbeing and to respond to any questions the patient may have.
- 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.
- 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.
- Patient information leaflets were available in all clinical areas such as wound care, pain management and skin care. Leaflets were not available in other languages.

Learning from complaints and concerns

- 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 clinical areas, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- From November 2016 to November 2016, there were 26 complaints relating to surgical services at the Kidderminster Hospital and Treatment Centre, 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?

Requires improvement

We rated well-led as requires improvement because:

- Managers did not have clear oversight of mixed sex breaches or the need to report them in line with national guidance at the time of the inspection.
- Staff reported the executive team were not visible in their areas.

However,

- The governance framework had improved since the last inspection. However we found that senior managers were still not cited on all local risks.
- There were regular staff meetings at all levels and information was shared with staff.
- Most staff were aware of the trust's values.
- Local department leadership was good and matrons, ward and theatre managers were visible and supportive to staff.
- There was evidence of patient and staff engagement.

Leadership of service

- The surgical services division was led by a divisional medical director, divisional director of operations and divisional director of nursing. We met some of the management team and they were dedicated to their roles and responsibilities.
- The surgical services at Kidderminster Hospital and Treatment Centre were led by a ward manager and theatre manager who provided day to day leadership to staff members. There was a matron on site who staff found to be responsive and supportive.
- We observed the ward, day case area and theatres were well managed with good strong leadership. The local management teams were responsive, accessible and available to support staff during challenging situations and staff felt they looked after their welfare.
- Junior surgical doctors reported that consultant surgeons were supportive. Junior doctors told us they felt well supervised by consultants.
- Most staff were aware of the trust's chief executive officer (CEO) and the chief nurse. However, they had not seen them visit their area.

Vision and strategy for this service

- The trust's values were Patients, Respect, Improve, Dependable, and Empowered (PRIDE) and 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, we found that plans for a countywide management of emergency surgery were not fully implemented. During this inspection, we found these had still not been implemented and not all staff were aware of these plans. As a result of this staff were confused about the county wide plans, such as which

surgical services each hospital would provide. Some senior staff had raised concerns about lack of engagement, planning and decision making with the surgical leaders and trust board.
- There was no clear county wide strategy for surgical services. We saw a surgical division control plan for 2016/17 which had identified risk areas within the surgical division and priorities. This included vacancies, referral to treatment times and theatre utilisation. Each risk had a specific action plan for example reviewing of job plans and weekly monitoring of theatre utilisation.
- The hospital had plans to review the patient admission area to help maintain patient privacy and dignity. The plans were waiting to be reviewed by the surgical division.

Governance, risk management and quality measurement

- The trust had a clear 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 and ward managers attended divisional meetings, which enabled the sharing of information across specialities and the four hospital sites. However, we found that despite these improvements, senior managers did not have oversight of all risks.
- Surgical services had regular divisional quality governance meetings with management representation including consultants, matrons, and directorate managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed. Staff from Kidderminster Hospital and Treatment Centre would attend these meetings.
- The theatre and ward manager held team meetings to cascade information. We saw minutes of meetings where items such as incidents, complaints and staff training were discussed. The ward manager had recently implemented an electronic newsletter to share information with staff such as training, complaints, incidents and audit results.
- Managers did not have clear oversight of mixed sex breaches within the theatre admissions' area or the need to report them in line with national guidance at the time of the inspection. This was not on the risk register.
- The theatre and ward staff held some joint meetings and occasionally ward staff would attend the theatre staff meetings.
- 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, waiting times and inadequate pre-operative services. We saw action plans were in place such as daily monitoring of waiting times and utilising ward staff to assist with pre-operative assessments.

Culture within the service

- Staff were enthusiastic about working at Kidderminster Hospital and Treatment Centre. They also felt respected and valued.
- Staff we spoke with worked well together as a team, and said they were proud to work at the Kidderminster Hospital and Treatment Centre site.
- We saw there was a good culture within the surgical division, staff communicated well, worked together and helped each other. For example, there was a joint huddle meeting between the ward, day surgery and theatres every morning to share information.
- 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, were 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.
- The Kidderminster Hospital and Treatment Centre League of Friends charity group ran a coffee shop and charity shops to raise funds for the hospital.

Staff engagement

Surgery

- 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 work on addressing work related stress, improve recruitment and retention and improve the culture.

Innovation, improvement and sustainability

- The breast unit worked in partnership with a breast cancer charity, which provided free complementary therapy for breast cancer patients, 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.
- The governance framework had improved.
- There were 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:

- There were still a number of vacancy rates for nursing and medical staff .
- Staff said there no clear strategy for a county wide surgical service. County wide management of emergency surgery had not been fully implemented.
- The admitted referral to treatment time (RTT) was consistently below the England average of 80%, in all specialities at 68%, apart from ophthalmology which was 86%.
- Cancellations of operations trust wide remained high at 14% compared to the national average of 6%.
- Patients were not always offered a choice about where they were discharged to for continuing care.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology outpatient services provided by Worcestershire Acute Hospital NHS Trust (WAHT) are located on three hospital sites, the Worcestershire Royal Hospital (WRH), Alexandra Hospital (AH) and Kidderminster Hospital and Treatment Centre (KHTC). Services at WRH and AH are reported on separately. However, services on all sites are run by one maternity and gynaecology management team. They are regarded within the trust as one service, with some of the staff working across the different sites. For this reason it is inevitable there is some duplication contained in the three reports.

KHTC forms part of WAHT trust. The maternity and gynaecology services provided are; antenatal and gynaecology outpatients clinics, a maternity assessment unit and gynaecology treatments. These include colposcopies, dilation and curettage, sterilisation, laparoscopic hysterectomy and other laparoscopic procedures. All gynaecology and obstetric outpatient clinics and the maternity assessment unit are in one purpose built department. Gynaecology in patients are cared for on either Ward 1(a general surgical ward) or on the surgical day case unit. Obstetric investigations include pregnancy scans and amniocentesis. There is no labour suite or facilities to give birth at this site and no early pregnancy unit.

Additional information about the inspection of operating theatres can be found in the surgical section of the KHTC report.

In July 2015 the Care Quality Commission carried out an inspection which highlighted some areas of concern. These included poor compliance with mandatory training, different compliance targets for trust wide and midwifery specific mandatory training, targets which were often not met. Clinics were often cancelled at short notice due to medical staff shortages. Staff did not know there was a strategy for the maternity and gynaecology service; however, staff were able to tell us about the trust wide strategy.

We visited the hospital during our inspection of the trust on 22 to 25 November 2016. We looked at the facilities and the environment, spoke with five members of nursing and midwifery staff, six service leaders, three patients and looked at five sets of patient records. We considered policies, collected data about the services provided, and patient outcomes.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

- Environmental checks were inconsistent. Systems for monitoring equipment safety were not robust.
- Limited use of local audit meant that some outcomes with regards to patient safety, care and effectiveness were not fully understood. This was especially noticeable with regards to documentation and assessment.
- Compliance with mandatory training modules remained below the trusts target of 90%.
- Multiple sets of patient notes led to gaps in information in some records that we saw.
- Senior leaders were not always visible and some had limited capacity due to multiple roles.
- New pathways were not dated or referenced with up to date evidence.
- Staff had a poor understanding of female genital mutilation, child sexual exploitation, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Leaders had told us that all staff had been trained in these areas.
- Medical staff vacancy rates in obstetrics and gynaecology were above the national average, leading to cancellation of clinics.
- There was no awareness, amongst staff, of major incident plans or roles that individuals would take should there be a major incident.
- Midwives were not rotated to different areas, potentially resulting in loss of some skills.

However:

- All staff considered patients' needs, were respectful and caring in their interactions.
- Staff were valued and respected. There was open and honest communication between staff and managers. Local leaders were visible and approachable.
- Divisional leaders had a clear vision and strategy for maternity services.
- Incident, comments and complaints processes were thorough; lessons were learned and disseminated well. However, the target to complete these was often missed.
- Nursing and midwifery leaders were always available on the telephone or email.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Not all incidents were investigated and closed with within the trust's own target time of 20 days.
- There was lack of oversight with regards to safety of equipment and the environment.
- Local surgical site infection audits were not routinely carried out.
- Local hand hygiene audits were not regularly carried out.
- Good hand hygiene practice was not embedded amongst staff.
- Record keeping audits were not routinely carried out.
- Not all staff were up to date with mandatory training.
- Staff had a poor understanding of female genital mutilation and child exploitation.
- Not all staff were up to date with safeguarding training or had an awareness of all safeguarding issues. However, we were told that the service aimed for 90% compliance by March 2017.
- Vacancies were at 24% vacancy rate in doctors for the service.

However:

- When incidents had been investigated, lessons learned were shared.
- Midwifery teams ensured safe staffing levels at all times.
- Safety measures were recorded and used to inform areas for improvement.
- Patient assessment tools were comprehensive and thorough.
- Medications were safely stored.

Incidents

- Staff we spoke with understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them. Staff were confident in using the trust's electronic reporting system and gave examples of incidents that they had reported, for example, not having received discharge data about a patient.
- Between October 2015 and September 2016, the trust reported no never events for maternity and gynaecology. Never events are serious incidents that are wholly preventable, where 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.
- The trust introduced a standard to investigate and close incidents within 20 days that had been reported in May 2016. Incidents were allocated to a specific manager to investigate, report and feedback on. In the maternity and gynaecology services, 67% of incidents were dealt with and closed within 20 days. Policy dictated that the division monitored compliance every two weeks and would write to individuals whose incidents were open for over 20 days.
- Mortality and morbidity meetings were not formally minuted. In addition, there was no information arising from this meeting. This meant that there was a lack of documented learning.
- Most staff we spoke with knew about the duty of candour. However, they were unable to tell us in detail about the process involved. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, came into force in November 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.
- Two serious incidents that we reviewed had undergone thorough investigations, and had associated reports and recommendations with time specific actions in place. Duty of candour had been applied. In both incidents, patients had cancer diagnosis delayed after their results were overlooked. One recommendation was development of an automated pathology alert system for the escalation of abnormal results.
- Lessons learned from incidents, comments or complaints were used to inform and improve services. For example, a recent incident had occurred where blood samples had not been correctly labelled before

being sent to the laboratory for testing. This meant that they could not be used and the patient had to have a repeat test. The incident was investigated, causes found and measures put in place to help prevent future similar occurrences.
- Lessons were shared through weekly newsletters that were emailed to staff, in team meetings and when necessary, by individual discussion and support.

Safety thermometer

- The maternity safety thermometer is a national tool that has been designed to measure commonly occurring harms within maternity care. It integrates measurement for improvement into daily routines and supports advancement in patient care. The maternity safety thermometer prompts data collection on the following harms: maternal infection, perineal trauma, post-partum haemorrhage, term babies Apgar scores (a simple assessment of how a baby is doing at birth, which helps determine whether the baby requires additional medical assistance), term baby treatment, mother and baby separation and women's perception of safety. In maternity outpatients and the community, there was no maternity safety thermometer in use.
- A maternity dashboard was in use that gave information about various safety measures as well as outcomes and responsiveness of the service. This was up to date. Senior staff we spoke with used some of this information to monitor and improve safety. For example, weekly monitoring by the governance team had reduced the number of incidents that remained open. An email prompt was sent out if targets were not being met.
- There was no specific gynaecology safety thermometer because patients are treated in mixed speciality wards. Safety thermometers are reported on a ward level, not speciality. For gynaecology inpatients, please refer to the surgery part of this report.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean. The design and use of facilities and premises allowed ease of cleaning and maintenance.
- Waste disposal was managed appropriately with different types of waste and laundry separated. Sharps boxes for the disposal of needles were assembled and dated.
- Taps which were not in constant use had a flushing schedule to prevent infection such as legionella thriving. A robust system was in place to ensure that this was done as required.
- All fridges we saw had temperature checks daily. These were all within safe limits for storage of items.
- Standards of cleanliness and hygiene were maintained most of the time.
- Personal protective equipment was available for staff to use in all areas we visited.
- There were no MRSA or Clostridium difficile cases reported in the maternity services in the year to November 2016.
- There had been 2254 gynaecology procedures performed at the hospital in the year to November 2016. However, there had not been an audit of surgical site infections within the gynaecology department. This meant that there was a lack of awareness with regards to how many women may have had surgical site infections in this speciality.
- In the antenatal and gynaecology outpatients, maternity assessment unit and early pregnancy assessment unit (EPAU) staff complied with the "arms bare below the elbow" policy. However, when we observed staff moving from one area to another they did not always decontaminate their hands.
- Hand hygiene audits carried out in May and July 2016 showed 100% compliance with recommended practice.
- All pregnant women were offered the influenza (flu) vaccination and pertussis (whooping cough) vaccination during their antenatal appointments after 20 weeks gestation. We saw posters displayed in the antenatal clinic emphasising the importance of the vaccines.
- For gynaecology inpatient services please refer to the surgery section of this report.

Environment and equipment

- The flooring in the all areas we visited was non-slip and in good condition.
- Resuscitation equipment in the antenatal clinic area was examined. We found two cylinder valves that required safety testing. In addition, an emergency box containing medicines had been unsealed and not returned to pharmacy for checks and resealing. This meant that we were not assured that the medicines had not been tampered with or removed and not replaced.
- Throughout the outpatients department some equipment was out of date or requiring evidence of up

to date safety testing. This included three lamps, two fans, one set of scales for weighing babies, one set of scales for weighing adults, two sonic aids (for listening to a baby's heart), cleaning fluids, mercury spillage sets and a box of blood collection bottles. We raised this at the time of inspection and staff immediately took action to rectify all the issues we found.

- One window in the department, accessible to patients, did not have a restrictor attached, which meant that patients could be at risk of falling out of the window.
- Daily cleaning schedules were in each room in the department; however, not all were complete or up to date.
- In the room used for urodynamics, we found a cupboard where various cleaning items, patient gowns and other clinical items such as paper roll were piled up and not stored properly or safely.
- A bag containing items of clinical equipment, which could have been used in an emergency if a patient suddenly went into labour, was found in the maternity assessment unit. A list of contents was with it. The list did not have a place where it could be dated or signed by anyone checking the contents. This means that we were not assured that the contents had been checked, when or by whom. There were bags of intravenous fluids in the side pockets of the bag that could be tampered with because the bag was neither tamper proof nor stored securely.
- One scanning room had multiple notices on the walls which were on paper and not washable.
- In each consulting room in outpatients, there was appropriate washing and hand hygiene facilities.
- Cardiotocography (CTG) equipment for monitoring a baby in the uterus and scanning equipment was maintained and serviced by the manufacturer in accordance with the contract.
- The department was spacious and light. The room temperature in the department was comfortable at 21 degrees Celsius.
- Detailed and thorough environment audits were carried in December 2015, March and July 2016. They showed that in December 2015 the department scored 92%, in March 2016 89% and in July 83%. Despite the score deteriorating, in each report there were different areas that had poor scores. Some areas for improvement were through wear and tear, for example, scuffs on paintwork and some were for human factors, such as fire doors being propped open. Each area for improvement was allocated to a responsible department and reported to an individual named person. However, there was no evidence that any action had been taken to bring about improvements since July 2016.

Medicines

- Please see the surgical section of this report for inpatient and day case patients.
- There were arrangements in place for managing medicines and medical gases. Medicines were stored securely in lockable cupboards.
- No controlled drugs were kept in the antenatal and gynaecology outpatients departments.
- Medicines were stored according to the temperature limits set by the manufacturers.
- An improvement plan was in place and on display that provided learning points to staff. This was part of trust wide learning from incidents. One example reminded staff to, "Ensure medicines are stored in line with trust guidelines."

Records

- Records were not always accurate, up to date and complete. They were however, legible and stored securely. Maternity patients were issued with patient held maternity record at their booking appointment. If a patient attended a clinic in the hospital, a paper, hospital obstetric record was used to record the details of the appointment. Any tests results, such as blood tests or scans, were filed in the hospital obstetric record. A copy was sent to the community clinics and then given to the patient for insertion into their patient held records. If a patient had risk factors identified, or highly confidential information in the record, a pink envelope was inserted in the front of their hospital records to store sensitive information and to alert the relevant member of staff to any specific issues. There were two electronic records systems in use. One was for recording information about patients seen in any other part of the hospital, for example by a cardiologist. The other was a system used in maternity when monitoring a woman and her baby either as an outpatient or an inpatient. The quantity of record keeping systems was a known risk and had been highlighted in our previous inspection. However, the trust still had this recorded as a risk to the safety of patients, with a limited plan for improvement in place.

- Hospital records not in use were stored safely in locked cabinets in a locked room. Records for clinics were in a locked trolley.
- We viewed five sets of hospital records in the maternity outpatients department. All records were legible, signed and dated where required. However, some assessment information had not been transferred from the patient held records to the hospital records. For example, local policy dictates that; "women must be asked twice during their pregnancy if she is or ever has been a victim of domestic violence". This is based on the domestic violence and abuse: multi-agency working public health guideline [PH50] (2014). In none of the records was there evidence of the second domestic violence question having been asked. In one set of records, there were incomplete assessments on the first page of the assessment records. For example, there were minimal personal details, next of kin contacts and allergy details.
- In one set of records, we saw how a doctor had recorded that they had reviewed electronic records in conjunction with a paper obstetric record, and discussion with the patient which gave enough information to plan care.
- There was no record keeping audit performed by the outpatients and community midwifery services. This meant that there was no awareness of how well records were kept over time and by different teams or individuals.
- Personal child health records or "red books" were issued to parents following the birth of their baby in hospital. Red books were issued to parents who had home deliveries by the community midwives.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The trust set a target of 90% for completion of mandatory safeguarding training. Nursing staff within maternity and gynaecology exceeded the trust target of 90% for safeguarding adults although completion rates for safeguarding children level 2 (44%) and safeguarding children level 3 (51%) did not meet the trust target.
- Medical staff within maternity and gynaecology had not met the trust target of 90% for any of the three safeguarding training modules. Training for safeguarding adults had a completion rate of 86%. Safeguarding children level 2 had a 0% completion rate and safeguarding children level 3 had a completion rate of 19%. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) 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.
- An action plan was in place to ensure compliance with safeguarding training. This 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. Plans were in place for all medical staff to be booked on 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.
- Some staff told us that they were booked onto safeguarding training in the coming weeks.
- A safeguarding named midwife, who also had responsibility for other vulnerable patients, for example, substance misusers, was employed by the trust. All staff we spoke with knew how to contact the safeguarding named midwife.
- Safeguarding policies and guidelines were available on the intranet and contained clear, up to date and evidence based instructions on what to do if a member of staff was concerned about a child.
- Staff generally understood their responsibilities and followed safeguarding policies and procedures. Whilst staff had a good knowledge of general safeguarding principles, we found that there was poor awareness of female genital mutilation (FGM) or child sexual exploitation (CSE). The head of division told us that there were two female genital mutilation (FGM) leads. Although we were told that this was part of their safeguarding training, some staff told us they had not had any training at all. We did not see any leaflets available regarding CSE or FGM or details of contact details of support groups. We reviewed the FGM and CSE policies, which were 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.
- 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 presents to the maternity or termination of pregnancy service disclosure to social services is usually required in the best interests of the child.
- The service's FGM guidance was thorough and contained both descriptions and diagrams to aid staff in identifying FGM.

Mandatory training

- The trust had set a target of 90% for completion of mandatory training. Nursing staff within maternity and gynaecology failed to meet the trust target of 90% for all of the nine mandatory training modules. Fire awareness, resuscitation, infection control, information governance and health and safety training had a completion rate between 82% and 87%. Manual handling had a completion rate of 74% and conflict resolution, medicine management and equality and diversity training had a completion rate between 19% and 38%.
- Medical staff within maternity and gynaecology failed to meet the trust target of 90% for all of the nine mandatory training modules. Manual handling, resuscitation and infection control training had a completion rate between 80% and 87%. Health and safety, fire awareness and information governance training had a completion rate between 64% and 78%. Medicine management, conflict resolution and equality and diversity training had the lowest completions rates of between 22% and 33%.
- Mandatory training specific to maternity had a compliance rate for midwives of 95%, for medical staff of 97%. Cardiotocography (CTG) online training for midwives had a compliance rate of 92% and for medical staff of 94%.
- Community midwives had an annual "escape day". This was used to provide up to date training with essential emergency skills. However, midwives in other parts of the trust told us that this had been reduced to once every two years because of staffing and financial constraints.

Assessing and responding to patient risk

- For gynaecology inpatients, please refer to the surgery section of this report.
- Risk assessments were carried out for patients and risk management plans were developed based on National Institute for Health and Care Excellence (NICE) national guidelines.
- Community staff were responsible for carrying out full assessments of women at their initial booking visit. These included social, medical and mental health assessment and referral as necessary. Other assessments included tobacco use, drug use, family history and previous pregnancies. Assessments of venous thromboembolism (VTE) and of immunisation history were also recorded. VTE is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis. A blood clot in the lungs is called pulmonary embolism.
- Risk assessments were used to help patients choose their preferred place of delivery, recommend further investigations and inform a plan of care. This included whether a patient should have midwife or consultant led care, or be referred to other professionals within the multidisciplinary team.
- Nationally, patients seen and assessed before the end of the 12th week of pregnancy have better outcomes than those who were seen for the first time later on in pregnancy. Within the service overall, 87% of women in the year to September 2016 booked their care before 10 weeks and 6 days. This is against a service target of 90%.
- The use of nursing early warning scores was introduced trust wide in July 2016. This was a tool that allowed nurses to assess a patient's condition, identify indications that the patient may be deteriorating and escalate appropriately.
- The World Health Organisation (WHO) surgical checklist "Five Steps to Safer Surgery" was in use within the trust. From August 2015 to July 2016 local audits showed that the tool was used in 100% of obstetric and gynaecology surgery.

Midwifery staffing

- Service leaders told us that they used "Birth Rate Plus" a nationally recognised tool for planning staffing levels. In all areas we visited, there was a mix of qualified staff and support workers to care for patients. In the outpatients' area, we saw details of the names and numbers of staff displayed in the clinic.
- In the community, midwives held an average caseload of one midwife to 117 patients. This was above recommended levels and the trust had agreed plans with the clinical commissioning groups to reduce this to one midwife to 98 patients by 2018 to 2019.
- In September 2016, KHTC reported a vacancy rate was 14% in maternity and gynaecology and the turnover rate

was 11%. This was higher than the rates in Worcestershire Royal Hospital. This was due to the merger of the maternity services, with some staff members who previously worked at KHTC, leaving their employment upon the relocation.
- In June 2016, there had been a trust wide work force review that acknowledged difficulties in recruitment and retention of staff, particularly in the gynaecology nursing posts. A recruitment open day had taken place. However, the reason that nurses gave for not wanting to work within the division was lack of ring fenced beds for the sole use of gynaecology patients and having to work on mixed sex wards.
- From April 2015 to March 2016, there was a sickness rate of 3% in maternity and gynaecology. This was below the target of 3%.
- We were not supplied fill rate figures (that is the number of planned verses actual number of staff) for the services provided at KHTC.

Medical staffing

- The medical staffing skill mix was similar to the England average. The service had 37% consultants, 7% middle grades, 48% registrars and 8% junior doctors. The England average was 40% consultants, 8% middle grade, 45% registrars and 7% junior doctors. Obstetric and gynaecology doctors' rotas were organised so that they all worked in multiple locations within the trust. The proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England average.
- The service had a middle grade vacancy rate of 40% and reported that recruiting doctors to these posts, especially within gynaecology, was difficult. Applications had been limited. As a result, the service relied on locum staff to cover gaps in the medical rotas. From September 2015 to August 2016 the trust used 6% bank or locum staff.
- As at October 2016, the trust as a whole reported a vacancy rate of 24% in maternity and gynaecology. This risk was on the divisional risk register. There was a maternity patient care improvement plan in place; one action within the plan was to monitor rotas on a weekly basis. Consultants would act down and support in extreme circumstances.
- Four new consultants had recently been appointed, which meant that there were no current vacancies at consultant level.
- An obstetrician or gynaecologist was in the hospital either in the operating theatre or in the outpatients department during clinics on weekdays. They were called on for review of inpatients and day case patients, if necessary. Leaders told us that this was under review and job plans would be revised to formalise daily ward rounds for gynaecology patients in early 2017.
- There was no dedicated gynaecology service out of hours. However, junior general surgical doctors were available to review gynaecology patients. A consultant was on call from home when post-operative gynaecology patients remained in the hospital overnight.
- From April 2016 to October 2016 the trust reported a doctor turnover rate of 9% in maternity and gynaecology. This was lower than the hospital average of 12%.
- Between September 2015 and October 2016, the trust reported a sickness rate of 1% in maternity and gynaecology. This was better than the trust's target of 4%.
- Locum doctors received an induction letter and pack. They were appointed a supervisor to ensure induction processes were adhered to. A policy was in place for management of locum doctors. This was monitored and mentioned on the risk register for women's services.

Major incident awareness and training

- A major incident plan was in place for the trust. However, no staff we spoke with knew what their specific role was within this nor had received any major incident training either in theory or in practical scenarios.
- Community midwives were used to provide assistance on the delivery unit at WRH if required to keep patients safe.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- Local audits were limited which made some areas of patient care and treatment difficult to monitor and change if required.

- Four record keeping systems were in use across maternity services. This meant that not all information about patients was always available for staff at one time.
- Midwives were not routinely rotated between areas. This meant that some midwives might have lost some skills over time.
- Staff had limited understanding and low compliance in training with regards to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Working arrangements and relationships with GPs in the community were variable.

However:

- Information was collected and benchmarked against national targets.
- Robust pathways to ensure patients were treated by the right person at the right time were in place for all maternity patients.
- Specialist midwives were based at Worcestershire Royal Hospital (WRH). They visited the Kidderminster Hospital and Treatment Centre (KHTC) when required.
- The trust had achieved level 3 in the UNICEF Baby Friendly awards.

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 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, staff awareness of how to find the correct pathway was limited.
- Policies, guidelines and pathways were available via two systems on the trust wide intranet. All staff we spoke with knew this. However, the older system was difficult to navigate and users had trouble locating policies. The newer system was easier to navigate but there were no reference documents attached to the new pathways. This meant there was no indication when the pathways had been written, reviewed or by whom, or if they were based on appropriate, up to date evidence and guidance.
- Patient treatment assessments and plans were documented on patient held records. These assessments were based on up to date relevant National Institute for Health and Care Excellence Quality Standards (QS). They included antenatal care (QS22) and antenatal and postnatal mental health quality standards (QS115).
- There was a diabetes antenatal clinic, ran by a diabetes link midwife. Women at the clinic were offered glucose tolerance testing, in line with NICE guidance (NG3).
- New domestic violence assessment guidelines had been introduced and the patient documents had been recently changed to reflect this. Staff were being trained on the use of this new assessment. An audit of the use of the guidelines on asking patients about their experiences of domestic violence had taken place between January and March 2016. The results of this had been used, along with Care Quality Commission (CQC) recommendations about making the domestic violence question part of routine enquiries, to produce a plan of action. The actions included; discussion at midwifery forum to community midwives, cascade of information from community team leaders to community midwives and information sharing via effective handovers. In addition, the domestic violence pathway had been updated to include the routine use of the question, specific mandatory training was being considered for all the women's services and there audit was planned to be repeated to track progress with changes.
- There was no general documentation audit carried out within the maternity services. This meant that we were not assured that all the other assessments were being used as intended.
- Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, including; "safer childbirth" were used for the organisation and delivery of care in labour.
- Services were being developed to provide a "hub" model of care for antenatal and gynaecology services in the gynaecology and antenatal unit. This was in line with the national maternity review report (2016). The concept of a community hub is that it is a local centre where women can access various elements of their maternity care. Different providers of care work from a community hub, offering midwifery, obstetric and other services easily accessible for women. These might include ultrasound services, smoking cessation services

or voluntary services providing peer support. Women were also able to meet professionals who would be involved with them after childbirth, for example, their health visitor.
- Technology and equipment was used to enhance the delivery of effective care and treatment. A midwife was employed who was a specialist in scanning. There were plans in place to train three more. Obstetric scanners were available in the antenatal clinics and the maternity assessment unit.
- 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 to women during each antenatal contact in the clinics, the importance of foetal movements at in accordance with MBRRACE-UK 2015 and RCOG guidance. We saw posters displaying this information in the antenatal clinic.
- Maternity dashboards provided data and information to set targets which were benchmarked against national targets. These targets and the pathways to achieve them were produced by using on evidence-based guidance, standards, and legislation. The dashboard was on display for all staff to see.
- Several electronic record systems were in use throughout the trust sites. They allowed doctors and nurses to access information in a timely manner to help make clinical decisions. However, they did not always contain all the information that was also in patients' paper records and vice versa. This had been recognised as a safeguarding risk at our previous inspection, because for example, safeguarding concerns may have been omitted from one document and missed.

Pain relief

- Please refer to the surgical section of this report regarding gynaecology patients treated on ward 1 or the surgical day case unit.
- Pain was assessed and managed well.
- If a patient had pain in early pregnancy, they would be directed immediately to the maternity assessment unit at Worcestershire Royal Hospital.
- Patients in early labour in the community were assessed by either a community midwife or a midwife over the telephone. Pain relief advice would be given according to pathways of care developed for use in the trust.
- For patients choosing a home birth pain relief options were Entonox (gas and air) or Meptazinol (an opioid pain killer). Women choosing a home birth could ask their GP to prescribe pethidine, in which case the women had the responsibility for storing it.

Nutrition and hydration

- For gynaecology patients on Ward 1 and the day case unit please see the surgery part of this report.
- The service had been awarded the UNICEF baby friendly initiative, level three. The baby friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. We saw posters displayed in the waiting areas 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 caused by a tongue tie.
- Infant feeding support services were widely available in the community. Patients were given a card with links to multiple providers of support, including the NHS, charity and private groups and individuals. Midwives and infant feeding support workers were available to support babies and their mothers who had feeding difficulties in the community.
- Babies who had lost weight were referred to the paediatric service at WRH or another local NHS trust following the appropriate pathways. Babies who were jaundiced in the community could be tested at home by midwives and referred when necessary to the paediatric service at WRH or other local hospitals.

Patient outcomes

- Information about the outcomes of patient care and treatment were routinely collected and monitored on the maternity and gynaecology dashboard. National audits were contributed to so that the service could benchmark their performance against others in England. However, the majority of this data was in relation to hospital care.

Maternity and gynaecology

- There were 60 home births delivered by the community team in the area covered by the community midwives, from 1 December 2015 and 30 November 2016. This accounted for 1.5% of all births in the trust, lower than the national average of 2.4%.
- The service performed poorly in relation to antenatal detection of intrauterine growth restriction (IUGR) (a condition where an unborn baby does not grow at a normal rate). From April to July 2016 the service identified this in 16% of cases, significantly lower than the target of 40%. This was acknowledged by the trust and a clear plan was in place to gather accurate data, work with commissioners, continue with staff training and offer additional services to women who have higher risk of IUGR.
- The number of patients who were still smoking at the date of delivery in the year to July 2016 was 10.8%. This was less than the national average of 11.5%.
- Between January and March 2016 four audits were due to be completed. These were; pregnancies in women with complex social issues; foetal heart oscillation; an audit in response to CQC recommendation around the asking of the 'routine enquiry question and the disclosure of domestic abuse ' and an audit in response to CQC recommendations around risk assessment in pregnancy. Of these audits, as at September 2016, only the audit of pregnancies in women with complex social issues had been completed. All other audits had incomplete action plans.
- The service audited its compliance with the UK National Screening Committee's standards for screening programmes. The audit considered 26 pairs of women's' hand held and newborn notes and assessed whether they had evidence of screening for sickle cell and thalassaemia (SCT), infectious diseases (IDSP), foetal anomalies (FAS), newborn blood spot (NBBS), newborn infant physical examination (NIPE) and newborn hearing (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.

Competent staff

- For further information about staff on Ward 1 and the day case unit please see the surgery part of this report.
- There were four safeguarding supervisors within the trust that provided safeguarding supervision. Out of the 75 community midwives employed, 30 received safeguarding supervision every two months. All specialist midwives also received safeguarding supervision every two months from the named midwife for safeguarding.
- Staff generally had the right qualifications, skills, knowledge and experience to do their job. Newly qualified midwives had a comprehensive induction and preceptorship programme when joining the service. Maternity teams comprised of both qualified and unqualified staff so that patients received the appropriate level of care as required. However, gynaecology patients being treated and cared for on Ward 1 were not cared for by gynaecology trained nurses. Senior managers told us that during daytime hours there was an obstetric and gynaecology consultant on site who was allocated to normal duties in theatre or in clinic. They were available to review gynaecology inpatients and/or referrals from other specialities. Job plans were being reviewed to build in a daily consultant ward round (0.125 additional sessions) in order to formalise the process.
- Out of hours, surgical junior doctors provided first line cover for elective gynaecology patients. A consultant was on call from home when gynaecology elective patients remained in hospital overnight.
- Between April 2015 and March 2016, 87% of staff within maternity and gynaecology at WAHT had received an appraisal above the trust target of 85%. Between April and August 2016, 88% of medical staff and 82% of non-medical staff had received an appraisal.
- All the staff we spoke with had either had their appraisal, or were due to have one in the near future. Appraisals were used to identify individual learning needs. Staff we spoke with gave us examples of learning needs that had been identified and courses that had been done or were planned.
- The maternity service had a practice development midwife who was responsible for identifying individual and service learning needs.
- Midwives were allocated supervisor of midwives (SoMs) who would meet with individuals assess on going competencies. SoMs were experienced midwives who have had additional training to enable them to help those with less experience provide the best quality care. They supervised the work of the midwives and met with

them regularly to ensure that high standards of care were provided. They also guided and supported midwives in developing their skills and expertise. SoMs were also responsible for investigations into poor staff performance or incidents. The service's supervisor to midwife ratio from July 2015 to July 2016 was one supervisor to 20 midwives, worse than the national target of one supervisor to 15 midwives. All midwives had a supervisor allocated who supported them in their clinical practice.
- Other ways of supporting and managing staff were provided through team meetings and providing information by email and newsletters.

Multidisciplinary working

- Please see the surgical section of this report regarding gynaecology patients on ward 1 or the surgical day case unit.
- Laboratory, pharmacy, physiotherapy, scanning and diabetic and endocrinology services were all available to patients KHTC. Senior midwives told us that patients could be referred directly to these services.
- Good links were available between medical disciplines when patients needed them. For example, we saw records that showed referrals and appointments with a nephrologist (a specialist kidney doctor), mental health professionals and cardiologists.
- As antenatal patients had hand held records, they were able to take these to all their appointments, including their GP, community midwives, mental health professional or physiotherapists. However, not all relevant professionals had access to patient's electronic record or hospital records.
- When patients were discharged from hospital services, a discharge summary was sent to the GP.
- Service level agreements existed between the trust and other trusts to provide maternity services for women who chose to book their delivery closer to home. Midwives told us that at times there was limited information received from other trusts, for example blood test results.
- Patients who had multiple and complex needs had information within their records which demonstrated coordinated care. For example, when the woman had additional medical needs, the relevant speciality consultant was involved. In cases of safeguarding concerns there were multidisciplinary, multi-agency safeguarding meetings and plans put in place to protect the relevant members of the family.
- Community midwives were employed by the acute trust and based at seven locations around the county. One team was based at the KHTC. Community teams were able to access all the same services available to the hospital based obstetric and midwifery service as well as additional community services such as children's centres.
- Community midwives worked over seven days and were able to see patients at the weekends to discharge them if necessary. Care was coordinated with the health visiting team and infant feeding specialists as required. Patients with complex needs had discharge planning meetings to ensure the right support was in place prior to discharge.

Seven-day services

- Please refer to the surgery section of this report for gynaecology day case and inpatients.
- Antenatal clinics were held Monday to Friday from 8.30am to 4.30pm.
- There were gynaecology outpatients clinics held during the week.
- There were no gynaecology or early pregnancy assessment services available at weekends.
- The maternity assessment unit was open weekdays only. When women presented out of hours, they were directed to services at the Worcestershire Royal Hospital.
- Imaging (x-rays and scans) were available 9am until 6pm Monday to Friday. X-ray was only available in the minor injuries unit from 9.30am to 5pm on Saturdays, Sundays and bank holidays. Outside of these hours, there was no service on site.
- Pathology provided a service to process blood and other tests, from 9am to 5pm from Monday to Friday.
- Physiotherapy and occupational therapy responded to direct referrals but we were told that they did not have staff based on site. Should a patient have required emergency access to these services, they were transferred to the Worcester Royal Hospital site.

Access to information

- Information needed to deliver effective care and treatment available to relevant staff was not always available in a timely and accessible way.
- Maternity patients had paper obstetric records for the duration of each pregnancy, hand held records to take to each maternity appointment and if required an electronic record for all other medical conditions treated in the trust. In addition, when maternity patients had foetal heart rate monitoring or were in labour, records were kept in a specific maternity electronic system. Service leaders told us that the maternity service had to continue with the obstetric paper record system because the ante and post-natal electronic records programmes were not available at the time of purchase. Since they had become available, the maternity division had not been successful in bidding for the financing of the programmes. The maternity division was working with partners in the wider area to plan for an alternative system in the financial year 2016 and 2017.
- We saw examples of how doctors had accessed electronic records and noted in the paper hospital obstetric records that treatment decisions had been made based on all the available information. However, other speciality doctors, based on other sites, were unable to quickly view the obstetric records of patients at the KHTC, as they were paper and not electronic. With multiple record systems in place there was a risk that information would not have been accessible to all people at all times. This was recorded on the trusts risk register.
- Information was sent by fax to GPs when a patient was discharged from midwifery services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were only able to give minimal explanations of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, they were aware that they could seek advice from the safeguarding midwife or relevant line managers who more often dealt with these issues. They were also aware of the referral pathways to mental health professionals.
- WAHT reported that as at September 2016, MCA and DoLS training had been completed by 37% of staff in within maternity and gynaecology. Medical staff had a training completion rate of 44% while nursing staff had a completion rate of 31%.
- Assessment records provided an area to complete regarding past or present mental illness. However, we saw no evidence of assessment of capacity to consent to treatment.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Surveys of care consistently showed high levels of patient satisfaction.
- Staff were consistently observed to be respectful, kind and caring.
- Additional measures were taken to protect privacy and dignity where possible.
- Patients told us that staff were always kind.

Compassionate care

- All interactions we observed between staff and patients were respectful, kind and considerate. This included reception staff, nurses, midwives and doctors.
- All staff told us that they felt comfortable raising concerns about disrespectful, discriminatory or abusive behaviour or attitudes.
- In July 2016 the trust's performance for people who would have recommended the postnatal community services was 100% compared to a national average of 97%.
- There were measures in place to protect women's' confidentiality and dignity. Consultations were in private rooms and in the gynaecology clinic area, additional screening was in place to further protect patient's dignity and confidentiality.
- For patients who had received bad news or were distressed, arrangements were in place in the outpatients clinics to allow them privacy and time either alone or with a professional.
- All staff including maternity support workers, clerical staff and clinical staff took all necessary steps to

maintain patient confidentiality for example by keeping records secure or if they needed to discuss a patient, they moved to an area where they could not be overheard.

Understanding and involvement of patients and those close to them

- Partners and families were welcomed to be involved in the care and treatment of patients.
- 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.
- Patients and those close to them were routinely involved in planning and making decisions about their care and treatment.
- Midwives told us that a patient's choice was paramount and that they would do all they could to facilitate a woman's birth choices. Even if that was against best advice.
- One maternity patient we spoke with told us their care was; "Good, my midwife is always available." Other patients told us that they were seen in a timely way and their plans of care were discussed with them.
- One patient we spoke with told us that; "The nurses were lovely" and that she felt listened to. She told us that all her worries and questions were answered. Another gynaecology patient told us that although she was having her first appointment all the staff had listened to her questions.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition could have on their wellbeing and on those close to them. Specialist midwives were available trust wide to support patients with specific needs. For example, there was a bereavement midwife in post and plans were in place to expand this service. A safeguarding midwife also looked after patients with mental health and substance misuse problems. Specialist midwives were also available for antenatal screening, infant feeding, teenage mothers, diabetes and risk and governance.
- Patients were routinely screened for anxiety and or depression. They were provided with additional support or referred to mental health services as required. In the community, patients were supported by midwives and if necessary referred to their GPs for further assessment and referral. Midwives would also liaise with health visitors to ensure continuity of care.
- Midwifery staff we spoke with were passionate about providing accurate information to enable patients to be able to make their own choices regarding their care and options for labour and birth.
- We were told that there had been a service to allow patients to reflect on any distressing birth experiences; however, this had been discontinued recently.

Are maternity and gynaecology services responsive?

Good

We rated the service for responsive as good because:

- A wide variety of antenatal services were available at the hospital.
- Patients were provided with clear information about who to contact if they were worried, or in an emergency situation.
- Gynaecology services provided a range of routine, and some specialist procedures.
- The majority of gynaecology patients with "red flag" symptoms (those that need reviewing swiftly) were seen within two weeks.
- Translation services including signing were available to patients through an interpreter service.
- Services were planned in maternity according to national guidelines for women's services.

However:

- A much lower than the national average home birth rate was achieved, with no clear explanation.
- There was limited consideration towards patients who may have had additional needs.
- Complaints were not always dealt with and closed within 25 days, in line with trust guidelines.

Service planning and delivery to meet the needs of local people

- Service leaders involved matrons and midwives in planning the future delivery of services at the hospital.

For example, one matron told us of the vision to provide an enhanced service for patients involving public health messages, refreshments and relaxing therapies, based on a "hub" model of care.

- The maternity services liaison committee was a local group with multiple stakeholders including service users, Healthwatch, and charitable organisations. It had an interest in local maternity services. We saw meeting minutes from the meeting held in March 2016. Matters discussed were; antenatal education, home assessment of labour, breast feeding support and partners staying overnight in hospital. The minutes showed that local people were able to have their views listened to.
- Antenatal services were for all patients locally. Maternity assessment and gynaecology services were for patients with a low risk of complications. This was due to the current vacancies in both neonatal and obstetric and gynaecology doctors for the whole of the trust. Higher risk patients were seen at the Worcestershire Royal Hospital (WRH) where there were more specialist doctors and facilities available.
- Service leaders told us that they planned to concentrate on improving the gynaecology service in the coming year.

Access and flow

- For gynaecology patients, please see the surgery part of this report.
- Patients booked with their community midwife or GP at the beginning of their pregnancy. When patients were assessed as requiring consultant led care they were immediately referred. During routine antenatal care, patients arranged mutually convenient appointments.
- There was a robust and routine antenatal pathway for each patient based on Royal College of Obstetricians and Gynaecologist and Royal College of Midwives guidelines.
- Most patients travelled to WRH for labour and birth. However, some patients chose to go to other hospitals outside the trust. For all antenatal patients, a full consultant led service was available at the Kidderminster Hospital and Treatment Centre (KHTC).
- At each appointment, the majority of patient's subsequent appointments were booked. If this could not be done, an appointment was booked at the next opportunity and the patient was alerted by text message or by letter.
- When a woman was in labour, she was advised to telephone the trust wide triage telephone number for a telephone assessment. Alternatively, she could go directly to the triage centre at the hospital where she was booked to deliver. If a home delivery was booked, she could telephone the community midwives 24 hours a day.
- The rate of homebirths for the trust was 1.5%. This was lower than the national average of 2.4%. One staff member told us that woman: "Seem to want a hospital delivery here".
- Women who were booked before 10 weeks and six days of pregnancy totalled 87%; this was close to the trust target of 90%. Of the women who did not meet this target, a senior midwife told us the data had been analysed to show that 48% of these women referred themselves late, and approximately 30% had either recently moved into the area of were out of the country during the early part of their pregnancy.
- There were sufficient midwives available to care for women who chose a home birth. No women were transferred to hospital for this reason between November 2015 and November 2016.
- Patients who required urgent assessment were given details of who to contact for advice. Low risk assessment of maternity patients was available Monday to Friday 8am to 4pm. Patients in later pregnancy with high risk factors were referred to the WRH. Outside of those hours, urgent pregnancy care and assessment was delivered at the WRH, where specialist services were available to patients with the highest risk factors.
- We were told that most antenatal clinics ran on time and patients were seen as planned. However, this was not audited so there was no evidence available to support this.
- Maternity patients who were seen for their outpatient appointments at the hospital were provided with details of who to contact out of normal working hours. Women less than 20 weeks pregnant were advised to contact their GP or visit the hospital accident and emergency department if they had pain or blood loss. Women over 20 weeks of pregnancy were advised to contact WRH maternity triage for further advice.
- Patients with gynaecology problems were referred by a GP or accident and emergency to the gynaecology assessment unit at WRH.

Maternity and gynaecology

- From November 2015 to November 2016, 95% of gynaecology patients who had "red flag" symptoms (these are symptoms indicative of a cancer), were seen within 2 weeks of referral.
- Patients who experienced gynaecology symptoms out of hours were referred to the gynaecology assessment unit at the Worcestershire Royal Hospital (WRH) by their GP or accident and emergency.
- In September 2016, 80% of gynaecology patients were seen before 18 weeks gestation following their referral. The service had a detailed plan to reduce the waiting times for patients so that at least 90% of patients were seen before 18 weeks by March 2017. For example, consultants had been requested to carry out additional clinics and surgical lists, additional administration time had been allocated to support with this. Alternative NHS and private providers had been approached to see if they were able to care for any patients. However, the projections to clear the backlog of patients were slightly behind what had been planned.

Meeting people's individual needs

- Women with complex needs had access to a variety of specialist midwives. Staff told us that they knew how to access learning disability nurses for support and advice if required, however, there was limited consideration towards patients who may have had additional needs. At times women would be accompanied by learning disability support workers.
- Translation services were advertised throughout the hospital. We saw information on notice boards and in leaflets. Staff also told us that they knew that this service was available and how to use it.
- One member of staff told us of personalised plans that had been made for women with disabilities or special needs. However, we were not assured that all staff had a deep understanding of minority groups' cultural, social, special and religious needs. For example we were told on several occasions that if a patient had a learning disability or communication difficulties that they would be accompanied by a parent.
- A multi-faith room was available in the hospital.
- Specialist midwives were available when required. For example, there were specialist diabetes, teens, safeguarding and bereavement midwives. They were all visible, accessible and approachable at KHTC when required. They were also available on email or by phone when not on site.

Learning from complaints and concerns

- Patients we spoke with 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 and gynaecology waiting area. We also saw complaints leaflets displayed which contained the details of PALS, the independent complaints and advocacy service, the Parliamentary and Health Service Ombudsmen and the Care Quality Commission.
- Lessons learned from concerns and complaints were shared during team meetings and in a 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 at WRH for friends and family.
- We reviewed details of two complaints, from November and December 2016. These showed that the complainant was telephoned within 24 hours of the complaint being received. One of the complaints had a written response within 16 days. The other complaint had a written response in 27 days. This was due to a meeting with the complainant requesting a meeting four weeks after the initial complaint.
- Between August 2015 and August 2016 there were four complaints about maternity and gynaecology at KHTC. The service took an average of 28 days to investigate and close the majority of complaints; this is not in line with the trust's complaints policy, which states that 90% of complaints should be closed within 25 days.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Gynaecology day case and inpatient services had a limited strategy in place for the future of services.

- Visibility of senior leaders was limited, due to the trust's multi-site configuration.
- Some senior nurses had multiple roles that impacted on their availability.
- There were some gaps in the senior leadership team's awareness of staff competencies.
- There was a lack of oversight from senior leaders with regards to some audits, mandatory training and staff knowledge with regards to managing a major incident.
- Information specifically for maternity patients, on the trust website, to help the public understand what maternity services were available where in the trust, had not been updated for more than a year.

However:

- Maternity services vision and strategy were clear, comprehensive and well documented.
- Leaders had a good insight into the risks and challenges facing the service.
- Local leaders were well respected and approachable. They kept patient safety and experience at the centre of service delivery and development.
- All staff we spoke with felt respected and valued.
- A culture of honesty and openness was reported throughout the service.

Leadership of service

- Senior leadership in the service had been inconsistent because of changes of people in different roles. Two of the five roles in the service were interim posts (temporary). The non-executive director for the service had recently retired. Plans were in place to recruit to this post.
- The acting Divisional Medical Director (DMD) had been in post since June 2016; this was an interim post, due to end in March 2017. They were responsible for the women's and children's division within the trust. The acting clinical lead for gynaecology had been in post two weeks when we visited; this was to provide leadership in the gynaecology service whilst the substantive clinical lead was on sick leave. This recent change of clinical lead had been managed well. The acting lead had a thorough understanding of the service and the problems within it. The priority was patient safety. Because of this new position, the doctor concerned had changed one session a week from clinical practice to management.
- The director of operations, the clinical lead for women's services, which incorporated both obstetrics and gynaecology, and the director of nursing and midwifery had had been in post between three months and three years.
- All of the divisional team had a good insight of the challenges that the service had faced over the previous 18 months. There had been rapid and safe transfer of delivery services to Worcestershire Royal Hospital (WRH).
- Divisional leads were passionate, informed and dedicated to continually improving the service to patients. They were clear about their roles in achieving the service vision. Staff told us that divisional leads were concerned about not only the "big picture" but also about patients' individual care at the hospital. Staff also told us the senior team would take time to see patients when necessary.
- Staff told us that all members of the senior leadership team were approachable and were very responsive.
- Matrons in gynaecology and community and outpatients services covered multiple sites in the trust and therefore, had limited time to be present in the hospital. However, they and staff told us that they were always available by email or telephone.
- One matron was responsible for two separate services, which limited time to monitor and manage their part of the women's division. Staff told us that this matron was rarely visible at the hospital.
- All leaders had a desire to concentrate on developing and improving the gynaecology service within the hospital. Limited plans were in place to develop gynaecology at the hospital further. However, due to external factors including national plans for reconfiguration it was uncertain whether these plans would come to fruition.
- Local leaders within the maternity services had a good understanding of challenges within the service and actively sought ways to improve.
- Leaders told us that they were proud of the teams they managed. Midwives told us they admired and appreciated their leaders. We observed positive interactions between managers and staff of all levels and saw that good working relationships had been formed.

Vision and strategy for this service

- Clear values had been defined by the trust. All staff we spoke with were aware of the trust "PRIDE" values. This stood for patients, respect, innovation, dependable and empowerment. Staff we spoke with were familiar with the acronym and were able to describe most of the values. They were clearly displayed on notice boards in the maternity and gynaecology outpatients department.
- Following our inspection in July 2015, a plan had been developed for 2016/2017. There was a clear relationship between the trust values and priorities. Patients' safety, outcomes and experience were always at the centre of these. The patient care improvement plan (PCIP) included reference to the future of acute hospital services review and the Sustainability and Transformation Plan (STP). This outlined the service's priorities in investing in staff by ensuring they had annual appraisals and appropriate training. Other priorities included 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 had been 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 have been open on the electronic reporting system. Some of these objectives had already been achieved, notably the caesarean section rate and the number of open electronic incident reports.
- The PCIP was reviewed regularly and a record was made of updates, new actions and target dates. Weekly priorities were identified and brought to the attention of all staff through email, team meetings and notice boards.
- At the Kidderminster Hospital and Treatment Centre (KHTC) some of the monthly topics on display for staff information in the department were; "to ensure all staff receive appraisals; leaflets contain the most up to date information and should be available in other formats; medicines should be stored and prescribed in accordance with trust policy; ensure sufficient levels of medical staff; mandatory training should be at 90% compliance."
- The service had a sustainability and transformation plan (STP) clinical enabler work stream outlining the sustainability and transformation plans up to 2020. Plans included reorganisation of community midwifery around community hubs. This directed that women would 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. This fitted in with the STP plans around the 'hub' model of care. This meant that antenatal maternity and gynaecology outpatient services would all be placed together. Additionally specialist consultant clinics, midwifery clinics, scanning and phlebotomy services would all be in one place, alongside gynaecology and early pregnancy assessment units. All staff we spoke with clearly understood the local vision of the service. They were all optimistic about these plans to reconfigure and improve services.
- The gynaecology service had a vision to provide a dedicated gynaecology ward on another site. This new ward was linked into the trust wide future plans with the Future of Acute Hospital Services in Worcestershire. However, we were told this was not planned to be completed for two or three years. Nursing staff were unsure about the certainty of this plan being completed.

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 and saw 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. There was also evidence of discussions surrounding recent serious incidents with a focus on the duty of candour, clinical performance indicators, for example, percentage rates of third and fourth degree tears were discussed, so that the service was aware of their performance in these areas.
- Information from ward or department level was collected on a weekly basis. This informed the divisional governance meetings, which were held every four weeks. At the divisional governance meeting, data was finalised and corrective actions and processes were agreed for ongoing monitoring. Information was then escalated to the clinical governance group and in turn to the quality governance committee. Within nine weeks from the initial discussion at ward or departmental level this information was presented to the board.
- Clear reporting lines were in place from board to ward and ward to board. Staff we spoke with were clear about

their roles and understood what they were accountable for. Leaders were, for most of the time, aware of their roles and responsibilities. There were clear accountabilities in job plans.
- Staff told us that they felt confident in escalating concerns and had clear lines of accountability.
- Data was collected to measure quality of the services provided at trust level. However, we were not assured that local leaders had asked for audits in all relevant areas of practice. For example, there were no record keeping audits in place to monitor effectiveness and quality of clinical records or research in place to understand why fewer than expected deliveries were taking place at home.
- There was however, a lack of oversight from senior leaders with regards to the levels of mandatory training, the Mental Capacity Act and its application and staff knowledge with regards to managing a major incident.
- Senior leaders told us they were confident that all staff were trained to recognise female genital mutilation and child sexual exploitation. However, when we spoke with staff most were unable to tell us in detail about either. Training data also showed poor levels of training in these areas.
- Arrangements were in place with other neighbouring hospitals to support women who could not access services within the Worcestershire Acute Hospitals Trust for example, if they lived nearer to another hospital. Meetings were held as required to develop service level agreements between trusts.
- The PCIP demonstrated that the division had a holistic understanding of performance which integrated the views of people with safety, quality, activity and financial information. The plan demonstrated that there was an awareness of what measures were in place to help understand and improve services. For example, staff monitoring of referral to treatment times and waiting lists identified where extra clinics were needed, in an effort to reduce waiting lists.
- Leaders monitored responses to staff satisfaction surveys to understand and improve staff turnover rates.
- The dashboards we saw were up to date and included data from September 2016. This meant that they were produced in a timely way to monitor quality and performance. The type of data collected followed NHS guidelines. For example, women experiencing third and fourth degree tears, staff sickness rates and staff training rates for various competences were included on the dashboard. In addition, maternal outcomes such as caesarean section rate and breast feeding initiation rates were recorded.
- Following the move from the Alexandra Hospital to Worcestershire Royal Hospital (WRH) in November 2015, caesarean section rates had started to fall. Leaders told us this was because there was less reliance on locum doctors and a concentration of consultants on one site.
- There was a programme of clinical and internal audits, used to monitor quality. These included national audits such as the postmenopausal bleeding and internal performance indicators such as percentage of women that were still smoking at the date of their delivery. However, the service did not audit compliance with completion of documentation or rates of gynaecology post-operative infections. This meant that there were some areas where the service did not have access to information regarding performance and risks in these areas may not have been identified.
- A risk management policy and associated register was used to identify and manage risk. All items on the register had review dates and almost all had evidence of progress.

Culture within the service

- All staff we spoke with and observed had the needs, experience and care of patients as their highest priority.
- From July 2015 to July 2016, there had been a 6% staff sickness rates, above the trust target of 4%.
- Staff told us that occupational health services were good and that they had used the service effectively. Managers encouraged use of the occupational health counselling service.
- Staff socialised together and told us that they felt that they achieved a good work/life balance.
- Staff told us that their teams worked very well together in a supportive and open honest manner. Staff felt confident in raising any concerns and worked hard to ensure that patients were kept safe.

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 the community midwives office.

- There were regular meetings with the maternity services liaison committee in the trust area. These meetings provided an opportunity for service users and other interested stakeholders to have their views and ideas heard.
- The trust website had not been updated since November 2015.

Staff engagement

- 'Listening in action' groups had been introduced. These allowed staff to let the senior management team what they would like for their service.
- Noticeboards were observed to have details of the maternity patient improvement plan clearly displayed.
- Departmental and staff meetings were held. The minutes of these demonstrated that information was given regarding developments in the trust and that staff had the opportunity to discuss the services in which they worked.
- Staff were sent regular newsletters and updates by email.

Innovation, improvement and sustainability

- In April 2016, the service was rated as 'outstanding' by the Nursing and Midwifery Council for its mentorship and training.
- No one we spoke with could tell us of a time when financial pressures had compromised care.

Services for children and young people

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

Information about the service

Services for children and young people at Kidderminster Hospital and Treatment Centre include the children's clinic, an outpatient facility, minor injuries unit (MIU) as well as day surgery facilities for children up to the age of 17.

A dedicated day each week is assigned for paediatric day surgery and can cater for a total of 24 children. However, there is no day surgery on the fourth Tuesday of the month. There are four theatres dedicated to paediatrics which are used for community dental surgery, ear, nose and throat (ENT), head and neck, ophthalmology as well as general surgery.

Day surgery is for children over the age of two and at least 15kg in weight. The children's clinic is held four days per week. There are two clinics comprised of two consultation rooms and a treatment room, which is used for some nurse led procedures.

Patients undergoing day surgery had staggered admission times. There were six bedded day case bays for patients in recovery with 14 spaces available, although on average the unit had six patients at any one time.

The MIU was open 24 hours a day, seven days a week to treat children and young people for a wide range of minor injuries including cuts, grazes, wounds, and minor burns.

During the inspection we spoke with eight members of staff including theatre and nursing staff as well as support staff. We also spoke with patients and their relatives or visitors. We made observations during the inspection and reviewed a range of documents during and following the inspection.

We were unable to speak with day surgery staff as there were no day surgery lists during our inspection. We were also unable to speak with children's healthcare assistants (HCA) and reception staff as they were on leave during our visit to the hospital.

Children and young people's services provided by this trust were located on three hospital sites, the others being Worcestershire Royal Hospital (WRH) and Alexandra Hospital, these are reported on in a separate report. However, services on each hospital site were run by one management team. They were regarded within and reported upon by the trust as one service, with some of the staff working across each 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 this service as requires improvement because:

- Staff were not aware of any guidance to support them in identifying what incidents should be reported. This created a risk of under reporting of incidents.
- Incident reports did not always identify learning. This meant there was a risk of both the service and staff not learning from incidents.
- Record templates were not always clear and did not contain columns on documents that clearly identified where height and weight should be recorded.
- 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.
- Level three safeguarding children's training was not always face to face and was not updated annually; this was not compliant with the guidance on safeguarding training.
- The operating theatres sometimes had young people on theatre lists. Staff in the main theatres were not trained to level three in safeguarding. In addition, staff were not trained in paediatric immediate life support (PILS).
- The safeguarding supervision policy stated on the intranet, that it was 'in development'. There were though, some policies relating to safeguarding children that were not available on the trust intranet, including a 'no allegations policy'; and a 'managing celebrity visits' policy.
- There was no clinical audit plan for the children's clinic. There was little evidence that continual improvement of the service and compliance with best practice was identified or actions taken to address shortfalls.
- The women and children's division had introduced a performance dashboard to monitor patients' outcomes. There was little evidence that performance in the children's clinic was discussed.
- We viewed nursing staff competency assessment records and found these were all out of date. This meant the hospital could not be sure that staff were competent in all the skills required for their role.
- There had been no training for nursing staff to enable them to recognise sepsis.
- There was no formal clinical supervision for nursing staff. Supervision was provided by an outpatient's manager via telephone as they worked at another location. However, the manager also worked in WRH as an advanced nurse practitioner and could only offer staff telephone support when there were quiet periods at WRH.
- The NHS Friends and Family Test (FFT) had been suspended in children's clinics since the service reconfiguration. Patients' feedback could not be used to monitor and improve services.
- The 'did not attend' (DNA) appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%.
- The allergy service had a waiting time of up to 14 weeks due to the service only having one consultant.
- As a result of the emergency service reconfiguration which took place during the spring of 2016, the children's service did not have a clear vision, and did not have a long-term strategy. Staff were unaware of the vision and values for the children's outpatients' service as these were not defined.
- The governance framework was not effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings.
- Monthly divisional governance meetings were not consistently adhering to their terms of reference. This included: not focusing on themes and trends from incidents; safeguarding training performance, being reported as mandatory training, and not broken down to include compliance with level three safeguarding training. Discussions in regards to the divisional risk register focused on the number of risks recorded rather than how they were being managed. There had been little discussion around how the children's services transitional period was being managed.
- The outpatients manager had not been allocated any contracted hours for service leadership and they were fitting this in with their ANP role at WRH. This meant it was likely that staff would not receive timely supervision and advice.

However:

Services for children and young people

- The environment was observed to be visibility clean and staff followed correct protocols.
- Medicine cupboards and treatment rooms were sufficiently secure to prevent unauthorised access.
- Overall, care records were generally written and managed well. However, record templates were not always clear, and did not contain columns on documents to clearly identify where height and weight should be recorded.
- Medical and nursing staffing levels were planned and reviewed in advance, based on an agreed number of staff per shift.
- The trust had a major incident plan in place. However, staff were not aware of a local formal business continuity plan.
- The trust's 95% target for referral to treatment time (RTT) for non-admitted children and young people receiving an appointment within 18 weeks was regularly met.
- Staff who worked in the children's clinic 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.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts including privacy and about care and treatment and staff friendliness.
- Staff communicated with children, young people and their families in a way that they could understand their care and treatment. Staff understood the impact that a patients care, treatment and condition had on them and those close to them.
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of information available on the children's clinic.
- Services in the children's clinic took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- There was good teamwork and committed staff in the children's clinic.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were not aware of any guidance to support them in identifying what incidents should be reported. This created a risk of under reporting of incidents.
- Incident reports did not always identify learning from incidents. This meant there was a risk of the service and staff not learning from incidents.
- Record templates were not always clear and did not contain columns on documents that clearly identified where height and weight should be recorded.
- Staff were unaware of female genital mutilation (FGM) and child sexual abuse (CSE). There was a risk that staff would not recognise when a child was being abused or exploited.
- Level three safeguarding children's training was not always face to face and was not updated annually; this was not compliant with current guidance on safeguarding training.
- The operating theatres sometimes had young people on theatre lists. Staff in the main theatres were not trained to level three in safeguarding.
- There had been no training for nursing staff to enable them to recognise sepsis.

However:

- The environment was observed to be visibility clean and staff followed correct protocols.
- Medicine cupboards and treatment rooms were sufficiently secure to prevent access.
- Overall, care records were generally written and managed in a way that kept children and young people safe. However, record templates were not always user friendly and did not contain columns on documents to clearly identify where height and weight should be recorded.
- Medical nursing staffing levels were planned and reviewed in advance based on an agreed number of staff per shift.
- The trust had a major incident plan in place. However, staff were not aware of a formal business continuity plan to deal with adverse weather.
- There was a multidisciplinary approach locally at the hospital to provide support for children with their long-term nutritional needs, including diabetes clinics and input from dietitians.
- The trend for appraisal rates from April 2015 to August 2016 demonstrated improvement, with an appraisal rate of 89% for medical and dental staff.
- Non-clinical staff told us they met daily with the band 5 staff nurse and could ask for advice throughout the day as they worked closely as a team.
- There was support for patients from allied health professional services, including physiotherapy and dietetics.
- Children, young people and parents and carers were supported by staff to make decisions.

Incidents

- The trust used an electronic incident reporting tool to report incidents and had developed an incident reporting policy which was available to staff on the trust intranet. The staff we spoke with were able to use the electronic system and told us they always reported incidents where it was appropriate to do so. Review of the policy confirmed it outlined the reporting process and responsibilities, together with a risk scoring matrix for the categorisation of incidents. However, staff in the children's clinic told us they were not aware of any guidance to support them in identifying what incidents should be reported. This meant staff were not aware of the guidance to clearly assess the category of an incident when reporting, and there was a risk that reporting did not fully reflect all incidents with potential harm to children.
- There were 12 incidents reported within the children and young people's services at Kidderminster Hospital and Treatment Centre from 30 August 2015 to 6 July 2016. Three related to day surgery, four related to outpatients at the children's day clinic; two related to the day hospital; and two related to the recovery suite. All reports had been graded as having caused 'no harm' to children or young people on the incident report in accordance with the trust's policy. The incidents had been approved by a manager but there was no record of agreed actions in response to the incident on the electronic incident report. We noted that day surgery had two incidents involving clinics over running their allocated time.

- There had been no serious incidents (SI) which met the SI reporting criteria set by NHS England that related to the Kidderminster Hospital and Treatment Centre children and young people's services from October 2015 to September 2016. There was a policy in place for the investigation of SIs. The trust target was for SIs to be investigated within 60 days. However, managers told us they were reviewing the investigation time period and there was a move towards introducing localised investigation targets. Staff at the MIU told us there had been an SI in January 2016 involving a child that had arrived at the MIU. This had not been reported by any of the paediatric staff or directly linked to paediatrics on the reporting tool.
- Incidents were considered at monthly incident review meetings. The outpatients' manager attended the monthly meeting. Managers and staff told us lessons learnt from incidents were cascaded to staff by the outpatients' manager who disseminated the minutes from meetings.
- There had been no never events reported from October 2015 to September 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.
- Staff who worked in the children's clinic told us that there were few incidents in outpatients at Kidderminster Hospital and Treatment Centre. However, they were unaware of recent incidents reported by other departments in the trust, but were aware that there was a trust wide monthly 'risk bulletin' that shared this information.
- 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. 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 the duty of candour regulation and told us that they would share information with children and their parents or carers as soon as practicable following an incident. Staff at the children's clinic said they had not used the duty of candour formally as they had not had reason to use it. Managers said the trust had two "open" duty of candour incidents that were undergoing investigation. However, neither of the duty of candour incidents related to Kidderminster Hospital and Treatment Centre.
- We were unable to speak with medical staff at Kidderminster Hospital and Treatment Centre. However, a consultant at Alexandra Hospital told us paediatric mortality and morbidity meetings were held at the Worcestershire Royal Hospital (WRH). The same medical staff told us paediatric deaths were discussed in detail, and learning points were identified and followed up at subsequent meetings. However, there had been no reviews related to the children's clinic at Kidderminster Hospital and Treatment Centre.
- The outpatients' manager told us they were sent patient safety alerts from the Department of Health's central alerting system (CAS) by the communications team. They would cascade any relevant alerts to all staff via email. Staff confirmed that they received patient safety alerts by email from the outpatients' manager.

Safety Thermometer

- The children's clinic was an outpatients department and did not use the NHS Safety Thermometer.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained in the outpatient department. Areas we visited were visibly clean and the staff we spoke with told us they were satisfied with the level of cleanliness and had no concerns.
- We observed staff complying with infection control guidance. For example, staff arms were bare below the elbows and personal protective equipment was worn as required. Personal protective equipment, hand washing facilities and hand gel was available throughout the clinical areas.
- We saw "I am clean" stickers in use across all clinical areas stating the date and time of last cleaning. This showed that equipment was clean and ready for use.
- In the CQC children's survey 2014 the trust scored 8.97 for the question: 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.
- Equipment we reviewed was visibly clean and we saw that labels were used, dating when equipment had been cleaned.

- Clinical and domestic waste bins as well as sharps bins on the children's clinic were used and stored appropriately.
- All staff were required to compete infection control training. Infection control training had been completed by 80% of paediatric medical and nursing staff. However, these figures related to the whole women and children's division.
- We saw that toys in the children's clinic were cleaned as required and the hospital did not use soft toys in children's play areas.
- The trust's lead infection prevention and control (IPC) nurse visited the children's clinic during our visit to deliver training on the statement of purpose (SOP) for hand hygiene to the band 5 staff nurse who worked in the children's clinic. The IPC nurse showed us evidence that the children's clinic had achieved 94% in an IPC audit on 12 August 2016. As this was below the trust's 95% target, the clinic had been re-audited on 9 September 2016 and achieved 96%.
- We viewed a sample of cleaning schedules at the children's clinic. We saw these were up to date and complete. This meant there was guidance available to staff on the frequency of cleaning on the clinic.
- There had been no reported cases of MRSA or Clostridium difficile from September 2016 to November 2016 at the Kidderminster Hospital and Treatment Centre children's service.

Environment and equipment

- The children's clinic had adequate equipment to meet the needs of children and young people. Equipment was maintained and portable appliances had been subject to relevant safety tests.
- The children's clinic was a dedicated outpatient's clinic consisting of two consulting rooms and a treatment room, where children's height and weight was measured, and staff conducted blood tests and skin prick tests for the allergy clinics.
- Clinical waste was appropriately stored and disposed of.
- The resuscitation equipment in the children's clinic, contained varied sizes of kit to cater for the potential range in ages and sizes of the children. Daily checks were performed to ensure required equipment was available and that emergency medicines on the resuscitation trolley remained in date.
- Resuscitation rooms in the MIU and resuscitation equipment were interchangeable and age appropriate. However, we found two paediatric airways that were out of date on the MIU resuscitation trolley. We drew this to staff attention and they said they would replace these immediately.
- Treatment rooms were secured appropriately and locked by use of a keypad.
- The children's clinic was adequately secure to ensure intruders did not enter the ward. There was a swipe card entry for staff and visitors to the clinic had to ring reception at the clinic entrance to gain entry.
- The children's clinic had piped oxygen and suction, this had remained on the ward from the reconfiguration, although staff said they had never needed to use it.
- The trust scored 9.51 for the question: 'Did you feel that your child was safe on the hospital ward?' This was about the same as other trusts.
- The trust scored 8.87 for the question: 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' This was about the same as other trusts.

Medicines

- There were suitable arrangements in place for management of medicines which included the safe ordering, prescribing, dispensing, recording, handling and storage of medicines.
- Medicines were stored securely in the children's clinic. Room and fridge temperatures were checked daily and that these had all been within the required range.
- Controlled drugs were stored in accordance with required legislation. A register was used to record details of controlled drugs received into the cupboard, administered to individual patients as well as those that had been disposed of. We reviewed a sample of controlled drugs and found that accurate records had been maintained. Staff told us controlled drugs would be rotated to the children's ward at WRH before their expiry date, to save on wastage.
- Medicine administration records specifically for children was used to record medication prescribed and administered and we saw these had been completed appropriately in the patient files we reviewed. Each patient had their weight checked and prescriptions were written accordingly.
- If patients were allergic to any medicines this was recorded on their prescription chart.

- Checks were made on stock levels by the band 5 staff nurse and doctors. Keys to the medicines room and cupboards were held by the band 5 nurse, who was the nurse in charge, throughout the shift.
- There had been no medication incidents reported from September 2016 to November 2016.

Records

- Children and young people's individual care records were available on every shift at the children's clinic. Records were generally written and managed well. However, record templates were not always clear. For example, staff at the children's clinic recorded children's height and weight at every appointment. This was recorded in the patient history section of their records, but there was no specific area on the record for patients' height and weight to be recorded. Therefore, staff were recording this information in the patient history section that their written records referred to the height and weight of the child or young person. This could have confused someone reading the record from the trust's electronic record system.
- We found children and young people's records were locked securely in the children's clinic office. Records we reviewed were mainly legible and up to date and contained an appropriate level of information.
- Children and young people's records were scanned following every clinic onto the trust's electronic system. We viewed five children and young people's clinical records and found these were mostly clear and legible.
- Children and young people with child protection plans records could only be accessed by staff that had authorised access.
- There were flags on the system to identify vulnerable patients. For example, children subject to child protection plans.
- Staff told us there had not been any record audits since the service reconfiguration and they were not aware of any planned records audits.

Safeguarding

- There were systems in place to ensure safeguarding concerns were identified and reported. Nursing staff at the children's clinic told us safeguarding concerns would be recorded on the trust's electronic system. Staff would be alerted on the electronic system where there were safeguarding concerns in regards to a child.
- A new head of safeguarding was appointed in January 2016 and commenced in post May 2016. Staff at the children's clinic could name members of the safeguarding team and knew how to contact them if they needed support in identifying concerns and taking appropriate action. Staff at the children's clinic said they had not made any safeguarding referrals since the reconfiguration of services. Staff understood the safeguarding process and how to make a referral.
- There was an alert field in children and young people's notes to alert staff if there were safeguarding concerns relating to a child or young person.
- Staff we spoke with had an understanding of the types of concerns that would prompt them to make a safeguarding referral including; neglect, physical, emotional, and sexual abuse. However, nursing and support staff said they were not aware of female genital mutilation (FGM) and said they had not received any training on child sexual exploitation (CSE); although most of the staff told us they would seek advice from the safeguarding team if they had concerns.
- There were arrangements for safeguarding supervision and the staff we spoke with told us they could access this from the safeguarding team.
- There are four levels of safeguarding training, levels one, two, three and four. 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 three'. Named professionals must be trained to level four. Registered nursing staff at the children's clinic said they had completed their level three training on the day prior to our inspection.
- We also found some staff were receiving level three training via e-learning, this was not compliant with the intercollegiate document which states that level three training should include face to face training, and this should be updated annually.
- Young people aged between 16 and 19 would sometimes choose to join adult theatre lists. Senior nursing staff in the main theatres were unaware of the

intercollegiate document guidance and didn't know what level of safeguarding training they had completed. Staff we spoke with in theatres told us they were level one safeguarding trained.
- Staff in the main theatres told us they didn't have any staff that were trained in paediatric immediate life support (PILS).
- Staff in the main adults' outpatients department were expected to do safeguarding adults and children at level two. However, data submitted by the trust showed that only 58% were compliant with level 2 safeguarding children training.

Mandatory training

- There was a structured induction and mandatory training programme for staff.
- We viewed the women and children's division 'workforce and training metrics' which provided us with information from July 2015 to June 2016. 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.
- Staff were allocated dedicated time to complete 'face to face' mandatory training, such as basic life support. Some of the mandatory training was completed online and it was expected that staff complete 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. However, we viewed staff training records and found that not all mandatory training had been updated in accordance with the trust policy.
- Overall, the women and children's division had a compliance rate of 64% for all mandatory training courses. The training percentages were not presented to us for each site, this data related to all sites. Some courses had been poorly attended by specific staff groups whilst others had been well attended, for example, 0% of additional professional and technical staff had completed conflict resolution and equality and diversity, although 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 for example, 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 life support (BPLS). This was against a trust target of 90%.
- Across all sites the percentage of children and young people's staff trained Paediatric Immediate 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 the figure in 2015, 68% of nursing staff had completed EPLS compared to 48% in 2015.

Assessing and responding to patient risk

- Nursing staff at the children's clinic told us they did not complete risk assessments. Risks were assessed on an ongoing basis at each appointment for long-term outpatients or at individual clinics for children or young people attending one appointment. Staff told us visiting nursing or medical would assess risks to patients on the day of their appointment and would escalate any concerns for further investigation or transfer the child or young person to WRH.
- Staff in the MIU had received training in paediatric life support to mitigate the risks to a child in the hospital needing immediate resuscitation.
- There had been no training for nursing staff to enable them to recognise sepsis.
- Staff in the children's clinic were trained in PILS and able to describe what actions they would take if a patient's condition deteriorated within the department. The trust had a deteriorating patient policy available to staff on the trust intranet.
- The MIU did not have support from a paediatrician. Staff told us children attending the MIU who required inpatient care would be stabilised and transferred to WRH by a 'blue light' ambulance.
- There were clear protocols describing how children should be transferred to WRH if they needed to be treated by a specialist paediatric doctor. Staff told us as part of the trust's reconfiguration all clinical staff in the

MIU had received training in advanced paediatric life support. The hospital did not have a paediatric 'crash team' but staff in the MIU were trained in paediatric life support.

- Staff at the children's clinic told us the paediatric early warning score (PEWS) tool was used at WRH and was used at Kidderminster Hospital MIU and the children's day ward to monitor and manage children and young people. The children's clinic did not complete PEWS on outpatients.

Nursing staffing

- Staffing levels were planned and reviewed in advance based on an agreed number of staff per shift.
- Women and children's division had a performance dashboard; this was used to monitor staffing levels, sickness levels, and vacancies. The dashboard was a useful tool for managers in giving them an oversight of staffing across the division. However, it did not provide information on specific services or site level information.
- Managers told us that during the service reconfiguration, skill mix required for the children's clinic and how to utilise the staff skill set had been considered. The nursing staff at the children's clinic were all registered nurses (child branch) and trained in advanced paediatric life support. Staff at the children's clinic told us that staffing arrangements worked well.
- The MIU had three dual registered paediatric nurses, these are nurses qualified to work with both children and adults. Staff on the MIU told us paediatric trained nursing staff were rotated to ensure there was a nurse with paediatric nurse on every shift during the day. However, staff said they could not always ensure there was a paediatric nurse available during the night.
- The senior nurse on site was a registered band 5 nurse who worked 30 hours a week Monday to Thursday. The nurse had support on Mondays from a health care assistant (HCA) and a receptionist on Monday, Tuesday and Thursday. The nurse was supported by telephone by the outpatient's manager who was based at WRH. As at September 2016, the trust reported a vacancy rate of 13% in children's services across all sites. There were no nursing vacancies in the children's clinic in November 2016.
- As at September 2016 the trust reported a vacancy rate of 13% in children's services across all sites including: WRH, Alexandra Hospital and Kidderminster Hospital and Treatment Centre.
- As at September 2016 the trust reported a turnover rate of 17% in children's services, across all sites.
- From March 2015 to April 2016, the trust reported a sickness rate of 3% across all sites in children's services. Children's clinic staff told us if the band 5 nurse was absent due to sickness the hospital would not use agency staff. A nurse would be sent from WRH to cover the band 5's absence.
- The minor injuries unit (MIU) employed three part time registered children's nurses. These were rotated on the MIU roster to provide cover during the day, but staff said they did not always have a paediatric nurse on the roster at night.

Medical staffing

- Managers told us one of the reasons for the reconfiguration was to alleviate pressure on the middle grade doctors' rota across the trust. There were no vacancies for paediatric medical staff at Alexandra Hospital.
- Staffing levels and skill mix were planned at the children's clinic so that patients received safe care and treatment. Outpatient clinics were held at Kidderminster Hospital and Treatment Centre Monday to Thursday. Outpatient clinics were staffed by visiting consultants and middle grade doctors from a range of specialties.
- Wednesday was a dedicated day for day case surgery. A consultant paediatrician was on site in the clinic on Wednesdays to offer support to the children's day surgery facility. However, we did not speak to any medical staff from the day surgery unit as there was no operating going on whilst we were in the hospital.
- The children's clinic had contact telephone numbers and access to advice from specialist paediatric consultant at the paediatric assessment unit (PAU) at all times.
- As at September 2016 the trust reported a consultants vacancy rate of 7% in children's services across all sites including: WRH, Alexandra Hospital and Kidderminster Hospital and Treatment Centre. The vacancy rate for other medical staff was 18% across all sites.
- From September 2015 to August 2016, the proportion of consultant and junior (foundation year one to two) doctors reported to be working at the trust were about the same as the England average for consultants and higher than the England average for junior doctors. A breakdown of the staffing skills mix was:

- 39% consultants, compared to the England average of 40%
- 3% middle career doctors, compared to the England average of 7%
- 39% registrars, compared to the England average of 46%
- 18% junior doctors, compared to the England average of 7%.

- Bank and locum usage across all sites varied between 5% and 10% from September 2015 to August 2016 across the trust's sites.

Major incident awareness and training

- The trust had a major incident plan in place and staff knew how to access this on the trust's intranet. However, staff in the children's clinic told us there was no business continuity plan they were aware of, to deal with issues, for example, adverse weather. Staff told us that they had an informal business continuity plan, whereby a staff member who lived locally would come in to the clinic and telephone families to cancel and rearrange their appointments.
- Staff at the children's clinic told us they had not been involved in any major incident scenarios.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

- There were some out of date policies relating to safeguarding children that were not available on the trust intranet, including a 'no allegations policy'; and a 'managing celebrity visits' policy. The safeguarding supervision policy also stated that it was in development on the intranet safeguarding pages.
- There was no clinical audit plan for the children's clinic. There was little evidence that continual improvement of the service and compliance with best practice was identified or actions taken to address shortfalls.
- The women and children's division had introduced a performance dashboard to monitor patients' outcomes. There was little evidence that performance in the children's clinic was discussed.
- We viewed nursing staff competency assessment records and found these were all out of date. This meant the hospital could not be sure that staff were competent in all the skills required for their role.
- There was no formal clinical supervision for nursing staff. Supervision was provided by an outpatient's manager, working at a different site, via telephone. However, this manager also worked in WRH as an approved nurse practitioner, and could only offer staff telephone support when there were quiet periods at WRH.

However:

- There was a multidisciplinary approach locally at the hospital to provide support for children with their long-term nutritional needs, including diabetes clinics and input from dietitians.
- The trend for appraisal rates from April 2015 to August 2016 demonstrated improvement, with an appraisal rate of 89% for medical and dental staff.
- Non-clinical staff told us they met daily with the band 5 staff nurse and could ask for advice throughout the day as they worked closely as a team.
- There was support for patients from allied health professional services, including physiotherapy and dietetics.
- Children, young people and parents and carers were supported by staff to make decisions.

Evidence-based care and treatment

- Patient's care was mostly planned and delivered in line with evidence based guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines. For example, we viewed the transitional care pathway for young people with diabetes, treated in outpatients that were transitioning to adult services. The pathway was based upon the National Service Framework (NSF) for young people and the NSF for diabetes. However, there were no audits of guidelines or quality standards planned or in process.
- Policies and guidelines were available on the trust intranet along with regional and national guidance. There were a range of trust wide policies as well as those specific to children and young people. However, some were out of date, for example, the mental health pathway for children under 12 years.

Pain relief

- Staff at the children's clinic told us pain assessments were not undertaken at the children's clinic. However, staff offered parents and carers advice following vaccinations to ensure pain was managed effectively.
- Distraction techniques were used to divert children from painful procedures such as vaccinations, and anaesthetic cream was used when taking blood from children.
- We were unable to speak with staff in the day surgery unit with regards to pain relief due to their not being any paediatric lists or staff available at the time of our visit.

Nutrition and hydration

- Patient's nutritional and hydration needs were met at the children's clinic. Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs, including input from dietitians.
- Water was available in the children's clinic and visitors could help themselves as required.
- Staff in theatres told us drinks, snacks and an appropriate choice of food were available for children and young people who had undergone surgical procedures. Special foods, for example Kosher and Halal were available on request.
- The children, young people and parents we spoke with told us they were satisfied with the food and drinks provided.
- Snacks were available from machines in the hospital 24 hours a day. These included fruit, sandwiches, crisps and cereals. This meant that patients could buy food at any time.
- Staff working in the children's clinic promoted breastfeeding without judgement. They offered support to help mothers as much as possible, including offering a private bay.
- Children and young people were weighed at every appointment and their weight assessed for their specific condition.
- Children and young people had access to speech and language therapists for swallowing assessments, advice and support via referral form the children's clinic.

Patient outcomes

- There was no local clinical audit plan for the children's clinic at Kidderminster Hospital and Treatment Centre. Staff told us audits had been suspended to allow staff to concentrate on the service reconfiguration. This meant that information that would provide continual improvement of the service or monitor compliance with best practice was not collected.
- Outcomes from patient's care and treatment was collected and monitored in line with national audit requirements by the children's service. However, intended outcomes for some patients were worse than the national average and the trust had reconfigured children's services to make improvements. For example, the trust took part in the National Paediatric Diabetes Audit (NPDA) 2014/15 which showed that the percentage of patients with controlled diabetes was worse than other trusts.
- HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/l and 58 mmol/l (7% and 8%)". In the 2014/15 diabetes audit the trust performed worse than the England average. There were fewer patients at Alexandra Hospital (17%) having a HbA1c value of less than 58 mmol/l compared to the England average (22%). The hospitals mean HbA1c (73%) was higher than the England average (71%).
- The women and children's division had introduced a performance dashboard to monitor patients' outcomes. We viewed the dashboard and found it was largely aimed at monitoring children and young people that were admitted as inpatients to WRH. However, the performance and efficiency metrics dashboard monitored the number of children and young people's waiting for outpatients' appointments, the referral to treatment (RTT) times, and the numbers of children and young people that did not attend their appointment. Even though there was evidence in governance meeting minutes that performance dashboard was reviewed, there was little evidence in the minutes that performance in the children's clinic was discussed.

Competent staff

- Staff completed an annual appraisal as part of their personal development review. Staff at the children's clinic told us they had completed their appraisal within the preceding 12 months. From April 2015 to March 2016, 85% of staff within children's services and across

all sites at the trust had received an appraisal, meeting the trust target of 85%. In this period 88% of medical and dental and 76% of other medical staff received an appraisal. From April to August 2016 88% of medical and 82% of other medical staff received an appraisal. However, it should be noted that the data provided by the trust did not differentiate between children's services and women's services, therefore, these percentages included data provided under women's and children's services

- The trend for appraisal rates from April 2015 to August 2016 demonstrated improvement, with and appraisal rate of 89% for medical and dental staff, compared with the figure from April 2015 to March 2016, when the rate had been 87%. There was also improvements in appraisal rates for non-medical staff groups with the rate having risen from the April 2015 to March 2016 rate of 76%, to the April to August 2016 rate of 82%. Neither of the two staff groups reached the trust target of 90% although appraisal rates for non-medical staff had improved noticeably between the two periods.
- Most staff had the right qualifications and experience to carry out their role, for example there were specialist nurses for clinics, including diabetes, respiratory, asthma and epilepsy. Staff told us work was in progress to introduce urology clinics to the children's clinic.
- Staff told us the trust would fund staff gaining further qualifications and training as long as this was relevant to their role.
- We viewed nursing staff competency assessment records and found these were all out of date. Staff conceded that the competency assessments should have been done. This meant the hospital could not be sure that staff were competent in all the skills required for their role.
- Registered nursing staff at the children's clinic told us there was no formal or regular clinical supervision. Staff said they could ask for clinical supervision. Nursing staff told us the outpatients' manager was available on the telephone if staff needed advice and the medical staff at children's clinics would also offer advice. The outpatients' manager told us they would return telephone calls during quiet periods in their work at the outpatients department at WRH.
- The children's clinic band 5 registered staff nurse told us they met daily on an 'ad hoc' basis with the clinics health care assistant (HCA) as they worked closely as a team
- The main outpatients department did not have any paediatric trained staff, even though some clinics had mixed lists for both adults and children. However, staff in the children's clinic told us if the children's clinic was not busy, they would sometimes support children and young people in adult clinics.
- Nursing staff told us they had not received any training in recognising the signs and symptoms of sepsis (blood poisoning), although staff said there had been risk briefings circulated by the trust that carried information in regards to sepsis.
- There was a process in place to ensure all medical and nursing professionals had their registration status monitored. We confirmed through review that all staff listed as employed and registered had a valid registration.
- The Royal College of Nursing safer staffing guidance recommends that each ward or department has at least one qualified member of staff working each shift who has undertaken European Paediatric Life Support (EPLS) training. We reviewed the band 5 lead nurse's training record which confirmed this recommendation had been met for each for each shift at the children's clinic.
- Nursing staff attended monthly outpatients' clinic meetings. These were meetings where staff from across all the trust's children's outpatients' teams met. Staff told us the meeting was an opportunity for staff to share learning and new practice.

Multidisciplinary working

- We did not get the opportunity to observe how nursing and support staff worked together in the children's clinic, due to both the HCA and receptionist being on annual leave.
- Clinics were staffed by a range of visiting medical staff and therapists. We spoke with a visiting GP who told us they worked well with the children's outpatients' team.
- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patients care and treatment.
- Staff at the children's clinic told us there were regular multidisciplinary team (MDT) meeting that were attended by managers and therapy staff. Staff told us they received minutes from the meetings, but did not attend any MDT meetings. The outpatients' manager told us that children and young people's services

worked collaboratively across sites and said other departments worked well with children and young people's services; however, we did not see evidence of this.
- The staff we spoke with in the children's clinic told us that there was good support for patients from allied health professional services, including physiotherapy.
- Nurse specialists in respiratory medicine, diabetes and epilepsy were employed to provide expert support to children, young people and parents or carers in the outpatient clinics.
- We saw multidisciplinary team involvement in care was documented in children and young people's notes.
- Staff told us they liaised regularly with staff at the inpatient ward at WRH and the children's clinic at Alexandra Hospital.
- In the CQC children's survey 2014 the trust scored 9.18 for the question: 'Did the members of staff caring for your child work well together?' This was better than other trusts.

Seven-day services

- The minor injuries unit (MIU) at Kidderminster Hospital and Treatment Centre was open 24 hours a day, seven days a week. In total, it saw 20,211 patients between November 2015 and October 2016. Of those, 5,755 were aged between zero and 16 years old. The percentage of patients attending the unit had decreased by 22% since our last inspection in July 2015.
- The children's clinic operated from 9am to 5pm Monday to Thursday.

Access to information

- Patients care and treatment was planned and shared with other services as necessary.
- Patient records were requested 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 approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- A copy of the child or young person's discharge summary was sent to their GP on discharge from the service.
- 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.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff said they understood the relevant consent and decision-making requirements of legislation and guidance.
- We did not see any examples of Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) assessments. However, staff we spoke with had a good understanding of gaining consent from children and young people and the guidance in regard to a child's capacity to consent, including Gillick competency. These are guidelines which help to balance children and young people's rights and wishes with regards to consenting for treatment without their parent or carer.
- The trust reported as at September 2016 that MCA and 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%.
- Nursing and support staff told us they would consult medical staff if they had concerns in regards to MCA and the DoLS. Nursing staff said they had never had to use the MCA or DoLS.
- Children, young people and parents or carers were supported by staff to make decisions. Staff and patients we spoke told us their care and treatment was explained to them and they were told about different the care and treatment options available.
- The trust informed us a consent audit for children's services was not part of the forward plan for 2016/17, 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?

Services for children and young people

Good

We rated caring as good because:

- Staff who worked on the children's departments 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.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts including privacy and about care and treatment and staff friendliness.
- Staff communicated with children, young people and their families in a way that they could understand their care and treatment
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of information available in the children's clinic.
- Staff understood the impact that a patients care, treatment and condition had on them and those close to them.

However:

- The NHS Friends and Family Test (FFT) had been suspended in the departments where children were treated since the service reconfiguration. Patients' feedback could not be used to monitor and improve services.

Compassionate care

- Staff who worked on the children's clinic took the time to interact with patients and their parents in a manner which was respectful and supportive. We observed staff supporting children and young people in a kind and caring manner. For example, a band 5 nurse spent time reading to children in the waiting area on the clinic.
- 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. A parent told us, "They've been really lovely."
- The trust performed about the same as the England average for 11 out of 14 questions relating to compassionate care in the CQC children's survey 2014. The trust performed better than other trusts for the questions, 'Were members of staff available when you or your child needed attention?' 'Did new members of staff treating your child introduce themselves?' and 'Do you feel that the people looking after you listened to you?'
- Patients did not have the opportunity to provide feedback via the NHS Friends and Family Test. The NHS 'Friends and Family' Test (FFT) 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. However, the FFT had been suspended in children's clinics since the service reconfiguration. This meant the children's clinic was missing an opportunity to measure children, young people, parents and carers opinions on their care and treatment at the clinics following the reconfiguration.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts including privacy and about care and treatment and staff friendliness; the survey found feedback was better than other trusts for staff attentiveness when a child or young person needed attention and staff introducing themselves.

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. For example, children's services had introduced a teenage care pathway to support young people and involve them in their care planning.
- All of the patients and relatives we spoke with in the children's clinic told us that staff had communicated well with them and that they were satisfied with explanations provided about their care and treatment.
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- Staff told us parents and carers stayed with children throughout their patient journey, by escorting children and young people to theatres and being reunited with the children in the recovery bay.

Services for children and young people

- There was a range of information available on the children's clinic for parents or children and young people to take away with them or read in the waiting room, this included information on what children, young people, parents and carers could expect following a vaccination and the flu vaccine. There were also leaflets providing information on how to make a complaint and how to contact the patient advice and liaison service (PALS).
- The trust performed better than other trusts for two out of 19 questions relating to understanding and involvement of patients and those close to them in the CQC children's survey 2014. The trust performed better than other trusts for the questions: 'Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?' and 'Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?' The trust performed the same as other trusts for the remaining 17 questions.
- The Care Quality Commission (CQC) children and young people's survey 2014 reported that the children's service had performed about the same as other trusts for communication.

Emotional support

- The trust performed better than other trusts for three out of three questions relating to emotional support in the CQC children's survey 2014.
- Staff understood the impact that a patients care, treatment and condition had on them and those close to them. Emotional support was provided whilst caring for patients; however there was minimal formal support available. For patients and families, who may have been distressed, support was provided by the medical, nursing, and HCA staff team, not trained counsellors.
- Patients and their families could access support from the chaplaincy service which provided support across the hospital.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Services in the children's clinic took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities.
- Transition arrangements were in place for patients approaching adulthood. This ensured children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- The trust's 95% target for referral to treatment time (RTT) for non-admitted children and young people receiving an appointment within 18 weeks was regularly met.

However:

- The 'did not attend' (DNA) appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%.
- Allergy service waiting time was up to 14 weeks due to the service only having one consultant.

Service planning and delivery to meet the needs of local people

- Information on the needs of the local population was used to inform how services were delivered. The trust informed us the annual business plan 2016/17 for neonatal and paediatric services was in development. The 2015/16 plan was based upon the centralisation of paediatric and neonatal inpatient services at WRH. The trust told us the goals of the plan had been achieved with the centralisation of inpatient services at WRH.
- The trust's children's inpatient services had been temporarily transferred to Riverbank Ward at WRH from 7 September 2016. Managers told us this was an emergency measure. Inpatient services at the hospital had been gradually reduced from April to September 2016 It was estimated that the service change would be in place until the outcome of the 'Future of Acute Hospital Services in Worcestershire,' public consultation was available, or until there was consistent 24/7 medical

cover for two paediatric rotas to ensure safe services. Managers told us the service reconfiguration had been a "huge move" and had involved the "whole health economy."

- Patients and stakeholders were involved in service development, with targets set by the commissioners considered. Managers said the public consultation would involve patients and stakeholders in service planning, and added that they hoped the outcome of the consultation was that the trust could maintain the reconfiguration model with WRH as a 'central hub' and the Alexandra Hospital and Kidderminster Hospital and Treatment Centre acting as satellite clinics.
- Managers told us that prior to the reconfiguration of services the trust had informed the public via the local press, as well as other stakeholders including the local Member of Parliament (MP).
- Children and young people who arrived at the hospital, requiring acute inpatient admission or emergency care that could not be managed in the MIU would be transferred to the WRH.
- Staff told us the reconfiguration had not made a significant difference in children and young people's services at Kidderminster Hospital and Treatment Centre. Staff told us a new 12 week outpatients' clinics rota was being introduced across all sites at the trust. Staff said this would mean consultants would rotate across the trust sites and there would not be a regular consultant on any site.
- The outpatients' manager said they were putting together a business case to have a band 7 and two further band 6 nurses for the children's clinics. The outpatients' manager told us, they were in the process of costing the business plan, once this had been completed, the plan would be submitted for consideration.
- The children's clinic offered two to three clinics a day. On the day we visited there was one community paediatric clinic. Children also had scheduled appointments with the nurse to have blood tests. Staff told us the service also offered a fortnightly diabetic clinic and a pre-operative clinic at the children's clinic. Staff told us from December 2016 children and young people's services were introducing a new 12 week rolling programme of clinics and the children's clinic would be offering extra clinics.
- There were four theatres dedicated to paediatrics on a Wednesday morning, which were used for community dental surgery, ear, nose and Throat (ENT), head and neck, ophthalmology and general surgery. Day surgery was available to children and young people between the age of two and 17 years. There were day surgery lists on three Wednesdays a month. These were staffed by a visiting paediatric team from WRH.
- Staff at the MIU said the department would accept children in ambulances, but the ambulance service would telephone the department prior to taking a child to the MIU.
- In the CQC children's survey 2014 the trust scored 9.17 for the question 'Did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts.

Meeting people's individual needs

- Services were planned in a way that took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities. For example, there was a dedicated child friendly playroom waiting area for younger children equipped with toys and play equipment. The main children's clinic waiting room was equipped with magazines and books for older young people.
- Staff told us there were no psychiatric support clinics available at the children's clinic; but that clinics were due to be increased in December 2016. Staff did not know whether psychiatric support clinics would be offered; but said they could refer children in need of psychiatric support to the child and adolescent mental health service (CAMHS).
- Staff told us children or young people with a learning disability would be offered a private bay upon request if they did not wish to wait in the main waiting room. We saw a band 5 nurse supporting a child with a learning disability by explaining an 'easy read' format document to the child. Staff told us they could liaise with the learning disability team based at WRH if they required advice on supporting children or young people with a disability.
- Translation services were available either by using a telephone translation service, or face to face interpreter services could be arranged during office hours if required. We were told there was limited demand for translation services.
- Staff in theatres told us play therapists were available at Kidderminster Hospital and Treatment Centre for

children attending day surgery. Play therapists facilitate communication between medical and nursing staff and patients and their parents to ensure the child's needs are catered for during care and treatment.
- Children and young people's ethnicity and religious needs were recorded on their patient records at the time of first registration with the children's clinic.
- The trust performed better than other trusts in the CQC children's survey 2014 for the question: 'Did you have access to hot drinks facilities in the hospital?' and about the same as other trusts for the question 'how would you rate the facilities for parents or carers staying overnight?'
- Staff told us the treatment room would be made available to women that were breast feeding.
- Staff had been pro-active in resourcing the children's clinic. Staff showed us activity books for children aged five to 12 years which were offered to children in the waiting area to occupy them when waiting for their appointment. Staff had also produced quiz sheets for parents or carers to complete with children or young people, as well as sticker books and crayons and paper. However, staff told us the hospital: "Could do more for children with sensory needs."
- Theatre staff told us visiting day surgery staff brought a range of toys and equipment with them when there were children's lists.
- The MIU had a children's waiting area, opposite the MIU reception desk. An alarm had been installed to ring for help if required. We were told by staff that children generally waited in the main waiting area where there was also a small provision of toys.
- The fracture clinic in the MIU was child friendly and had a 'hungry butterfly' theme.
- Staff told us children would join the main waiting list for MIU. However, staff added that if there were concerns about a child they would be seen without delay.
- The main outpatients department had mixed adults and children's lists for ENT and dermatology. Older children and young people waited for their appointment in the main outpatients department waiting area, which had no special facilities for children or young people, such as toys, books or magazines. However, the main outpatients waiting area was next door to the children's clinic waiting room and younger children could wait in the children's clinic waiting room.
- There were suitable bathroom facilities for patients with a physical disability and adequate space on the all the wards and clinic areas we visited to accommodate children, young people and their families or carers who used wheelchairs.
- Patients had access to a chapel and multi faith room on site.
- In the CQC children's survey 2014 the trust scored 9.80 for the question 'for most of their stay in hospital what type of ward did your child stay on?' This was about the same as other trusts, but related to all of the trust's hospital sites and Alexandra Hospital prior to the service reconfiguration.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.

Access and flow

- Across all the trust's hospital sites, from April 2015 to March 2016 the median length of stay for elective patients under the age of one was zero, for emergency patients it was one day, these were the same the England average. However, these figures relate to a period prior to the service reconfiguration.
- Across all the trust's hospital sites, from April 2015 to March 2016 the median length of stay for both elective and emergency patients aged one to 17 years was one day this was the same as the England average. However, these figures relate to a period prior to the service reconfiguration.
- We viewed the children's services performance and efficiency metrics dashboard. We found the number of children or young people on the trust's outpatients' waiting list had steadily increased from 327 in October 2015 to a peak of 855 in April 2016. The numbers of children and young people waiting was over 800 until September 2016 when the figure reduced to 791. The trend was again downward in October 2016 with 723 children and young people waiting for appointments across all the trust's sites. The downward trend coincided with the service reconfiguration.
- The trust's 95% target for referral to treatment time (RTT) for non-admitted children and young people receiving an appointment within 18 weeks was regularly met across all sites, with the exception of October, February, June and July 2016, when the percentage of

children and young people seen within the 18 week target was 94%. The percentage of children and young people waiting for an appointment had stabilised and was regularly 97%.

- The 'did not attend' (DNA) appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%, and was 10% or above in May, July, and August 2016. The DNA rate for follow up appointments was regularly above the trust's 7% target, reaching a peak of 17% in August 2016. This meant hospital resources were wasted and there was a financial cost implication for the trust. Staff at the children's clinic were unable to tell us what measures the trust had introduced to reduce the numbers of children and young people that did not attend appointments.
- Access to the children's clinic was via a single point of access (SPA). This was a call centre based at the hospital. GPs could make e-referrals to the children's clinic via the NHS e-referrals scheme. Urgent referrals would be seen within two weeks; routine referrals would be seen within seven weeks. Emergency referrals would go directly to the paediatric assessment unit (PAU) at WRH and be triaged on the same day. However, staff at the booking service told us the allergy service wait was up to 14 weeks due to there only being one consultant who offered allergy testing.
- All referrals from any source were triaged by the PAU consultant at Riverbank Ward at WRH. The PAU team would book a time for a child's appointment, and would send an email to the children's clinic team at Kidderminster Hospital and Treatment Centre to inform them of the booking.
- There was a consultant available on the PAU at all times for staff to access advice. The PAU consultant also acted as the urgent on-call consultant.
- All children and young people arriving at the children's clinic would first book in with the clinic receptionist, and then have their height and weight measured and recorded. Children and young people would then wait in the waiting room until called for their appointment.
- The children's clinic administrator arranged appointments on the electronic appointments system. Clinics were co-ordinated by the department of medical records at WRH, and some clinic times had been changed as a result of the service reconfiguration. Managers told us: "There have been no complaints about clinics being reconfigured."
- Staff told us children and young people were sent an appointment time for clinics. Staff told us if parents or carers wished to change an appointment they could telephone the children's clinic to rearrange it.
- None of the parents and carers we spoke with told us they had long waits at the children's clinic. We did not see any children or young people waiting for over 20 minutes for their appointment. The outpatients' manager told us the children's clinic staff were; "excellent at keeping to appointment times."
- Parents and carers we spoke with told us they had not had clinics cancelled. The policy for cancellation was the hospital would provide six weeks' notice. Staff we spoke with were aware of the policy. Staff told us that where a clinic had to be cancelled due to staff sickness, patients would be telephoned as soon as the children's clinic were aware of the absence, informed of the clinic cancellation, and given a new appointment in the same telephone call. Staff at the booking office told us clinics could be cancelled within six weeks, but this needed directorate approval. Staff said cancelling clinics with under six weeks did not happen frequently.
- Children, young people and their families were positive about services at the children's clinic and told us waiting times in the clinic were short. One parent said: "We don't wait long at all."
- Children and young people arriving for day surgery would use the main theatre admission procedure. However, on Wednesday mornings theatres and surgery did not admit adult patients and were dedicated to children's surgery.
- Day surgery had staggered admission times. There were six bedded day case bays for patients in recovery with 14 spaces available, although on average the unit had six patients at any one time. However, from a review of incidents we saw that one incident in March 2016 had been recorded due to day surgery running over the 12.30pm deadline and four patients having their procedures cancelled.

Learning from complaints and concerns

- From September 2015 to August 2016 there were 10 complaints about children's services. The trust took an average of 29 days to investigate and close complaints; this is not in line with their complaints policy, which states that 90% of complaints should be closed within

25 days. However, managers told us the children and young people's service had been compliant with the trust's 25 day complaints investigation target since June 2016.
- There was a process in place for responding to complaints and information was available to make patients aware of how to make a complaint.
- Leaflets and posters informing patients how to make a complaint or contact patient advice and liaison service (PALS) were available in the children's clinic.
- Staff told that most complaints were resolved and responded to immediately. Managers told us they identified trends from complaints, and complaints were mostly due to communication issues from nursing and medical staff. Staff and managers told us formal complaints were rarely received.
- Although complaints were received infrequently we were told by staff that they would be discussed with the outpatients' manager. Managers told us complaints handling in children and young people's services had improved. This was due to joint weekly and monthly reviews of complaints with staff. Managers had also completed multidisciplinary training in complaints handling. Staff told us learning from complaints was disseminated by the outpatients manager via email or when the manager visited the department.

Are services for children and young people well-led?

Inadequate

We rated well-led as inadequate because:

- The delivery of high quality care was not assured by the leadership, governance or culture. As a result of the urgent, temporary service reconfiguration the children's service did not have a clear vision, and did not have a long-term strategy for children's services. Staff were unaware of the vision and values for the children's outpatients' service as these were undefined and staff were not involved.
- The governance framework was not effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings.
- Monthly divisional governance meetings were not consistently adhering to their terms of reference (TOR). This included: not focusing on themes and trends from incidents; safeguarding training performance, being reported as mandatory training, and not broken down to include compliance with level three safeguarding training. Discussions with regards to the divisional risk register focused on the number of risks recorded rather than how they were being managed. There had been little discussion around how the children's services transitional period was being managed.
- The outpatients manager had not been allocated any contracted hours for service leadership and they were fitting this in with their advanced nurse practitioner (ANP) role at WRH. Therefore, was completely out of touch with day to day issues that affected the service as it was run, by a band 5 nurse, who was completely unsupported.
- Staff did not receive timely supervision and advice.

However:

- There was good teamwork in the children's clinic and committed staff.

Leadership of service

- In September 2016, the trust introduced a new divisional structure. Children's and young people's services featured within the women and children's division. Leadership was provided by a divisional team which included the acting divisional medical director, the director of nursing and midwifery, and the director of operations.
- The children's service had a documented accountability structure. The senior staff nurse and specialist nurses reported to the outpatients' manager. The outpatients' manager reported to the divisional quality and governance lead. The divisional lead reported to the divisional team. Medical staff reported to the interim clinical director, who also reported to the divisional team.
- Senior managers told us the chief executive was approachable and always responded to emails. The managers said they had been consulted and involved in the service reconfiguration, mostly by the project

manager who ensured they stayed informed. However, staff in the children's clinic told us they had not been visited by any directors or divisional managers since the reconfiguration.

- The outpatients' manager told us divisional leaders were visible and approachable; and ward staff understood the challenges at a local level. However, it was not apparent that divisional leaders fully understood the challenges children and young people's services presented in the children's clinic. For example, managers were unaware of staff confusion over incident reporting guidance.
- The staff we spoke with told us that they had good working relationships with the manager for outpatient clinics, and the manager was supportive and approachable. The outpatients' manager was a band 8. They told us they managed 19 staff as well as working in their role as an ANP at WRH. The outpatients manager told us they had not been allocated any contracted hours for service leadership and they were fitting this in with their ANP role. The outpatients' manager was supported at WRH by a band 6 senior staff nurse that worked across all sites. The manager said the band 6 gave them a management day; "Where they can." However, due to their other commitments the manager could not visit the children's clinic at Kidderminster Hospital and Treatment Centre on a regular basis. This meant that staff did not receive timely supervision and advice as the outpatients manager could only contact staff when they were not busy at WRH
- The children's clinic was a nurse led clinic. The local leadership at the clinic was a band 5 staff nurse.

Vision and strategy for this service

- As a result of the emergency reconfiguration the children's service did not have a clear vision. Managers told us there was not a fixed date for the public consultation on service reconfiguration, but the consultation process would take three months. Managers said the consultation would probably take place early in 2017. Managers told us the trust had a vision for children's services that was based on the reconfiguration central hub model; but the trust could not produce a long term strategy for the service until the outcome of the public consultation was available.
- Staff were unaware of the vision and values for the children's outpatients' service as these were not defined.
- Staff were aware of the trust's 'Patients, Respect, Improve, Dependable, and Empower' (PRIDE) values, and told us staff annual appraisals were structured around the trust's values.

Governance, risk management and quality measurement

- Kidderminster Hospital and Treatment Centre children's services were part of the Women and Children's Division. There was a 'ward to board' flowchart that demonstrated clearly the divisional structure and lines of accountability. However, children and young people's outpatients were not identified on the flowchart. Paediatric reporting was identified, but this only listed WRH, Riverbank Ward.
- The governance framework had been restructured in September 2016 with the trust moving to a new divisional structure to manage the delivery of clinical services. There was a four weekly divisional report based upon weekly current situation reports.
- The outpatients managers reported to the divisional meetings, these meetings fed into the clinical governance group and quality governance committee, these meetings fed into the trust board meeting.
- The governance framework was not effective because there was no evidence that information with regards to paediatric outpatients 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 committee's terms.
- There was a women and children's division monthly governance (WCGM) meeting, as well as a monthly children's directorate quality improvement committee (QIC). Both committees were independent of each other and there was no formal approach for information to flow between the two committees.
- 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 September 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 meeting minutes. For example, discussions around incidents still focused on the numbers and the length of time they had taken to complete rather than themes and trends. Also, safeguarding training performance, was reported as mandatory training, and not broken down to include compliance with level three safeguarding training.
- Discussions with regards to the divisional risk register, focused on the number of risks recorded rather than how they were being managed. For example, the September 2016 minutes recorded: four moderate risks recorded, with no actions. Overdue actions were due to be reviewed by end of September 2016. There was no indication of which directorate the risks related to, what they were and whether they were being managed effectively.
- Review of the quality improvement meeting minutes for September and October 2016 both included standing agenda items in accordance with its TOR. There was evidence of relevant discussion around some items presented, but not all. There was a process in place to carry actions forward to the next meeting.
- During the September 2015 inspection we noted that there was a lack of discussion around incidents, in particular themes and trends or categorisation of incidents. 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 and that there was no discussion around the dashboard. We saw no improvement with regards to discussion around risks or incidents. There had been some improvement in relation to the dashboard. However, minutes listed areas where underperformance had occurred but there was no further detail, in particular around how this could be improved or possible reasons for the underperformance.
- There were nine risks recorded on the paediatric risk register. 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 effective controls to ensure the risk was managed. We saw that improvements had been made on since the previous inspection in September 2015 because many of the long standing risks had since been reviewed and closed or reviewed and revised.
- 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 report. There had been no completed audits taken to the September or October 2016 meetings and there was no meeting held in August.

Culture within the service

- The care provided in the children's clinic was patient focused.
- Staff told us there were good working relationships amongst their peers as well as other disciplines and that Kidderminster Hospital and Treatment Centre was a pleasant place to work. Staff told us there was good teamwork in the children's clinic and staff were very committed to providing a person focused service.
- The outpatients manager said they always disseminated all information in regards to the service reconfiguration to staff to ensure staff had the same information as they had. The outpatients lead told us they had attended a 'listening into action' event at the hospital that had been geared to staff working in outpatients departments and had found it helpful in understanding the service reconfiguration plans

Public engagement

- Staff told us feedback from the public since the service reconfiguration had been mostly positive. The trust were planning a public consultation in 2017 in regards to the reconfiguration of services.
- Patients were given the opportunity to provide feedback as part of the Care Quality Commission's children and young people's survey 2014.
- The children's clinic were not providing children, young people or their families with the opportunity to provide feedback via the NHS FFT data collection. Staff said the FFT was temporarily suspended whilst services continued to be reconfigured.

Staff engagement

Services for children and young people

- Staff told us there had been 'listening into action' groups with staff in regards to the reconfiguration of service. However, staff said they had not been able to attend the groups due to limited staffing numbers on the children's clinic.
- Staff at the children's clinic told us they felt well supported and listened to by the outpatients' manager. However, staff said they didn't get much information from other services or shared learning.
- An annual staff survey took place each year to gauge staff perception on a range of matters.
- We were told that staff were able to raise issues as part as part of their annual appraisal.
- Staff received a monthly trust newsletter as well as divisional 'risk bulletins' which informed staff of issue that had been discussed at the QIM meetings.

Innovation, improvement and sustainability

- Managers told us service reconfiguration was made with the objective of making improvements for patients and staff. However, at the time of our visit it was too early in the reconfiguration process to measure whether this would result in sustainable improvements to children and young people's care. A manager told us the service were, "enjoying having enough staff."

Outpatients and diagnostic imaging

Safe	Inadequate
Effective	Not sufficient evidence to rate
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. There are 50 beds Kidderminster and 5,904 WTE staff across the trust.

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.

The trust had 748,073 first and follow up outpatient appointments from April 2015 to March 2016. Kidderminster's total number of outpatient appointments was 177,744

There are 600 staff based at the hospital, 70 consultants visit the hospital providing outpatient and in-patient services.

Facilities at the Kidderminster site include a full range of outpatient clinics including outpatient cancer treatment in the Millbrook Suite, MRI and CT scanners and a renal dialysis unit.

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 diagnostic imaging department at Kidderminster sits in the specialised clinical services division within the Trust. The department consists of two x-ray rooms, one computer tomography (CT) scanner, one magnetic resonance imaging (MRI) scanner, and three diagnostic ultrasound rooms. Trust-wide, the imaging departments undertake around 32,000 examinations each month.

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 and diagnostic services, including radiology, cardiology, dermatology, trauma and orthopaedics, ophthalmology and diabetes.

We spoke with five patients and their relatives and 25 staff, including consultants, radiographers, radiologists, nurses, healthcare assistants, allied health professionals, reception staff and medical secretaries. We also reviewed six sets of notes and 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 Kidderminster Hospital and Treatment Centre only has been used where available.

Outpatients and diagnostic imaging

Summary of findings

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

We rated the service inadequate for safe, responsive, and being 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:

- We were not assured patients were always protected from harm, as not all staff were confident to report incidents.
- Safety was not a sufficient priority with regards to replacement of aging and potentially unsafe x-ray equipment across the Trust.
- There was a lack of radiation protection infrastructure.
- Examination protocols for standard x-ray examinations were not routinely reviewed and not subject to document control.
- Patients were unable to access the majority of services in a timely way for initial assessments, diagnoses and/or treatment
- The trust did not consistently meet all cancer targets for referral to treatment times.
- Staff we spoke with were unaware of any patient harm reviews undertaken to mitigate risks to patients who had breached the 18 weeks referral to treatment times and cancer waits.
- We could not be assured that all equipment was suitable for purpose. We saw a blood pressure monitoring machine had not been calibrated. Ageing and unsafe equipment across the trust that was being inadequately risk rated with a lack of capital rolling replacement programmes in place.
- 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.
- Not all nursing and medical staff had had appropriate levels of children's safeguarding training.
- There were moderate to high level of clinic cancellations with less than six weeks' notice across particular specialties.
- Hand hygiene and arms bare below the elbow audits were not regularly carried out with only one weekly audit carried out so far in the current financial year.
- There was a shortage of medical staff across all specialities. This meant there could be a delay in patients being seen for new or follow-up appointments.
- We were not assured that all complaints were dealt with in a timely manner and in accordance with trust policy.
- We could not be assured the service had a robust, realistic strategy for achieving the priorities and delivering good quality care.

However we also found:

- Staff were dedicated and caring. Patients were treated with kindness, dignity and respect and were provided the appropriate emotional support.
- Compliance with mandatory training had improved since the last inspection. Training figures showed training compliance met the trust's target of 90%.
- The premises were visibly clean.
- The process for keeping patients informed when clinics overran was good.
- There were effective systems in place regarding the handling of medicines.
- FP10 prescription pads were stored securely.
- Patient's medical records were accurate, complete, legible, up to date and stored securely.
- Leadership within the outpatient's team was visible, however, the management of risk was insufficiently robust and further improvements were necessary.
- 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.
- 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.

Outpatients and diagnostic imaging

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.
- Staff were aware of the duty of candour regulation. However, not all staff we spoke with, were able to apply the principle to an incident.
- We could not be assured there was a system in place to monitor and manage the risk to patients on the waiting list.
- There was a shortage of medical staff 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 was no robust capital replacement programme within radiology with medical devices on the risk register being downgraded with no consultation with the radiology senior management team.
- Radiation protection surveys had raised concerns in 2014 about image quality and doses to patients.
- Standard operating procedures within radiology were not adequately reviewed and were not subject to robust document control.
- Examination protocols including medical exposure parameters are insufficiently revised.
- Local quality assurance of equipment involving ionising radiation was not regularly completed, meaning doses and field sizes were not being monitored on the plain film equipment.
- Staff had raised concerns around aging equipment and image quality
- 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.
- Not all nursing and medical staff had had appropriate levels of children's safeguarding training.

However:

- There were effective systems in place regarding the handling of medicines.
- Medicine management in diagnostic imaging was good, with appropriate patient group directives in place and appropriate storage and temperature monitoring.
- Most equipment used by the service 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.
- Patient's 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.
- Compliance with mandatory training had improved since the last inspection. July 2016 training figures showed training compliance in all but one area (manual handling) areas met the trust's target of 90%.

Incidents: Outpatients

- We were not assured patients were always protected from abuse and harm, as not all staff were confident to report incidents. Staff were not able to identify what incidents should be reported. 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 on this inspection.
- There were limited arrangements in place to implement good practice in 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 a trigger list for staff to use to assist them to identify what incidents should be reported.
- Kidderminster outpatients department reported nine incidents from 1 September 2015 to 31 August 2016. Incidents were graded in severity from low to no harm, or moderate to severe harm. We saw three were recorded to have resulted in no harm and six with minor harm. At the last inspection, the number of incidents reported within the outpatient department was felt 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, which was not accessible to outpatient 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 between October 2015 and September 2016. One was reported at Kidderminster Hospital and Treatment Centre: which was termed a diagnostic incident including delay meeting SI criteria.
- 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 to confirm that learning from incidents was shared across 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. However, not all staff we spoke with, were able to apply the principle of duty of candour to a recent incident.
- When things went wrong, thorough and robust reviews or investigations were carried out. We reviewed the investigation of two serious incidents and saw they had been managed in line with the duty of candour regulation. We saw processes and evidence of written apologies. We saw relevant staff and people who used services were involved in the review or investigation.
- 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 to minimise the risk of similar incidents reoccurring.
- All incidents which are 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 service delivery problems, 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.

Incidents: Diagnostic imaging services

- There had been no recorded never events.
- Across the trust, there had been four reportable incidents to CQC as required under the Ionising Radiation (Medical Exposures) Regulations 2000 [IR(ME)R] in the last 12 months, one of which occurred at the Kidderminster Hospital and Treatment Centre in September 2016. At the time of the inspection (two months later), discussions were still being held, and

there was still debate on where the fault lay and an action plan was yet to be formulated. This incident was deemed as low risk that had not resulted in serious harm to the patient.

- All reportable incidents were shared via the monthly site meetings and the radiation protection committee meeting held annually.
- The imaging department had reported 69 incidents from 1 September 2015 to 31 August 2016 across all imaging modalities. These incidents covered a wide range of near misses and minor harm to patients. Five incidents that were reported related to a delay in reporting of images, with a further two incidents reported about the failure to verify reports in a timely manner (delay better writing the report and realising it to the clinical teams for viewing). Eleven incidents related to administrative duties, which included six relating to mammography appointments sent either too soon or too late.
- We saw posters for staff on the topic of duty of candour. Staff understood what this meant and their role in being open and honest when things went wrong.
- We were told that when an intravenous injection had accidentally leaked into the surrounding tissue (extravasation), a leaflet was given to patients and an incident was raised on their incident management system. This is a common complication to any intravenous injection, however we saw evidence of only one incident reported in a twelve month period (from 1 September 2015 to 31 August 2016) on the incident management system, meaning it was likely that the staff were not reporting them as discussed, though it was not clear why.

Radiation Protection

- The department had a full set of IR(ME)R procedures and standard operating procedures as required under the regulations.
- Local rules as required under Ionising Radiation Regulation 1999 (IRR99) were displayed on doors for each x-ray room. These were seen to be within review dates.
- We also 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 a private radiological protection service and were employed by the trust on the 1 April 2016. The company were responsible for the provision of a radiation protection advisor (RPA), medical physics expert, radiation waste advisor and magnetic responsible persons as required by various UK laws. Prior to this date, the service provision was through another third party provider.
- At the start of the contract, there was a 'kick-start' meeting to discuss the new ways of working. There was no action plan formulated around areas the trust was particularly concerned about or required focussed support for.
- Discussion with the medical physics service described a detailed RPA audit process they have undertaken since commencing service to the trust, which was undertaken in July 2016. This involved looking at the department's compliance with IR(ME)R and IRR99.
- We were told that a radiation protection committee (RPC) meeting was carried out annually. This was the only formal meeting scheduled with the medical physics expert and radiation protection advisor as part of the service level agreement with the private radiological protection service. The RPC minutes in 2015 highlighted multiple areas where departmental actions were required. At the time of inspection, many of these actions were still incomplete such as images quality deterioration on aging equipment, variations on performance of rooms across the trust and accuracy of exposure settings. This was due to departmental constraints from clinical workload and staff shortages.
- There was a technique folder in the fluoroscopy room, which included information for staff including protocols and standard operating procedures. Anonymous hand written changes were and there was no evidence of version or document control. Some protocols were dated 2008 with others having no dates on at all.
- There were two radiation protection supervisors at the treatment centre. Radiation Protection Supervisor (RPS) are required for the purpose of securing compliance with the IRR99 in respect of work carried out in an area, which is subject to local rules. It was noted during the latest RPA audit that these members of staff had not received any update to their training since initial training more than six years ago. Guidance suggest that refresher training should be carried out every three to five years after initial training. We found no evidence that this was being actioned upon.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene: Outpatients

- 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.
- Staff told us that nursing staff cleaned equipment daily. The environment was cleaned daily by 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.
- 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 11 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 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 2016 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 control and prevention guidance. We reviewed this during our inspection. Staff also had access to infection control policies via the trust intranet.
- As of December 2016, 54% 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

- Hand hygiene and arms bare below the elbow audits were not regularly carried out, with only one weekly audit carried out so far in the current financial year. The audit showed 88% compliance with hand hygiene, however, 100% of staff audited were arms bare below the elbow. During the inspection, we observed all staff working with arms bare below elbow and there was good use of hand gel between patients.
- There were concerns that ultrasound intra-cavity probes, these are probes used for intimate examinations inside the body were not being cleaned sufficiently. After speaking with the ultrasound lead, we were informed that there had been conflicting advice from the infection control team as to which cleaning agent was to be used. Staff investigated a probe sterilisation cabinet as an alternative, which was a cheaper overall option, which would not reduce capacity due to waiting time for the probes to be cleaned however there was no capital budget to purchase the initial equipment required.
- We reviewed two patient environment audits, which looked at the hygiene and condition of the imaging department. In January 2016, the department was given overall outcome percentage of 88%, with 89% cleanliness and 79% condition and appearance. In May 2016, the overall percentage was 79%, with cleanliness being 81% and condition and appearance 73%. Areas for improvement included the general dustiness and plaster repairs to walls. During the inspection, we still found some dust at high levels such as on curtain rails and in changing rooms. We raised this with staff at the time of the inspection and actions were taken to remove the dust from these areas.

Environment and equipment: Outpatients

- Generally, the design, maintenance and use of facilities and premises met patients' needs.
- 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 to be 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 to 23 November 2016. We saw one trolley had been checked daily; however, we saw that some dates in October had been missed on one trolley. Therefore, we could not be assured there was a reliable system in place to ensure emergency equipment was checked in line with trust policy. We raised this with the nurse in charge at the time of the inspection, they were aware that there had been a problem but this issue had now been addressed. We saw checks had been carried out daily in November.
- The oxygen cylinders and emergency medicines were all in date.
- The outpatient clinics were located on the ground floor of Kidderminster Hospital and Treatment Centre.
- 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.
- 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. We saw in pre-assessment room 22 a blood pressure monitoring machine had not been calibrated. Therefore we could not ensure that all equipment was suitable for purpose. We raised this with the nurse in charge at the time of inspection.

Environment and equipment: Diagnostic imaging services

- An inventory of equipment was seen however, there was no formal capital rolling replacement programme for some of the aging equipment across the trust. The two x-ray rooms at Kidderminster had been replaced in 2016, following multiple failures of the old equipment. The fluoroscopy unit in the imaging department was due for replacement according to senior managers; however, there were no formal plans in place at the time of the inspection.
- 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.
- Local diagnostic imaging equipment QA was due to be carried out by key members of the radiographer team,

one in x-ray and one in CT. However due to staff sickness local QA had not been carried monthly as per the planned testing frequency for all equipment and professional guidance.

- We saw an example of the mobile x-ray machine only being tested once from January 2015 to April 2016. At the time of the inspection, two new members of staff had just been trained to undertake these tasks, with baselines for these tests only just being established for one of the x-ray machines. This was flagged in the RPA audit in July 2016 however; this was not picked up in the interim period of the radiographer going off sick and the date of the audit. In contrast, the daily local QA records for the CT scanner, showed testing was up to date.
- There was seen to be adequate amounts of staff personal protection equipment (PPE) that protects staff working in areas from ionising radiation. These were seen to be regularly tested over the past three years to ensure they were still offering suitable protection. The PPE was visually clean and appropriately stored**.**
- Sharps appropriately stored with all sharps boxes seen to be labelled and dates.
- There was a resuscitation trolley readily available for staff in the diagnostic imaging department. We saw they were checked were regularly and recorded appropriately.

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 (NMC) 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, these 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 with 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. 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 directive (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.

Medicines: Diagnostic imaging services

- Patient group directions (PGDs) were seen in place and date for all medicines given in the diagnostic imaging department. This meant that appropriately trained radiographers were able to administer contrast and other intravenous medications to patients without the need for radiologists to prescribe this medication.
- The medicines used in the diagnostic imaging department were well managed. The drugs were all

stored safely, and regularly checked for use by dates. Most medication was kept in locked cupboards, with the exception of the contrast media, which was stored in an office, which was only accessible by key members of staff. Temperatures were regularly recorded for both the fridge and the storage cupboard and were seen to be within range.

- The imaging department had a good process in place for prescribing medication used for CT colonograms. Patients would attend the department to pick up the medication, where radiographers we 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.
- An anaphylaxis kit was kept in CT in case of any allergic reactions to the contrast media given to patients during the scans.

Records: **Outpatients**

- Patients' medical records were accurate, complete, legible, up to date and stored securely out of view or reach 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 to 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. Staff told us 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, we saw evidence of this process. 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

- The imaging department used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- Manual records including patient information was still recorded and stored manually in the fluoroscopy room unnecessarily. This information was stored electronically, such as pregnancy forms and examination details. We observed 12 months of signed pregnancy forms stored in a folder and multiple years' worth of examination information stored in a logbook. These were not securely stored and were left in the fluoroscopy room behind the lead screen. There was no evidence that staff were aware of this issue, however when discussed with the staff lead, actions to remove this information was undertaken.
- We saw good use of a whiteboard in CT, displaying the patients' pathway throughout the department during their appointments. This showed times when patients started drinking their contrast media, their changing status, whether the patient had been cannulated and a comments section for information such as allergies and needle phobias.

Safeguarding: Outpatients

- 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. All of the Kidderminster outpatient's staff and 97% of medical and dental staff within the specialised clinical services division had attended safe adult training. However, not all nursing and medical staff had had appropriate levels of children's safeguarding training. In July 2016 84% of Kidderminster outpatient's staff had attended safe child training, which was below the 90% target set by the Clinical Commissioning Group (CCG). 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%. 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 are 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**

- 100% of radiology staffing had received child and adult safeguarding level 2 training.
- Medical staff had completed 90% child and 93% 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.
- Compliance with mandatory training had improved since the last inspection. The July 2016 training figures showed training compliance in these areas met the trust's target of 90%:
  - 92% OPD staff had attended information governance training
  - 92% OPD staff had attended fire safety training
  - 92% OPD staff had attended resuscitation training.
  - 92% OPD staff had attended health and safety training
  - 100% OPD staff had attended hand hygiene training
  - 92% OPD staff had attended infection control 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 manual handling 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

Mandatory training: Diagnostic imaging services

- Compliance with mandatory training in some areas did not meet the trust's 90% target. The July 2016 training figures showed radiology medical staffing compliance was
  - 63% information governance
  - 83% fire
  - 90% manual handling
  - 83% resuscitation
  - 90% health and safety
  - 93% hand hygiene
  - 83% infection control
- The July 2016 training figures showed radiology staffing compliance as:
  - 74% information governance
  - 84% fire
  - 92% manual handling
  - 80% resuscitation
  - 87% health and safety
  - 97% hand hygiene
  - 87% 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 during inspection, a total of 5,100 patients 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 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

- We were told that radiologists were not always on site to cover contrast lists, usually due to last minute sickness or annual leave. In these circumstances the resident medical officer for the site was expected be attend only if patients were unwell following their injections.

- We saw evacuation plans in place for patients who may collapse in MRI. These plans differ in MRI from the rest of the hospital due to the high level of magnetism, which prevent normal crash teams and equipment from entering into the scanning rooms.
- The MRI safety-screening checklist was seen to be completed for all patients. These were sent to patients with their appointments and completed documentation is stored on RIS. If there is any uncertainty regarding a patient's compatibility with the magnet this is referred to a consultant radiologist or to the referrer. CT contrast screening forms were also seen to be used and stored on RIS as appropriate.

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 10.4 whole time equivalent (WTE) registered nurses and 12.71 WTE healthcare assistants. As of August 2016, 9.37 WTE nursing staff and 10.57 WTE healthcare assistants were in post; this equated to a 0.67% and 2.14% 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 cites a continuous staffing issue across all diagnostic imaging staffing groups at the trust. During the inspection, we were told that there had been proactive attempts in recruitment, with European agencies looking abroad and university visits to assist in filling current vacancies.
- At Kidderminster, there were two current radiographer vacancies. The department was also in the process of training an imaging assistant to undertake basic x-rays as an assistant practitioner.
- All radiographers working at the treatment centre were band 6 or above. There were no junior radiographers working at this site, as they tended to be more attracted to the acute sites to gain experience. X-ray and CT staff worked solely at Kidderminster, whilst ultrasound and MRI staff rotated across the trust.
- During the weekends, the radiographers would spend long period's lone working. To ensure safety of these staff, they wore alert buttons, which were linked to security.

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 whole time equivalent (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%.

Medical staffing: Diagnostic imaging services

- At the time of the inspection, the trust had six consultant radiologist vacancies across sites. The trust was proactively looking to recruitment worldwide and are awaiting a sign off of an attractive package to help with the recruitment issues. This includes home working where reporting stations are set up at their residents. Radiologists would rotate across sites to cover contrast lists in CT and MRI and ultrasound sessions.

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

- We saw a major incident folder in the x-ray viewing area detailing procedures in place for such emergencies. All staff we spoke to were able to locate this information. 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?

Not sufficient evidence to rate

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:

- From April 2015 to March 2016, the follow-up to new rate patient ratio for Worcestershire Acute Hospitals NHS Trust was lower the England average.
- Specialities within outpatient and diagnostic services delivered care and treatment in line with the National Institute for Health and Care Excellence and national guidelines where appropriate.
- 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.
- 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.
- Radiographers were found to have comprehensive training records for all radiation equipment they used.
- We saw evidence that the physiotherapy department had developed treatment pathways and guidelines.

- Pain relief could be prescribed within the outpatient department and subsequently dispensed by the pharmacy department as required.
- 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.
- 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.
- Clinical nurse specialist nurses provided support in clinics to support patients.
- 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.
- Nursing, diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.

However:

- There were some radiology clinical audits but these were infrequent and not part of a schedule.
- 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.

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.
- 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 (clouding of the lens in the eyes) and glaucoma (increased pressure in the eye), for example.
- 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. It was to be included in the forward plan for 2017/18.
- Although a defined audit schedule was not in place, 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. 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 be carried out. We did not see evidence that the service were carrying audits that IR(ME)R would expect around employers procedures and standards of procedure.

- A number of local clinical audits are carried out and have been registered with the trust's 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 fall outside of the age limits for breast imaging undergo MRI scans at Kidderminster Hospital and Treatment Centre.
- The medical physics service were consulted for the purpose of establishing research procedures and dose constraints.

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 (such as paracetamol) 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 to 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 2016 and the service hoped 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 (COPD). This was in line with NICE recommendations.

Patient outcomes: Diagnostic imaging services

- At the time of the inspection, the trust was beginning to consider applying for the Imaging Services Accreditation Scheme (ISAS). They had established a connection with a buddy trust for assistance with the accreditation.
- 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.

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's 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.
- The occupational therapy department had a formal supervision process in place to support and develop staff. All occupational therapists were allocated a supervisor, who they met with on a regular basis. Staff told us they could contact their supervisor for additional support and advice when required. We saw evidence that supervision records were meaningful and up to date.
- 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. 79% of radiology staff had completed their appraisal.
- We saw completed up to date training records for the CT and x-ray staff. These included equipment training for the new x-ray rooms installed this year. We heard how there were three core trainers for CT who had received applications training from the manufacturer on installation. This was then cascaded to all other staff.
- A new matrix of training made recently, had been developed, which included dates and details for imaging staff's mandatory training and any CPD. This information was due to be used in their annual PDR.
- Non-medical x-ray referrers are trained by senior radiographic staff and radiologists and monitored over a six to eight weeks for competencies prior to being able to request medical exposures

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, nurse specialist for review and treatment. Dressings would also be reviewed and changed if necessary.
- Treatment and information about ongoing care following appointments, was sent to the patients' GP. When people were discharged from a service, all relevant teams and services such as district nurses or community care provider were informed.
- Clinical nurse specialist nurses provided support in clinics to support patients. For example, leg ulcer nurse specialist, rheumatology nurse specialist and a Parkinson's nurse.
- There were also oncology and cancer 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 multidisciplinary team (MDT) meetings being held. These included urology, dermatology and ophthalmology.

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

- The x-ray department was open seven days a week. Radiographers worked in x-ray between 9am and 6pm Monday to Thursday, 9am and 5pm on Fridays, and 9:30am and 5pm at weekend.
- There was no on call system in place for outside working hours. Any patients who required x-rays outside of these hours would be transferred to Worcestershire Royal Hospital. This was normal practice for such treatment centres as they are not an acute hospital and anything serious would require transferring under normal hospital protocol.

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 safeguarding from abuse was displayed on notice boards in outpatients departments where service users would see it.

Access to information: Diagnostic imaging services

- The trust has a radiology information system (RIS) and picture archiving and communication. (PACS) for the storage of radiology images and patient information and reports. Both systems are password protected
- The risk register for radiology cites concerns around PACS archiving and stability of the storage solution. Additional storage has been purchased however, the archive is not reliable and the trust are awaiting transfer to the new data centre. This will provide a permanent solution but the date of this transfer has been delayed
- The RIS server is also at end of life and full, radiology were waiting to move to the trust dataset to allow the directorate to replace the RIS server. The project is in the early stages of constructing a plan to move into the virtual server set-up
- The imaging department stored all information on a shared computer drive, which meant staff were able to access policies and procedures across the trust at any location.

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 100% of outpatient nursing staff had completed MCA and DoLS training, which was above the trust target of 90% compliance. Therefore, we were assured that all outpatient nursing staff had up-to-date knowledge of the MCA and DoLS. ENT and 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.
- Staff said that they had some training in MCA and DoLS as part of their mandatory training
- 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 not 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 hard copy form because two consultants were required to complete it.
- Medical and nursing staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. We observed nursing staff obtain verbal consent from patients before they carried out baseline observations, such as blood pressure measurement.

Outpatients and diagnostic imaging

- 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

- We saw evidence of consent being taken for CT colons and aftercare leaflets are given to patients. Verbal consent was used for intimate examinations in ultrasound.

Are outpatient and diagnostic imaging services caring?

Good

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

- 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.
- Radiology staff were polite and courteous when dealing with patients.
- There was evidence of some good feedback form patients regarding their care and treatment.
- Staff were observed to communicate with and provided information to patients in a way that they could understand.
- An average of 71% of patients would recommend the service to friends or family from April 2016 to November 2016. However, the response rate was low 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. However, the response rate was low 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

- We saw an audit carried out by the imaging department, which questioned patients about their experience of attending for a CT scan. We saw 31 patients were asked

to complete questionnaires in CT, and the department was at the time of inspection, awaiting results for MRI and US. We saw that 87% of patients rated their experience as excellent, 10% good and 3% neutral.
- We observed patients being treated with respect compassion and kindness. Patients were greeted in a friendly manner and examinations were explained to them prior to commencing.

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 "I am very happy with the care I have received". Another patient said, "The staff are really helpful".
- From the review of notes, we saw patients' preferences for sharing information with those close to them were established and reviewed throughout their care.
- 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.
- 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 so they understood their 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 able them make informed decisions about 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 being responsive because:

- The trust did not meet the referral to treatment times (RTTs). In October 2016, 5,100 patients exceeded the 18 week RTT. 3,151 patients waited 18-25 weeks, 1,949 patients waited 26-51 weeks.
- The trust did not consistently meet all cancer targets for referral to treatment times.
- 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.
- The service did not have a robust demand and capacity assessment in place.

However:

- Translation services were available to patients.
- Feedback from complaints was fed back to staff.
- Following enforcement action on the trust in summer 2016 regarding the imaging backlog, work had gone in to reduce the backlog and at the time of the inspection, reporting turnaround times were good.
- The cannulation process in radiology for CT and MRI examinations was good, enabling a better flow for patients.

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

- 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 Clinical Commissioning Groups (CCG) NHS South Worcestershire and NHS Wyre Forest 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. People 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.
- There was clear signage to outpatient areas. Reception areas were manned during clinic times to assist patients with directions.
- The 'did not attend' rate for Kidderminster Hospital and Treatment Centre was lower than the England average from April 2015 to March 2016.
- There was adequate seating and equipment available in all areas of the outpatient department we visited.
- 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.

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 to around 88% from the beginning of the financial year (April 2016 to June 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%
- 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 18-25 weeks, 1,949 patients waited 26-51 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 26-51 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 18-25 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 to 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 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). The 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.

Outpatients and diagnostic imaging

- 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 and 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 106 appointments occurred at the Kidderminster Hospital and Treatment Centre for the period May to October 2016. The majority of these were in ophthalmology and thoracic medicine, with an additional 44, and 19 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. 3%, of clinics were cancelled with over six weeks' notice in 2016, 4% in June 2016, 5% in July 2016 and August 2016. Kidderminster outpatients department reported 258 clinics had been cancelled between May and October 2016, 15% (38) were cancelled less than six weeks' notice or less before the appointment date. Care and treatment was only cancelled or delayed when necessary. Patients told us reasons for cancellations were explained to them and we saw evidence of this during the inspection. Patients told us when appointments had been cancelled they had been supported to access care and treatment again as soon as possible.
- The main reasons for cancellations as reported by the trust were: annual leave of consultant, on-call, 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.
- 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 258 clinics had been cancelled but the trust were unable to 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.
- 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 2016. Data was being collected until 1 December 2016 and the results were to be reported 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.

Access and flow: Diagnostic imaging services

- At the time of the inspection, the length of time patients were waiting in the department for their appointments was not being monitored. The management teams were exploring options in the future to audit this data.
- Demand in ultrasound is in excess of capacity and has been cited on the risk register as a moderate risk. There are vacancies in the department and some staff members have been off sick due to the pressures that they feel at work. Two radiographers were recruited for training posts in September 2016 but this is a long term plan, due to the two year training programme. Bank and agency staff had been utilised in an attempt to reduce the pressures
- 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, with images available on the PACS system on all sites as soon as the patient examination had been completed. Any CT examination querying a pulmonary embolism was also immediately reported to aid quicker treatment for patients.
- The department utilises a short notice cancellation system whereby patients who are able to accept short notice appointments are contacted if an appointment becomes available due to a cancellation or if patients did not attend.
- The auto reporting policy for patients that undergo a medical exposure but do not require a formal radiological report has been approved within radiology and is available on the intranet. This ensures that radiographers are aware which examinations require no formal report and ensures that regular audit is carried out on these images, which should have a clinical evaluation, by the referring clinician associated with them.
- The radiology IT manager stated that there were issues with the new IT structure in the trust and that since it was taken over by a private provider there were access and flow issues relating to logging IT faults.
- Between September 2015 and February 2016 the percentage of patients, waiting more than six weeks have a diagnostic imaging test was lower than the England average. From March 2016 to August 2016 the trusts performance was higher than the England average of around 2%. Data from 1 February 2016 to 1 August 2016 showed the percentage of patients waiting six weeks or more for an appointment was:
  - MRI 2.23%
  - CT 5.17%
  - Ultrasound 7.83%
- The diagnostic imaging department had a good process in place for the cannulation of patients in anticipation for CT and MRI scans. The radiology assistants were trained to cannulate patients, and used a doorbell system to call for a radiographer to flush cannulas where they were not certified to do so.
- The current waiting time for plain film reporting lies at 0.6 days for any urgent request and 1.89 days for routine imaging. These reporting times have improved since July 2016 following on from enforcement action served on the trust. This was excellent 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 loop was available within the outpatients department.

Outpatients and diagnostic imaging

- We observed notice boards in outpatient and diagnostic imaging departments contained information about domestic abuse and safeguarding.
- 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 (RNIB) 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 living 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.
- The outpatient clinics we visited were generally accessible to patients living with physical disabilities and wheelchair users.
- 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

- Translation services were available when required via a pre-booked translator if required.
- Posters with examination information relating to CT scans and the contrast media were available. There was also information about how to get results as well as information about PALS and how to make complaints along with safeguarding information.
- Information leaflets were given to patients when appointment letters were sent describing procedures and giving information on what was going to happen. Aftercare leaflets were also given to patients following CT colonograms.
- During the inspection, we saw multiple laminated signs for patients across the imaging department. Some of these were seen to have spelling mistakes and did not look professional.
- The imaging department was accessible to patients living with physical disabilities and wheelchair users and appropriate changing facilities were available.

Learning from complaints and concerns: Outpatients

- The trust reported that there were 32 complaints regarding all outpatient and diagnostic areas at Kidderminster Hospital and Treatment Centre from December 2015 to December 2016. Themes included delays in appointment times, not being able to contact service to discuss appointment times. 78% (25) were investigated 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.
- 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

Outpatients and diagnostic imaging

- There had been four complaints received at Kidderminster Hospital and Treatment Centre regarding the diagnostic imaging department from August 2015 to August 2016.
- Two complaints relate to complications following an ultrasound scan and another following an ultrasound guided biopsy. The other two complaints related to breast screening which was not inspected at this time.
- We saw evidence of a change in practise relating to these complaints and the information relating to these complaints and subsequent actions being discussed at staff meetings for shared learning.

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 service had a robust, realistic strategy for achieving the priorities and delivering good quality care.
- The service was in the early stages of a 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.

However:

- Progress against delivering the improvement plan was monitored and reviewed.
- Senior staff we spoke to felt that the outpatient department 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 served on the trust in July 2016, the reporting service had greatly improved and was now more sustainable for the future.

Leadership of service: Outpatients

- The trust had changed the divisional structure since the last inspection. 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 managed 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 good, 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 directorate that radiology belonged to. A number of management posts within radiology were new, and roles and responsibilities changed. Some senior managers stated that there have been some issues with the management structure within the directorate. This had been rectified at the time of the inspection and staff were now in post.
- A new clinical director (CD) for radiology was announced during the week of the inspection. Multiple members of staff of various grades and specialities were extremely positive about the change. The old CD was described as not being dynamic enough. The new clinical director had tackled numerous tasks even prior to his appointment, staff had confidence in his abilities
- Some staff felt that at divisional level no one really understood radiology and they felt that local leadership was good but divisional and trust leadership was poor. This was 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
- Since the revision of the management structure, we were told local management were more accessible and that there were approachable and visible both when they were needed and on a general day to day basis. Radiographers spoke highly of the local management. Local management was supported by the leads at the Alexandra hospital but had little involvement with the more senior management and the division.
- Numerous staff told us that they felt that historically the hospitals within the trust were "sitest" with 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.

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 outpatients department was fragmented and there was a need to standardise process across all outpatient clinics in the trust. The service was in the process of detailing understanding of all services 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 was completed in September 2016 and had been circulated for comment.
  - Clinic room scheduling and utilisation
    - Develop / Update a 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. 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 a 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 the 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

- Prior to the inspection, we saw a draft strategy document for 2016. This lacked detail of site-specific actions for the Kidderminster Hospital and Treatment Centre diagnostic imaging department. The site managers were unaware of this document and was unable to explain progress on many of the actions.
- A capacity and demand model was being undertaken countywide, reviewing staffing and equipment availability. When completed, this is likely to provide further detail to support a decisions relating to extending current working hours and provide details of required skills countywide to maximise the diagnostic imaging services and efficiencies.

Governance, risk management and quality measurement: Outpatients

- Senior staff we spoke to felt that outpatients was represented at board level. The chief operating officer (COO) was the executive lead for the outpatient patient 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 department, 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) w. Also, how to monitor and manage the risk to all patients on the waiting list was also 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 referral to treatment time (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.

Governance, risk management and quality measurement: Diagnostic imaging services

- A new radiology governance lead had been in place since February 2016. There were seen to be a lack of clear objectives set or action plans that would have given the governance lead 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.
- We heard how the governance lead was feeling 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 World Health Organisation (WHO) interventional checklists. Following discussion, the governance lead told us that this was now fully implemented and was in the process of having its compliancy audited. There had 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. We heard there was a newly developed radiology clinical governance team who have been meeting monthly since July and discussed local governance inside of radiology including the risk register incident and complaints.
- The risk register included a range of risks across the trust, such as aging equipment, staffing levels and the reporting backlog. Prior to the new governance structure, the risk register was reviewed by the cross site senior managers. Previously, it was felt that concerns within radiology across all trust sites were not being listened to and that some staff at directorate level had a lack of understanding of the needs of the radiology department hence the new structure. 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 in a timely manner as per trust policy as the site leads did not prioritise these reviews prior to the governance lead joining. Training had now been provided to the site leads to improve the investigating of incidents.
- The trust held an annual radiation protection committee (RPC) meeting, which was chaired by the clinical director. It was unclear how the RPC fed into the trust wide governance structure. The RPC minutes in 2015 highlighted multiple areas where departmental actions were required. At the time of inspection, many of these actions were still incomplete such as images quality deterioration on aging equipment, variations on performance of rooms across the trust and accuracy of exposure settings. It was noted during the inspection that this was due to staffing, pressures of the clinical workload, finances and lack of training opportunities.
- The local quality assurance (QA) equipment testing schedule was not well managed and there was seen to

be very little testing carried out on the fluoroscopy and plain film equipment. This had been due to long term sickness of the radiographer who lead the QA programme. This was being addressed at the time of the inspection with more staff being trained to undertake routine level a testing as required.

- The site leads held six weekly team meetings where they met with the cross site lead. Radiation protection is a standing agenda item and any concerns are fed to the directorate and divisional meetings. They also discussed items, which were discussed at directorate level, in order to disseminate information to local sites. 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.
- There was no capital replacement programme for the diagnostic imaging department across the trust. There were several pieces of equipment that were on the risk register as being at their end of life or failing repeatedly. At the time of the inspection, there were no plans in place to replace this equipment through capital procurement and the only way of replacing the equipment would be to lease it with the cost absorbed by the radiology department. It was felt that there is a lack of forward planning to replace very costly equipment for which failures have trust wide impact for patient throughput and access. Several members of staff we spoke to, highlighted their concerns about patient safety due to aging equipment, parts being obsolete and the equipment not being mechanically sound.
- The Care Quality Commission 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. Concerns were initially raised by a member of the public, and the trust was given the opportunity to respond to these, however; when satisfactory assurances were not received, the local inspection team decided to conduct an unannounced inspection. In particular, we looked at the time that it took 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. 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, 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.
- 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 backlog 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 are 0.36 days for urgent and 1.89 for routine. This demonstrates that the department have utilised external and internal additional reporting capacity and have resourced the action plan at trust level to ensure the requirements of the notice have 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 section 31 there is a more longer term strategy. There has been an increase in cold reporting sessions for radiographers, employment of additional staff enabling a more robust and sustainable workforce, and the appointment of a new radiographer to undertake chest and abdominal x-ray reporting which is where the majority of the reporting delays lay.

Culture within the service: Outpatients

Outpatients and diagnostic imaging

- 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.
- 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

- The staff working in CT were really happy in their roles and stated they "love it here". Team working in this area was good. Following a death of a member of staff the team had worked together to raise money for charity.
- Since the visit in July 2016 from the CQC, the consultant radiographer told us that 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 were "the best thing that could have happened to us".
- The ethic of the radiographers working in x-ray was poor as many were not engaged in any additional duties and only wanted to work the bare minimum required for such a job. We heard of an example of a radiographer having the opportunity to work in CT, and following a full training programme, decided that they just wanted to return to plain film.
- 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 standardising 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. 2016. 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.
- 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 minuted 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 department. 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) was 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. The LiA group 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.

Staff engagement: Diagnostic imaging services

- Radiographers working in MRI felt that there was a lack of communication amongst the team and that there was little opportunity for engagement with the lead radiographer. There was no staff meetings and no other opportunity to bring suggestions about the work. The MRI radiographers felt their suggestions regarding a change in working hours had been ignored. Communication was said to be limited to email for this team.
- There had recently been a feedback exercise for the static staff at Kidderminster, where radiographers were able to anonymously feedback on any concerns or compliments about the service.
- Staff were working with aging equipment and they were concerned about patients' safety. The aging equipment did little in the way to motivate staff to want to stay and it had an impact on staff recruitment. Radiology technology is rapidly advancing and staff want to work in departments where equipment is modern and also safe for them and patients
- One radiologist we spoke to raised concerns that the inspection process was of limited use because no one listens and nothing gets done. They felt there were long standing issues with equipment faults, staffing and demand on the service but that noting changes. Staff were suffering due to the demands placed on them and they raised concerns around front line staff receiving abusive phones calls from frustrated patients. They felt that staff were doing their best but that they were not appreciated.

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, standardised 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.
- 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 clinics such as the falls clinic had been cancelled with no notice to the public in July 2016 as a result there

were lack of access for new patients and follow up appointments for existing patients. The falls clinic had resumed at Worcestershire Royal Hospital in October 2016.

- 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 identify which patients would be appropriate to be sent letter, to inform them of the delay and asking if they still needed the appointment, 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.

Innovation, improvement and sustainability: Diagnostic imaging services

- Following enforcement action in July 2016, the reporting radiographer service has increased the amount of cold reporting sessions. The imaging department was also 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 2016.

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.
- Establish female genital mutilation and child sexual exploitation training that is to be completed by all staff working in children and young people's services.
- Ensure administration of controlled drugs are always documented contemporaneously with signature as appropriate.
- Ensure that medicines are always stored within the recommended temperature ranges to ensure their efficacy or safety.
- Ensure all equipment is in date and used, stored and maintained in line with manufacturers' instructions.
- Ensure that resuscitation equipment is readily available for use when required without posing a risk.
- Ensure that there is an effective system in place to ensure that all electrical equipment has safety checks as recommended by the manufacturer.
- Ensure that equipment is checked as per policy.
- 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 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.
- Ensure there is a strategy in place for diagnostic and imaging services that staff are aware of.
- Develop a clear strategy for surgical services which includes a review of arrangements for county wide management of emergency surgery.
- Ensure there is a process for collecting data regarding the effectiveness of the children's outpatients department to recognise and plan where improvements can be made.
- Ensure mixed sex breaches are reported as required.
- Ensure patient notes are stored securely and safely.
- Increase staff awareness of the trust's incident reporting procedures and risk matrix tool.
- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets trust target of 90%.
- Ensure all staff receive an annual appraisal.
- Ensure staff receive appropriate clinical supervision.

Action the hospital SHOULD take to improve

- Ensure there is a clear consistent approach to streaming patients in the minor injuries unit at all times, to ensure patients with the most urgent needs are prioritised.
- Ensure every child has a pain assessment and pain scores are documented.
- Ensure pain relief given to children is audited in the minor injuries unit.
- Ensure that guidelines are in date and are in line with national best practice guidance.
- Ensure patient outcomes are collected, monitored, analysed and used to drive service improvements.
- Ensure there is a clear minor injuries unit strategy.
- Consider developing a formal clinical audit plan, including regular, local audit of documentation, environment, equipment and hand hygiene. Then share the results with staff to improve patient care.
- Ensure all additional training identified is completed by staff.
- Ensure that World Health Organisations' Five Steps to Safer Surgery checklists is reviewed and completed appropriately.
- Review the systems in place to ensure staff feel safe, respected and valued within the workplace.
- Ensure staff have knowledge of the key objectives within the service.
- Consider involving staff in strategic plans and developments within surgical services.
- Review the number of cancelled operations in line with the national average of 6%.
- Review the choices offered to patients about where they are discharged too for continuing care.

Outstanding practice and areas for improvement

- Record templates should be developed that clearly identify where information should be recorded.
- Record meetings where performance in the children's clinic is discussed.
- Ensure there are appropriate and child friendly waiting areas for children and young people and provide appropriate environments for them, including room temperatures.
- Take action to address the 'did not attend' appointment rate for new children and young people's clinic appointments.
- Ensure complaints are investigated within the timescales stated in the trust's complaints policy.
- Ensure there is a clear flow of information from the children's clinic to the board via effective governance processes.
- Ensure there is senior oversight of the minor injury unit.
- Ensure there are suitable arrangements for the maintenance, renewal and replacement of equipment and medical consumables.
- Ensure that risks are identified, escalated and acted on without delay.
- Ensure that processes are in place to assess, monitor and mitigate risks relating to service users.
- Ensure that systems and processes are operated effectively.
- Ensure that records and information in relation to equipment is accurate, analysed and reviewed by people with the appropriate skills and competence to understand its significance.
- Ensure effective governance measures are in place to ensure staff adhere to trust policies and processes.

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 was maintained at all times in the surgery service. • All surgical wards had white electronic boards with names of patients and some aspects of their care displayed which could be seen by all visitors.

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; C. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

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Requirement notices

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; G. the proper and safe management of medicines; I. 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:

- Training on female genital mutilation and child sexual exploitation had not been established or completed by all staff who worked within children and young people's services.
- Administration of controlled drugs was not always documented contemporaneously, with the controlled drugs book being signed at the end of the endoscopy list. We found evidence of drugs that had been dispensed with no signature.
- Medications were not always stored within the recommended temperature ranges to ensure their efficacy or safety.
- Radiology equipment was found to be unsafe in that it had not been quality assessed regularly.
- 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 maternity day assessment unit, discharge lounge and the medical wards.
- An emergency labour bag was found to be unchecked and contained IV fluids that were not tamper evident.
- There were not adequate systems in place to ensure emergency equipment was fit for purpose. For example, an oxygen cylinder on the resuscitation trolley was empty even though the checklist was signed that day and the previous day to state it was full.

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Requirement notices

- Equipment was not always in date. For example, two paediatric airways were out of date on the resuscitation trolley. We also found numerous items that were out of date in the department store room and the plaster room including airways and dressings.
- 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 two week wait national target 93%.
- 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 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

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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;

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:

- 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.
- 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.
- Cancelled operations within 28 days rates for the trust were 14% against an England average of 6%. There were no risk assessments undertaken on patient that are cancelled and no defined action plans to improve.
- No audits were carried out in the children's outpatients department. This meant there was a risk of the effectiveness and improvements to services not being recognised and acted upon.
- There was no clear strategy for county wide surgical services, especially for the management of emergency surgery.
- Mixed sex breaches were not all reported in line with national guidance.
- Medical records were not always stored securely in the surgery service.
- Staff in children's outpatients were not aware of a risk matrix which provided guidance on what to report as an incident. This meant there was a risk of under reporting of incidents.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

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Requirement notices

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.
- Band 5 nurses in the children's outpatient department did not receive formal clinical supervision.
- The provider had not ensured staff in the surgery service received mandatory training and appraisals to provide safe and effective care. Compliance with mandatory training and appraisals were below the trusts target.