George Eliot Hospital NHS Trust

George Eliot NHS Hospital

Quality Report

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Date of inspection visit: 30 April and 1 May 2014
Date of publication: 16/07/2014

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

Ratings

Overall rating for this hospital	Requires improvement
Accident and emergency	Requires improvement
Medical care	Good
Surgery	Requires improvement
Critical care	Good
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Good
Outpatients	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The George Eliot Hospital is part of George Eliot Hospital NHS Trust. It is an acute hospital and provides accident and emergency (A&E), medical care, surgery, critical care, maternity, children and young people's services, end of life care and outpatient services, which are the eight core services always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection.

The George Eliot Hospital is a 352-bed district general hospital, based on the outskirts of Nuneaton. The hospital employs approximately 1,676 staff. It provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E department, maternity and outpatient services.

We carried out this comprehensive inspection because the George Eliot NHS Trust had been flagged as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system due to being in special measures as a result of the trust inspection as part of the Keogh review.

The team of 31 included CQC inspectors and analysts, doctors, nurses, patients and public representatives, experts by experience and senior NHS managers. The inspection took place on 30 April and 1 May 2014 with an unannounced visit on 10 May between 4pm and 8pm.

Overall, we rated this hospital as 'requires improvement'. We rated it 'good' for providing effective, caring and responsive care, but it required improvement for safety and well led care in some services

We rated medical, critical care, maternity, children and young people's services, end of life care and outpatient services as 'good' and A&E and surgery services as 'requires improvement'.

Our key findings were as follows:

- Staff were caring and compassionate and treated patients with dignity and respect.
- Staff followed good infection control practices except in A&E where poor practices were observed. The hospital was clean and well maintained and infection control rates in the hospital were within an acceptable range.
- Patients' experiences of care were good and the NHS Friends and Family Test results were higher than the national average for most inpatient wards and A&E.
- A review of nurse staffing levels had been undertaken and staffing levels had been increased. Safe staffing levels were being monitored and maintained but there was a heavy reliance on nurse bank and agency staff in some areas. Staff recruitment was continuing.
- The trust had opened a new acute medical admissions unit (AMU), which, along with the ambulatory care unit (ACU), was intended to improve the flow of emergency patients through the hospital by speeding up their assessment, treatment and discharge.
- The hospital had worked to improve emergency care and had introduced the modified early warning system, care pathways and care bundles to standardise care for patients who were acutely ill. Seven-day services had been developed and mortality rates were now within the expected range.
- The number of pressure ulcers, falls and catheter related infections was higher than the England average. The hospital monitored harm-free care in all patient areas and had taken action that was reducing these avoidable harms.
- Incidents were reported but staff did not always receive feedback; nor were lessons learned widely shared. A&E and maternity services were under-reporting incidents. The trust was investing in a new electronic incident reporting system.
- Medicines were not always being safely stored and managed. This was particularly evident in the A&E department and the operating department. In both departments there were concerns relating to the storage and stock control of medicines, including controlled drugs, where legal requirements not been met.

Summary of findings

- Radiology services had been without appropriate leadership for many years. The service had antiquated procedures and these were not responding well to increasing service demands and there were long waiting times for services.
- Discharge arrangements were improving and there was early supported discharge coordinated by a discharge team.
- Staff were positive about the changes in the trust and they felt that the culture was open, transparent, educative and innovative.

We saw several areas of outstanding practice including:

- The ambulatory care unit (ACU) opened in December 2013 and had a positive impact on preventing patient admissions. It was helping to meet the needs of patients in the community who required medical intervention without the need for admission to hospital.
- There were physician associates, who were staff trained to support medical staff with assessment, investigation and diagnosis. One physician associates was trained to complete comprehensive assessments for frail elderly patients.
- The trust had developed initiatives to encourage people living with dementia to eat. They used coloured plates and adapted cutlery, and warmed plates to keep food warm.
- The trust had a 'carer's passport', which was a scheme whereby named relatives could offer their help by coming onto the ward and providing care for their loved one, such as help with eating meals or personal care. The hospital offered named relatives free parking or 10% off meals bought at the hospital.
- Discharge booklets were introduced in all medical wards. These were kept by every patient's bed and were completed by members of the multidisciplinary team (including intermediate care and social services) to record specific outcomes leading towards safe patient discharge.
- A nurse-led early discharge support team was provided for patients with chronic obstructive pulmonary disease. This included home visits and physiotherapy input. The team worked closely with the respiratory ward to ensure longer term management. A discharge bundle had been introduced that included follow-up within 72 hours.
- The Oasis Project identified patients during their pre-operative assessment who may be anxious about surgery. The project consisted of a team of volunteer therapists who had a professional qualification in relaxation. Therapists would talk through any anxieties at that time to provide reassurance to the patient and would make a note in the patient's file to prompt action for when they were admitted for surgery
- The trust had produced a leaflet for relatives and friends inviting them to contact the critical care outreach team directly if they had concerns about their relative.
- The hospital had made significant strides in the recognition and management of sepsis and the delivery of the 'Sepsis Six' care bundle. They had a critical care outreach nurse seconded as a Sepsis Nurse who monitored compliance and had introduced a sepsis recognition tool, sepsis boxes for the wards and stickers to improve fluid balance completion.
- Picture screens were used on the intensive therapy unit (ITU) that depicted, for example, a soothing flower blossom scene. Staff and relatives commented that these were calming and relaxing and gave the patients lovely visual images.
- A special service called 'Providing information and positive parenting support' (PIPPs) was available to give information and positive parenting support to teenage mothers and others who were vulnerable. Midwives developed close relationships with the women and offered additional support, continuity of care and coordinated multi-agency cases conferences involving social services.
- Multidisciplinary networks in children's and young people's services were being developed to deliver care closer to their homes.
- The hospital used the AMBER care bundle, which is a national approach to support advanced care planning when doctors are uncertain whether a patient may recover or be in the final stages of life (months or days). Trained team members acted as champions to drive high-quality care at these times. They encouraged staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about everyone's wishes and putting plans in place should the person die.

Summary of findings

- The end of life care team had rolled out care standards to ward areas using a strategy called 'Transform'. Staff were trained to ensure that patients in the hospital had a good experience of end of life care.

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

Importantly, the trust must ensure:

- Medicines are managed at all times in line with legal requirements.
- There is effective leadership and governance arrangements in the A&E, operating department, maternity and radiology.

In addition the trust should ensure:

- Safety standards in the A&E department are improved to be in line with current national guidance.
- Parents and Children have information if they have to have long waiting times in the Rose Goodwin observation unit in A&E.
- Care pathways and care bundles continue to be embedded into everyday practice and monitored.
- It continues to reduce the avoidable harms of pressure ulcers, falls, and catheter urinary tract infections.
- People living with dementia continue to have consistent care and support in all areas of the trust.
- The Five Steps to Safer Surgery checklist is audited to ensure appropriate and consistent use.
- Patients being 'checked in' for theatre have their privacy and dignity maintained.
- Staffing levels continue to improve (especially in A&E and surgery), and patient care is appropriately delivered by trained, experienced and skilled staff.
- The use of linen drapes in theatres is avoided.
- That all staff use the incident reporting system to report incidents, and that learning from incidents is cascaded and shared.
- Do Not Attempt Cardio Pulmonary Resuscitation orders are appropriately completed so that there is timely documentation of the decision by the appropriate person, and this decision is reviewed if there is a change in a patient's condition, and mental capacity is assessed.
- Radiology services improve so that patients do not experience delays and long waiting times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

16 July 2014

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The trust had invested in developing the emergency medicine department and providing a dedicated children's assessment unit and an adult clinical decision unit. Staffing levels in the department had improved but there was still reliance on agency staff and junior doctors identified the need for more senior staff support. Safety standards for infection prevention and control, equipment and medicines management, particularly controlled drugs, were not met. The department was a low reporter of patient safety incidents and staff described the reporting system as slow with limited feedback to staff. National guidance was used to treat patients, and local care pathways and care bundles were ensuring consistency of treatment. Staff were passionate about the A&E department and the service offered to the public, and they treated patients with dignity and respect. Patient feedback was positive. The department was performing well against national waiting time targets for A&E, although some children could spend a long time under observation in the children's assessment unit . It was supportive of vulnerable patients, such as those with mental health conditions, learning disabilities or dementia, but this support could be inconsistent. The department did not have good governance processes to monitor quality and risk, and there was no culture of learning and innovation.
Medical care	Good 	There were effective procedures for patients to receive safe and effective care. Both medical and nurse staffing levels had improved and there were safe staffing levels with lower numbers of agency and locum staff. Safety standards were followed for infection prevention and control and the use of equipment but medicines management needed to improve. National guidance was used to treat patients, and local care pathways and care bundles were ensuring consistency of treatment. Multidisciplinary working was widespread. There had been significant progress with the development of seven-day services.

Summary of findings

Staff were caring and patients and relatives told us they were treated with dignity, compassion and respect. Patients were involved in planning their treatment and were always given an opportunity to speak with the consultants looking after them. Efforts were made to ensure patients stayed in contact with friends and relatives, and extended visiting hours had helped to improve communication between staff and relatives. The service was well-led. Staff felt supported, valued and proud to be part of the organisation. Quality and patient experience were seen as priorities and everyone's responsibility, and there was a developing culture of innovation and learning.

Surgery **Requires improvement**

Patients were assessed before surgery and monitored so that their risks were managed. However, the use of the 'Five steps to safer surgery' checklist was completed but there had not been ongoing observational audit to ensure it was appropriately embedded into clinical practice. Safety standards were met for infection prevention and control and the use of equipment, but medicines management needed to improve. Staffing levels had improved and recruitment was ongoing. In the eight weeks leading up to the CQC visit, out of 2,013 shifts only one shift was escalated as a red shift in surgery. There was still a high use of agency staff, however, and staff reported they were often understaffed and worked longer hours and overtime to support colleagues. Although. Patients were treated in line with national guidelines and received good pain relief.

Staff provided compassionate care and treated patients with dignity and respect. Patients we spoke with during our inspection were positive about the care and treatment they had received. They were complimentary about the staff in the service, and felt informed and involved in their care and treatment. Overall, national waiting times for surgery within 18 weeks were being met, although not in oral surgery, orthopaedics or colorectal surgery, and the trust was taking action to address this. Some patients had surgery cancelled at short notice because of staff shortages. There was some good leadership at ward levels and staff felt well supported by their managers; however, this was not

Summary of findings

			the case for the operating department and there were plans to improve the management of this service. Governance arrangements did not provide assurance around risk and efficiency. There was a developing culture of innovation and learning.
Critical care	Good		There were effective procedures to protect patients and support safe care. Visitors we spoke with were pleased with the care their relatives had received in the intensive therapy unit (ITU) and spoke highly of the staff. Clinical outcomes for patients in the unit were good. Staff worked well together as a team and were enthusiastic about their work. Patients we spoke with gave us examples of the good care they had received in the unit. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. The unit had an annual clinical audit programme to monitor how guidance was adhered to. Information was collected for the Intensive Care National Audit and Research Centre (ICNARC) database. There was good multidisciplinary team working although specific therapy support was not available over seven days. There was strong local leadership of the unit. Openness and honesty was encouraged at all levels, and staff were encouraged to learn new skills and develop the service.
Maternity and family planning	Good		There were effective procedures that supported safe and effective care for women. Staff were caring and compassionate and treated women with dignity and respect. National guidelines were adhered to and outcomes were good. Women had choices during birth and were involved in decisions about their care and treatment. There was additional support for vulnerable women and teenage mothers. The staff were loyal, committed and enthusiastic, and there was evidence of effective team work. The gaps in the leadership staffing structure had creating some instability and concern within the service and governance arrangements had deteriorated. Service plans did not go beyond operational requirements and staff were not learning from incidents and complaints. Staff were positive overall and fully engaged, but staff were striving to cover the gaps and were reporting some fatigue and a lack of direction overall. Team work

Summary of findings

remained good and there were high levels of respect and support. Although there were some good examples of improvement, staff said overall that there was a reluctance to change and innovation.

Services for children and young people

Good

There had been a review of the children's service that had resulted in changes. The review had been undertaken to ensure that the needs of the local population were met in a safe and responsive way. There were no inpatient children's services at the trust and children were cared for on the day procedure unit. They were cared for in a safe way in an environment that met their needs, and by staff with appropriate skills and experience. Children who were seriously ill were appropriately escalated for specialised care and this might involve transfer to a neighbouring trust. Staff provided compassionate care and treated children and their families with kindness, dignity and respect. The service was developing networks to ensure that care could be provided close to home when safe to do so. The service was well-led with a learning and innovative culture.

End of life care

Good

There were effective procedures to support patients to have safe and effective end of life care. Staff were caring and compassionate and treated patients with dignity and respect. They were committed to providing person-centred care and ensuring that patients had choices, a good experience and their preferences met at the end of life. Patients spoke positively about the way they were being supported with their care requirements.

Staff in all the ward areas we visited were aware of the guidance for patients receiving end of life care and all knew how to contact the specialist palliative care team. Not all patients were appropriately referred to the specialist palliative care team, but there were nurses called 'Transform Champions' in the ward areas who were responsible for ensuring that end of life care training was cascaded within the ward areas.

The Liverpool Care Pathway was still in use for patients but it was being used appropriately according to interim national guidelines. The hospital had planned to phase it out, as expected nationally after a national review. The specialist palliative care team was working to develop an end

Summary of findings

of life care pathway that would be rolled out in June 2014. This team provided outstanding leadership. It was a small team that was passionate and dedicated to their role.

Outpatients

Good

There were effective procedures to support a safe service for patients. Staff were caring and treated patients with dignity and respect. Most patients were seen within national waiting times although there were delays in orthopaedics and neurosurgery. Patients told us they were happy with the care they had received while attending their appointments within the outpatient department.
Most of the patients we spoke with felt they were seen promptly and were kept informed if clinics were running late. Each clinic had a board that displayed the length of time patients might expect to wait to be seen. The radiology department, however, was overcrowded and people were waiting a long time for x-rays. The service was part of a 'transform' programme to improve efficiency (for example, to reduce 'did not attend' rates and become more responsive). The leadership of the service was good except in radiology where the lack of strong leadership was having an impact on staff and the running of clinics.

Good

George Eliot NHS Hospital

Detailed findings

Services we looked at
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to George Eliot NHS Hospital

The George Eliot Hospital is an acute hospital that forms part of George Eliot Hospital NHS Trust. The trust provides a range of hospital and community-based services to 300,000 people in North Warwickshire, South West Leicestershire and North Coventry, and employs around 1,917 staff. The George Eliot Hospital is a 352-bed district general hospital, based on the outskirts of Nuneaton. The hospital provides a range of elective and non-elective inpatient surgical and medical services as well as a 24-hour A&E department, maternity and outpatient services.

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in May that year. After that review, in July 2013, the trust entered special measures. This was because there were concerns about the role of the leadership team in driving improvements in the quality of care and treatment, the pace of quality improvement, the number of unnecessary bed moves for patients, the level of clinical staff out of hours and at weekends, the quality of medical handovers, the use of nationally recognised pathways of care, the procedures for incident reporting, the prevalence of pressure ulcers and the need to clarify the grading of pressure ulcers.

The George Eliot Hospital had been inspected five times since registration. The last inspection was in March 2014 and the hospital was found to be compliant for all the outcomes inspected.

We carried out this comprehensive inspection because the George Eliot NHS Trust had been flagged as potentially high risk on the Care Quality Commission's (CQC) Intelligent Monitoring system. We inspected accident and emergency, medical care (including older people's care), surgery, critical care, maternity and family planning, services for children and young people, end of life care and outpatient services.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant in Cardiac Radiology and Clinical Management

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 31 included CQC inspectors and analysts and a variety of specialists: junior doctor and consultant from emergency medicine; medical consultant; consultant gynaecologist and obstetrician; surgical doctor; paramedic; midwife; surgical nurse; medical nurse; board level nurse; critical care nurse; student nurse; dementia care nurse and experts by experience.

How we carried out this inspection

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

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

The inspection took place on 30 April and 1 May 2014 with an unannounced visit on 10 May between 4pm and 8pm.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); NHS Trust Development Authority; NHS England, Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of

Detailed findings

Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Warwickshire County Council; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event in Bedworth on 29 April 2914, when people shared their views and experiences of the George Eliot Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or telephone.

We carried out an announced inspection visit on 30 April and 1 May 2014. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We also spoke with members of the patients' forum and one of the support groups. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out unannounced inspections from 4pm to 8pm on Saturday, 10 May 2014. We looked at how the hospital ran at the weekend, the levels and type of staff available, and how they cared for patients.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the George Eliot Hospital.

Facts and data about George Eliot NHS Hospital

1. Context

- Around 352 beds
- Population around 300,000 (North Warwickshire, South West Leicestershire and North Coventry)
- Staff: 1,917
- Annual turnover(total income) £122,494m (2012-13)
- Surplus (deficit) £300,000 (2012/13)

Note: This is the trust's financial performance for the year 2012/13. The trust has an accumulated deficit of £2.4 million.

- The trust runs an urgent care centre, four GP surgeries and a range of community services, including dentistry.

2. Activity

- Inpatient admissions: 38,138 (2012-13)
- Outpatient attendances: 207,419
- A&E attendances: 65,831
- Births: 2,502 (October 2012-November 2013)
- Deaths in hospital: 697 (2013/14)

3. Bed occupancy

- General and acute: 90.3% (October-December 2013). This is above the England average (87.5%), and above the level (85%) at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital
- Maternity: 90.3% (higher than England average 58.6%)
- Adult critical care: 79.2% (lower than England average 82.9%)
- Neonatal Intensive Care Unit: n/a

4. Intelligent Monitoring

- Safe: Risk = 0, Elevated = 0, Score = 0
- Effective: Risk = 2, Elevated = 1, Score = 4
- Caring: Risk = 0, Elevated = 0, Score = 0
- Responsive: Risk = 0, Elevated = 0, Score = 0
- Well led: Risk = 1, Elevated = 1, Score = 3

Total: Risk = 3, Elevated = 2, Score = 7

Individual risks/elevated risks

- **Elevated risk:** Dr Foster Intelligence: Composite of Hospital Standardised Mortality Ratio indicators
- **Elevated risk:** TDA - Escalation score
- **Risk:** Composite indicator: In-hospital mortality - Cardiological conditions and procedure
- **Risk:** Composite indicator: In-hospital mortality - Respiratory conditions and procedures

Detailed findings

- **Risk**: GMC National Training Survey – trainee's overall satisfaction

5. Safe:

Never events in past year: 2 (December 2012 and January 2014)

Serious incidents (STEIs): 135 (December 2012 and January 2014)

National reporting and learning system (NRLS) March 2013-February 2014:

- Deaths: 3 (Note: It is one death; the trust incorrectly coded two as deaths)
- Severe: 67
- Moderate: 250
- Abuse: 10 (potential abuse or safeguarding prior to patient admission)
- **Total: 328**

Safety thermometer:

- Pressure ulcers - High but decreasing
- VTE – Low
- Catheter UTIs – High but variable
- Falls – high but variable

6. Effective:

- HSMR: Elevated Risk (Intelligent Monitoring); Within expected limits (March 2014)
- SHMI: No evidence of risk (Intelligent Monitoring)

7. Caring:

- CQC inpatient survey (10 areas): Worse for one area 'doctors' (communication, confidence in treatment); about the same as other trusts for the remaining nine areas
- FFT inpatient: Above the England average
- FFT A&E: Above the England average
- Cancer patient experience survey (69 questions): Above England average for 16 questions; average for 41 questions; below average for 12 questions

8. Responsive:

- A&E 4 hour standard – Variable but improved over the course of the year (2013/14). Target was missed for eight out of 52 weeks the lowest level (was 85% for weeks in April and October 2013).
- A&E left without being seen: better than average.
- Cancelled operations: Similar to expected
- Delayed discharges: Average
- 18 week RTT: No evidence or risk

9. Well led:

- Staff survey (28 questions): Above England average for 7 questions; average for 4 questions; below for 17 questions
- Sickness rate 3.5 %: Below 4.2 % which is the England average
- GMC training survey: The trust was worse than expected in three areas in Anaesthetics and Emergency Medicine, and had one or more areas that were worse than expected in six other specialties. The trust was better than expected for workload in general surgery and workload and regional teaching in obstetrics and gynaecology.

10. CQC inspection history

- Six inspections at the trust since its registration in April 2010.
- The trust was compliant against outcomes relating to care and welfare, meeting patients' nutritional needs, and staffing at the most recent inspection in March 2014.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	☆ Outstanding	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for either A&E or Outpatients.

Accident and emergency

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

Information about the service

The accident and emergency (A&E) service treated 65,831 patients during the past year and 14,762 patients were admitted to hospital. Approximately 16,500 of the A&E attendances were children and 20% of these were transferred to inpatient facilities at the University of Coventry and Warwick Hospital NHS Foundation Trust. The service has recently opened a children's assessment unit as part of the A&E department to provide services to children and young people under 16 years of age.

The 'minors' area within the main A&E department has eight cubicles, which includes one for eye patients and one for dental patients. The 'majors' area within the main A&E has eight monitored cubicles and two unmonitored cubicles. The children's assessment unit (CAU) has 10 cubicles and there is a paediatric trolley within the resuscitation area. There are two adult beds within the resuscitation area. There are seven beds within the adult clinical decision unit (CDU), which support single-sex accommodation. There is a dedicated waiting area with chairs.

We spoke with nine patients, 11 relatives, 12 members of nursing staff, two consultants, three staff grade doctors, two junior doctors, one pharmacy technician, one healthcare support worker and two domestic staff. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

The trust had invested in developing the emergency medicine department and providing a dedicated children's assessment unit (CAU) and an adult clinical decision unit (CDU). Staffing levels in the department had improved but there was still reliance on agency staff and junior doctors identified the need for more senior staff support. Safety standards for infection prevention and control, equipment and medicines management, including controlled drugs, were not met. The department was a low reporter of patient safety incidents and staff described the reporting system as slow with limited feedback to staff. National guidance was used to treat patients, and local care pathways and care bundles were ensuring consistency of treatment.

Staff were passionate about the A&E department and the service offered to the public, and they treated patients with dignity and respect. The department was performing well against national waiting time targets for A&E, although some children could spend a long time under observation in the CAU. Patient feedback was positive about the service. It was supportive of vulnerable patients, such as those with mental health conditions, learning disabilities or dementia, but this support could be inconsistent. The department did not have good governance processes to monitor quality and risk, and there was no culture of learning and innovation.

Accident and emergency

Are accident and emergency services safe?

Requires improvement

Staffing levels in the department had improved and there was appropriate medical and nursing cover over a 24-hour period, seven days a week. However, recruitment was ongoing and there was still a high use of agency staff. Incidents were under-reported and staff said they did not have regular feedback and lessons learned were not widely shared. Infection prevention and control practices were not consistently followed to manage the risk of infection. Patients were appropriately referred if there was an identified risk to their condition, but patients were not consistently assessed for potential risks such as falls, pressure ulcers and dementia care. The number of falls on the CDU was high.

The service had enough suitable equipment, but we did not see evidence of routine maintenance and reporting of faults. There was a central system for safety alerts; however, these were only recorded as received within the department: there was no information on which areas had been checked or actions taken if required. Medicines were not appropriately managed and the management of controlled drugs did not meet legal requirements. Children received safe care in the CAU.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There had been no Never Events between December 2013 and February 2014 in the A&E department.
- Incidents were under-reported in A&E. Senior nursing staff told us that they continued to report incidents, other nursing staff and some medical staff told us they did not always report them.
- There was no evidence that themes from incidents were discussed at weekly meetings and staff were unable to give us examples of where practice had changed as a result of any recent incidents having been reported. None of the staff said they got feedback when incidents were reported.

Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. This was for inpatients.
- The A&E department did not have its own safety thermometer data on display.
- The CDU monitored harm-free care and displayed 'Simply Safer' data on all wards. This data covered infections, high-impact interventions (such as hand hygiene and peripheral line insertion), the NHS Safety Thermometer, information on patient experience, complaints and assessments (for example, for medication, nutrition, continence and pain). The data also included appropriate staffing ratios for qualified and non-qualified staff.
- In February 2014, the CDU data demonstrated that standards were being met in all areas with the exception of falls with harm and assessments. Eleven patients had sustained a fall while on the unit, which was higher than expected against the trust's own performance targets. Assessments were low for nutritional status and pain management.

Cleanliness, infection control and hygiene

- The A&E department was clean. There was, however, a taped black line for people to wait behind at the walk-in entrance to the reception and this was frayed and partially missing. This area had become resistant to effective cleaning and was dirty. Some of the seating within A&E was ripped and torn. This posed a risk to the prevention and control of infection.
- Staff did not adhere to the trust policy on infection control. They wore clothes that allowed their arms to be bare below the elbow; however, we observed five doctors and four nurses wearing blue gloves inappropriately. Although these were worn appropriately to treat patients, they were not removed after clinical procedures but continued to be worn when carrying out clerical duties or accessing items from other areas.
- There were sufficient hand-washing facilities but staff did not wash their hands as often as expected; nor did they wash or clean their hands after they removed blue gloves, which was best practice.
- Foot-operated pedal bins were used for the disposal of waste in line with current national guidance.

- Incontinence sheets were used to cover the equipment used for resuscitation within the A&E department. This was not in line with best practice because the sheets absorb moisture from the air and could become bacteria reservoirs.
- Linen was being carried into a dirty sluice area within the majors area but a linen skip should have been taken to the bay to minimise the risk of cross infection.

Environment and equipment

- The environment on the unit was safe for the number of patients attending. There was swipe card access to the CAU so that staff could be identified entering from the main A&E.
- The CAU had automatic door switches at a level that enabled small children to let themselves out of the department. Staff did not know of any risk assessments that had been done to assess and mitigate this risk.
- The CDU used a blue rose label on the board to indicate a patient who may require more support or could have dementia. The environment, however, was not dementia friendly: whole walls were plain and light coloured, with little contrast or stimulation to help orientate a patient who might have dementia.
- The radiology department was situated next door to the unit and was easily accessible.
- The patient monitoring equipment had data pods that meant it could be safely moved with a patient to any unit without losing vital patient data that had been recorded in the A&E department.
- Equipment was appropriately checked and cleaned regularly. However, staff were uncertain if faulty equipment had been reported and some staff told us that they thought someone else would have reported the fault. Locks that had needed attention for 12 months had not been reported via the incident system as an outstanding concern, nor escalated as outstanding repair work within the division. Staff were not sure what happened after they reported equipment for maintenance or repair. There was no central log of equipment and serial numbers were not maintained or available within the department in order to support the checking process.
- All cubicles had trolleys fitted with a deep mattress and a further overlay for pressure relief. There was an additional heated pad that fitted into the overlay mattress when needed. This heated pad could be used to support a patient suffering from hypothermia (very low temperature).
- When required, a bed would replace the trolley in the cubicles within the main A& E adult department. A warming cabinet kept blankets warm and was situated immediately outside the resuscitation area for easy and fast access when needed.
- Security in the department had been identified as a risk. Swipe access had been implemented but only 34% of staff had attended conflict resolution training. The department had requested bespoke training so that more staff could attend, but this had not been arranged.

Medicines

- Medicines were not stored correctly. One cupboard that required two working locks only had one. Fridge temperatures were checked to ensure that they were within the required limits. Urinalysis reagent strips were stored inappropriately within a public toilet.
- Medicines were not being managed appropriately. The department did not have an agreed drug stock list of what medicines should be available and there was a large number of out-of-date or return-to-pharmacy medicine items in the cupboards.
- Patient Group Directions (PGDs) were not being used in the department. These are specific written direction which allow some registered health professionals to supply and or administer a specified medicine(s) to a predefined group of without them having to see a doctor. They can only do so as named individuals. Staff were suitably trained and had requested to use PGDs to improve patients access to treatment.
- Controlled drugs were not managed appropriately. They were kept in damaged boxes or boxes taped together, which made it difficult to check the batch number and the expiry date of the medicines. The controlled drugs register had damaged pages meaning that there was an unclear record of signatories for some medicines administered. These issues had been corrected at the time of our unannounced inspection visit.
- Intravenous medications were not appropriately labelled. There were no morphine stickers available so a tramadol sticker was used with morphine handwritten

over the label. This contravened guidelines for the safe management and administration of controlled drugs. On our unannounced inspection visit, we saw that it this had been corrected.

- The stock within the controlled drug cupboard did not reflect that recorded in the register. When further reviewed, this was found to be a reoccurring theme and staff were not including expired medication in their running totals. When we revisited the department on our unannounced visit, a new controlled drug register had been introduced to prevent errors.
- A pharmacy assistant visited the department to check and order stock medication against a set checklist. Nursing staff in the department had relied on these assistants to check the contents of the medicines cupboard, and they were not aware that this support was not being provided by pharmacy.
- On the CDU, there were effective systems to identify medicines that were nearing their expiry date and needed to be returned to the pharmacy and reordered. Daily checks on the controlled drugs, however, did not always take place. Staff told us that this was because the ward was extremely busy and a new system had been introduced to check the controlled drugs at the time of shift changes.
- There had not been any incident reports, audits or risk assessments relating to medicines management. Staff confirmed that incidents relating to medicines management had been reported but they could not identify any action taken.
- Security staff carried out hospital-wide drug security audits. The faulty lock on the medicine cupboard within the A&E department had not been identified, nor had the discrepancies in the recording of the controlled drugs. Staff told us there were plans for the pharmacy to undertake audits in future.

Medicines in the Children's Assessment Unit (CAU)

- PGDs were used in the CAU but staff had not completed the training to be able to use them.
- Medicines were not stored appropriately in the CAU. The refrigerator used to store medicines was maintained at a temperature within the required range, and this was checked and recorded daily. However, the temperature in the CAU was 270 Celsius which was above the recommended temperature for the storage of medicines. Staff told the trust would be providing air-conditioning but could not tell us when, or if this had been approved. The door to the medicines storage area was locked with a keypad, but the access code was the same as that used within the rest of the department.
- The cupboard for take-out medicines contained antibiotics that were labelled as ward issue and had not been reconstituted. A further paper label had been taped over the adhesive label, which partially occluded the recommended dosage of the medication. The sister in charge of the unit told us that, because of this issue, they had not been able to give this medicine to patients since the unit opened in August 2013, but the issue had not been raised as an incident.
- The controlled drugs cupboard had recently been replaced and was now an appropriately lockable cupboard with a smaller lockable section within it. There was evidence that controlled drugs were checked and managed according to legal requirements.
- The FP10 prescription pads were stored within the outer locking controlled drugs cupboard. There were two pads in the cupboard and both were in use. There was no audit process to monitor and account for each script from the FP10 pad.
- There were effective systems to identify medicines that were nearing their expiry date and needed to be returned to the pharmacy. However, the unit did not keep an agreed stock list and there were no effective systems to reorder medicines. It was not possible to determine what the stock level within the unit should have been.
- Medication administered to children was checked and witnessed by two members of staff, which was safe practice.

Records

- All records were in paper format and all healthcare professionals made their notes in the same place.
- All the patient records we reviewed showed that the initial assessments of risk were being completed but they did not record the time pain relief and antibiotics were given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for consent to procedures appropriately and correctly. We saw examples of

patients who did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately and that Deprivation of Liberty Safeguarding was applied.

Safeguarding

- An alert would be added to a patient's record if there were any concerns regarding child welfare in the A&E department. However, if a child was transferred to another hospital, the system was not failsafe. The trust had recently begun a project, led by a named consultant, to review this and improve the process, which would involve other agencies. Staff told us they were proactive in contacting safeguarding social workers and health visitors if they had concerns.
- There was a dedicated pack for staff to use if there were concerns about a child's safety and staff within the CAU were clear about the location of these packs and when to use them.
- There was a safeguarding lead for vulnerable adults. Staff knew how to contact this person and could talk us through the escalation process.

Mandatory training

- Statutory training covered fire safety, health and safety and manual handling. Mandatory training covered infection control, information governance and safeguarding (which included dementia awareness training).
- The trust had a target to achieve 80% compliance with statutory and mandatory training; 84% of staff in the division had done statutory training and 98% mandatory training.
- The trust target was for 90% of staff to have relevant safeguarding training. In the A&E, all staff had had level 1 safeguarding training; 80% had had level 2 training. Within the CAU, all staff (expect one who was new to the unit) had had level 3 child protection training.

Assessing and responding to patient risks

- The department used a recognised the modified early warning system (MEWS) tool to escalate risks to patients. There were clear directions for escalation printed on the reverse of the observation charts and staff were aware of the appropriate action to be taken if a patient scored higher than expected.
- The department used the paediatric early warning system (PEWS) tool for children. Staff talked us though the risk assessment process for transfer. All grades were able to tell us to whom they would report and escalate a deteriorating child and the action they would take to keep the child safe.
- We looked at completed charts. We saw that staff had escalated patients correctly, and repeat observations had been taken within the necessary time frames.

Nursing staffing

- Nursing numbers were assessed using the national safer nursing staffing tool. Minimum staffing levels were clearly identified for each shift in the department. Staff reported that they were only rarely understaffed and that vacancies were filled with agency staff.
- The agency spend for this directorate had reduced after a recruitment initiative. There was still a high use of agency staff in A&E. All agency staff underwent appropriate local induction on arrival for their shift. The department used regular agency staff from one agency.
- Staff did not have access to agency staff profiles or qualifications. Senior staff confirmed that unsatisfactory agency staff were not booked to work in the department again.
- Within the main A&E unit, there was a staff rota that indicated that skill mix was taken into consideration when planning rotas. All disciplines of staff confirmed that they found the skill mix within the unit appropriate.
- The CDU was staffed with only two nurses using a planned rota. The rota identified, however, that the unit had been staffed by a single qualified nurse up to three times a week. Patients on this unit had a variety of needs, which included people living with dementia, who may require additional support at night when in unfamiliar surroundings. The department had applied for a healthcare worker to support these patients.
- The CAU had a full-time unit manager, four senior nurses, 11 staff nurses and dedicated night staff to provide cover 24 hours a day, seven days a week.

Medical staffing

- There were four substantive whole time equivalent (WTE) consultants and two locum consultants. Consultants were present and active within the department from 8am to 8pm Monday to Friday and 9am to 9pm at the weekend. We looked at the consultants' rota and saw that consultant cover was planned for 24 hours a day, seven days a week; this included additional on-call cover when required.

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- The unit had one specialty doctor and one physician's assistant.
- There were three vacancies at middle grade with eight of the 11 posts filled. The rota planned for a middle grade doctor to be on duty in the department at all times and vacancies were filled by a locum or agency doctor.
- There were no gaps at junior doctor level. There were four doctors undertaking GP placements. There were two foundation year 2 doctors on rotation.
- Junior doctors told us there were adequate numbers of junior doctors on the unit out of hours and that consultants were contactable by phone if they needed any support. However, they also said that they did not see consultants "on the floor" as often as we would have expected from the rota.
- The CAU was consultant led and paediatric consultants were active in the unit 24 hours a day, seven days a week. A&E consultants also provided support to the unit, and if the unit was busy they would call in an additional on-call consultant for support.

Major incident awareness and training

- The trust had a duty as a category 1 responder under the Civil Contingencies Act 2004 to be prepared to respond in the event of a major incident or disaster. The A&E department had a major incident plan. Staff from both the main A&E and CAU were informed about the plan and where to locate it, and also their particular roles.
- The trust had partnerships with other Local Health Resilience Groups to ensure a multi-agency response would be able to deal with any casualties contaminated with chemical, biological or radiological material (HAZMAT).

Initial assessment of patients

- Patients received timely and appropriate initial assessments. Those arriving by ambulance were assessed within six minutes. Walk-in patients were seen jointly by a receptionist and a band 6 or above nurse. They used a formal triage system (the Manchester Triage guidance) that was completed within recommended time frames. This was also monitored at the department's monthly meeting.
- Patients with chest pain were transferred immediately to the 'majors' area for an electrocardiogram (ECG).

Nursing and medical handover

- We observed both medical and nursing handover. Nursing handovers occurred twice a day, and were supported by a dedicated handover book. Staffing for the shift was discussed as well as any high-risk patients or potential issues.
- Medical handover occurred twice a day and was led by the consultant within the department. The medical handover was not formally structured and not all doctors were included in the handover. Some grades of doctor left out of handover required the nurse in charge to keep them up to date.
- Board rounds took place at 8am and 10pm. We observed that the monitoring boards were not anonymous in all areas. In the majors area and CDU, the boards were in areas where patients and relatives could read confidential information about other patients.

Safety bulletins

- National safety bulletins which relate to specific equipment, medicines, or substances used within healthcare were recorded as received within the department.
- There was no specific area by area confirmation that the hazard was not present or had been removed. There was no record of any action taken to check for stock that related to the safety bulletin.

Security

- Security in the department had been identified as a risk in 2011. Security was available on site and there were now closed circuit television cameras (CCTV) within the department. Swipe access to the A&E department had been implemented. Staff commented that security staff responded quickly when needed.
- Security also included suitable training for all staff in conflict resolution. By the end of 2013, only 34% of staff had attended conflict resolution training. The department had requested bespoke training so that more staff could attend, but this had not been arranged. Most staff were up to date with this training by May 2014.
- The trust operated a red and yellow card system to deter people from inappropriate violence and aggression towards staff, including racism and equality and diversity intolerance. Red cards prevented the person being allowed onto trust property and the trust

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received support from Warwickshire Police in prosecuting violent or aggressive people. Within the current year, the trust has issued two initial warning letters: one yellow card and 11 red cards.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

We report on the effectiveness of A&E below. However, we are not currently confident that, overall, CQC is able to collect enough evidence to give a rating for effectiveness in the A&E department.

Guidelines from the College of Emergency Medicine (CEM) and the National Institute for Health and Care Excellence (NICE) best practice guidelines were followed. Staff used care pathways and care bundles. Patients we spoke with all told us that they had had their pain assessed and had been offered suitable pain relief. Staff were supported in training and development. Senior medical staff worked seven days a week but some clinical support services were not as well developed to support out-of-hours and weekend work.

Evidence-based care and treatment

- The A&E department including the children's assessment unit (CAU) used a combination of NICE and CEM guidelines to determine the treatment they provided.
- Local policies were written in line with these and updated every two years or if national guidance changed. The department ensured that the A&E department was managed In accordance with the principles in 'Clinical standards for emergency departments' (CEM) and there was participation in national audit.
- There were specific pathways for certain conditions: for example, sepsis, fractured neck of femur, diabetic ketoacidosis and ST segment elevation myocardial infarction. There were care bundles for sepsis, heart failure and pneumonia. All grades of staff we spoke with knew about these and how to use them. Clinical pathways were being followed appropriately for the patients we tracked through the department.
- The hospital had adopted the 'sepsis six' pathway. This was designed to save lives by taking six clear steps for all patients presenting with signs of sepsis. All staff within the A&E department carried a small reminder of the pathway attached to their name badge.
- The lead clinician for the department ran a weekly programme in which team members reported audit findings. However, we did not find evidence of continuous improvement following audit and staff could not tell us what the last change in practice as a result of clinical audit had been.
- There was an example of one audit that had led to improvement. An audit of difficult airway trolleys had led to all the trolleys being brought up to date and regularly checked. The trolleys were now laid out according to the Difficult Airway Society's guidelines for failed intubation.
- Multidisciplinary mortality reviews were undertaken.

Pain relief

- Patients told us that they had their level of pain assessed quickly and were offered suitable pain relief. They said that staff had checked on the effectiveness of the pain relief at intervals patients found appropriate.
- Children were given pain relief in a timely manner.
- Patients in the waiting room of the clinical decision unit (CDU) who were waiting for test results were offered pain relief and their comfort levels checked.

Nutrition and hydration

- The CDU was supported with hot meals served on plates, and jugs of cold drinks were available to patients if clinically appropriate.
- A vending machine was available within the A&E reception area. Hot drinks were made available to patients every 2–3 hours.
- There was no readily available drinking water within the minors or majors areas to promote adequate hydration.
- There was no water fountain available within the majors area. We asked about obtaining drinking water and one member of staff offered us with a plastic cup of water from a tap clearly marked 'not drinking water'.

Patient outcomes

- The unit contributed to many of the CEM audits including vital signs in majors, fractured neck of femur, renal colic, severe sepsis and septic shock. The trust had made improvements after these audits in 2011/2012.

For example, the CEM standard is 95% for the sepsis pathway. The trust was 75% compliant in 2011/2012; the most recent audit demonstrated that the trust was now 90% complaint.
- There was less evidence available on compliance with care bundles for heart failure and pneumonia.
- Unplanned re-attendances were between 5% and 6%. This was above the target of 5% set by the CEM, but below the average for NHS hospitals in England (7%).

Competent staff
- There was a comprehensive induction and competency training package for all nursing staff new to the department. Staff told us that they felt supported with this. The training was undertaken by staff with an emergency nurse practitioner (ENP) qualification. There were 12 ENPs in the department.
- Members of staff confirmed that x-rays were sometimes requested by an ENP before a patient was assessed. Not all ENPs were trained to review x-rays even though they were responsible for checking them if they had asked for them.
- Nursing staff in the CAU had completed advanced practitioner and advanced paediatric life support training.
- Foundation trust doctors had training on Thursdays; doctors in training to be GPs attended relevant training on Tuesdays. The National Training Scheme Survey, GMC, 2013, identified that the hospital was similar to other trusts in terms of training but worse than expected for overall satisfaction, adequate experience and educational supervision in emergency medicine.
- Staff appraisals had improved and staff told us that there was now more interest in them. Senior staff told us that 80% of appraisals had been completed across the whole department.
- Nursing staff told us that they were able to access both professional development training and mandatory training.
- Healthcare support workers told us that that they were able to apply for secondments to nurse training and that the trust ran study days especially for

Multidisciplinary working
- Specialist nurses (for example, stroke or cardiology nurses) were available and would attend the department on request. The cardiology nurse had reviewed electrocardiographs in the department.
- There was input from the mental health team, based in the department, for people with mental health problems. The department also had support from dedicated mental health-trained nurses from the Coventry and Warwickshire Partnership trust. They were in the department every day of the week from 9am to 9pm, Monday to Friday, and 9am to 5pm at weekends and during bank holidays.
- The changes in emergency medicine including the ambulatory medical unit and the CDU, which supported a reduction in admissions. These two units had been open for less than a year and data from them was still being collected.

Seven-day services
- A consultant was present on the unit from 8am to 8pm at weekends. This was in line with CEM guidelines for a department of this size. They were supported by middle grade doctors, a senior registrar and a junior doctor who were present in the department at all times. Outside those hours consultants were on call.
- Pathology services were on call out of hours and provided weekday services from 9am to 1pm. Laboratory tests were available electronically. However, staff working within the majors area during our unannounced inspection told us that laboratory staff were on call between 8pm and 9am and that staff sometimes waited until they had several patients requiring blood tests. This practice could delay treatment.
- Pharmacy staff provided weekend services from 9am to 12.30pm on Saturday and 10.30am to 2.30pm on Sundays. Outside those hours there was an on-call pharmacist to dispense urgent medications.
- Plain film radiology was provided 24 hours a day, seven days a week. Weekend cover was provided on site by radiographers from 9am to 5pm. A consultant radiologist worked from 9am to 5pm on the weekend for CT, MRI and ultrasound scans. Staff were on call outside these hours. The protocol for referral to an on-call consultant radiologist was via another consultant and staff told us that this could cause delays.
- There were no occupational therapy services out of hours or at weekends.
  - Two physiotherapists and a physiotherapy assistant were on call out of hours and available between 9am

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and 3.30pm at weekends for intensive therapy unit (ITU)/respiratory cover, discharge mobility assessments, A&E and CDU cover, and stroke assessments.

Are accident and emergency services caring?

Good

Staff provided compassionate care and treated patients with dignity and respect. Patient feedback in the NHS Friends and Family Test was above the England average. Patients told us they were involved in their care but patient feedback surveys indicated that they did not always have an explanation from doctors or nurses as to why they were waiting for an examination or treatment.

Compassionate care

- Since April 2013, patients had been asked whether they would recommend the hospital wards to their friends and family if they needed similar care or treatment; the results of this informal survey have been used to formulate the NHS Friends and Family Test. The trust's A&E Friends and Family Test results had improved over the past six months and the trust scored well above the England average for November 2013 to February 2014.
- The Adult Inpatient Survey, CQC, 2013, showed that the A&E department had performed the same as other trusts in England for patients being given enough information about their condition and being examined in privacy.
- The CQC analysis of the NHS A&E Survey, 2013, showed that the trust had scored worse than expected for patients waiting to have a first conversation with a doctor or nurse or to be examined.
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We only observed one person who was being examined by a doctor and did not have their privacy adequately maintained. In this instance, the curtain was not fully drawn around the cubicle.
- We looked at patient records and found they had been completed sensitively and outlined discussions that had taken place with patients and relatives.

Patient understanding and involvement

- Patients and relatives told us that they had been consulted about their treatment and felt involved in their care.
- All but one patient and their relatives told us that they knew what to expect next and what was happening to them. One patient within the CAU told us that they did not know why there was a delay in their treatment. They had not received an explanation as to why they were waiting.

Emotional support

- We witnessed staff supporting vulnerable people who were in distress.
- We observed staff being sensitive to patients' needs. For example, one patient had requested a chaplaincy visit and the doctor waited until the visit had ended before returning to the patient.

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

Good

The trust had invested in developing the emergency medicine department and providing a dedicated children's assessment unit (CAU) and an adult clinical decision unit (CDU). The trust was generally performing well and achieving national waiting time targets for A&E, although some children could spend a long time under observation in the CAU. The department provided specific support to patients with mental health conditions, learning disabilities and dementia, although the dementia care pathway was not consistently used. There were translation services and information leaflets available in different languages. The department received many compliments and these were on display in the staff room, although complaint handling procedures needed to improve.

Service planning and delivery to meet the needs of local people

- The trust had remodelled its emergency medicine provision to improve the flow within the A&E department and the hospital generally. The emphasis

was now to stop the 'push' of patients out of A&E when the department was overcrowded and under pressure, and to 'pull' the most appropriate patients through A&E into appropriate treatment pathways.
- The trust was proactive in working with their commissioners and local GPs to introduce admission avoidance measures. For example, they had established ambulatory care pathways for deep vein thrombosis (DVT), pulmonary embolism (PE) and cellulitis.
- The CDU was for short stay patients of up to 24 hours. It was intended to reduce admissions to the hospital and there was a clear protocol for admission.
- The A&E included a dedicated children's assessment unit (CAU) which was opened in August 2013, part of this unit was called the Rose Goodwin Unit and this was used for the observation of children. The CAU was opened from 8am until 10pm.
- The department had a clear escalation policy that was based on advice in 'Crowding in emergency departments' by the College of Emergency Medicine. The department was supported by the trust-wide discharge team so that there was joined-up working at busy times.

Access and flow

- The trust did not have any breaches of 30- or 60-minute waiting times for ambulances that had brought patients to the hospital and needed to be available again for calls.
- The trust had improved its performance against the national four-hour waiting time target from attendance in A&E to admission, transfer or discharge. In 2013, having been as low as 85% in April 2013, the trust was mainly above the 95% target and in the last quarter (January–March 2014) it had achieved the target with only a dip in February 2014 to 91%. The trust was seventh in a list of top 10 NHS trusts in the country for seeing patients within four hours in A&E in the 20-week period to 23 March 2014.
- The trust's performance was better than the national average for both the percentage of patients leaving A&E before being seen (less than 1% compared with an England average of over 2%) and unplanned re-admittance within seven days (less than 6% compared with a 7% England average between November 2012 and March 2014.
- Since September, 2013, the trust had performed better than the England average for the percentage of emergency admissions waiting 4–12 hours from the decision to admit to being admitted.
- Staff told us that children in the Rose Goodwin Unit were not counted in the four-hour wait for A&E because they were on trolleys, not beds, and were under observation in the CAU. Some children had waited for more than four hours in the unit. The Trust subsequently identified that all children on the unit were counted against the four hour wait and breaches were recorded as expected by national requirement.
- The CQC analysis of the NHS A&E Survey, 2013, showed that the trust scored similar to other trusts for transition from ambulance to A&E, but better than expected for the length of waiting time in A&E.
- The waiting room consistently displayed a waiting time of 45 minutes over the inspection period, even when the waiting room was empty.
- Patients were accurately monitored for time spent in the department and the trust reported that the average time from arriving in the department to completing treatment was 144 minutes. We tracked one patient who had been identified as requiring a bed within the hospital 2.5 hours after they presented at the department. Within a further 30 minutes they had been found a bed.
- Staff told us that patients in the department for over four hours would be transferred to a bed with a pressure-relieving mattress if appropriate. This practice was not audited.

Meeting people's individual needs

- Support was available for patients with dementia and learning disabilities. Nurses with specialist skills could be requested from either the mental health team within the main A&E (for support for people with learning disabilities) or from within the medical wards (for support for people living with dementia).
- Staff told us that they were using a dementia care pathway identified as good practice in other trusts. Currently all patients over the age of 75 admitted as emergencies were screened to identify problems with memory. However, patients with dementia were not consistently identified or supported. Documentation within the CDU included a mini-mental test, but the A&E department did not use the 'This is me' pathway for dementia care.

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- There were many information leaflets on display for a wide range of minor complaints. These were available in all the main languages spoken in the community.
- Translation services were available through a central hospital number. The services were provided by bilingual or multilingual members of staff. The hospital offered translation in Urdu, Hindi and Punjabi.
- Within the department it was possible to request an interpreter. The staff had a wide multicultural background in line with the population the hospital served, and they told us they would therefore usually use other staff members to translate.
- Discharge sisters involved social services when patients within the CDU had complex needs and required support to return home.
- A discharge summary was sent to the GP by email within 24 hours of discharge from the department. This detailed the reason for admission and any investigation results and treatment undertaken.
- The Trust had a handover policy which includes a written checklist for both medical and nursing handovers. There were nurse-to-nurse and doctor-to-doctor handovers on the wards but we did not observe the handover sheet or checklist in use.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.
- The A&E department had records of more compliments than complaints in the staff room. However, the records did not include responses to complaints or a summary of the complaints received. There was no identification of lessons that could be learned for continuous improvement within the department.
- Complaints leaflets were available at the entrance to the hospital and outside the wards.
- Patients were confident that they could raise concerns with ward managers without fear of reprisals.

Are accident and emergency services well-led?

Requires improvement

All staff in the service were proud to work in what was described as a highly supportive and cohesive team that placed patient care at its centre. However, staff expressed their concerns that they felt isolated from the rest of the hospital. The service had changed and developed to meet service demands and there were short-term plans to consolidate changes and ensure financial stability. This was a challenge. Long-term service and cost-improvement plans had not been agreed and ongoing recruitment to medical and nursing posts was required.

The governance processes in the department were underdeveloped and there was a lack of assurance about actions taken after audits and incidents. The department did not have a culture of innovation and learning. Staff were engaged with changes, but they were not aware of shared learning from the rest of the hospital and they did not lead on innovation projects.

Vision and strategy for this service

- The clinical lead had a vision for developing the department. This was to make better use of the space, consolidate changes in current practice, and become financially stable. The vision had been shared widely with the staff.
- The staff were positive about the changes in the department within the CAU, CDU and the main A&E and said that this had improved the flow in, and the pressures experienced, in the department.
- There was no written strategy within the department identifying how the staff was to achieve the vision for further improvements.

Governance, risk management and quality measurement

- The department did not hold dedicated monthly governance meetings. The lead nurse told us that they had plans to develop these.
- The department had a lead clinician with governance responsibilities. However, the clinician did not attend governance meetings or become involved with

trust-wide governance arrangements. There was no demonstrable process to support clinicians with governance responsibilities for promoting shared learning or raising concerns within the department.
- Staff did not know about clinical audit or quality initiatives within the department.
- Staff told us that they did not receive information about governance or learning from incidents within the rest of the hospital, and they did not receive governance support to analyse incidents and complaints for themes or trends.
- The risk register for the division did not identify the areas of concern in the department, with particular regard to medicines management, equipment maintenance and the lack of assurance about divisional governance arrangements.
- Feedback from incidents and complaints was either missing or ill-timed, preventing the division from maximising opportunities to share learning and develop plans to prevent recurrence.
- All staff disciplines repeatedly expressed concern that they did not receive feedback in response to issues raised. Senior nursing staff continued to raise these concerns. However, staff from all other grades told us that they saw little point in reporting issues because the lack of feedback.

Leadership of service

- The department was within Division A of the trust. This division included A&E, medical specialities, cancer services and clinical support departments, including physiotherapy, occupational therapy, radiology, pathology and pharmacy. The division was managed by a divisional manager with dedicated support for each department from a lead nurse and a lead clinician.
- Staff told us that the lead clinician in A&E was very visible and had engaged with staff about service changes.
- The A&E matron was new in post and did not have A&E experience. However, she was appointed by the trust specifically because of her strong leadership skills and ability to transform departments to improve performance.
- The Trust had appointed a nurse consultant for emergency flow.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. They said they were proud to work in the department and worked hard as a cohesive team to provide a good service.
- Staff told us that they felt part of the A&E team but isolated from the rest of the hospital.
- Staff confirmed that they felt supported when experiencing violence, bullying or harassment from patients or their friends or relatives.

Public and staff engagement

- The department engaged with the public via the Friends and Family Test and this had shown improvement over the past four months and was above the England average. The department had not undertaken any other public engagement to learn and improve from patient experiences of care.
- The staff satisfaction survey indicated a gradual increase from the previous year in the number of staff who were happy to work at the hospital. The same trend was noted among staff who would be happy to be treated, or have a member of their family treated, at the hospital.
- Sickness levels within the department had fallen from 5.7%, above the national average of 4.0%, to 0.44%, which was significantly below the national average. Staff told us that the increased levels of staffing within the department had been a positive factor in this reduction. Some staff had also returned to work from long-term sick leave.
- Staff were engaged with the Trusts emergency care transformation programme which radically changed the way the department worked.

Innovation, improvement and sustainability

- There was no culture of staff involvement with innovation projects in the department and innovations that had started were not always completed (for example, the appropriate use of patient group directives) and this was leading staff to feeling frustrated.
- Staff across all grades of the multidisciplinary team told us that they were concerned about the sustainability of some of the developments within emergency medicine. Staff numbers had recently been increased and new members had fitted into the team well. Established

members of the A&E team welcomed the new members but felt that the whole team needed to embed and consolidate practice before moving on further in the development plan.

- The trust had not yet confirmed its quality innovation productivity and prevention (QIPP) plans with commissioners. This meant it had not determined the cost savings through innovations required for the A&E department. The directorate manager told us they were planning internal key performance indicators that would support these. The trust was still discussing with the commissioners what the QIPP plans would look like for A&E, and they were not available in the department in draft form.
- The trust had been innovative in its emergency care transformation programme. There was a redesign of the A&E, seven day working, development of ambulatory care and clinical decision unit and children' admission and assessment unit.

Medical care (including older people's care)

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

Information about the service

The George Eliot Hospital provides cardiology, gastroenterology, respiratory medicine, endocrinology and stroke services within the medical division. Thrombolysis for stroke patients is not provided. It also provides services to elderly patients and those with dementia. It had a 41-bed acute medical unit (AMU), an ambulatory care unit (ACU), and a level 1 coronary care unit (CCU) as well as endoscopy (which is reported in the outpatient section of this report).

We inspected the ACU, AMU, CCU, stroke unit (Felix Holt Ward), elderly care and dementia unit (Bob Jakin Ward), respiratory ward (Elizabeth Ward), cardiac and general medical ward (Melly Ward) and gastrointestinal ward (Adam Bede Ward). We spoke with 24 patients including their family members. We spoke with 29 staff members including clinical leads, service managers and matrons, ward staff, therapists, junior doctors, consultants and other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

There were effective procedures for patients to receive safe and effective care. Both medical and nurse staffing levels had improved and there were safe staffing levels with lower numbers of agency and locum staff. Safety standards were followed for infection prevention and control and the use of equipment but medicines management needed to improve. National guidance was used to treat patients, and local care pathways and care bundles were ensuring consistency of treatment. Multidisciplinary working was widespread. There had been significant progress with the development of seven-day services.

Staff were caring and patients and relatives told us they were treated with dignity, compassion and respect. Patients were involved in planning their treatment and were always given an opportunity to speak with the consultants looking after them. Efforts were made to ensure patients stayed in contact with friends and relatives, and extended visiting hours had helped to improve communication between staff and relatives. The service was well-led. Staff felt supported, valued and proud to be part of the organisation. Quality and patient experience were seen as priorities and everyone's responsibility, and there was a developing culture of innovation and learning.

Medical care (including older people's care)

Are medical care services safe?

Good

Nurse and medical staffing levels had improved and there were safe staffing levels with low numbers of agency staff being used. There was a good culture of reporting incidents among the nursing staff but this had to improve for medical staff. All the clinical areas were clean and well maintained and there were good standards for infection control. There were suitable arrangements to manage equipment but medicines management needed to improve. Patients were appropriately escalated if their condition deteriorated. Action was being taken to ensure harm-free care and reduce the incidence of avoidable harms, such as falls and pressure ulcers.

Incidents

- The trust had three Never Events between December 2012 and January 2014. These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. One of these events was in the medical division and involved the removal of the wrong mole in a dermatology clinic. The event had been investigated and action taken to prevent reoccurrence.
- Staff were reporting incidents but there was variation in both the reporting and learning from them. Nursing staff were well versed in how to report an incident and said they reported them often. They told us they received individual feedback on the incidents they had reported. There was evidence of this in the minutes of their monthly ward meetings, which showed that the themes of incidents were fed back to staff.
- There was less of an incident-reporting culture among the medical staff. The junior doctors told us they rarely reported incidents. There did not appear to be any regular opportunity for the medical staff to routinely learn from incident themes.
- Some staff used the trust electronic reporting system; others used the paper system. Staff told us the electronic system was difficult and time consuming to use. The trust was aware of this and had plans to introduce a new electronic system in the summer of 2014.
- Incidents reviewed during our visit showed that thorough investigations and root cause analyses had taken place, and that there were clear action plans for feeding back to staff and sharing information with the trust Board.

Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls. Between February 2013 and January 2014, the trust performed worse than the England average in relation to patients who had had a pressure sore, catheter-acquired urinary tract infection or a fall with harm. The number of patients with new VTE was below the England average.
- The trust was taking action to reduce these avoidable harms. Pressure ulcers had accounted for 50% of all patient incidents reported between December 2012 and January 2014. Patients were risk assessed for pressure ulcers on admission to all the wards inspected and the risk assessments were updated throughout patients' stay. A care bundle for pressure ulcers was introduced and there were action plans to improve the management of patients at risk of pressure ulcers (for example, through repositioning and appropriate use of pressure-relieving mattresses).
- In response to falls, the trust had developed a 'Falls care bundle' for all patients identified as being at risk of falls. Throughout our inspection, we saw that patients at high risk of falls were clearly identified and actions taken to minimise the risk, such as the use of red non-slip socks and low-level beds.
- The directorate monitored harm-free care weekly and displayed 'Simply Safer' data on all wards. This information was presented in a format that could be easily understood by the general public. The data covered infections, high-impact interventions (such as hand hygiene and peripheral line insertion), the NHS Safety Thermometer, information on patient experience, complaints and assessments (for example, for medication, nutrition, continence and pain). The data also included appropriate staffing ratios for qualified and non-qualified staff. In February 2014, most wards were meetings standards and targets. The AMU was

required to reduce falls and improve assessments; Felix Holt Ward had to reduce pressure ulcers and improve assessments; and both Elizabeth Ward and Mary Garth Ward had also to improve assessments.

Cleanliness, infection control and hygiene

- All the wards we inspected were visibly clean.
- Staff followed the trust infection control policy. We observed a high degree of compliance with hand hygiene, isolation procedures and the correct use of personal protective equipment such as gloves and aprons. We saw that staff adhered to the trust's 'bare below the elbows' policy.
- The hospital's infection rates for C. difficile and MRSA were within a statistically acceptable range, taking into account the size of the hospital and the national level of infection. There had only been one reported MRSA infection in the past 12 months.
- Each medical ward inspected by us had a visible poster demonstrating the last episode of C. difficile and MRSA infection. Felix Holt Ward showed a recent increase in figures related to C. difficile infection. In response to this, an environmental audit was undertaken that demonstrated issues around cleanliness in certain areas of this ward, and an action plan to address these issues was implemented.

Environment and equipment

- We observed that each ward area had sufficient moving and handling equipment to enable patients to be cared for safely.
- Equipment was maintained and checked regularly to ensure it continued to be safe to use. The items of equipment was clearly labelled indicating when they were next due for service.
- The CCU also kept their own stock of regularly used equipment, such as monitors and infusion pumps.
- All resuscitation trolleys were found to be stocked according to their checklist.

Medicines

- Medicines were stored correctly. Fridges on the AMU and the wards were at the correct temperature and were checked and recorded on a daily basis. Medicines, including controlled drugs were kept appropriately in locked cupboards.
- Medicines were not always managed appropriately. Staff on the AMU told us they had their own pharmacist and pharmacy support technicians who undertook medication checks on a regular basis. All the medicines we looked at were within their expiry date. However, staff on the AMU were not dating and signing bottles of liquid preparations, such as antibiotic syrup, eye drops and creams, at the time of opening. These preparations should be used within a specified number of days once opened. Medicines within fridges were not managed appropriately and patients were at risk of receiving medicines that had expired.
- Records to monitor controlled drugs were signed by two practitioners to indicate that the entire stock had been checked, and these were completed on a daily basis. However, the standard operating procedure for managing stock balance discrepancies of controlled drugs was not correctly followed on Bob Jakin Ward. The stock balance for the drug Oromorph showed that, on 18 March 2014, 18mls was missing or unaccounted for. This should have been reported and recorded in the controlled drugs register, and a clinical incident form completed and an incident report raised at the time. However, there was no evidence that this had occurred.
- Medicines on the AMU were administered in a way that did not reflect the prescribing policy**.** One patient in the unit had more than one prescribing order document, one of which was not signed by the prescriber.

Records

- Records were in both paper and electronic format and all healthcare professionals made their notes in the same place. Patient records were generally well maintained and well completed with clear dates, times and designation of the person documenting. The records we examined were written legibly and assessments were comprehensive and complete, with associated action plans and dates.
- Separate documents within the notes were available for patients presenting with sepsis, stroke and transient ischaemic attack (TIA). The appropriate risk assessments were completed for patients at risk of pressure ulcers or falls.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent to treatment was obtained appropriately and correctly. We saw that where patients did not have the capacity to give consent to their

treatment the Mental Capacity Act 2005 was appropriately implemented. This was particularly observed on Bob Jakin Ward for the patients who had been diagnosed as having dementia.

Safeguarding

- Safeguarding procedures were clearly displayed on the walls of the wards and units we inspected.
- The nursing and therapy staff on the wards had a good understanding of the trust's safeguarding policy. Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns. A member of the therapy staff working on the Felix Holt Ward was able to give examples of when they had invoked the hospital safeguarding policy.

Mandatory training

- Staff told us they were up to date with their mandatory training and they were always supported by the senior team to attend training and complete updates.
- Statutory training covered fire safety, health and safety, and manual handling. Mandatory training covered infection control, information governance and safeguarding (which included dementia awareness training).
- The trust had a target to achieve 80% compliance with statutory and mandatory training; 84% of staff in the division had done statutory training and 98% had done mandatory training.
- The trust target was for 90% of staff to have done relevant safeguarding training, and 95% of staff had completed safeguarding (level 2) training.

Management of deteriorating patients

- The medical wards, AMU and CCU, used the modified early warning score (MEWS). Handheld devices were used to record scores by doctors and nurses, and medical and nursing staff were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed MEWS charts and saw that staff had escalated patients appropriately, and repeat observations were taken within the necessary time frames. We saw evidence of this in practice when a patient scored more highly than expected and was immediately referred to the critical care outreach team for assessment and treatment. We observed staff implementing the 'Response to raised MEWS' guidelines on Melly Ward while treating patients with deteriorating conditions.
- The hospital had a pathway for patients with sepsis (SEPSIS Bundle) to enable early recognition of the sick person, prompt treatment and clinical stabilisation.

Nursing staffing

- Nursing staffing levels had been reviewed and ideal and actual staffing numbers were displayed on every ward. Staff reported that they were only rarely understaffed and that vacancies were filled with agency staff.
- We checked the nursing rota for the past month on the Adam Bede Ward, Felix Holt Ward and Bob Jakin Ward. The rotas demonstrated good staffing levels with a low number of agency staff being used. Staff managing the Bob Jakin Ward, for patients with dementia, were able to maintain continuity in patient care by requesting agency staff who already had experience of working on that ward.
- Nurse staffing in the AMU had been a complex issue because the unit had changed from being an 18-bed unit to a 41-bed unit short stay ward. The unit sister had worked hard to improve the vacancy rate and the time of our inspection this had decreased from 19 qualified whole time equivalent (WTE) staff in December 2013 to three WTE by the end of March 2014.
- The agency spend for this directorate had reduced after a recruitment initiative, but there was still a high use of agency staff in the AMU. They told us they were given a good local induction and handover at the beginning of their shift.
- Staff on Elizabeth Ward were not able to accurately describe the acuity tool they had used. However, we saw that the staff on shift were appropriate to the changing needs of the patients on the ward. We noted an innovative change to shift hours. Some nursing staff now started at 6am to ensure there were sufficient staff to deal with the early morning requirements of patients. Patients and staff told us this was an effective change with direct benefit to patient care.
- We observed a nurse handover on Elizabeth Ward. The information given was relevant, pertinent and covered all expected issues and risks to patients. Patients were referred to with dignity and respect, and appropriate further actions were noted for the incoming shift of staff.

Medical care (including older people's care)

Medical staffing

- The trust had recruited two acute consultant physicians for the AMU and there was a consultant present seven days a week. Four more consultants were needed for acute medicine and the trust was continuing to recruit. The trust was also recruiting to its consultant posts in care of the elderly (where there were three vacant posts), cardiology, dermatology and respiratory medicine.
- There were vacancies for middle grade doctors in acute medicine, cardiology, care of the elderly and dermatology (where there were three vacant posts). There was a high use of locum staff in the division.
- Junior doctors reported they felt well supported by both registrars and consultants.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support.
- There were eight physician associates who were trained to support medical staff with assessment, investigation and diagnosis.
- Patients were seen daily by consultants on the AMU, including the weekends, and a medical consultant was on call out of hours. There was a daily consultant ward round on the Bob Jakin Ward and Felix Holt Ward. On the other medical wards, named consultants undertook ward rounds twice a week. At other times, cover was provided by the consultant on call.
- Multidisciplinary team board rounds took place in each of the ward areas every morning when plans relating to appropriate discharge and reviews of unwell patients were discussed. We observed a board round on Bob Jakin Ward. This was attended by the ward sister, doctors and medical students.
- Patients on the CCU, AMU, Felix Holt Ward and Bob Jakin Ward were seen daily by consultants. Patients on other medical wards saw their named consultant twice a week.

Major incident awareness and training

- Staff we spoke to had a good awareness of the procedure for managing major incidents like winter pressure and fire safety.
- The AMU senior nursing staff were aware of major incident planning and their role within this framework. Nursing and medical staff had been appropriately identified for further training in intermediate and advanced life support courses.

Are medical care services effective?

Good

Care was provided in line with national best practice guidelines and the trust performed similar to other hospitals providing the same type of treatment. The use of care pathways and care bundles was developing and clinical audit was leading to improvement in patient care. Patients had good pain relief and appropriate nutrition and hydration. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working. Staff received a good level of training and this included training to support people with dementia.

Evidence-based care and treatment

- The medicine directorate adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients with strokes and transient ischaemic attacks (TIAs). Local policies, like the pressure ulcer prevention and management policy, were written in line with national guidelines and staff we spoke with had a good awareness of them.
- There were specific pathways for certain conditions: for example, sepsis, diabetic ketoacidosis and S T elevated myocardial infarction. There were care bundles for sepsis, heart failure and pneumonia. All grades of staff we spoke with knew about these and how to use them. Staff used these pathways and care bundles in the AMU to treat patients with respiratory conditions.
- The medical directorate took part in all the national clinical audits that it was eligible for. The directorate had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified. Not all clinical audits had dates for completion but most audits were ongoing and there were examples of improvement as a result. For example, there had been improvements in the nutrition and hydration of dementia patients using adapted crockery and cutlery and volunteers to promote good practice.

- Nursing staff did weekly audits on harm-free care and patient experiences as part of the 'Simply Safer' data.
- Audits were undertaken of ward environments under the '15 Steps Challenge'. This was designed by the National Institute for Innovation and Improvement toolkit to assess first impressions on entry to a ward or unit and to ensure that the ward or unit was safe, caring and involving, well-led and calm. Actions were identified for improvement.

Pain relief

- We observed nurses and junior doctors monitoring the pain levels of patients and recording the information.
- Patients on the CCU told us that pain relief was given as it was needed and that nursing staff always checked if it had been effective. Staff followed best practice and confirmed that it was usual practice to ask the patient if the medication had been effective half an hour after it had been administered.

Nutrition and hydration

- Patients' nutrition and hydration status was accurately assessed and recorded on the medical wards. For example, on Elizabeth Ward, we noted clear evidence of accurate nutrition and hydration recording. The AMU had detailed fluid balance charts and these were totalled accurately to enable clinical decisions to be made that took this information into consideration.
- The 'Malnutrition Universal Screening **Tool**' (MUST) was used in all the wards and medical units. Patients who were nutritionally at risk were identified by a 'cupcake' sign above their bed and on the boards.
- We saw that all patients had access to drinks that were within their reach. Care support staff checked that regular drinks were taken when required.
- The patients we spoke with told us they were always given choices for food and snack menus and were happy with the quality and variety of the food available.
- The trust had developed initiatives to encourage patients with dementia to eat. They used coloured plates and adapted cutlery, and warmed plates to keep food warm.

Patient outcomes

- The trust had a mortality outlier for acute mortality infarction in 2013 when mortality rates were higher than expected. Medical mortality reviews were undertaken and the trust had opened the new AMU and introduced seven-day working and care bundles for emergency care. The trust no longer had mortality outliers and mortality rates were within the expected range in March 2014.
- The myocardial ischaemia national audit project (MINAP) is a national clinical audit of the management of heart attack. MINAP provides comparative data to help clinicians and managers to monitor and improve the quality and outcomes of acute coronary syndromes. For 2012 and 2013 quality reports, the hospital's performance was found to be within expectations for MINAP audit indicators.
- The trust scored similar to the national average in the national sentinel stroke audit. The Felix Holt Ward had scored over and above 75% on most of the indicators in achieving stroke targets from April 2013 to March 2014. The ward had scored 100% on indicators like CT scan within 24 hours, swallowing assessment within four hours, and input of speech and language therapy and rehabilitation team within 24 hours. The ward had scored below 50% in screening for depression and for daily living activities within five days.
- There was 90% compliance with the sepsis care pathway. There was less evidence available on compliance with care bundles for heart failure and pneumonia.

Competent staff

- Nursing staff showed specific and detailed skills in both the AMU and CCU. They displayed high levels of competence and knowledge in dealing with complex issues (for example, dealing with a patient with respiratory distress, supported by a respiratory specialist nurse who had undertaken specific dedicated training to undertake her role and was supporting others in developing their skill set). On the CCU, we observed staff dealing with an emergency. There was a joined-up approach with doctors and nurses working as a team. There was clear understanding of what was required and compassion shown to the patient and their family, ensuring that they understood what was happening.
- We noted a good skill mix of staff on the Felix Holt and Bob Jakin Wards. Felix Holt Ward was led by a stroke coordinator. Bob Jakin Ward had input from a dementia specialist nurse.
- The nurses on Felix Holt Ward had undertaken stroke-specific competencies and had also undertaken

training for people who had difficulty swallowing. Dementia training was undertaken by all the staff on Bob Jakin Ward, the preferred ward for patients with dementia. Other staff completed dementia awareness training as part of their adult safeguarding training.

- The National Training Scheme Survey, GMC, 2013, identified that the hospital was similar to other trusts in terms of training but worse than expected for workload in general medicine, local teaching in internal medicine and induction in respiratory medicine.
- Junior doctors we spoke with described the training at the hospital as 'good'. Those who worked in a medical specialty had a daily protected training hour.
- We observed a clinical medical round and heard the respiratory registrar teaching junior medical staff before the round began. Clear guidelines were being issued to junior staff to meet specific patient requirements. One patient had specific respiratory disease requiring monitoring of his blood gases. The registrar took the opportunity to teach junior medical staff about arterial blood gas results and the implications of these for further personalised treatment for the acutely ill patient.
- Staff told us that they received annual appraisals and had regular supervisions within their ward areas. By December 2013, 88% of staff in Division A had completed an appraisal.

Multidisciplinary working

- Throughout our inspection we saw evidence of multidisciplinary team working within the ward areas, AMU and CCU. On the CCU, for example, staff were discussing a patient requiring a specific intervention, and how that could most effectively be delivered within a specific time frame. All staff contributed to this conversation to ensure a good clinical outcome for the patient.
- Junior doctors told us nurses and doctors worked well together within the medical specialty. We saw evidence of this on the wards we inspected.
- Felix Holt Ward had a dedicated rehabilitation area that was led by physiotherapists and occupational therapists. Speech and language therapists also attended the ward regularly and patients were referred to clinical psychologists if necessary.
- Multidisciplinary team meetings were conducted on Felix Holt and Bob Jakin Wards once a week to discuss current and new patients.
- Patients on the medical wards told us they were regularly seen by therapists, doctors and nurses.

Seven-day services

- Seven-day services had been developed for emergency care. Consultant staff worked for seven days on the CCU and AMU and patients were seen daily by a consultant. The consultant cover was available on the AMU, Monday to Friday, between 9am and 7pm. During the weekend, patients on the AMU were seen by a consultant following admission, an acute physician and a discharge consultant.
- Physician associates worked on the AMU and one was trained to complete comprehensive assessments for frail older patients. The trust was planning to introduce 24/7 cover in the near future.
- Consultants worked seven days a week for stroke services. The on-call stroke consultant would see new admissions on Felix Holt Ward and in the TIA clinic over the weekend and the post-take consultant would review all new admissions and deteriorating patients on medical wards over the weekend.
- Medical patients on Felix Holt and Bob Jakin Wards were seen daily by consultants but twice weekly on other medical wards.
- Consultants were supported by middle grade, specialist registrar and junior doctors out of hours and at weekends. On-call consultants provided 24-hour cover on all the medical wards and were responsible at all times for the management of acutely ill patients requiring immediate reviews.
- The ACU was open seven days a week from 8am to 8pm weekdays and 9am to 1pm at weekends. The unit had medical support from the discharge team.
- Pathology services were on call out of hours and provided weekday services from 9am to 1pm.
- Pharmacy staff provided weekend services from 9am to 12.30pm on Saturday and 10.30am to 2.30pm on Sundays. Outside those hours there was an on-call pharmacist to dispense urgent medications.
- Plain film radiology and urgent CT scans was provided 24 hours a day, seven days a week. There was a consultant radiologist working from 9am to 5pm at weekends to carry out CT, MRI and ultrasound scans. Staff were on call outside these hours.
- There were no occupational therapy services out of hours or at weekends.

Medical care (including older people's care)

- Two physiotherapists and a physiotherapy assistant were on call out of hours and available between 9am and 3.30pm at weekends for ITU/respiratory cover, discharge mobility assessments, A&E and CDU cover, and stroke assessments.

Are medical care services caring?

Good

Patients received compassionate care and we saw that patients were treated with dignity and respect. Patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them.

Compassionate care

- The NHS Friends and Family Test inpatient results were above the England average for all medical wards between November 2013 and February 2014.
- Results of the Friends and Family Test were displayed on every ward, and there were posters that encouraged patients to provide feedback so that the hospital could improve the care given.
- Patients told us, "The care is marvellous here." One said, "I could not fault the care one little bit." A patient's relative in the AMU told us, "We are really impressed with the care and the attention to detail that is given by nurses and doctors toward our mother."
- Throughout our inspection, we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were helping patients with personal care.
- The patients' relatives we spoke with on Melly and Felix Holt Wards told us the call bells were answered in a timely manner and the nurses were always available to help. The patients we spoke with told us they felt safe on the ward and received a very good level of care.

Patient understanding and involvement

- Patients and relatives we spoke with said they felt involved in their care. They had been given the opportunity to speak with the consultants who were looking after them.
- Patients told us the doctors had explained their diagnosis to them and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns with regard to how staff had communicated with them, and all were complimentary about the way in which they had been treated.
- We witnessed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about their care, treatment and options.
- Every patient on Melly Ward was given an information sheet with details of their named consultant, schedule of consultants' rounds, changes in medications, planned treatment and investigations, and opportunities were given for families and patients to ask questions. Patients told us they found this information very useful.

Emotional support

- During our inspection, we observed that staff were responsive to patients' needs, and we witnessed many episodes of kindness from motivated staff towards patients and their relatives.
- On Bob Jakin Ward, patients' relatives were encouraged to participate in the care of family member. This helped to give emotional support to older patients and those who had been diagnosed with dementia.
- Therapy staff on Felix Holt Ward (the stroke unit) assessed patients using the 'Mood screening scale' and 'Anxiety and depression scale', and patients were referred to clinical psychologists appropriately.
- On Elizabeth Ward, we saw close attention being paid to the specific requirements of a very ill patient. We heard a conversation requesting that the palliative care team visit and advise on the most appropriate approach for further management. The patient's family were included in this conversation and were being supported.

Are medical care services responsive?

Good

The opening of the acute medical unit (AMU) and ambulatory care unit (ACU) enabled the hospital to respond better to pressures and surges in demand for service. Patients on the AMU had continuity of care across seven days and most patients attending ambulatory care avoided admission and were able to return home the same day. Most patients continued to receive care on the same

ward and the number of patient moves had decreased. There was good support for patients with dementia. Translation services were available and used, although cultural food choices were limited. Extended visiting hours helped patients to have contact with friends and relatives and to improve communication between staff and relatives. The hospital was working to improve the coordination, safety and speed of discharge. Complaints were managed appropriately.

Service planning and delivery to meet the needs of local people

- Bed occupancy in the hospital was 90.3%, which was consistently higher than the 85% national target. Occupancy rates above 85% can start to affect the quality of care given to patients and the running of a hospital more generally.
- The medical division opened the AMU in December 2013. The 41-bed unit was for medical emergency admissions and was staffed 24 hours a day, seven days a week. There was good specialist nursing staff with advanced nurse practitioners available to support staff. High-dependency patients were also nursed there while awaiting a specialist bed. The unit alleviated pressures on the A&E department.
- The medical division opened the new ACU in December 2013 to prevent inpatient admissions and manage increases in the number of patients requiring emergency admission. Patients could be admitted to the ACU via several different routes including a dedicated telephone link whereby GPs could discuss and agree appropriate care pathways and treatment options for their patients. Staff told us the ACU was helping to meet the needs of patients in the community who required medical intervention without being admitted to the hospital. During the week of our inspection, the unit had seen 34 patients; 33 had been transferred back to the care of their GP and only one had to be admitted to hospital.

Access and flow

- There was a central operational group that worked across the trust to coordinate capacity and bed availability. They liaised with individual wards to establish bed status. Bed occupancy and any required action were discussed at safety meeting that were held three times a day.
- Most patients stayed on the appropriate inpatient ward. The number of medical outliers and patient moves was decreasing and within target levels. Patient outliers were monitored at the site safety meetings and moved to the most appropriate area when a bed became available. There was a patient transfer checklist in patients' notes for those who were transferred within the hospital. We saw a checklist that had been completed appropriately and this ensured that the transfer was safe and the patient's care continued with minimal interruption and risk.
- Access to the CCU was being managed but sometimes patients had to wait for an appropriate bed within this specialist facility. In these circumstances, patients were cared for in the AMU where nursing and medical staff had been trained to understand the specific requirements of cardiac medicine. Staff told us that medical staff in both units liaised closely with each other to ensure the best outcome for patients.
- The hospital achieved its referral to treatment times of fewer than 18 weeks for patients waiting for medical procedures or interventions, except in endocrinology. Diagnostic and cancer waiting times were within the expected targets.
- The discharge planning process on every ward started on admission. Each of the medical wards undertook daily morning multidisciplinary board rounds when updates to patients' medical condition and plans for discharge were communicated. Discharge booklets were introduced in all medical wards. These were kept by every patient's bed and were completed by members of the multidisciplinary team (including intermediate care and social services) to record specific outcomes leading towards safe patient discharge.
- A nurse-led early discharge support team was provided for patients with chronic obstructive pulmonary disease. Its service included home visits and physiotherapist input. The team worked closely with the respiratory ward to ensure longer term management. A discharge bundle had been introduced that included follow-up within 72 hours.
- There was an intermediate care team that would support patients who required increased support for a short period of time after discharge.

Meeting people's individual needs

- Support was available for patients with dementia. On Bob Jakin Ward, we saw that all patients with dementia had a 'This is me' booklet that was appropriately completed. (The 'This is me' booklet was an initiative

developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of patients with dementia). There was a dementia specialist nurse within this ward area and all the staff had undertaken dementia awareness training. The trust had developed a 'dementia care bundle' that was helping the staff to meet the additional needs of these patients. Adapted cutlery was also available if required for a patient.

- An interpretation service was available in the trust. However, staff told us that this service was not always used and there was high reliance on family members to overcome any communication difficulties. We observed this to be the case for one patient on Bob Jakin Ward who could not speak English.
- Food choices on the wards were nutritious and there was a separate menu available for patients who required culturally appropriate food. However, most of the cultural food choices were curry based.
- Efforts were made to ensure patients stayed in contact with friends and relatives and extended visiting hours had helped to improve communication between staff and relatives. The wards had long visiting hours from 11am to 8pm, which the patients and their relatives found beneficial.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.
- Complaints leaflets were available at the entrance to the hospital and outside the wards.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- Action plans were drawn up following incidents and complaints. Staff on Elizabeth Ward, for example, told us of a recent initiative to improve care after a recent complaint when the deterioration of a patient had been remarked on by the family. The early warning score now had an added parameter of an 'expected' score for that particular patient. This meant that staff could immediately see if the score was within the agreed parameters for that person.

Are medical care services well-led?

Good

Medical care services were well-led and the nursing leadership within the coronary care unit (CCU) was described as outstanding. Staff within the medical directorate were passionate about the hospital and spoke positively about the service they provided for patients. Quality and patient experience were seen as priorities and everyone's responsibility. The strategy of the division was to improve the care of acutely ill medical patients and there were good governance arrangements around quality and risk. Staff were actively engaged. The division had a developing culture of innovation and learning, but needed to ensure that examples of good practice were widely shared.

Vision and strategy for this service

- The trust encompassed its vision in the strapline, 'To ExCEL at Patient Care'. This was achieved through Effective open communication; eXcellence and safety in all that we do; Challenge but support; Expect respect and dignity; Local healthcare that inspires confidence. Posters detailing the trust's vision to 'ExCEL' at patient care were visible throughout the wards and corridors. The vision focused on ensuring consistent safe services.
- We spoke with staff from all levels in the medicine division. They were proud to be part of the hospital and passionately shared the trust vision. They consistently told us that it was their primary concern to ensure that patients were treated with respect and compassion and received good care at the hospital.
- Staff we spoke with were aware of the recent challenges faced by the trust and the subsequent changes in the trust's strategy.
- The division did not have a long-term strategy but priorities were identified around the acute medical unit (AMU). This was part of the planned financial and resource strategy to improve the care of acutely ill medical patients and ensure sustainability. The development of the unit had required planning and resources over six to nine months and changes had to be embedded. The unit had taken pressure off the A&E department. The medical leads spoke about the unit as the 'hospital lynchpin' and there had been a huge effort to make it successful.

Medical care (including older people's care)

Governance, risk management and quality measurement

- Governance meetings were held monthly within the directorate and all staff were encouraged to attend. Complaints, incidents, audits and quality improvement projects were discussed at these meetings.
- The division had quality dashboards and performance was on display in the ward areas we visited.
- Monitoring of incidents and complaints was reported at local level and board level with action plans identified to reduce risk.
- The division had a risk register that included areas of risk identified within the medicine directorate. These were clearly documented. The details showed that action was being taken where possible to reduce the level of risk, and that the identified risks were being monitored.

Leadership of service

- Staff told us the chief executive was often visible within the trust and was approachable. The medical director had a visual presence on the wards during our visit.
- Nursing and medical staff told us that the senior sister on the CCU was an excellent role model. They said she worked clinically to lead by example and supported her staff in a positive and dynamic manner, thereby ensuring that high standards of care were maintained. Two patients on the unit told us that the unit was well-run and that communications from the medical and nursing teams "were excellent".
- Junior doctors told us the senior support they received was 'good'.
- The student nurses felt well supported on the ward and received supervision from the senior staff. The trust had a practice facilitator who supported the newly qualified nurses in a supervisory role.
- The staff on Felix Holt Ward told us, "We have got an excellent team and it feels like home."

Culture within the service

- Staff on the AMU said that unit and senior managers worked hard to actively encourage staff to deliver knowledgeable and competent care. Training was said to be a high priority although recent staff shortage had impacted on this as the unit had moved from a small unit to a much larger one.
- Staff within the medical division spoke positively about the service they provided for patients and were very passionate about the hospital. Quality and patient experience was seen as a priority and everyone's responsibility.
- Staff worked well together and there was obvious respect between not only the specialities but across disciplines.
- Staff in the AMU and ambulatory care unit (ACU) were highly motivated to ensure their model of care was successful.

Public and staff engagement

- The NHS Staff Survey (2013) found that staff job satisfaction was within expectations but staff were less likely to agree that their role made a difference to patients. Staff on the AMU told us of an open culture in which staff opinions were actively sought. The junior doctors told us they were able to raise concerns and the trust conducted junior doctor forums where they could express their views and share new ideas.
- Patients' relatives told us the long visiting hours had given them an opportunity to engage with patient care and this had led to an improved communication between carers and ward staff.
- The trust had conducted an inpatient experience survey review and developed an action plan where further improvement was required. For example, a discharge improvement group had been formed. There had been some improvement in the outcomes for patients in relation to discharge according to the survey results.
- The patients attending the listening event told us they felt engaged with the trust activities and felt passionate about the trust.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines, although the division did not have effective mechanisms to share and adopt good practice.
- CCU staff told us of an overnight cardiac pacing service (to implant pacemakers). They said that a consultant was available overnight for advice and clinical input. A patient had recently benefited from this service and this had had a positive impact positively on their health outcome.
- A 'carer's passport' had been introduced on Bob Jakin Ward. This was a scheme whereby named relatives could offer their help by coming into the ward and

providing care for their loved one, such as help with eating meals or personal care. The hospital offered the named relative free parking or 10% off meals bought at the hospital.

Surgery

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

Information about the service

The trust provides elective and emergency surgery in a range of specialties including trauma, orthopaedic, urology, gynaecology, and general surgery. The trust also provides paediatric day care surgery. The trust does not provide ear, nose and throat (ENT) surgery and this done as an outpatient activity only. There were seven operating theatres, three of which are dedicated to day surgery patients.

Patients who attend the hospital as emergencies and whose surgery is unplanned are seen in the A&E department. They are then either transferred to the acute care unit (ACU) or straight to theatre. They are monitored in the recovery area before being transferred to one of three dedicated surgical wards or the intensive therapy unit (ITU).

We visited theatres and the recovery area, day surgery unit, the three surgical wards and the central sterile services department (CSSD). We spoke with 15 patients, seven visitors and 31 staff including senior and junior medical staff, senior and junior nurses, care assistants, domestic staff, and administrative and clerical staff. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Patients were assessed before surgery and monitored so that their risks were managed. However, the use of the 'Five steps to safer surgery' checklist was completed but there had not been ongoing observational audit to ensure it was appropriately embedded into clinical practice. Safety standards were met for infection prevention and control and the use of equipment, but medicines management needed to improve. Staffing levels had improved and recruitment was ongoing. In the eight weeks leading up to the CQC visit, out of 2,013 shifts only one shift was escalated as a red shift in surgery. There was still a high use of agency staff, however, and staff reported they were often understaffed and worked longer hours and overtime to support colleagues. Although. Patients were treated in line with national guidelines and received good pain relief.

Staff provided compassionate care and treated patients with dignity and respect. Patients we spoke with during our inspection were positive about the care and treatment they had received. They were complimentary about the staff in the service, and felt informed and involved in their care and treatment. Overall, national waiting times for surgery within 18 weeks were being met, although not in oral surgery, orthopaedics or colorectal surgery, and the trust was taking action to address this. Some patients had surgery cancelled at short notice because of staff shortages. There was some good leadership at ward levels and staff felt well

Surgery

supported by their managers; however, this was not the case for the operating department and there were plans to improve the management of this service. Governance arrangements did not provide assurance around risk and efficiency. There was a developing culture of innovation and learning.

Are surgery services safe?

Requires improvement

Staffing levels had improved and recruitment was ongoing. In the eight weeks leading up to the CQC visit, out of 2,013 shifts only one shift was escalated as a red shift in surgery. There was still a high use of agency staff, however, and staff reported they were often understaffed and worked longer hours and overtime to support colleagues. Incidents were reported but staff said they did not have regular feedback and lessons learned were not widely shared. All the clinical areas were clean and well maintained, and overall infection control standards were met. There were suitable arrangements to manage equipment but medicines, particularly controlled drugs in theatres, were not managed according to legal requirements.

There was compliance with the 'Five steps to safer surgery' checklist, but there had not been an audit to ensure that the checklist was being completed appropriately and was embedded into clinical practice. Patients were appropriately escalated if their condition deteriorated, Action was being taken to ensure harm-free care and reduce the incidence of avoidable harms such as falls and pressure ulcers.

Incidents

- The hospital had had three Never Events between December 2012 and March 2014. These are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Two never events related to surgery and involved the removal of the wrong tooth and an incision made to the wrong digit on a person's hand. Both Never Events were investigated and action taken to prevent reoccurrence. For example, pre-operative surgical site marking and four verification checks would be completed by staff before procedures started.
- Staff within surgery were aware of the Never Events and of safety priorities.
- All the staff we spoke with said they were aware of how to report incidents and understood their responsibilities with regard to doing so. However, they told us that they did not always receive feedback and lessons learned

from incidents were not widely shared. Some staff were clear about actions taken and learning outcomes, but others did not know about incidents that had happened in their own area of work.

Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls. Between February 2013 and January 2014, the trust performed worse than the England average in relation to patients who had developed pressure ulcers and catheter-acquired urinary tract infections, and those who had had falls with harm. Patients with new VTE were below the England average.
- Ward sisters undertook regular audits (for example, hand hygiene, nutrition, patient assurance and venous thromboembolism [VTE] audits). Action was taken when issues were identified, for example, to reduce a high level of falls.
- The patient records we reviewed demonstrated good clinical practice in relation to pressure area care. Patients had a risk assessment in place and when a risk was identified action was taken to ensure they were turned at prescribed intervals to protect their skin from pressure damage, and also that they had an appropriate pressure-relieving mattress. No avoidable pressure ulcers were reported for January and February 2014.
- Information on harm-free care and 'Simply Safer' data was displayed on all wards. This information was presented in a format that could be easily understood by the general public. The data covered infections, high-impact interventions (such as peripheral line insertion), the NHS Safety Thermometer and information on patient experience, complaints and assessments (for example, for medication, nutrition, continence and pain). The data also included appropriate staffing ratios for qualified and non-qualified staff. In February 2014, overall standards and targets were being met but Alexandra Ward had to reduce catheter related urinary tract infections and falls, Nason Ward had to reduce falls and Victoria Ward had to reduce infections.

Cleanliness, infection control and hygiene

- The hospital's infection rates for C. difficile and MRSA were within a statistically acceptable range, taking into account the size of the hospital and the national level of infection. There had only been one reported MRSA infection in the past 12 months.
- All ward areas were clean and each ward had domestic staff who were responsible for ensuring that the environment was clean and tidy. Theatre and recovery areas were clean and well maintained.
- Throughout the clinical areas, general and surgical waste bins were covered and foot operated, and the appropriate signage was used for waste products.
- Equipment was regularly cleaned and labelled to identify that it was ready for use.
- Staff followed the trust infection control policy and the 'bare below the elbow policy' was adhered to. Staff used personal protective equipment (for example, gloves and aprons) to provide personal care, and disposed of this when care was completed. Hygiene gel was available at the entrance to each clinical area, at the end of each bed or outside side rooms and staff were observed to be using this appropriately.
- We noted that linen drapes were being used in theatres rather than disposable gowns and drapes. Linen has a limited life and research has shown that post-operative infection rates are reduced when a disposable gown and drape are used instead of linen. Staff told us they had run out of disposable drapes and did not know if a further supply had been ordered. Staff in the central sterile services department told us that the use of linen drapes was common practice.

Environment and equipment

- Checks for emergency equipment, including equipment used for resuscitation, were carried out on a daily basis.
- Equipment was available, well maintained and regularly serviced in the operating department. Electrical equipment had had portable appliance tests.

Medicines

- Medicines were not stored appropriately in all areas. Most medicines were in locked cupboards and fridge temperatures were correct and regularly checked. However, the fridge in the main corridor in the operating department was out of the acceptable, safe range. This

had not been identified or acted on by staff and there was no evidence of any recent temperature checks. This could have reduced the efficacy of medication given to patients.
- There was no evidence that the fridge used to store medicines in the operating department had a recent portable appliance or electrical safety test.
- The medicines management in the operating department was not safe. We checked the medicines management in anaesthetic rooms 1 and 2, the recovery area and the main corridor medicines cupboard. The management of controlled drugs in the operating theatres did not follow best practice and national guidelines. There were incomplete list of signatories to order controlled drugs; incomplete entries in controlled drugs registers; incomplete entries in the controlled drugs order book and incomplete records of administration of controlled drugs.
- The dispensing, administration and disposal of controlled drugs were not effectively monitored and the replenishment of stocks was not tightly controlled. Drugs could therefore be misused and it would not be noticed.
- There was also an ineffective system to monitor and replenish the stock of medicines in the operating department.
- The trust took immediate action to rectify and monitor these issues.
- There were effective arrangements for the urgent supply of medicines out of hours and each clinical area had an in-date anaphylaxis and sepsis box for the urgent use of medicines in line with local and best practice guidance.

Records

- Records were kept in paper and, in some areas, electronic format. Risk assessments were undertaken promptly for each patient when they were admitted to the wards.
- Care bundles had been implemented to alert staff to identified risks such as the risk of falls or developing pressure ulcers, and these provided prompts on the actions to be taken to manage these risks. Different coloured stickers were affixed to patients' records to alert staff that specific care bundles were in place.
- Patients had their care needs risk assessed and recorded in all the patient records we examined. For example, for one patient, who had been identified as being at high risk of developing a pressure ulcer, a pressure ulcer prevention care pathway had been initiated. An air mattress had been provided and a re-positioning regime planned. The documentation specified what the regime was and the records of re-positioning were consistent with the regime prescribed.
- Clinical records were held securely and remained confidential.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients' consent was obtained appropriately and correctly before any procedure.
- Patients we spoke with told us they had been asked for their consent before surgery. They said the risks and benefits had been explained to them and they had been given information about what to expect from their surgery. The patient records we looked at reflected this.
- We saw examples of patients who did not have capacity to consent to their procedure. The Mental Capacity Act 2005 was adhered to appropriately.
- Staff were able to describe how to determine whether or not a patient had the capacity to consent to their treatment. They were also clear about whom to involve if patients did not have the capacity to do this.
- Training data from February 2014 showed that 96% of staff received safeguarding adults training that included training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Safeguarding

- Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns. Records demonstrated that 96% of staff received safeguarding (level 2) training.

Mandatory training

- Staff told us they received adequate training to meet patients' needs.
- Statutory training covered fire safety, health and safety, and manual handling. Mandatory training covered infection control, information governance and safeguarding (which included dementia awareness training).
- The trust had a target to achieve 80% compliance with statutory and mandatory training; 84% of staff in the division had done statutory training and 90% had done mandatory training.

- The trust target was for 90% of staff to have relevant safeguarding training; 79% of all staff had completed safeguarding (level 2) training.
- A staff member told us that, because of staff shortages in some areas, some staff had to cancel their attendance on training days to meet staffing levels on the wards. They then had to wait for until the next round of training was arranged.

Assessing and responding to patient risks

- The modified early warning system tool was used to identify patients whose medical condition was deteriorating. There were clear directions for escalation and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at two completed charts and saw that staff had escalated their concerns correctly and repeat observations had been taken within the necessary time.
- The hospital critical outreach team was available seven days a week. Contact details were clearly displayed in the unit.
- We observed a theatre team undertaking the 'Five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. This checklist is designed to prevent avoidable errors. The theatre staff completed safety checks before, during and after surgery. The trust was using both electronic and paper records systems. Staff completed both versions of the surgical safety checklist and this information was then monitored from the electronic records. The hospital noted 99.97% compliance with the checklist; however, there had not been ongoing observational audit to observe and check compliance. This would be necessary to ensure that actual actions on the checklist was being completed in a consistent and appropriate manner and that the checklist was actually embedded into clinical practice.
- We observed three patients admitted for day surgery and found that all the relevant checks had been undertaken.

Nursing staffing

- Nursing numbers were assessed bi-annually using the national safer nursing staffing tool to identify minimum staffing levels. This had shown a need to increase staffing levels in some areas, in particular in the operating department where there was a high use of agency staff. The trust was currently recruiting to these additional posts but understaffing was a concern in the operating department.
- Ideal and actual staffing numbers were displayed on every ward visited. The dependency levels of patients on wards were reviewed daily by ward managers. Some staff could not accurately describe the acuity tool they had used. Staff reported that they were often understaffed, but said that in most areas this was improving.
- If the staffing levels were lower than planned, the actions taken was also displayed for patients and visitors to see. Additional staff could be requested to meet the specific safety needs of patients, and bank and agency staff were used to fill shortfalls, although such staff were not always available.
- An agency nurse confirmed that they had received appropriate induction and support.
- Nursing handovers occurred at least twice a day, depending on shift rotas, and included a safety briefing. Staffing for the shift was discussed as well as each patient's condition, any high-risk patients and potential issues of concern. There was a handover sheet that summarised the current situation including diagnosis, problems and any known allergies.

Medical staffing

- The trust had recruited to consultants posts but all substantive posts were filled there only remained one middle grade doctor vacancy in trauma and orthopaedics.
- Junior doctors told us that there were adequate numbers of junior staff on the wards and that the consultants were contactable by phone if they required advice or support. Junior doctors told us they felt well supported by their senior colleagues.
- Consultants undertook daily ward rounds; surgical handovers occurred twice a day.

Major incident awareness and training

- The hospital and surgical services had various major incident and business continuity plans. Staff were aware of hospital-wide plans (for example, if there was no water supply, if the electricity failed and what action to take in the case of a heat wave).

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- There were agreed protocols in surgery to defer elective activity in order to give adequate priority to unscheduled admissions. The staff we spoke with were aware of these protocols.

Are surgery services effective?

Good

Care was provided in line with national best practice guidelines and the trust performed similar to other hospitals providing the same type of treatment. Enhanced recovery pathways were used and clinical audit had led to improvements in patient care. Patients received good pain relief and had appropriate nutrition and hydration. There was multidisciplinary working and some progress towards seven-day working. Staff training and appraisal had improved but nursing staff did not have appropriate clinical supervision.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics Great Britain and Ireland and the Royal College of Surgeons.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations. We found the Royal College of Surgeons' standards for emergency surgery and surgery out of hours were consultant-led and delivered.
- Local policies were written in line with these guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice. We saw evidence in patient records to demonstrate compliance with local hospital policies.
- Enhanced recovery pathways were used for patients requiring colorectal surgery and those admitted for fractured neck of femur.
- The enhanced recovery pathway for patients admitted with a fractured neck of femur was in line with the British Orthopaedic Association and British Geriatrics Society guidelines. Weekday support was available from an ortho-geriatrician and all patients admitted with a fractured neck of femur were seen by an ortho-geriatrician within 24 hours.
- The surgery departments took part in all the national clinical audits that they were eligible for. The directorate had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified. Not all clinical audits had dates for completion but most audits were ongoing and there were examples of improvement as a result. For example, pre-operative tests showed 93% compliance with NICE guidance, there were new procedures agreed to manage patients with diabetes in surgery, and an acute abdomen pathway and cardiac monitoring were introduced for emergency laparotomies.
- Nursing staff did weekly audits on harm-free care and patient experiences as part of the 'Simply Safer' data.
- Audits were undertaken of ward environments under the '15 Steps Challenge'. This was designed by the National Institute for Innovation and Improvement toolkit to assess first impressions on entry to a ward or unit and to ensure that the ward was safe, caring and involving, well-led and calm. Actions were identified for improvement.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- Patients reported that their pain was well-controlled.
- Some patients having day surgery had their operations under local anaesthetic and so stayed awake during the procedure. Patients we spoke with told us they felt no discomfort but were advised to take pain relief at home when the anaesthetic wore off.
- We observed patients alerting nursing staff to their increased pain levels and that their pain was addressed in a timely manner.

Nutrition and hydration

- Fluid input and output records were used appropriately to monitor patients' hydration.
- Patients were screened using the Malnutrition Universal Screening Tool (MUST). If a risk of malnutrition was identified, a food diary was kept by the staff caring for that patient.
- Patients' weights were recorded on admission and monitored to identify any weight loss during their hospital admission. There was evidence of good clinical practice on the wards with most patients being weighed according to hospital policy.

Surgery

Patient outcomes

- Surgical mortality reviews were completed. There were no mortality outliers and mortality rates were within the expected range.
- In 2012, only 59% of patients with fractured neck of femur were operated on within 24 hours and 79% within 48 hours. Evidence obtained from the National Hip Fracture Database in 2013 indicated that the trust had achieved compliance with national standards of care.
- The trust's emergency readmission rates after surgery indicated that the trust was within the expected ranges for both elective and emergency surgery when compared with similar trusts.
- Day case surgery rates were 84% for specified conditions. This was slightly below the national expectation of 91%.

Competent staff

- Most staff had received an appraisal. Records provided by the trust showed that, in December 2013, 83% of staff had completed an appraisal. Staff told us that they were supported but clinical supervision sessions were not a regular occurrence.
- Nursing pin numbers were checked annually to ensure that all nursing staff had a valid registration and appeared on the national register.
- Consultant medical staff were engaged in regular revalidation processes.
- The National Training Scheme Survey, GMC, 2013, identified that the hospital was similar to other trusts in terms of training. It was better than expected in terms of workload in general surgery, but worse than expected for adequate experience in general surgery and anaesthetics, and also worse than expected for overall satisfaction and local teaching in trauma, orthopaedics and anaesthetics.
- Junior medical staff told us that in the past year support systems in the trust had improved, they had better access to training and senior staff support, and they enjoyed working in the hospital.
- Feedback from a deanery visit in March 2014 identified the support provided for a learning environment and team clinical practice and audit activity in general surgery and trauma and orthopaedics. Audit had involved all trainees and was shown to be valuable.

Multidisciplinary working

- There was allocated physiotherapy and occupational therapy support to the surgical wards and daily board rounds were carried out with members of the multidisciplinary team.
- Consultants attended board rounds for their patients on the surgical wards.

Seven-day services

- Consultant staff were present Monday to Friday, 9am to 5pm. Consultants were present 8.30am to 1pm at weekends to undertake emergency operations as required and review new admissions, patient care plans and patients ready for discharge. Consultants were on call for emergency care. There was senior registrar and junior doctor support out of hours and at weekends.
- Pathology services were on call out of hours and provided weekday services from 9am to 1pm.
- Pharmacy staff provided weekend services from 9am to 12.30pm on Saturday and 10.30am to 2.30pm on Sundays. Outside those hours there was an on-call pharmacist to dispense urgent medications.
- Plain film radiology and urgent CT scans were provided 24 hours a day, seven days a week. There was a consultant radiologist who worked from 9am to 5pm at weekends for CT, MRI and ultrasound scans. Staff were on call outside those hours.
- There were no occupational therapy services out of hours or at weekends.
- Two physiotherapists and a physiotherapy assistant were on call out of hours and were available between 9am and 3.30pm at weekends for ITU/respiratory cover, discharge mobility assessments, A&E and CDU cover, and stroke assessments.

Are surgery services caring?

Good

Staff were caring and compassionate and treated patients with dignity and respect. We observed that call bells were answered promptly and staff engaged positively with patients. They reassured those who were anxious about their operation. Patients we spoke with told us they felt well

looked after and considered they had received good care. However, patients were checked into theatre in the corridor because there was no admission area, and this did not support their privacy and dignity.

Compassionate care

- The NHS Family and Friends Test results between November 2013 and February 2014 demonstrated that the hospital performed below the England average for two of the three surgical wards. For example, one ward scored 65, which was below the England average of 72.
- We observed staff delivering caring and compassionate care to patients.
- The patients and relatives we spoke with were complimentary about the nursing and medical teams. Patients and their relatives said they were treated with dignity and respect during their stay.
- We observed in the operating department area that patients were 'checked in' in the corridor leading to the operating theatre; this caused some congestion in the area and did not support the privacy and dignity of patients.
- Information obtained from the trust about surgery services for the period September 2013 to February 2014 indicated that there had been no incidences of same-sex accommodation breaches.
- Patient were supported to eat and drink, when appropriate. We observed a meal time on one of the surgical wards. Student nurses and healthcare assistants were helping patients with dementia to eat their meal in a kind, encouraging and caring way.
- Patients we spoke with told us they felt well looked after and considered they had received good care.

Patient understanding and involvement

- The patients we spoke with felt they understood their care options and were given enough information about their conditions.

Emotional support

- During the pre-operative assessment, patients were asked if they had any anxieties. The trust operated relaxation sessions via the Oasis Project. This project consisted of a team of volunteer therapists who had a professional relaxation qualification to help patients who were anxious about their operation. Therapists would talk through any anxieties at that time to provide reassurance to the patient and would make a note in the patient's file to prompt action for when they were admitted for surgery
- The chaplaincy service was available five days a week 9am to 5pm as well as providing an on-call service to both patients and relatives.

Are surgery services responsive?

Good

Patients' needs were assessed when they attended their pre-assessment appointment or when they were admitted through A&E department. Surgical patients were cared for on dedicated surgical wards. Overall, the trust was meeting national targets for patients to wait fewer than 18 weeks for operations or procedures. Although this was not met in oral surgery, orthopaedics and colorectal surgery and the trust had actions to meet the standards. The majority of patients told us that their operations had gone ahead as planned but some told us that their operations had been cancelled at short notice. Cancellations rates within national expectations but the hospital had an increasing number of short notice cancellations because of staff shortages in theatre.

There was specialist support for people with dementia. Translation services were available and information leaflets in different languages. Complaints were not always responded well or in a timely manner.

Service planning and delivery to meet the needs of local people

- Between October 2013 and December 2013, the trust's bed occupancy was 90.3% and above the England average of 85.9% which is the level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Patients who attended the hospital as emergencies and whose surgery was unplanned were seen in the A&E department. They were then either transferred to the acute care unit (ACU) or straight to the theatre.
- Elective surgical patients were assessed in the day case unit before their admission. The staff we spoke with confirmed that this process was satisfactory and provided in line with national guidance.

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Access and flow

- Patients were cared for on appropriate surgical wards and the number of patient moves was low and within trust expected levels.
- The trust was achieving the 18-week referral to treatment times except for oral surgery, orthopaedics and colorectal surgery. There were detailed action plans for these specialties. The trust was achieving the 62-day waiting time for patients to be seen and treated for cancer, and diagnostic waiting times were within the expected targets.
- The hospital performed better than other trusts for the number of cancelled operations. The rate of cancelled operations was 0.3%, which was below the national target of 0.8%. However, the number of patients being cancelled the day before surgery had been increasing since December 2013. The inability to safely staff theatre lists was resulting in the cancellation of waiting lists.
- Most patients we spoke with during our inspection visit told us that their operations had gone ahead as planned and that they had not had to wait long for their surgery. Two patients told us their surgery was cancelled at short notice and they were not informed of the cancellation. One person wrote and told us they had recently arrived at the hospital for their surgery and had been sent home after a four-hour wait because there were no available inpatient beds.
- The trust scored similar to expected, when compared with other trusts, regarding the number of patients not treated within 28 days of last-minute cancellation for non-clinical reasons.
- The discharge process was started as soon as a patient was admitted to hospital. Multidisciplinary team board rounds were undertaken on each of the three surgical wards each morning when plans relating to appropriate discharge were discussed. When patients required additional support post-discharge, referrals were made to social services or the community nursing team.
- However, the trust scored worse than other trusts of a similar size regarding the amount of notice given to patients about when they were going to be discharged.
- The theatre teams reported that there were occasionally delays in moving patients from recovery to the wards because patients on the wards had not been discharged. The ward manager on one of the surgical wards explained that patients who needed social service support sometimes experienced delays because they had to wait for a social care assessment.
- There was an intermediate care team who could support patients who required increased support for a short period of time after discharge. We spoke with one patient who explained how they were ready to be discharged and were waiting for confirmation from the team that appropriate support had been made available to them at home.

Meeting people's individual needs

- Support was available for patients with dementia. On Nason Ward, we saw that all patients with dementia had a 'This is me' booklet that was appropriately filled out.
- Staff had undertaken dementia awareness training.
- There was a range of patient information leaflets about medical conditions available for patients and their relatives. One patient told us that they had received leaflets relating to their operation, which provided useful information for them to read.
- The trust had clinical and support staff who were able to act as interpreters. This meant translation support could be provided immediately. There were also agreements in place for external interpreter to provide support for patients if necessary. Information leaflets were available in different languages.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Staff said they attempted to resolve issues as they arose, but were aware of the escalation procedure if they were unable to.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- There were leaflets, posters and information booklets in the ward areas about contacting the Patient Advice and Liaison Service if patients or their relatives wanted to raise a concern or make a formal complaint. Information booklets were also given to patients on admission.
- Some people told us that they felt formal complaints were either not handled well or not responded to. For example, three people wrote advising us that they had not had a response from the trust to their complaint and two people said they were not satisfied with the response they had received.
- Ophthalmology was one of the top 10 concerns identified by patients whose queries mainly related to surgery dates for cataracts and anxieties after surgery. The department now offered further advice and was contacting patient for follow-up care.

Surgery

Are surgery services well-led?

Requires improvement

Surgery services required improvement in leadership. Staff felt well supported by their immediate line managers, and matrons and staff within the division spoke positively about the service they provided for patients and the support they gave to each other. The service did not have an overall strategy to respond to sustainability issues and concerns. Governance arrangements needed to improve to ensure that risks and efficiencies were appropriately identified and managed. Leadership in theatres, in terms of a substantive theatre manager, needed to be put in place. Inconsistent management had led to cancelled surgery, under-use of theatre and risks that had not been dealt with effectively. The division had a developing culture of innovation and learning but needed to ensure that examples of good practice were widely shared.

Vision and strategy for this service

- The trust encompassed its vision in the strapline, 'To ExCEL at Patient Care'. This was achieved through Effective open communication; eXcellence and safety in all that we do; Challenge but support; Expect respect and dignity; Local healthcare that inspires confidence. Posters detailing the trust's vision to 'ExCEL' at patient care were visible throughout the wards and corridors. The vision focused on ensuring consistent safe services.
- Staff spoken with were aware of the trust's expectations and felt that everyone had a commitment to deliver the best care possible.
- Staff told us they were aware of the recent challenges faced by the trust and the subsequent changes in the trust's strategy.
- The service itself did not have a specific strategy.

Governance, risk management and quality measurement

- Monthly departmental meetings were held within the division for theatre and day surgery staff, and complaints, incidents, audits and quality improvement projects were discussed at these meetings. Although feedback from incidents and complaints was not always shared and was not being used appropriately to make improvements to the service.
- A quality dashboard was available so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to be able to provide. These dashboards were displayed in ward areas.
- Although performance data was widely collected, analysis of this data was not always done or followed up in some areas. We saw several examples of this. The 'Five steps to safer surgery' checklist was monitored to demonstrate that the checklist was being completed but there had not been ongoing observational audit to demonstrate this was being done in an appropriate and consistent manner. There was no analysis of theatre use to monitor efficiency. The theatre manager told us that they had started to audit operation cancellations and their reasons, so as to be able to identify trends. Instruments were checked against the tray list before surgery; however, we saw incomplete paperwork relating to instruments in the sterile services department. There was a verbal team brief at the start of the theatre list; however, this was not currently documented.
- The risk register for the division had identified risks and there were action plans in response. The register did not identify risks around the 'Five steps to safer surgery' checklist. Actions taken did not always mitigate risks, for example, actions to improve medicines management in the operating department.

Leadership of service

- Each ward had a band 7 nurse as a ward manager and there was a matron who oversaw a group of wards. Staff told us the matrons were visible, coming to each of the wards at least once a day.
- Theatre staff raised concerns that there had been no long-term theatre manager. Staff told us that the theatre managers had changed every year for many years. The current theatre manager was on a 12 month secondment from University Hospitals Birmingham NHS Foundation Trust. There was also a theatre matron from that trust who provided support once a week. The lead clinician for the surgery division told us that the trust were actively recruiting staff to the division.
- Staff informed us that they believed the chief executive wanted to improve quality care in the trust. Some staff said they knew who the members of the trust Board were, including the director of nursing. However, many staff informed us that they had not seen members of the trust Board visit ward areas.

Surgery

Culture within the service

- Staff spoke about the difficulties of providing a service when there was a shortage of nurses on the wards. Although there had only been one red flag shift escalated in the last eight weeks prior to this inspection, nurses told us they often worked overtime or longer than the end of their shift to ensure their teams were appropriately supported.
- The nursing teams worked well together and there was a culture of support and respect. There was a lot of goodwill among staff, which enabled the wards to be staffed adequately.
- Staff in theatres had lacked appropriate leadership for some time but they were positive and keen to identify areas for improvement.
- Nursing and medical staff told us they worked well together to provide coordinated care.

Public and staff engagement

- Public engagement was now a prime focus of the trust and strategies had been developed to improve engagement.
- Patients were regularly asked to give their feedback and views on the care and treatment they had received. They were asked to complete questionnaires after their treatment. Staff were unclear about what happened to any feedback that was received.
- Information was available for staff and patients about the trust's performance in terms of reducing the incidence of falls, pressure ulcers and hospital-acquired infections.
- Some staff told us about the open drop-in sessions arranged by the chief executive for staff to comment or raise a concern before our inspection visit. However, some staff were not aware of the sessions and others said that they were aware but had not had an opportunity to attend.
- Staff told us that the chief executive had a blog on the trust website where staff and the public were updated on any developments at the trust. These initiatives meant that steps were being taken to promote public and staff engagement.
- The Trust participated in the safe and well project. This was being piloted by NHS England and used the Wellbeing Insight prediction tool for predicting organisational wellbeing and resilience to support staff and reduce sickness levels. The tool was used in theatres and staff were surveyed in July 2013. The survey was completed by 70 staff. The trust has established a well-being group to agree action on the top priorities for change, support staff and provide practical interventions. A development programme has also been established to promote effective team working.

Innovation, improvement and sustainability

- A number of medical staff we spoke with told us the trust was committed to the continuous improvement of outcomes for patients.
- The service did have a developing culture of innovation and learning and many improvements in surgery had occurred as a result of audit; however, staff told us that these were not widely shared.
- There were sustainability issues identified for staffing, theatres and referral to treatment times, but there was no strategy that considered future service sustainability or cost-improvement measures.

Critical care

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

Information about the service

The trust's critical care unit includes an intensive therapy unit (ITU) and a high dependency unit (HDU). These are located together and the unit has eight beds in total. A critical care outreach team is present 24 hours a day. The critical care service also has consultants or registrars present on the unit 24 hours a day.

We talked with two visitors and five members of staff. These included nursing staff, a doctor, a consultant and senior management. We observed care and treatment and looked at two sets of patient records, including medical and nursing notes. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

There were effective procedures to support patients to receive safe and effective. Visitors we spoke with were pleased with the care their relative had received in the intensive therapy unit (ITU) and spoke highly of the staff. Clinical outcomes for patients in the unit were good. Staff worked well together as a team and were enthusiastic about their work. Patients we spoke with gave us examples of the good care they had received in the unit. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.

The unit had an annual clinical audit programme to monitor how guidance was adhered to. Information was collected for the ICNARC database. There was good multidisciplinary team working although specific therapy support was not available over seven days. There was strong local leadership of the units. Openness and honesty was encouraged at all levels, and staff were encouraged to learn new skills and develop the service.

Critical care

Are critical care services safe?

Good

There were effective procedures to protect patients and support safe care on the and in ward areas from the critical care outreach team. There were sufficient numbers of nursing and medical staff on duty. Nursing handovers occurred twice a day and were conducted well. Consultants worked over five consecutive days to ensure continuity of care and all new admissions were seen by a consultant. All staff we spoke with said they were encouraged to report incidents, although lessons learned were not always shared. The environment was clean and staff followed infection control practice. Equipment was available and medicines were stored correctly. Staffing levels were appropriate and risks to patients whose condition might deteriorate were escalated appropriately. All professionals involved with a patient during their admission to the unit added their notes to the same records; this ensured continuity and a team approach to delivering care.

Incidents

- There had been no Never Events reported that related to critical care between December 2012 and February 2014.
- Staff were encouraged to raise concerns and report incidents and staff were aware of how to do this. They told us that 'lessons learned' throughout the hospital were included on the hospital intranet. However, staff were not aware of any recent reported incidents although there had been three patient safety incidents with a rating of moderate harm reported between December 2012 and January 2014. Staff were not aware of the action taken on these.

Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- The unit monitored harm-free care and displayed 'Simply Safer' data on all wards. The data covered infections, high-impact interventions (such as peripheral line insertion), the NHS Safety Thermometer, information on patient experience, complaints and assessments (for example, on medication, nutrition, continence and pain). The data also included appropriate staffing ratios for qualified and non-qualified staff. The unit was meeting trust targets and standards across all the measures.
- There was a process for risk assessment and safety checks that were specific to ITU staff and patients. For example, daily infection control and safety checks were undertaken in greater detail than those undertaken on general ward areas.

Cleanliness, infection control and hygiene

- The unit was clean and staff were observing the trust infection control policy. They complied with the trust's 'bare below the elbows' policy and we observed staff washing their hands or using hand hygiene gel. Recent audits showed staff achieved 100% compliance with hand hygiene. Staff used personal protective equipment, such as gloves and apron, to care for patients and disposed of these appropriately afterwards.
- A recent infection audit by the trust infection prevention and control lead in the unit showed a 'good' performance and outcomes.
- The unit contributed their patient data and outcomes to ICNARC and so was evaluated against similar departments nationally. ICNARC data showed infection rates: for example, MRSA rates for the unit were low and below the national average. There had been no MRSA outbreaks reported by the trust for over 18 months.

Environment and equipment

- Equipment was checked and cleaned daily. Records were maintained by the technician on the duties they had completed each day.
- Resuscitation trolleys were stocked according to their respective checklist.

Medicines

- Medicines were stored securely and safely. Refrigerators used to store medicines were secured with locks operated by a key. The temperatures of the refrigerators were regularly checked and these were within the correct safe range.
- Medicines were managed appropriately. The process for managing controlled drugs followed national guidelines. Emergency medicines stored in the resuscitation trolleys were in date and fit for use.

Critical care

- Medication records were clear and medicines were administered as prescribed.

Records

- All records were in paper format and kept at the end of a patient's bed. All healthcare professionals used these records and there was regular and frequent multidisciplinary input into each patient's care records to keep them up to date.
- When a patient transferred to a ward from ITU, the appropriate documentation and observations were printed from the electronic record system and added to the paper record.
- Patient records included risk assessments and care plans that were completed on admission; these were reviewed daily.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. Staff told us they were aware of the Mental Capacity Act and how this related to consent to treatment.
- We saw an example of a patient who did not have capacity to consent to their treatment. The Mental Capacity Act had been appropriately applied. This was also confirmed to us by the relative of the patient.

Safeguarding

- There was a trust-wide policy on safeguarding adults. Staff told us they were aware of this policy and were able to explain what constituted a safeguarding concern and the steps required to report any concerns.

Mandatory training

- Staff told us that they were up to date with their mandatory training.
- Statutory training covered fire safety, health and safety and manual handling. Mandatory training covered infection control, information governance and safeguarding (which included dementia awareness training).
- The trust had a target to achieve 80% compliance with statutory and mandatory training; 84% of staff in the division had done statutory training and 98% had done mandatory training.
- The trust target was for 90% of staff to have relevant safeguarding training; 89% of staff in ITU had completed safeguarding (level 2) training.

Assessing and responding to patient risks

- The critical care outreach team was available 24 hours a day and contact details were clearly displayed in the unit.
- The modified early warning system tool was used to identify patients whose medical condition was deteriorating. It also included instructions for contacting the critical care outreach team.
- Ward staff told us they knew how to contact the outreach team and that, when contacted, the team responded within 30 minutes.
- Visiting professionals to the unit (for example, physiotherapists or speech and language therapists) were given an update on a patient's condition and progress before giving any treatment.
- The critical outreach team saw all patients discharged from the unit within 24 hours of their discharge.
- The hospital had produced a leaflet for relatives and friends inviting them to contact the critical care outreach team directly if they were concerns about their relative.
- The hospital had made significant strides in the recognition and management of sepsis and the delivery of the 'Sepsis Six' care bundle which include blood culture tests, giving antibiotics within one hour, fluid management, oxygen, urine output monitoring and serum lactate. They had a critical care outreach nurse seconded as a Sepsis Nurse who monitored compliance every month. The Sepsis Nurse had also introduced a sepsis recognition tool, sepsis boxes for the wards and stickers to improve fluid balance completion.

Nursing staffing

- The unit had staffing levels that met the needs of patients. All level 3 patients were nursed one-to-one, and all level 2 patients one-to-two in accordance with national guidelines for critical care.
- There was a supernumerary senior nurse who led each shift.
- The ward manager said that they rarely used agency staff and relied on bank staff to fill any staffing gaps. We looked at staff rotas and found shifts were regularly filled with adequate numbers of staff.
- Induction sheets were completed for any temporary or agency staff.
- If the unit had a number of patients with identified high levels of need, extra nursing staff were rostered so that patient safety was not compromised.

Critical care

- Sixty per cent of the nursing staff had achieved a post-registration award in critical care nursing.
- Nursing handovers occurred twice a day. There were good handover arrangements, ensuring that all necessary information was communicated about patients so that care remained safe and effective during shift changes.

Medical staffing

- Care in the ITU/HDU was led by a consultant in intensive care. A consultant was present on the unit from 8am to 9pm, 7 days a week. Staff told us that outside these hours a consultant was able to attend the unit within 30 minutes if required.
- The consultants worked in consecutive 5-day blocks, as expected in national guidelines.
- All potential admissions had to be discussed with a consultant and all new admissions were reviewed by them in person within 12 hours of admission.
- An intensive care registrar was based on the unit 24 hours a day.
- We did not observe any medical handover, but we saw a ward round in which critical care patients' conditions, care and treatment plans were reviewed. We saw that patients' privacy and dignity was maintained during ward rounds. We also noted that a patient's family was involved in any decisions made.

Major incident awareness and training

- The trust major incident plan, included winter pressures and fire safety, was kept in a prominent place on the unit.

Staff were aware of the procedures for managing such incidents.

Are critical care services effective?

Good

Patients received care and treatment according to national guidelines. The unit contributed to the ICNARC database and current data showed that patient outcomes were similar to those of other trusts. Patients had their pain assessed regularly and received good pain relief. The unit had competent staff who were supported to develop their skills and provide quality care to patients. There was good multidisciplinary working. A consultant or senior registrar was available on the unit 24 hours a day, although the unit did not have cover from specific therapy staff over seven days.

Evidence-based care and treatment

- The ITU used a combination of the National Institute of Health and Care Excellence (NICE), Intensive Care Society (ICS) and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided.
- There were local guidelines and care pathways to ensure appropriate and timely care for patients with specific conditions and in specific situations, such as if a patient was ventilated.
- A folder of guidelines and protocols and useful information was available at the end of each bed space for ease of use by staff.
- The unit had an annual clinical audit programme to monitor compliance with national guidance, and local clinical audit priorities were identified. Completed clinical audits were discussed at monthly meetings of the division and there was evidence of improvement as a result. For example, monthly observation audits on every patient on every ward were carried out.
- The ward manager and matron told us that lead consultants and senior nurses discussed ICNARC data and reviewed deaths. However, there was no paper record of these discussions available for audit purposes.
- Multidisciplinary mortality and morbidity meetings were held in ITU every fortnight. Expected and unexpected deaths were discussed and contributing factors to the deaths were established. Staff, however, were not able to provide any evidence that learning or improvement from this activity had taken place. Minutes of these meetings were also not available for review.
- Nursing staff did weekly audits on harm-free care and patient experiences as part of the 'Simply Safer' data.
- Audits were undertaken of ward environments under the '15 Steps Challenge'. This was designed by the National Institute for Innovation and Improvement toolkit to assess first impressions on entry to a ward or unit and to ensure that the ward was safe, caring and involving, well-led and calm. Actions were identified for improvement.

Critical care

Pain relief

- Patients' pain scores were regularly assessed and documented. Records showed that pain relief was administered promptly and patients' pain reassessed after administration to ensure their pain was adequately controlled at all times.
- One visitor we spoke with told us that they felt their relative was pain-free and comfortable.

Nutrition and hydration

- Staff provided hydration and nutrition through a regimen of intravenous fluids and specialist feeds. This was with the support of the dietitian service, which supported patients who were not able to eat and drink while they were critically ill.
- We observed that all fluids and feeds were recorded on patients' observation charts.

Patient outcomes

- The unit contributed to the ICNARC database, although figures for 2013 had not yet been validated. Because of staff sickness, some data had yet to be submitted by the unit.
- The available information showed that the unit's mortality rates, average length of stay and hospital-acquired infection rates were similar to those of other units across the country.

Competent staff

- There was a comprehensive induction programme. A staff nurse told us they had a four-week supernumerary period and competency assessments when they started in their role.
- Sixty per cent of nursing staff had a post-registration award in critical care nursing.
- Nursing staff were supported to attend specialised intensive care courses.
- Staff told us they received regular supervision and had an annual appraisal. Records showed that all staff had an up-to-date appraisal. Staff told us they felt supported to develop their skills to provide high-level support to very ill patients.
- Junior doctors rotated through the service and received good support. The trust performed similar to expected in the National Training Scheme Survey, GMC, 2013, for most aspects of anaesthetic training but was worse than expected for overall satisfaction, adequate experience and local teaching.

Multidisciplinary working

- There was a daily ward round that included medical, nursing and pharmacy staff. The unit did not have dedicated physiotherapy staff so they did not participate regularly in ward rounds. Similarly, microbiologists did not participate in ward rounds, although they provided daily input to the unit.
- We observed a clinical ward round and noted that clear instructions were given to medical and nursing staff to meet the specific requirements of ventilated patients.
- Patients had an assessment of their rehabilitation needs within 24 hours of admission to the critical care unit. Trust-based physiotherapists and occupational therapists were on call.
- The unit had access to dietitians and speech and language therapists, and all patients with a tracheostomy were assessed by a speech and language therapist.
- There was a weekly multidisciplinary meeting on the unit that had input from medical, nursing, pharmacy, speech and language therapy and physiotherapy.
- The trust had a critical outreach team that was available 24 hours a day. The outreach team was based in the critical care unit.
- The unit manager told us there were arrangements for multidisciplinary team working through a regional critical care network. Representatives from the trust attended quarterly meetings of the network in which learning from incidents that had occurred in another trust would be explored.

Seven-day services

- A consultant was present on the ITU/HDU from 8am to 9pm at weekends and undertook ward rounds twice daily. Consultants were supported by a senior registrar and junior doctor.
- The critical care outreach service was available 24 hours a day, 7 days a week.
- Pathology services were on call out of hours and provided weekday services from 9am to 1pm.
- Pharmacy staff provided weekend services from 9am to 12.30pm on Saturday and 10.30am to 2.30pm on Sunday. Outside those hours, there was an on-call pharmacist to dispense urgent medications.

Critical care

- Plain film radiology and urgent CT scans was provided 24 hours a day, seven days a week. There was a consultant radiologist who worked from 9am to 5pm at weekends for CT, MRI and ultrasound scans. Staff were on call outside those hours.
- Two physiotherapists and a physiotherapy assistant were on call out of hours and available between 9am and 3.30pm. They were not specific to ITU and the physiotherapy service also provided cover to A&E, CDU and the wards for respiratory concerns, discharge mobility assessments and stroke assessments.
- There were no occupational therapy services out of hours or at weekends.
- There were no speech and language or dietetic services available at weekends.

Are critical care services caring?

Good

Staff provided compassionate care and treated patients with dignity and respect. They built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients' relatives told us they were involved in care and treatment decisions.

Compassionate care

- We observed staff caring for patients in a kind and professional manner.
- Staff maintained patients' privacy and dignity by using curtains and screens.
- A visitor told us that they, and all patients and visitors, were always treated with dignity and respect.
- The ITU was a mixed-sex ward. The unit had screens and side rooms, which helped to maintain the privacy of male and female patients.
- The NHS Friends and Family Test was not promoted on this unit because the patients were too critically ill. However, we observed comments leaflets inviting feedback from patients and relatives in the waiting area. Some positive comments and thank you cards were also displayed on the unit.

Patient understanding and involvement

- Because of the nature of the care provided in a critical care unit, patients could not always be directly involved in their care. The ward manager told us that, when possible, the views and preferences of patients were taken into account when planning their care and treatment.
- Patients, and at times those close to them, were involved in decisions about their care and treatment. For example, a visiting family member told us they had received good levels of information about their relative's care and treatment from staff at all times.
- We observed doctors and nurses interacting with patients when delivering care. For example, we saw staff telling an unconscious patient that they were going to adjust their nasal tube.
- We observed that patient's families were involved in decisions that were made during ward rounds.
- The unit had introduced 'Patient diaries', which were completed by nursing staff and families, if they wished, about the patient's treatment in the unit.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way.
- A visiting family member told us that they felt their emotional needs were well supported. They said they stayed overnight with their relative and were always kept up to date about their relative's condition.
- The unit had input from a specialist organ donation nurse who supported relatives in making decisions about organ donations, end of life care and withdrawal of treatment.
- Chaplaincy staff visited the unit every day and offered support to relatives and patients if appropriate.

Are critical care services responsive?

Good

The critical care services were responsive to the needs of patients. Patients were admitted to the unit within standard times and appropriately discharged to the wards with support from the critical care team. Support for patients with physical and learning disabilities was available if needed, and staff used translation services for

patients and their relatives who did not speak English. Picture screens were used to provide a calm and relaxing environment on the unit. Complaints were handled appropriately.

Service planning and delivery to meet the needs of local people

- The unit had eight critical care beds available. Between November 2013 and February 2014, figures showed that the bed occupancy for adult critical care beds across the trust was 79.2% and below the national average of 82.9%. Bed occupancy, however, was above the Royal College of Anaesthetists' recommendations of 70%. Persistent occupancy of more than 70% suggests a unit is too small, and occupancy of 80% or more is likely to result in non-clinical transfers, with associated risks.
- The unit would transfer patients to a neighbouring trust if they required critical care and there were no available beds.

Access and flow

- The ICNARC data showed that non-clinical transfers was below the national average. Staff attended bed management meetings to make sure patients were placed in the right area for their clinical needs.
- During January to December 2013, there had been 498 admissions in total and the standard of four hours from decision to admission had been met.
- Length of stay on the unit was above the national average.
- Most discharges from the unit occurred during the day between 8am and 10pm; this followed national guidelines.
- Patients who were discharged to other wards had follow-up visits by the critical care outreach team.
- Readmissions to the ITU were similar to those in other trusts and there was no evidence of risk.
- Staff identified that the ITU bed capacity needed to expand.

Meeting people's individual needs

- Support for patients with physical and learning disabilities was available. For example, physiotherapists, occupational health therapists and a learning disability nurse provided support to staff in the unit.
- Translation services were available. Staff could contact the NHS interpretation service by phone, or request interpreters to visit the unit.
- Some patient bays had picture screens at the side of their bed. These showed, for example, pictures of a soothing flower blossom scene. Staff and relatives commented that these were calming and relaxing and gave patients lovely visual images. There were only two in the ITU and they were moved around the patient bays.
- There was a relatives' room that was used for private consultations with families. The room had facilities such as a fridge and tea and coffee making facilities. A visiting family member said they found the .relatives' room "invaluable".

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.
- Complaints leaflets were available on the unit.
- Action was taken following complaints. For example, there had been a complaint about the difference in care provided by outreach and nursing staff. The hospital was developing collaborative working between outreach and ward staff to establish their core values.
- The visitor we spoke with told us they knew how to make a complaint if they wished to.
- The unit had not received any recent complaints or concerns.

Are critical care services well-led?

Good

Critical care services were well-led with staff speaking positively about the nursing leadership within the unit and the service they provided for patients. Staff were passionate about the hospital and their unit. Quality and patient experience was seen as priorities and everyone's responsibility. Governance arrangements supported assurance around quality and risk although staff sickness had prevented data collection on patient outcomes. This was now being rectified. Patients' feedback was regularly sought to improve the service. Staff were engaged and felt supported to learn and make improvements.

Critical care

Vision and strategy for this service

- The trust encompassed its vision in the strapline, 'To ExCEL at Patient Care'. This was achieved through Effective open communication; eXcellence and safety in all that we do; Challenge but support; Expect respect and dignity; Local healthcare that inspires confidence. Posters detailing the trust's vision to 'ExCEL' at patient care were visible throughout the wards and corridors.
- Staff told us that this vision was at the forefront of all they did.
- The unit had identified priorities to improve its service but it did not have a long-term strategy. Staff told us they were aware of the recent challenges faced by the trust and the subsequent changes in the trust's strategy.

Governance, risk management and quality measurement

- The unit had monthly clinical governance meetings where the results from clinical audit, incidents, complaints and patient feedback were shared with staff. Clinical governance systems were effective and staff explained how these had an impact on patient care. For example, they discussed the results from the national cardiac arrest audit (NCAA) and the outreach activity audit, and how these could improve care in the unit.
- Results from ICNARC demonstrated that data was missing for 2013. The ITU manager told us the unit had been unable to submit the data because of staff sickness. The missing data related to two quarters in 2013 and was in the process of being submitted.
- The risk register for the division was up to date and did not include any risks identified for critical care.

Leadership of service

- Critical care services were well-led by a manager, matron and a consultant clinical lead.
- Staff told us that the senior staff worked well together, there was strong local leadership and they were well supported in their posts.

Culture within the service

- Staff on ITU were passionate about their work and responsive to patients. The culture of the unit was focused on patient safety and care.
- Staff worked well together and with other departments within the trust.
- Staff were friendly and professional at all times and there was obvious respect between staff groups.

Public and staff engagement

- Patient feedback on the ITU was usually received after a patient had been moved from intensive care to a general ward. Feedback was used to monitor and improve the service.
- We saw a number of cards and letters from patients and their families thanking staff for the care they had received while in ITU.
- Staff felt involved in making decisions about how the unit was run and said they could always raise concerns.

Innovation, improvement and sustainability

- Staff felt they worked in an environment that supported learning and there were examples of learning and improvement that involved the entire team. For example, all band 6 nurses had recently spent a week working at an inpatient hospice to improve their knowledge of end of life care for patients.

Maternity and family planning

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

Information about the service

Maternity facilities at the trust include two theatres, a 10-room delivery suite including a birthing pool and a newly opened bariatric room. There are also antenatal and postnatal facilities on the 23-bed Drayton Ward, an early pregnancy assessment unit (EPU), a maternity assessment unit (MAU) and a special care baby unit (SCBU), which is described in detail as part of the report on children's services. Babies born needing higher levels of support are transferred to a neighbouring hospital via ambulance for more intensive or high-dependency neonatal care.

Between April 2012 and March 2013, the trust delivered 2,281 babies. The delivery rate fell between April 2013 and March 2014 and 1,974 babies were delivered. These numbers included home births: there were 35 home births, accounting for 1.7% of the total number of births that year.

We visited the labour ward, Drayton Ward, the EPU and the MAU. We spoke with 15 women and 47 staff. There were 20 midwives in a focus group and about 10 staff in a department meeting. We also spoke with the two ward managers, 10 other managers and five doctors. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

There were effective procedures that supported safe and effective care for women. Staff were caring and compassionate and treated women with dignity and respect. National guidelines were adhered to and outcomes were good. Women had choices during birth and were involved in decisions about their care and treatment. There was additional support for vulnerable women and teenage mothers. The staff were loyal, committed and enthusiastic, and there was evidence of effective team work.

The gaps in the leadership staffing structure had creating some instability and concern within the service and governance arrangements had deteriorated. Service plans did not go beyond operational requirements and staff were not learning from incidents and complaints. Staff were positive overall and fully engaged, but staff were striving to cover the gaps and were reporting some fatigue and a lack of direction overall. Team work remained good and there were high levels of respect and support. Although there were some good examples of improvement, staff said overall that there was a reluctance to change and innovation.

Maternity and family planning

Are maternity and family planning services safe?

Good

There were effective procedures to support women and their babies to have safe care. The maternity ward areas were clean and equipment was regularly checked. Medicines were appropriately managed. The building was old, however, and refurbishments were planned. There were adequate numbers of midwives and medical staff on duty. The average ratio of births to midwives was only slightly higher than the national average and a new consultant was to be appointed to improve the hours of consultancy cover in the units.

The service used the modified obstetric early warning score (MOEWS) to escalate care if women became acutely ill. Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or more specialised care. Incidents were reported but staff had not received appropriate feedback and lessons learned were not widely shared.

Incidents

- There were no Never Events reported in maternity services between December 2012 and February 2014.
- Eight serious incidences were reported in 2013/2014. The incidents included a baby falling from a bed, a mother with sepsis, a mother and babies transferred to intensive care expectantly and an infant cardiac arrest at birth. The number of serious incidents reported was in line with the numbers expected in a trust of this size. The incidents had been comprehensively investigated but there was no systematic process by which to share the lessons learned with staff.
- Midwives we spoke with confirmed that they reported incidents on the electronic system but they were unable to provide details of the outcomes or recommendations resulting from investigations into the incidents. Consultants told us they had not received feedback on incidents. Senior staff were unaware of each other's incidents. There was no formal system for reporting on outcomes and sharing learning.
- The maternity triggers for incident reporting had recently been re-circulated to encourage and remind staff to report all incidents.

Safety thermometer

- The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE) and falls.
- The department monitored harm-free care and displayed data on all wards. The information was displayed in a way that the general public could understand. The data covered harm-free care as indicated by the NHS Safety Thermometer. The data from the labour ward and Drayton Ward showed that there had been no new pressure ulcers, falls, catheter-related urinary tract infections or venous thromboembolisms.

Cleanliness, infection control and hygiene

- The units and ward areas were clean. Staff adhered to the trust infection control policy. They washed their hands regularly, applied hand hygiene gel and wore clothes that adhered to the 'bare below the elbow' policy.
- Infection rates for the hospital were within expected limits.
- The Survey of Women's Experiences of Birth, CQC, 2013, revealed that the trust had performed about the same as other trusts in relation to the questions about the cleanliness of the wards, toilets and bathrooms.

Environment and equipment

- The environment in the maternity department was old and required refurbishment. The wall plaster was crumbling in places, there were holes in the walls and electrical wires were visible. This had been acknowledged by the trust and work had started to modernise and refurbish the building.
- The rooms were generally of a good size and there was a separate baby bathing room.
- The environment was calm and noise levels were not intrusive, even though the service was busy at the time of our inspection.
- Equipment was checked appropriately, cleaned regularly and marked with stickers to indicate that it was ready for use.
- Equipment used in emergencies was checked daily. Resuscitation equipment was available in every room and all the equipment on the 'crash trolley' was within the date of expiry.

- Birthing pools were available and there were also birthing balls and birth mats.

Medicines

- Medicines were stored correctly in locked cupboards and fridges as necessary. Fridge temperatures were monitored to ensure they stayed within the required range. There was a keypad that secured the door to the clinical room where the medicines were stored.
- All controlled drugs were checked and signed for by the senior midwife on duty and the medicines were checked again at every handover. In line with national guidance, there was a clear process to follow in the event of a discrepancy in the numbers of controlled drugs.

Records

- Records were in paper form, kept in good order and stored securely. The records we looked at reflected what women told us about their care.
- The hospital was using the red baby books to record information about the pregnancy and birth.
- On Drayton Ward, notes had been relocated to make them more accessible. Staff had been consulted about this change and had been able to express their views before a decision was made.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw evidence in the notes that consent had been sought and obtained as appropriate.
- Women we spoke with said that they had been involved in their care and had been asked for their consent before treatment.

Safeguarding

- The service had a lead midwife for safeguarding adults and children.
- There was an effective system for the process of alerts and referrals between community- and hospital-based teams.
- A special service called 'Providing information and positive parenting support' (PIPPs) was available to provide information and positive parenting support for teenage mothers and others who were vulnerable. The two midwives working as part of this service said that they developed a close relationship with the women and offered additional support, continuity of care and coordinated multi-agency case conferences involving social services when necessary.

Mandatory training

- The midwives we spoke with in the focus group said that they kept up to date with their mandatory training including medicines management, infection control and safeguarding.
- Statutory training covered fire safety, health and safety, and manual handling. Mandatory training covered infection control, information governance and safeguarding (which included dementia awareness training).
- The trust had a target to achieve 80% compliance with statutory and mandatory training; 84% of staff in the division had done statutory training and 98% had done mandatory training.
- The trust target was for 90% of staff to have relevant safeguarding training; 86% of midwives had completed safeguarding (level 2) training and 92% had completed safeguarding (level 3) training.

Management of deteriorating patients

- The service used MOEWS to escalate care if women became acutely ill. There were clear directions for escalation printed on observation charts and these were completed by midwives on the labour ward.
- Staff we spoke with were aware of the appropriate action to take if women scored higher than expected and required close monitoring or transfer for more specialised care.
- There was a multidisciplinary handover meeting daily at 8am. This meeting was used to reflect on activities in the labour ward in the past 24 hours, to identify any issues with women in the unit and to escalate concerns.
- A woman experiencing difficulties within maternity services and needing to be transferred to the intensive therapy unit (ITU) would require an ambulance transfer because of the physical separation of the maternity unit from the rest of the hospital.
- Babies born needing higher levels of support were offered transitional care on Drayton Ward or cared for in the SCBU. There was no upper limit placed on the number of babies requiring transitional support that could be accommodated on Drayton Ward but the numbers were monitored.
- One woman we spoke with said that doctors observed her baby very closely and came two to three times a day.

Maternity and family planning

- Babies requiring intensive or high-dependency neonatal care were transferred to a neighbouring hospital via ambulance.

Midwifery staffing

- The head of midwifery had been working reduced duties followed by a period of absence. Support was being provided temporarily by the head of midwifery on secondment from South Warwickshire Foundation Trust.
- The safe staffing dashboard was displayed on each ward and unit we visited. This showed details of the required levels of staffing and actual levels present on each shift. There was an escalation procedure to follow if required levels were not being met.
- Staffing levels were good and being adhered to. The midwife to staffing ratio was 1:29 for 2013/2014, which was only slightly above the national recommendation of 1:28. This ratio had improved as birth rates had fallen, even though there were vacancies for 5.5 whole time equivalent midwives. The service operated in-house cover arrangements through a text alert system inviting existing members of staff to work additional shifts to cover for absence. There was also a midwife on-call rota system in operation. Staff told us the system was working well and the service was able to offer one-to-one care for women in labour.
- The service was not using an acuity tool to take account of the dependency or condition of women and babies when assessing levels of staffing.
- We were informed that there was a supervisors of midwives to midwives ratio of 1:15, which was the recommended ratio, but staff said there was no time to perform this function adequately because of the number of midwifery vacancies.

Medical staffing

- Consultant obstetricians were present on the labour ward for 40 hours a week (84% of the time), which was below the target for the number of deliveries. For the remaining 16%, cover was available from staff running clinics, and clinics could be suspended if necessary.
- There were five consultants covering the labour ward with one additional appointment pending. The sixth consultant appointment was planned to ensure 100% consultant presence on the labour ward.
- There was a 'duty anaesthetist' immediately available for the obstetric unit 24 hours a day, as well as an anaesthetic assistant. The caesarean section list was consultant-led and there was a comprehensive pregnancy screening and ultrasound service.
- There was one vacancy at SHO level and one at specialist registrar level. There were, however, sufficient numbers of junior doctors in specialist training grades (middle grades) making up the rota in obstetrics.
- The National Training Scheme Survey, GMC, 2013, identified that the medical handover was worse than expected when compared with other trusts.

Major incident awareness and training

- There were regular safety training drills and staff we spoke with were aware of procedures for major incidents.

Are maternity and family planning services effective?

Good

The maternity service used evidence-based national guidance, and outcomes for women and babies were good. There was good multidisciplinary team working and learning throughout the service and specifically between community and hospital midwives and social services. Some seven-day working had developed. Staff training was well supported by midwives but required better supervision.

Evidence-based care and treatment

- The maternity service used evidence-based national guidance including the Royal College of Obstetricians and Gynaecologists Safer Childbirth standards and National Institute for Health and Care Excellence (NICE) guidance (for example, the policy for setting staffing levels and the risk management strategy for maternity services).
- Local clinical and procedural guidelines were used and these were updated based on national updates and local reviews. Clinical guidance and policies had recently been transferred to the trust's intranet and staff we spoke with did not know how to access the electronic guidance. They said the paper copies had been withdrawn before our inspection.

Maternity and family planning

- The service had a clinical audit programme and nursing and medical staff were involved. Compliance with national guidance was audited and local priorities for audit were identified. Not all clinical audits had dates for completion but most audits were ongoing and there were examples of improvement as a result.
- There was evidence of change following audit (for example, as the result of an infant feeding audit conducted in March 2014, which demonstrated some significant improvements with skin-to-skin contact initiated after birth). However, some clinical audit reports did not have an action plan based on recommendations.
- Nursing staff did weekly audits on harm-free care.
- Audits were undertaken of ward environments under the '15 Steps Challenge'. This was designed by the National Institute for Innovation and Improvement toolkit to assess first impressions on entry to a ward or unit and to ensure the ward was safe, caring and involving, well-led and calm. Actions were identified for improvement.

Pain relief

- Pain relief was available for birthing mothers; this included entonox, pethidine and remefentanil.
- Epidurals were available 24 hours a day, 7 days a week from a dedicated anaesthetist.
- An audit of pre-operative pain relief following caesarean section under spinal anaesthesia showed that 100% of women were satisfied or very satisfied with their pain relief.
- We spoke with six women who all said pain relief was available during labour and they had felt they had a choice.
- One women said that she had had 'gas and air' with her first birth and wanted to do the same with her second when she had it. However, she was aware that other forms of pain relief were available.

Nutrition and hydration

- Women had nutritious food choices and access to hot drinks and snacks between meals.
- Women who had had a caesarean section were monitored appropriately for hydration.

Patient outcomes

- Elective and emergency caesarean section rates showed no evidence of any greater risk than in other trusts, and the trust had a lower emergency caesarean rate between October 2012 and November 2013 when compared with other trusts nationally. It had a higher normal delivery rate when compared nationally within this time frame and a lower than average assisted delivery rate.
- There was a weekly meeting to discuss critical appraisal from recent caesarean sections and anything that could have been done differently, or would have improved patient outcomes.
- Outcomes were within the trust's target and thresholds and within expected levels. For example, rates of puerperal sepsis, puerperal infections, and maternal and neonatal readmissions were within expected levels.
- Midwives reported good outcomes for blood testing in newborn babies to screen for a number of conditions including cystic fibrosis and sickle cell disorder.
- The percentage of women whose breastfeeding status was recorded was 100% and breastfeeding had been initiated for 62% of women.

Competent staff

- Staff were experienced and up to date with relevant training. Midwives confirmed that they had access to additional training and study days.
- Training records showed that, in December 2013, 86% of nursing and midwifery staff were up to date with their annual appraisal. Midwives reported good support in general but said that they felt a little 'rudderless' and that they had been 'left to get on with it' without the substantive head of midwifery operating in her post.
- Midwives reported that there was insufficient time allocated to the role of supervisor of midwives.
- The National Training Scheme Survey, GMC, 2013, identified that the hospital was similar to other trusts in terms of training and better than expected for workload and regional teaching. The hospital was worse than expected for medical handover.

Multidisciplinary working

- The service held a daily multidisciplinary meeting to discuss staffing and acuity. The meeting was known as the 'The Hug'. This was attended by consultants from obstetrics and gynaecology and paediatrics, and midwife coordinators from the labour ward, Drayton Ward and the SCBU.
- There was cooperative team working and high levels of communication between the community and hospital midwife teams and with other healthcare professionals including GPs.

Maternity and family planning

- There was close working between the SCBU and the labour and postnatal, wards particularly in relation to monitoring the transitional care babies.
- There was close liaison with social services to support vulnerable women and their babies.
- There was a midwife available to offer specialist care and treatment to pregnant women who were diabetic.

Seven-day services

- Consultant medical staff were present on the labour suite from Monday to Friday, 9am to 5pm. Consultants were present from 8.30am to 11am at weekends to do ward rounds, and on call for emergency care. There was senior registrar and junior doctor support out of hours and at weekends.
- There was a 'duty anaesthetist' and an anaesthetic assistant immediately available for the obstetric unit 24 hours a day.
- Antenatal clinics and screening were available on weekdays.
- The maternity assessment unit (MAU) was available seven days a week.

Are maternity and family planning services caring?

Good

Women and their partners with told us about the positive care they had received and about the high levels of compassionate care they had received from staff. Women were encouraged to discuss their plans and choices with their midwife and to be actively involved in the planning and decision making. There was a high level of emotional support available for women who had had traumatic births.

Compassionate care

- The NHS Friends and Family Test results were displayed on notice boards. The scores for Drayton Ward were above the national average and high for women 'extremely likely' to recommend the ward. The scores were 97% positive for December 2013, 93% positive for January 2014 and 95% positive for February 2014.
- We spoke to six women on Drayton Ward and they all reported that they had had a positive experience at the hospital. Two were returning having had babies in the hospital before. They told us that they had actively chosen to come back because of the high levels of compassionate care they had received, even though it was further for them to travel than other facilities.
- We observed the midwives working with women and noticed how they knocked on the door before entering a side room and made sure women had privacy curtains drawn when offering personal care. We also heard midwives talking to women respectfully and with compassion.
- The trust performed about the same as other trusts across most of the areas covered in the Survey of Women's Experiences of Birth, CQC, 2013, including labour, birth and postnatal care. It also performed better than other trusts in relation to the time taken to respond to a call button.
- One woman said, "The quality of care more than makes up for the older building."
- The Survey of Women's Experiences of Birth, CQC, 2013, revealed that the trust performed about the same as other trusts on the question of whether women were treated with kindness and understanding.

Patient understanding and involvement

- Women and their partners said that the midwives and doctors explained their treatment and care and informed them of their choices.
- One woman told us that she had decided to have a particular procedure until the doctor told her about the other options available to her. She said that she made a different decision once she knew about the other options.
- The Survey of Women's Experiences of Birth, CQC, 2013, revealed that the trust performed about the same as other trusts in relation to whether women were spoken to in a way they could understand, and whether they were involved enough in decisions about their care.

Emotional support

- Counselling services were available for women who required additional support, for example traumatic births, and there were psychological services for new mothers
- There was chaplaincy service in the hospital each day and an out-of-hours on-call service.

Are maternity and family planning services responsive?

Maternity and family planning

Good

The maternity and family planning services were responsive to people's needs. Women had access to the full range of options for birth, subject to the appropriate risk assessment. Despite the high bed occupancy rates in the maternity service, there were no service closures and access to services was well managed. Antenatal clinics were not delayed. Women had an appropriate length of stay and their discharge was supported.

Women who were vulnerable and teenage mothers had specific support and care coordinated with community midwives and social services. Interpreter services were used and information leaflets were available in different languages. Some leaflets, however, were out of date.

Service planning and delivery to meet the needs of local people

- There was an early pregnancy assessment unit (EPA) and a maternity assessment unit (MAU) to assess and monitor women during pregnancy.
- There were short-term service plans to respond to service demands and access. These were managed through a daily early morning meeting called 'The Hug'. The ward coordinators used this meeting to monitor the flow of mothers and babies through the wards. The process was effective and staff confirmed that they did not need to close wards because of insufficient capacity.

Access and flow

- Between October and December 2013, bed occupancy rates for maternity were 90.3%, which is significantly higher than the England average of 58.6% and higher than the recommended levels for maternity.
- The average length of stay in the hospital was two days and women we spoke with said that they were happy with their length of stay.
- There were no delays in discharge because there were sufficient midwives trained in neonatal assessment to allow women to go home without having to wait for a specialist doctor to assess their baby.
- Screening and clinics were running smoothly with no delays in clinic or in making appointments.
- Communication and cooperation within and between wards and units and between the hospital and the community were timely and effective.

Meeting people's individual needs

- Facilities were available for partners to sleep over.
- The trust had developed an improvement plan for maternity services with action points following the Survey of Women's experiences of Birth, CQC, 2013. One of the actions involved reviewing the patient information leaflet about 'Choices for place of birth'. According to the action plan, this had not been completed by April 2014. A number of information leaflets were available and had been produced taking into consideration NICE guidance although some were out of date and required review.
- There was a leaflet on the trust website offering psychological services for new mothers. This leaflet gave useful contact information including for the trust's 'After birth listening service' and the National Childbirth trust. There were also leaflets called 'When giving birth is traumatic', with contact details for the Traumatic Birth Association, and 'Bereavement and loss in childbirth'. The leaflets were helpful, informative and up to date, and staff were aware of and used them.
- Translation services were available and these were being used by staff to support women. There were information leaflets available in different languages.
- A special service called 'Providing information and positive parenting support' (PIPPs) was available to provide information and positive parenting support for teenage mothers and others who were vulnerable. The two midwives working as part of this service said that they developed a close relationship with the women and offered additional support, continuity of care and coordinated multi-agency case conferences involving social services when necessary.

Learning from complaints and concerns

- Complaints about the maternity service were managed by the general manager who passed them on to the head of midwifery for investigation and response. The complaints were dealt with by the labour suite and outpatients leads in the absence of the head of midwifery.
- Complaints were monitored centrally. Thirty complaints were received in 2013/2014. These were mostly about clinical treatment and the attitude of members of staff.
- Information and lessons learnt from complaints were not shared consistently. One doctor was aware of the two complaints he had been involved with but unaware of the others.

Maternity and family planning

Are maternity and family planning services well-led?

Requires improvement

There was no vision or strategy for the maternity services and the service had a short-term operational focus. There were some significant gaps in the leadership structure leading to some instability and a failure to attend properly to aspects of governance and risk. There was a delay in putting interim solutions in place and issues were not resolved in a timely way. There was also a delay in some recruitment and staff felt like they were left to cope without adequate support.

Staff were buoyant overall and fully engaged, but staff were striving to cover the gaps and were reporting some fatigue and a lack of direction overall. Team work remained good and there were high levels of respect and support. Although there were some good examples of improvement, staff said overall that there was a reluctance to change and innovation.

Vision and strategy for this service

- There was no written vision or strategy for this service. The service had a short-term operational focus to respond to local service demands.
- Staff were not aware of any other strategy or vision for the service other than to strive to keep maternity services at the hospital.
- There was a comprehensive written risk management strategy for the maternity service that set out roles and responsibilities. However, with the head of midwifery absent from her post, many of the duties had not been completed. For example, the maternity service annual report had not been completed since 2011 and it had been some months since the Maternity Services Liaison Committee had met.
- The governance lead had had extended periods of sickness before resigning from the role. As a consequence, governance functions, including governance meetings, had not been completed since July 2013. Governance meetings had only just resumed and staff reported that they had lost confidence in the 'value' gained from the reporting system. The concern had been raised in the minutes of the maternity governance group meeting (8 April 2014) about the low numbers of incidents being reported and where the action taken was not known.
- The clinical governance lead for maternity services had been absent for nine months. Governance meetings had not taken place during that time and had only just resumed.
- Information and lessons learnt from complaints was not widely shared or used to improve the service.
- There were only two items on the maternity risk register. One related to the provision of 40 hours' consultant presence for which action had been taken and was nearing completion, and the other related to data management, which was being addressed. The risk register, however, did not include the absence of key post holders in the management structure.

Leadership of service

- The head of midwifery had been working reduced duties followed by a period of absence. Recognising the gap created and the support required, the trust had arranged for support to be provided from an interim head of midwifery from South Warwickshire Foundation Trust for six weeks. This interim head was returning to her substantive post shortly, but would continue to provide support for one day a week until the head of midwifery returned.
- Staff at the midwives focus group said that, without the substantive head of midwifery, the service had felt somewhat 'rudderless', but that it had improved a little with the arrival of the interim.
- Other key post holders, including the operations manager, labour suite manager, outpatients lead and deputy sister on the SCBU were taking on additional responsibilities and some said that they were beginning to feel the strain.
- The clinical director for this area said that the gaps in the leadership structure were creating some "instability".

Culture within the service

- From a focus group with midwifery staff and from individual sessions, it was clear that the team in the maternity service was committed to each other and to providing a high-quality service for pregnant women and their babies.
- We observed high levels of cooperation, support and respect for each other.

- There was effective working between the community and hospital midwives who worked closely together and attended team meetings to share information.
- There were, however, some allegations of bullying that were currently being investigated. The Director of Nursing had held a listening event with staff in September 2014 to understand the issues and consider support and further action.

Public and staff engagement

- There was public engagement about the design of the building housing the maternity services.
- Midwives who attended the focus group said that they felt they had been "left to our own devices" and "left to cope", and there was a sense of disconnection, both physically and psychologically, from the rest of the hospital.
- Staff at the focus group said that at times they had felt the service to under threat and that "it has been one negative thing after another". They thought this affected the reputation of the service because members of the public lacked confidence in the standard and quality of the care offered, and indeed the service's longer term future.

Innovation, improvement and sustainability

- In parts of the service, particularly in the labour ward and the SCBU, staff said that that there was a slower pace than in the neighbouring hospitals and some reluctance to introduce change and innovation.
- We observed, in some areas, staff striving to make improvements to the service. Examples were the work on neonatal blood spots to screen for conditions such as cystic fibrosis and sickle cell disorders, and the encouragement of breastfeeding.

Services for children and young people

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

Information about the service

The hospital did not have an inpatient service for children and young people. There was a children and young person's outpatient clinic area and a children's day procedure unit. This ward had six beds and was also used at least twice a month as a day surgical unit.

There was a 12-bed special care baby unit (SCBU) offering level 1 care. Babies requiring high-dependency or intensive care and treatment were transferred by ambulance to one of the neighbouring hospital with those facilities. There was also a clinical decision unit that formed part of the emergency department and is covered in the A&E section of this report.

We visited the children's day procedure unit, the outpatient area and the SCBU. We spoke with six members of staff including both medical and nursing staff, five parents and two children/young people. We observed interactions between patients and staff, considered the environment and looked at a care record. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

There had been a review of the children's service that had resulted in changes. The review had been undertaken to ensure that the needs of the local population were met in a safe and responsive way. There were no inpatient children's services at the trust and children were care for on the day procedures unit. They were cared for in a safe way in an environment that met their needs, and by staff with appropriate skills and experience. Children who were seriously ill were appropriately escalated for specialised care and this might involve transfer to a neighbouring trust. Staff provided compassionate care and treated children and their families with kindness, dignity and respect. The service was developing networks to ensure that care could be provided close to home when safe to do so. The service was well-led with a learning and innovative culture.

Services for children and young people

Are services for children and young people safe?

Good

There were effective procedures to support children and young people to have safe care. Ward areas and equipment were clean. Equipment was well maintained and medicines were appropriately managed. This was a consultant-led service and there were enough trained staff on duty to ensure that safe care would be delivered. Children's or their parents' consent to treatment was obtained appropriately. Children who required specialist care were appropriately identified and transferred and babies were appropriately transferred to the SCBU if they needed specialised care. Babies and children were appropriately identified for intensive care, which involved transfer to a neighbouring trust.

Incidents

- There had been no Never Event reported in the past 12 months that related to children's services. Staff reported incidents using the hospital's electronic system but told us that they did not always receive feedback. The trust recognised that the current system was inefficient and it was being replaced in the summer of 2014. Work was in progress to anonymise the incidents reported and to develop themes and trends so that learning could be extracted from the data.
- Incidents had been investigated and action taken to prevent reoccurrence. For example, the service had investigated an unplanned admission to the SCBU. Changes were made to assessment and monitoring procedures.
- Information about incidents was shared at a weekly service meeting.

Safety thermometer

- There was NHS Safety Thermometer information for the day procedure unit and displayed on the wards. The data covered harm-free care, pressure ulcers, venous thromboembolism assessments and prophylaxis, and assessments, for example, for medication, nutrition, continence and pain. This showed that there had been no hospital-acquired harm during April 2013 to March 2014.

Cleanliness, infection control and hygiene

- The areas we visited were clean. Hand-washing facilities were readily available and we observed staff adhering to the trust's 'bare below the elbow' policy.
- Equipment was regularly cleaned and labelled as clean and ready for use.

Environment and equipment

- The environment had been recently refurbished and was colourful and bright.
- Entrance to the children's areas was secure with access by swipe card, or entry granted by a member of staff. All staff wore appropriate identification.
- Equipment had been regularly serviced and maintained and was appropriate for the age of children being cared for.
- Equipment that might be needed in an emergency, such as resuscitation equipment, was available in the outpatient area and the children's day procedure unit. However, this equipment was only being checked once a week instead of daily as per hospital policy.
- There were plenty of toys and the environment was child friendly and welcoming.

Medicines

- Medicines were stored in locked cupboards in a room with secure key-coded entry.
- The stock was in date and the medication reviewed was of the correct strength for children. The emergency medication in the outpatient area and day procedure unit was stored in the key-coded room inside a key locking cupboard. This meant that it was not easily accessible because keys rather than a code were needed to open the cupboard.

Records

- We reviewed one set of notes in the outpatient clinic. The record was thorough and contained the relevant information.
- Children's records included alerts to indicate if there was a safeguarding concern .Alerts also appeared in the mother's records and those of siblings if appropriate.

Consent

- Parents were involved in giving consent for examinations, as were children when they were at an age to have a level of understanding (according to Gillick Competence).

Services for children and young people

Safeguarding

- There was a named lead nurse, midwife and medical consultant for children's safeguarding. Staff were aware of who these people were.
- We observed a multidisciplinary child protection meeting that included staff from the hospital and social services. Comprehensive protocols were used to identify children when there were concerns, and for linking to other siblings in the family. Communication between paediatricians and social workers was direct and effective, and there was a positive focus on the child with child-centred questioning.
- Information and record packs had been developed by the trust and were available in children's areas. Staff were clear about the need to use these and where they were stored.

Mandatory training

- Statutory training covered fire safety, health and safety, and manual handling. Mandatory training covered infection control, information governance and safeguarding (which included dementia awareness training).
- Staff were clear about their responsibilities to complete the trust's statutory and mandatory training. The trust had a target to achieve 80% compliance with statutory and mandatory training; 84% of staff in the division had done statutory training and 98% had done mandatory training.
- There was safeguarding training at induction for all trust staff and more intensive training for staff who had direct contact with children. Records showed 100% of staff in children's services were up to date with safeguarding level 3 training.
- A new member of staff confirmed that mandatory training had been covered at their trust and nursing induction.

Assessing and responding to patient risks

- The paediatric early warning system (PEWS) was used to monitor children and ensure early detection of any deterioration. Care was given by consultants at all times and children considered to be high risk were transferred to a neighbouring trust for further care.
- Nursing and medical staff met daily to undertake a safety briefing to ensure that identifiable risks were recognised and managed (for example, children with the same name).
- Staff were aware of the need to transfer children to another facility if they required inpatient care. There was a clear escalation and transfer policy that staff were well informed about.
- Babies born needing higher levels of support were offered transitional care on Drayton Ward (in the maternity unit) or cared for in the SCBU. There was no upper limit placed on the number of babies requiring transitional support that could be accommodated on Drayton Ward but the numbers were monitored.
- Babies requiring intensive or high-dependency neonatal care were transferred to a neighbouring hospital via ambulance.

Nursing staffing

- The safe staffing dashboard was displayed in the children's assessment unit (CAU) in A&E and the SCBU. This showed details of the required levels of staffing and actual levels present on each shift. There was an escalation procedure to follow if required levels were not being met. Staffing levels were adequate and there was the required skill mix.
- Staff in these units were all part of the same rota and children were cared for by those with a recognised children's nursing qualification.
- There was an ongoing vacancy for a senior nurse for the SCBU; however, this had not had an impact on patient outcomes because a member of staff had been covering this role.

Medical staffing

- The children's unit was covered by a team of 11 consultant paediatricians, the equivalent of 10 full-time consultants. The unit was consultant-led with care delivered by consultants. There was consultant presence 24 hours a day to ensure cover of both the A&E and the SCBU.
- There were five vacancies at middle grade level and there had been a high use of locum staff. The trust was recruiting to these posts.
- There were seven junior doctors including two trainee GPs, three trust grade doctors and two quality improvement fellows.

Major incident awareness and training

- The trust had major incident and business continuity plans in place. Staff were aware of these.

Services for children and young people

Are services for children and young people effective?

Good

Children were treated according to national guidance. The services had an annual clinical audit programme to monitor that guidelines were being adhered to. Clinical outcomes were good. Children were cared for by a multidisciplinary team of skilled and dedicated staff. Consultant presence and support was provided over seven days to the SCBU.

Evidence-based care and treatment

- Children were treated according to national guidance including guidance from the National Institute of Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). Local policies and procedures used within the department were based on national guidelines and were up to date.
- Children's protocols were developed that were specific to the needs of children when trust-level documents were not appropriate. Nurses were using the paediatric diabetes national guidelines and the best practice tariff to improve on the variable practice of the past.
- The departments took part in all the national clinical audits that they were eligible for. There was a formal clinical audit programme where national guidance was audited and local priorities for audit were identified. Not all clinical audits had dates for completion but most audits were ongoing. We did not see examples of improvement following audit or if audit was regularly discussed at departmental meetings.
- Nursing staff did weekly audits on harm-free care.
- Audits were undertaken of ward environments under the '15 Steps Challenge'. This was designed by the National Institute for Innovation and Improvement toolkit to assess first impressions on entry to a ward or unit and to ensure the ward was safe, caring and involving, well-led and calm. Actions were identified for improvement. In June 2013 and January 2014, recommendations included an improvement in signage to give a warmer welcome into the day procedure unit. The unit's environment was being refurbished.

Pain relief

- We did not observe any children post-surgery during our visit. Staff told us that pain control included age-appropriate methods.

Patient outcomes

- The trust performed similar to other trusts for paediatric national audits that it was eligible for.
- The paediatric diabetes team was achieving good outcomes for children and young people by meeting the Paediatric Diabetes Best Practice Tariff Criteria for 90% of their patients.
- The trust neonatal readmission rate was significantly lower than expected between October 2012 and October 2013.

Competent staff

- A change had been made in the way the unit was staffed. The service had been changed to a consultant-led and managed unit, with specialist knowledge and expertise within the team.
- Nurses had completed advanced practitioner and advanced paediatric life support training.
- Staff told us that training was available and that they were encouraged to develop their skills.
- A new member of staff told us that they had been supported since joining the hospital. They had completed a trust-wide induction and nurses' induction. They had also been supernumerary on the ward for a couple of weeks, giving them an opportunity to understand its processes and procedures. They had had one review, and another one was scheduled for six months' time.

Multidisciplinary working

- There was good multidisciplinary working with physiotherapists, paediatric dietitians and the diabetes team. There was a team of specialist nurses to support children with diabetes.
- The trust was recruiting a specialist paediatric psychologist.
- There was support out of hours with GPs having access to consultant paediatricians for advice and support.
- There were strong external links with three local authorities and regular contact with safeguarding leads and social workers.

Services for children and young people

Seven-day services

- The hospital did not have a children's inpatient service. Outpatient clinics were held Monday to Saturday and day case surgical procedures took place during the week on a planned basis. Care was led by consultant staff.
- There was consultant presence 24 hours a day in the A&E department and the SCBU.

Are services for children and young people caring?

Good

Children and their parents or carers were treated with dignity, respect and compassion. Staff involved children and their parents or carers in decisions about their care and treatment, and they were supported and reassured if they were worried.

Compassionate care

- We observed compassionate care from nurses and doctors across children's services. They dealt with children and their parents sensitively and with compassion.
- Reception staff were pleasant and processed appointments quickly and efficiently.
- Patient experience survey cards indicated that 100% of patients felt that they were given the appropriate care and treatment, 93% were seen in less time than they had expected and 93% said that the care was good.

Patient understanding and involvement

- Children and their parents or carers were involved in decisions about their care and treatment. We observed a consultant paediatrician with a mother and her child. The paediatrician was reassuring, explained the process and offered the women information and choices. He set out a treatment plan. He spoke kindly to the child and checked that the mother was all right.
- The doctor took a thorough history and asked a number of pertinent questions. He adopted a non-judgemental tone. He was effective in gaining the cooperation of the child who had presented as challenging.
- Support from a play specialist was available to support children to understand their illness and any procedures. They worked across the A&E and the children's day procedural unit.

Emotional support

- Emotional support was offered to worried parents through one-to-one discussion with medical and nursing staff.
- Support from the chaplaincy was also available if required.
- Patients were advised of the availability of counselling services.

Are services for children and young people responsive?

Good

There had been a review of the children's services that had resulted in changes to ensure that they were safe and responsive to the needs of children and young people and their families, and clinically sustainable. The service was developing networks to ensure that care for children could be provided close to home. These included links to GPs, community nursing and children's outreach services. There was specialist support for children with diabetes and for allergy testing.

Service planning and delivery to meet the needs of local people

- In August 2013, changes to the service provided at the George Eliot Hospital were implemented after a review into the future of women's and children's services. Inpatient services were removed. A children's assessment unit (CAU) was introduced as part of the A&E department and opened seven days a week from 8am to 10pm. Outpatient clinics continued and expanded with the appointment of 11 paediatric consultants. After further review, a children's day procedure unit with six beds was opened to accommodate both ambulatory care and day case surgery.
- There was a paediatric consultant present 24 hours a day in the A&E department and the Special Care Baby Unit (SCBU).
- Children who visited the hospital who then required an inpatient bed would be transferred to a neighbouring trust. There was an agreement with the ambulance service for these transfers to take place.

Services for children and young people

- During the day, the consultants undertook specific duties to cover the SCBU, the children's day procedure unit or the CAU. At night there was one consultant, supported by a middle grade doctor, to cover the CAU and the SCBU.
- Babies born requiring higher levels of support were transferred to a neighbouring hospital via ambulance for more intensive or high-dependency neonatal care.

Access and flow

- The lead consultant paediatrician said that they were seeing 1,000 children a month in children's services. Staff from children's services were present at the daily 'Hug' meeting to manage access and flow with colleagues from maternity and the SCBU.
- The paediatricians were working with local community providers and GPs to ensure that children who received treatment on a day case basis were able to stay at home. For one young person, there had been a positive impact with the opening of the children's day procedure unit. They were able to attend the hospital to have their bolus intravenous antibiotics which had meant they were able to continue with their schooling rather than being an inpatient at another hospital.
- Staff were also working with other specialists to provide care and treatment closer to home (for example, those patients able to attend the unit for a short period of time for infusions).

Meeting people's individual needs

- All children coming into the service who were medically unwell saw a consultant paediatrician.
- There was a specialist service for children with diabetes, which was supported by specialist nurses for diabetes.
- The children's allergy testing services were being further developed as nurses completed the required training.
- There was a translation service available within the hospital and via a telephone support line.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained unresolved.
- Complaints leaflets were available at the entrance to the hospital and outside the wards.
- Complaints were collated and actions required followed up. For example, special information leaflets had been produced, clearer directions around the hospital had been provided and there had been a change in the choice of toys.

Are services for children and young people well-led?

Good

There was clear leadership with a clear vision for the service. Staff told us the services was well-led and there was a flat hierarchical structure. Staff were positive about the service and quality was seen as everyone's responsibility. Staff felt supported by their managers and were encouraged to be involved in discussing their ideas for improvements. The service had a learning culture and there were many examples of innovative practice. Risks were appropriately managed and governance systems were being developed to learn effectively from incidents, complaints and audit.

Vision and strategy for this service

- There was a clear vision, strategy and rationale for the new service model in children's services. This related to providing a sustainable service close to home in a safe and effective way.

Governance, risk management and quality measurement

- There was a governance lead, and governance and risk management were being developed within the new service.
- The risk register was up to date and there was one entry on the divisional risk register relating to children's services. This concerned level 3 safeguarding children's' training and action had been taken to address the risk. Over the year, the percentage of staff training had risen from 50% in April 2013 to 80% in February 2014; 100% of staff now had this training.

Leadership of service

- The service had adopted a 'distributive leadership' approach. There was a flatter clinical structure that had shortened and improved the chains of communication and made the leadership decisions clear and focused.

Services for children and young people

- There was a lead doctor for the service and a band 7 nurse. The nurse had oversight of the children's service supported by a team of sisters. The nurse leadership team was working well together as a cohesive group.

Culture within the service

- The current children's nursing team had been formed by a merger of staff from the two previous inpatient wards and A&E staff. The team was working well and flexibly together to ensure the children and young people's service continued to operate and develop.
- Staff were positive about the service they were providing and considered quality everyone's responsibility.

Public and staff engagement

- Parents had been involved in the consultation about the updates to the fabric of the SCBU. Work had started that included aspects of their feedback.
- Children and young people were being encouraged to give feedback on the service they had received and the outcomes were displayed along with the action required (for example, access to wifi).
- Staff told us of good engagement in the service. They had been kept informed of service changes. They were able to continue to work for the trust with slightly different working conditions because there was no longer any inpatient service.

Innovation, improvement and sustainability

- There was a culture of learning and improvement in the service. There were two improvement fellows working for the trust to develop the service strategy.
- We heard about innovative plans for the management of asthma in children and for the delivery of Intravenous antibiotics local to home. This would enable children with complex management plans to receive some care local to home, thereby enabling them to continue with a normal home routine.
- The service was developing by creating new links in the community and with GPs, with the aim of ensuring that the services provided would best meet the needs of the local population.

End of life care

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

Information about the service

The George Eliot Hospital provided end of life care services both on site and in partnership with primary care services and the third sector. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and supported by nurses in the ward areas and the specialist palliative care team. In 2013/14, 697 patients died in the hospital. On average, patients in the final year of life had 2.1 unplanned admissions with an average stay of 30 days. They represented one quarter of all inpatients.

We visited Bob Jakin Ward, Melly Ward, Mary Garth Ward, Felix Holt Ward, Nason Ward, Victoria and Elizabeth Wards, the bereavement centre, the mortuary and the chapel of rest. We spoke with 12 patients, six relatives and 18 members of staff, including nurses, doctors, ward clerks, mortuary technicians and staff in the bereavement centre. We also spoke with one member of the specialist palliative care team and the medical director. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

There were effective procedures to support patients to have safe and effective end of life care. Staff were caring and compassionate and treated patients with dignity and respect. They were committed to providing person-centred care and ensuring that patients had choices, a good experience and their preferences met at the end of life. Patients spoke positively about the way they were being supported with their care requirements.

Staff in all the ward areas we visited were aware of the guidance for patients receiving end of life care and all knew how to contact the specialist palliative care team. Not all patients were appropriately referred to the specialist palliative care team, but there were nurses called 'Transform Champions' in the ward areas who were responsible for ensuring that end of life care training was cascaded within the ward areas.

The Liverpool Care Pathway was still in use for patients but it was being used appropriately according to interim national guidelines. The hospital had planned to phase it out, as expected nationally after a national review. The specialist palliative care team was working to develop an end of life care pathway that would be rolled out in June 2014. This team provided outstanding leadership. It was a small team that was passionate and dedicated to their role.

End of life care

Are end of life care services safe?

Good

There were effective procedures to support safe care for patients. There was appropriate equipment, and medicines were provided in line with national guidelines. Patients were appropriately monitored and risks were escalated when appropriate. Patients told us they felt safe on the wards. An AMBER care bundle was used to help staff and patients and their relatives deal with uncertainty in what may be the final stages of life. 'Do not attempt cardio-pulmonary resuscitation' forms (DNA CPR) were appropriately completed for the decision, but completion needed to improve for the mental capacity assessments. Staffing levels in the service was adequate but business cases had been made to increase the number of medical and nursing staff to a more appropriate level.

Incidents

- There had not been a Never Event reported for end of life care between December 2012 and February 2014.
- Staff we spoke with all stated they knew how to report incidents but many had not received direct feedback relating to incidents reported.
- Staff reported incidents by either an electronic system or a paper system. They told us the trust had recognised that these systems were not effective and a new electronic system was to be introduced in the summer of 2014.

Safety thermometer

- We observed figures relating to the NHS Safety Thermometer in each of the ward areas we visited. This provided up-to-date information about the ward's current status relating to falls, catheter-acquired urinary tract infections, pressure ulcers and new venous thromboembolisms (VTEs). There was no NHS safety thermometer data directly related to end of life care.

Environment and equipment

- Each ward area had sufficient moving and handling equipment to enable patients to be safely cared for.
- Equipment was maintained and checked to ensure it continued to be safe to use.
- Syringe drivers and associated equipment were available in baskets so that staff could start subcutaneous infusions to help with symptom control in a timely manner.
- All patients were able to reach their call bell in order to attract the attention of a member of staff as necessary.

Medicines

- Staff told us patients who required end of life care medicines were written up for anticipatory medicines (medication that they may need to make them more comfortable).
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients who needed them. Anticipatory end of life care medication was appropriately prescribed.

Records

- The trust monitored the use of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) to ensure the decision was approved by a consultant within 72 hours of the patient admission. From January to March 2014, 141 forms were reviewed and 74% had been endorsed by a consultant. Staff told us the consultant team would be contacted after 72 hours to endorse the form.
- We looked at eight DNA CPR forms throughout the ward areas and all had been completed in line with national guidance published by the General Medical Council (GMC) in relation to the DNACPR decision. The forms indicated that the decision had been made and recorded by an appropriate clinician. One form, however, contained out-of-date information relating to an aspect of the patient's condition that had been successfully treated. The form had not been reviewed after the change in the patient's condition.
- On Mary Garth Ward, we looked at the records of a patient who had a grade 2 pressure ulcer. Although the patient was receiving appropriate care relating to the pressure ulcer, there was no care plan in place to tell staff how to provide care for this patient's pressure ulcer.
- One patient had difficulty swallowing and we saw that they person required their fluids to be thickened. The ward sister told us that they had been assessed by a speech and language therapist (SALT) but there was no record of the assessment or a care plan. There was no

information to tell staff how to provide appropriate care for the patient's swallowing difficulty. A member of staff immediately contacted the SALT team in order to ensure a written assessment was provided.
- In all the ward areas we saw that records were stored securely so that they could not be accessed by people who did not have the authority to do so.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment was obtained appropriately from patients who had the capacity to give consent.
- The staff we spoke with told us that they had received training in relation to consent, the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The hospital safeguarding lead had introduced a caring for vulnerable adults programme. This covered defending dignity, person-centred care, understanding dementia and falls prevention. It also covered safeguarding, the Mental Capacity Act and Deprivation of Liberty Safeguards.
- We looked at eight DNA CPR forms throughout the ward areas and found that four had not been completed in line with national guidance published by the GMC. Two forms had missing information in relation to an advance directive or a welfare attorney. Two forms on one ward had no capacity assessment, or the person was noted as having no capacity at that time. However, there was no follow-up to this assessment by the medical staff and the person had been assessed by the mental health team as having capacity after the completion date. The DNA CPR form had not been reviewed to reflect the change in the situation, and two did not have appropriate mental capacity assessments

Safeguarding

- Staff told us that safeguarding training was mandatory and all the staff we spoke with had undertaken it. Training figures demonstrated that 97% of staff were up to date with their safeguarding adults training as of February 2014.
- Staff were able to explain what constituted a safeguarding concern and the steps required to report such concerns.
- Staff also knew about the whistleblowing policy and how to report concerns if they had them.
- Patients told us they felt safe being cared for within the hospital.

Mandatory training

- Staff told us that they felt supported to complete mandatory training. Information from the trust indicated that as of February 2014 88% of staff were up to date with their mandatory training.
- The lead nurse for end of life care told us that, although this was not a national expectation, they were in the process of making end of life care a part of mandatory training within the hospital.
- All new staff were given an induction period in which to undertake mandatory training. A new member of staff confirmed that they had undertaken a period of induction on starting at the hospital.
- The practice development nurse in end of life care had delivered training to clinical inductees, first and final year student nurses, junior doctors, senior nurses, consultants and transform champions.

Assessing and responding to patient risks

- The modified early warning system tool was being used to identify when patients were deteriorating.
- We saw evidence of the effective use of this tool on one of the wards where a patient was scoring more highly than normal. Medical staff were alerted and the patient was given treatment in order to stabilise their condition. We returned to review the patient on the second day of our inspection and found that they were stable and the early warning score was much lower than on the previous day.

Nursing staffing

- The hospital specialist palliative care team included a Macmillan clinical nurse specialist employed in March 2014 and a practice development nurse. The practice development nurse supported ward staff who were delivering end of life care and was also responsible for rolling out the transform programme that aimed to further develop the end of life care and support available in the trust.
- The team had developed a business case to employ another Macmillan nurse to support staff in the A&E department and the acute medical unit (AMU). The aims of this post were multiple, but included rapid identification of people requiring end of life care, reduced length of stay and improved ability to meet patients' preferred place of care.
- There was a nurse called a 'transform champion' in each of the ward areas. These were band 6 nurses who had received additional training in end of life care and were

responsible for cascading training throughout the ward areas. These transform champions were also responsible for reviewing patients receiving end of life care.

- The specialist palliative care team had been successful in achieving a Health Education England bid, which they would be using to employ a part-time band 6 nurse for 12 months to support the roll-out of the AMBER care bundle. The AMBER care bundle is a simple approach used in hospitals when doctors were uncertain whether a patient may recover or be in the final stages of life (months or days) and supports advanced care planning. Trained team members act as champions to drive high-quality care at these times. They encourage staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die.
- We observed a lunchtime handover on Nason Ward. This took place as a walk round handover so that staff could establish which patient was being referred to. Handover was concise, and the information exchanged was relevant and covered all relevant aspects of the patient's care. All patients were referred to with dignity and respect and appropriate further actions were communicated appropriately.
- Ideal and actual staffing numbers were displayed in the ward areas. When end of life care patients required one-to-one support, extra staff were brought in to care for patients.

Medical staffing

- The end of life care team had a 0.8 whole time equivalent consultant in palliative medicine employed. A business case was being developed for additional support from a trust grade doctor but no progress had been noted by the team.
- Specialist telephone advice was available from the consultant on call for palliative medicine via Warwick Myton Hospice.

Major incident awareness and training

- The mortuary technicians told us they had a contingency plan in the event that the mortuary became full. The senior technician had an agreement with a local undertaker, and was aware of the circumstances under which they should use this plan.

Are end of life care services effective?

Good

Patients were treated according to national guidance. The Liverpool Care Pathway was still in use but was being used appropriately according to interim national guidelines. The hospital had plans to phase it out as expected in July 2014. Patients had effective pain relief and appropriate nutrition and hydration. Staff in all the ward areas we visited were aware of the guidance to use for patients receiving end of life care, and all staff were aware of how to contact the specialist palliative care team. There were nurses called 'transform champions' in the ward areas who were responsible for ensuring standards for end of life care training were cascaded within the ward areas. Patients had access to seven-day services with out-of-hours and weekend support provided by Warwick Myton Hospice.

Evidence-based care and treatment

- The specialist palliative care team told us that care was based on the National Institute for Health and Care Excellence (NICE) quality standard 13. This quality standard defines clinical best practice in end of life care for adults.
- The trust had local guidelines and policies in place that were up to date and based on the NICE guidance. A number of initiatives had been rolled out throughout the trust to support the NICE guidance. For example, the AMBER care bundle was being rolled out to support the identification of patients with an uncertain recovery.
- The specialist palliative care team were drafting individual end of life care plans based on national guidance and these were being rolled out to ward areas by 1 June 2014.
- The specialist palliative care team prepared six-monthly updates for the end of life care strategy group and had audited and benchmarked where they were against the 16 quality statements for end of life care published by NICE. The team had made good progress, but also acknowledged where further progress needed to be made.
- The hospital was registered with the End of Life Care Quality Assessment Tool (ELQuA), which was recognised as a national tool to align its current progress with other trusts in England and to benchmark against national outcome measures.

End of life care

- The trust took part in the National Care of the Dying Audit for hospitals. Ward staff who were transform champions undertook local audits using the transform tools.
- The specialist end of life care team had put in a bid to roll out the gold standards framework. This was a systematic, evidence-based approach to optimising care for all patients approaching the end of life, delivered by generalist care providers.

Pain relief

- Patients in the ward areas told us that pain relief was given as needed. We did not observe patients to be in pain during our inspection.
- The specialist palliative care team had drawn up prescribing guidance to ensure that anticipatory prescribing took place and pain relief was administered to patients in a timely manner.
- Medical and nursing staff contacted the specialist palliative care team for advice about appropriate pain relief if required.

Nutrition and hydration

- We observed that all patients had access to drinks that were within their reach, and patients and their relatives on one ward told us the food was "very good". Patients told us they got enough to eat.
- Staff told us that snacks were available for patients throughout the day and night.
- We observed one person who was receiving nutrition, fluids and medicines via a percutaneous endoscopic gastrostomy (PEG) tube because they had lost the ability to swallow. There was a clear plan in place to ensure that this person received regular oral care.
- Patients' fluid and nutrition were accurately assessed and recorded as necessary and in circumstances that were appropriate for the patient. The ward areas maintained fluid balance charts, and these were accurately totalled. This meant they could be used to make clinical decisions when required.
- Patients were screened using the Malnutrition Universal Screening Tool (MUST) and those who were nutritionally at risk were identified by a 'cupcake' above their bed.
- Patient's relatives on Bob Jakin Ward were encouraged to come in at meal times if a patient required help to eat their meal.

Patient outcomes

- The George Eliot Hospital had undertaken the National Care of the Dying Audit. The results were not available at the time of our inspection.
- The trust did not currently use the electronic palliative care coordination system (epaccs) but were taking a regional approach to developing and rolling out a template suitable for Coventry and Warwickshire later this year. This should improve outcomes for patients because information about them would be held on a locality register and would support instant access to crucial information about people approaching the end of life.
- The specialist end of life care team were auditing their strategy for end of life care against the NICE guidance to ensure that all patients at the end of their lives and their relatives received high-quality and effective care

Competent staff

- The practice development nurse in end of life care had delivered training to clinical inductees, first and final year student nurses, junior doctors, senior nurses, consultants and transform champions.
- The practice development nurse told us that training in end of life care was being rolled out to junior and senior doctors throughout the trust.
- The specialist palliative care team told us that senior sisters from nine clinical areas had attended Quality End of Life Care for All (QELCA) training in conjunction with Warwick Myton Hospice. These nurses were known as 'transform champions' and were responsible for cascading training within their areas. The practice development nurse for end of life care told us that further training for more staff was due to take place throughout 2014.
- The AMBER care bundle has been introduced with detailed training and support provided to clinical staff.
- Staff told us that they received annual appraisals and that they had regular supervisions within their ward areas. Nursing staff on the wards displayed good knowledge about the needs of patients who required end of life care.

Multidisciplinary working

- In addition to leading on strategic development, the practice development nurse for end of life care also provided clinical care to patients who were at the end of

End of life care

life on the wards. At the same time, this nurse supporting and empowered staff, patients and carers, and promoted the use of recommended best practice tools.

- The specialist palliative care team worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre. All the staff told us they knew they could get support from the specialist palliative care team if required.
- Staff reported that there was an effective multidisciplinary team-working and decision-making approach to end of life care.
- Specialist support was available from the specialist palliative care team when required and out of hours specialist advice could be sought from the consultant at the Warwick Myton Hospice.
- The George Eliot Hospital was part of a regional steering group to address the needs of care planning at the end of life following the Department of Health guidance to completely withdraw the Liverpool Care Pathway by 14 July 2014.

Seven-day services

- The specialist palliative care team was available Monday to Friday from 9am to 5pm.
- Support out of hours and at the weekend was available from an on-call palliative care consultant at Warwick Myton Hospice. Ward staff confirmed that this service was easily accessible and available.
- The chaplaincy service provided pastoral and spiritual support and provided out-of-hours cover. One chaplain worked 9am to 5pm on Sundays.

Are end of life care services caring?

Good

Patients received attentive and compassionate care that was sensitive to their needs. Patients and their relatives or carers were involved in their care and had a high level of emotional support from trained staff. Patients were extremely positive about the care they received.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- The patients we spoke with were extremely positive about the way they were being supported with their care requirements. Comments included, “We’re very well cared for”, “It’s different from last year, it’s changed. They treat me well”, “The food’s very good. I always get my medicines on time”, “They look after me; they treat me with dignity and respect. Couldn’t do better.”
- We visited the mortuary and spoke with the mortuary technicians. Staff in the mortuary demonstrated compassion and respect while preserving the dignity and privacy of patients after death.

Patient understanding and involvement

- Patients we spoke with told us that they felt involved in their care.
- We observed that doctors and nurses spoke to patients about their care so that they could understand and be involved in decisions being made.
- When patients had been assessed as not having capacity to make decisions, care options had been discussed with their next of kin.
- On Nason Ward we saw that, when a patient’s condition had deteriorated, staff included their family in conversations relating to whether it was appropriate to place the patient on the Liverpool Care Pathway and whether to contact the specialist palliative care team.

Emotional support

- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their visitors.
- We observed instances within the ward areas when emotional support was given to patients and their extended families. For example, when a patient on one of the wards had deteriorated, we observed medical and nursing staff communicating with and offering support to the person’s family. Privacy and dignity for the patient were maintained and opportunities were taken to further inform the patient and their family of the situation.
- The hospital had a bereavement counselling service for family members of patients who had died in the hospital. Staff at the bereavement centre told us that

people could be referred to the centre or they could refer themselves. The bereavement centre was run by counsellors who were registered with the British Association of Counselling and Psychotherapy (BACP).
- Staff in the mortuary offered emotional support to families as they came to visit their loved ones in the chapel of rest.
- Chaplaincy staff were visible within the hospital and staff within the ward areas told us they could access religious representations from all denominations.
- The specialist palliative care team told us that there were plans to roll out 'Sage and Thyme', which was a model designed to train all grades of staff in how to listen and respond to patients or carers who were distressed or concerned.

Are end of life care services responsive?

Good

The specialist palliative care team was working hard to ensure every person receiving end of life care had a positive experience. A partnership had been formed with Warwick Myton Hospice to ensure support was available 24 hours a day. Not all patients were appropriately referred to the specialist palliative care team but there were ward staff who were trained to cascade end of life standards of care. There was specific support for people with learning disabilities or dementia, and for those from different cultural, religious and spiritual backgrounds. A pathway had been developed to support patients to be cared for and to die in their preferred place and the hospital was only slightly below the national average in support of patients' preferences. Lessons were learned from complaints and concerns to improve the service.

Service planning and delivery to meet the needs of local people

- The specialist palliative care service had formed a partnership with Warwick Myton Hospice to ensure support was available 24 hours a day.
- Patients who required end of life care were referred to the specialist palliative care team, although not all patients were appropriately referred. Throughout our inspection, staff on all the wards we inspected told us that they did not have patients who were in receipt of end of life care. We did, however, speak with patients in the ward areas.
- Transform champions had been trained to cascade training within the ward areas where patients and their families who required end of life care were supported.
- Recognised end of life care tools had been rolled out within the ward areas to facilitate coordinated care that gave the patient choice.

Access and flow

- The specialist palliative care team were looking to expand in order to better support staff and patients in A&E and the AMU.
- Multidisciplinary team board rounds were undertaken on each of the ward areas every morning when plans relating to appropriate discharge were discussed.
- The specialist palliative care team had introduced the Realising Individual Patient Preferences at Life's End (RIPPLE) pathway. This was used to facilitate a multidisciplinary approach to timely discharge when patients were identified as being in the final hours, days or weeks of life. The pathway enabled patients to be cared for and to die in their preferred place.
- The number of patients who died in their preferred place in the past year was slightly lower than the national average (24%) at 22%. Sixty per cent of these patients died in hospital, 30% died in their own home and 10% died in a hospice setting.

Meeting people's individual needs

- Support was available for people with dementia. The 'This is me booklet' was being used to identify and respond to the needs of people living with dementia and staff had undertaken a dementia awareness course. There was a dementia nurse specialist in the hospital.
- Support was available for patients with a learning disability. Staff told us there was a nurse qualified in the care of people with a learning disability within the hospital whom they could contact if support was needed.
- We did not see any patients who did not speak English, but staff told us that translation services were available within the hospital.
- The trust used a guide prepared by the Warwickshire Race Equality Partnership to assist staff to understand different cultural, religious and spiritual diversities,

including appropriate dress and etiquette, and how to conduct arrangements (for example, how to certify and register a death, and whom to contact concerning the funeral, a burial or a cremation.

- The mortuary technicians told us that they had close links with representatives from the local mosque who would provide them with any updates required to ensure they were fully aware of any developments within the Muslim community.
- The trust was unable to provide a figure for the number of deaths occurring at the hospital in 2013 that were in receipt of end of life care. However, the end of life care nurse did provide details of deaths of patients who had been in receipt of specialist palliative care. In this time period there were 484 deaths, and 128 of the patients had been cared for using the interim guidance for the Liverpool Care Pathway.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy.
- Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- We spoke with the specialist palliative care team in relation to complaints they had received. They were aware that the complaints stemmed around poor communication at the end of life and were putting measures in place to ensure that communication at the end of life was made a priority. Staff in the bereavement centre told us that a doctor would come back to talk with relatives after the death of their loved one. The staff we spoke with all highlighted communication as of vital importance in end of life care.
- The medical director told us there was a meeting for doctors every Wednesday which the practice development nurse for end of life care attended to present case reviews. This was found to be a useful way of communicating and learning from complaints and concerns.

Are end of life care services well-led?

Outstanding ☆

The end of life care services were well-led. The specialist palliative care team were a small, passionate and dedicated team. There was a clear strategy and vision to develop end of life care services and ensure patients and their families or carers had a good experience of care and choices at the end of life. Staff in the ward areas shared the visions and values that the specialist palliative care team were working to promote. Services were being developed in line with national guidance and there was participation in national quality assessment to measure outcomes.

Risks were appropriately managed and there was shared learning from incidents, complaints, audit and patient experience. Patients and the public were effectively engaged to provide feedback to improve services and to be part of the hospital's steering group for end of life care. There was a strong improvement culture within the service and many examples of innovation.

Vision and strategy for this service

- The team had a clear strategy and vision for end of life care and had taken ownership of delivering the strategy throughout the trust. They had taken steps to provide baseline and ongoing data to the National Transform Team and had registered with the End of Life care Quality Assessment Tool (ELCQuA) in order to ensure they could track their success in achieving their outcomes.
- The hospital had published its end of life care strategy for 2013–2015, which set out its strategic objectives to empower, develop and support its staff; encourage positive leadership at every level; enhance patient experience by providing local care tailored to the individual needs of patients; and develop partnership arrangements to promote and deliver integrated services.
- The specialist palliative care team had rolled out a strategy for end of life care across the hospital. The practice development nurse for end of life care told us that patients should expect to receive a good end of life care experience and support that offered them choice.
- The vision for end of life care was visible within the ward areas. The ward transform champions were keen to talk about their role and how they felt about supporting people at the end of their life. They were keen to share their experiences and how they were going to put their learning into practice.

Governance, risk management and quality measurement

- There was a steering group to develop the end of life care strategy across the trust. There were action plans to develop and improve the service across the hospital.

End of life care

- The specialist palliative care team had governance meetings and there was evidence that complaints, incidents, standards, audit and patient experience were reviewed. Action plans were drawn up for incidents and complaints and these would be reviewed by the medical director.
- There were no risks identified on the division risk register for end of life care.

Leadership of service

- There was strong leadership within the team responsible for end of life care. They were very clear about the vision and strategy for end of life care within the trust. The strategy involved the input of local key stakeholders. They were committed to supporting staff in the ward areas to ensure patients received a good end of life experience.
- All the specialist end of life care team were passionate about facilitating staff within the ward areas to ensure patients and their families received a good end of life care experience.
- All the staff we spoke with knew who the leads were for end of life care. Staff spoke highly of the practice development nurse for end of life care and felt she was supportive and visible in the ward areas.

Culture within the service

- Staff we spoke with thought highly of the hospital specialist palliative care team. They spoke positively about the service they provided and likened the hospital to a family community.
- Staff reported positive working relationships with the team.
- Staff on the wards were positive about the service they wanted to provide for patients requiring end of life care. They expressed how they wanted to do their best for patients.

Public and staff engagement

- The end of life care steering group outlined that patient representation would form part of the strategy group and they would ensure that complaints, compliments and incidents around end of life care were fed back throughout the organisation. This was being developed.
- A bereavement survey had been developed to give ongoing feedback on the experience of patients and carers to help ensure good care was identified and areas where improvements could be made were acted on.
- Staff were positive about the visibility of the leadership board and the chief executive officer was accessible and approachable. Staff told us they could approach the chief executive officer and felt they would be listened to.
- The staff we spoke with knew who the lead nurse for end of life care was. They felt that this lead nurse was visible in the ward areas.

Innovation, improvement and sustainability

- The specialist palliative care team was using national guidance and tools to improve the service.
- The team had plans to phase out the Liverpool Care Pathway as expected nationally. The specialist palliative care team was working to develop an end of life care pathway that was to be rolled out in June 2014.
- The end of life care team had rolled out the AMBER care bundle which was designed to enable treatment to occur alongside palliative care.
- The specialist palliative care team had introduced the Realising Individual Patient Preferences at Life's End (RIPPLE) pathway to facilitate a multidisciplinary approach to timely discharge when patients were identified as being in the final hours, days or weeks of life. The pathway enabled patients to be cared for and to die in their preferred place
- The end of life care team had put in a bid to roll out the gold standards framework within the local community and was committed to ensuring that patients could access end of life care in the community.
- Business cases were developed to improve staff levels that were needed to sustain the service. Extra medical and nursing staff were needed to continue to provide the service levels identified.

Outpatients

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

Information about the service

The George Eliot Hospital outpatient department included general outpatient clinics and a range of specialist clinics covering plastic surgery, urology, cardiology, ophthalmology and orthopaedics. Clinics were held from Monday to Friday but some clinics also ran on a Saturday or a Sunday to facilitate extra capacity. The outpatient department had a dedicated chemotherapy unit known at the Dorothea Unit.

We inspected the ophthalmology, orthopaedics areas, Endoscopy, the chemotherapy day unit as well as the radiology department. Throughout our inspection we spoke with 32 patients, 19 relatives and 15 members of staff including nurses, healthcare assistants, receptionists, the business manager and medical staff. We observed interactions between patients and staff, considered the environment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

There were effective procedures to support a safe service for patients. Staff were caring and treated patients with dignity and respect. Most patients were seen within national waiting times, although there were delays in orthopaedics and neurosurgery. Patients told us they were happy with the care they had received while attending their appointments within the outpatient department.

Most of the patients we spoke with felt they were seen promptly and were kept informed if clinics were running late. Each clinic had a board that displayed the length of time patients might expect to wait to be seen. The radiology department, however, was overcrowded and people were waiting a long time for x-rays. The service was part of a 'transform' programme to improve efficiency (for example, to reduce 'did not attend' rates and become more responsive). The leadership of the service was good except in radiology where the lack of strong leadership was having an impact on staff and the running of clinics.

Outpatients

Are outpatients services safe?

Good

Medicines and prescription pads were securely stored. The outpatient areas we visited were clean and equipment was well maintained. Staff vacancies were being managed appropriately although there were problems in the radiology department and this caused clinic delays. Patients were appropriately asked for consented to procedures. Staff reported and learned from incidents. There was an identified risk that patients could be seen in clinics without records but staff told us that this had improved.

Incidents

- There had been one Never Event in outpatients between December 2012 and February 2014. This was in dermatology when a patient had the wrong mole removed. The trust had investigated this incident and action was taken to prevent reoccurrences. The use of the 'Five steps to safer surgery' (which includes the World Health Organization checklist) was in place in all areas performing minor procedures outside of the operating department since January 2014.
- The staff we spoke with told us they knew how to report incidents and that incidents were taken seriously.
- Incidents were reported via the trust's electronic reporting system and staff told us actions were taken to prevent reoccurrence.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean throughout the outpatient department.
- Equipment within the radiology department was cleaned between patients.
- There were adequate hand-washing facilities and soap dispensers, hand hygiene gel and paper towels for staff and the public to use.
- Staff followed the hospital's infection control policy. We observed staff regularly washing their hands and using personal protective equipment, such as gloves and aprons, when required. Staff adhered to the trust's 'bare below the elbows' policy.
- We saw that the infection control policy was strictly adhered to in the Dorothea Unit where patients had a low white cell count and were more susceptible to picking up infections. Staff used correct procedures where an aseptic technique was required.
- Weekly audits for hand hygiene were carried out and these audits indicated that staff were 100% compliant with hand hygiene.

Environment and equipment

- The environment in outpatients was safe and fit for purpose.
- There was generally enough seating, although we observed that throughout busy periods there was not always enough seating within the radiology and oncology departments. In addition, we saw that most of the seating available was unsuitable for some patients with limited mobility because it was arranged in rows.
- Equipment in the department was regularly serviced, tested if electrical, and appropriately cleaned. There was adequate equipment available in all areas of the outpatient department.
- Resuscitation equipment was located in the department and regularly checked. The equipment was safe and ready to use in the event of an emergency.

Medicines

- Medicines and prescription pads were securely stored and appropriately managed.
- Medicines within the radiology department were stored correctly and according to the manufacturer's instructions. Fridge temperatures were checked daily and a new fridge had been installed because the temperatures of the old one had been reading higher than they should be.
- Controlled drugs were kept appropriately in a locked cupboard but some medicines had passed their expiry date of December 2013. Staff were aware of this and explained that it was difficult to get pharmacy to come to the department to dispose of the medication. Staff were aware that this could increase the risk of patients receiving medication that was out of date.
- Midazolam was stored within the controlled drugs cupboard. The amount of midazolam recorded in the controlled drugs register did not correlate with the amount recorded in the controlled drugs book. The drug did not need to be recorded in the register according to trust policy, but the staff had done this and the discrepancy could not be explained.

Outpatients

- Chemotherapy administered to patients in the Dorothea Unit was done safely and in a timely manner.

Records

- The absence of records for outpatient clinics was identified as a corporate risk in June 2011. Actions had been taken to improve staff use of record tracking systems. There was evidence of improvement and the percentage of missing notes for patients attending clinic was less than 0.02%.
- Staff we spoke with told us that patients' records were available for their clinic appointments.
- Records were stored appropriately to maintain confidentiality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for consent to procedures appropriately. Staff gave patients the information they needed to make informed decisions about treatment, explained diagnostic tests and asked for the patient's consent before any examination, procedure or treatment took place.
- Patients told us they were asked for their consent before any procedures were undertaken.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005 and were able to tell us what they would do if a person did not have the capacity to consent to their treatment or procedure.

Safeguarding

- All the staff we spoke with were clear about their responsibilities to safeguard patients and to report any concerns including reporting to an external agency if required.
- Nursing and administrative staff undertook both adult and children's safeguarding training and had also undertaken conflict resolution training. Training figures demonstrated that 79% of all staff had had safeguarding (level 2) training.
- The staff we spoke with understood what whistleblowing meant if they felt they needed to raise a concern.
- The patients we spoke with told us they felt safe while attending outpatient appointments.

Mandatory training

- Staff working in the outpatient department told us they had access to mandatory training and some staff received additional training when it was pertinent to their role.
- The trust report for statutory and mandatory training indicated that 93% of staff in elective care had completed their mandatory training.

Assessing and responding to patient risks

- All staff in outpatients were trained in basic life support. Staff were able to undertake observations of vital signs and these would be recorded and documented in patients' notes. The doctor would be informed and, if necessary, the patient would be taken to A&E.
- We observed a patient whose condition was deteriorating because of a low blood sugar level. This was dealt with appropriately.

Nursing staffing

- Staff in the general outpatients department told us they had been struggling with staffing levels and had recently employed three healthcare assistants, which equated to 90 hours of further support.
- We observed that there were nurses in each clinic and enough staff to meet the needs of the clinics within the general outpatient areas. A student nurse in the department told us they felt they were able to meet their training and development objectives in the outpatient department, which could be affected by staff shortages.
- Staff within the radiology department told us they were short of staff and appointment times were running late in the radiology.
- The staffing rotas in Endoscopy demonstrated good staffing levels with a low number of agency staff being used.

Medical staffing

- Outpatient clinics were appropriately staffed by the named clinician for each clinic.
- The radiology department had a vacancy for a consultant radiologist. The trust was trying to recruit for this vacancy.

Major incident awareness and training

- The trust had a major incident policy so that staff knew how to respond in the event of a major incident.

Outpatients

- There was an action card that detailed the responsibilities of the outpatients manager should they receive a major incident standby message.

Are outpatients services effective?

Not sufficient evidence to rate

We report on effectiveness for outpatients below. However, we are not currently confident that overall CQC is able to collect enough evidence to give a rating for effectiveness in the outpatient department.

Evidence-based care and treatment

- Staff told us they worked in line with the National Institute for Health and Care Excellence (NICE) guidance. This was particularly evident in the ophthalmology department where pathways had been redesigned at sub-specialist level for the diagnosis and treatment of patients with glaucoma.
- Staff told us they worked to local policies that were reviewed regularly.

Patient outcomes

- New to follow-up patient ratios were benchmarked nationally and indicated whether patients were being effectively managed and if outpatient appointments were being used efficiently to reduce repeated attendance. The trust identified that the new to follow-up patient ratio for some outpatient clinics did not meet effectiveness or efficiency targets required under cost improvement programmes.
- There were care pathways used in ophthalmology and dermatology.

Competent staff

- Staff told us they received annual appraisals so they were aware of their overall performance and any areas for further development.
- Staff told us they received additional training to develop specialist skills (for example, in the Dorothea Unit, nursing staff had undertaken training to ensure they could safely administer chemotherapy medication to patients).
- Endoscopy staff received specific training related to endoscopy and they were rotated within the unit to the procedure room, recovery area and decontamination rooms to maintain their competency levels.

Multidisciplinary working

- Multidisciplinary team working was evident in the outpatient department. Throughout our visit we saw that specialists such as physiotherapists, occupational therapists, dietitians, medical staff and nurses worked in collaboration. For example, there was physiotherapy input into the orthopaedic clinics and dietitians supported the diabetes clinics.
- A multidisciplinary approach was taken in the ophthalmology clinic where nurses, doctors and optometrists worked in collaboration.
- The ophthalmology clinic was a good example of a one-stop clinic within the outpatient department. This enabled patients to attend for one appointment and have tests and consultation at the same time.

Equipment and facilities

- There was a dedicated waiting area for children in the outpatient department.

Seven-day services

- Outpatient clinics were run Monday to Friday but some clinics also ran on a Saturday or Sunday to facilitate extra capacity.

Are outpatients services caring?

Good

Patients received compassionate care and were treated with dignity and respect. Patients told us that staff were kind and supportive, and they felt fully involved in making decisions about their care.

Compassionate care

- We observed staff talking to patients in a respectful polite manner while ensuring they were kept informed about any delays to clinics.
- Consultations took place in private rooms and chaperones were available if patients required them.
- Patients were very positive and spoke highly to us about the medical staff and the nurses they saw in outpatients. One patient, for example, told us that “the staff are polite and helpful”. Another person said, “The staff are approachable, I’m very happy with the service.”
- Family members or carers were enabled to support patients throughout their outpatient appointments.

Outpatients

- Throughout our inspection we saw gender-specific changing and waiting areas to ensure patients' privacy and dignity were maintained. However, we noticed that in the radiology department male patients had to walk past the female waiting area in order to get to access to radiology facilities. There was a notice in the changing areas to advise patients to use two gowns, one to be worn normally and one to be worn back to front in order to preserve their dignity. However, one male patient walked past the female waiting area with his back and underwear exposed. This was seen by two female patients and a child. This meant that people's dignity and privacy was not always protected.
- Curtains were used within consulting rooms to screen patients and preserve their dignity. Patients and their families told us they felt they were treated with dignity and respect.
- Patients were offered drinks while they waited for their appointment. Staff told us that if transport was delayed they could get patients sandwiches from the kitchen.
- Patients told us they were happy with the care they received while attending their appointments within the outpatient department.

Patient understanding and involvement

- We observed staff explaining procedures to patients to help them to understand and be involved in decisions concerning their treatment.
- Patients told us they were given appropriate information in a way they could understand and this helped them to be able to make decisions.
- We observed there was written information for patients to take away with them.

Emotional support

- The outpatient department had a private quiet room for patients who may have received difficult news and staff told us how they supported people in those circumstances.
- The staff we spoke with were all aware of the potential for people to require emotional support while attending the outpatient department.
- Patients spoke positively about the support they received from the staff in outpatients.
- Patients in the orthopaedic outpatient department told us that the lower limb consultant was "fantastic".

Are outpatients services responsive?

Good

The outpatient service was responsive to people's individual needs and the hospital was developing a transformation programme to improve the service further. Action to reduce did not attend (DNA) rates was currently being trialled.

Overall, patient were seen within national waiting times although there were longer waits for orthopaedics and neurosurgery. Delays in clinics were explained to patient. Some clinics were cancelled at short notice but this was lower than national levels. There was support for people with a learning disability or dementia. Translation services were available for people who did not speak English and all the staff we asked about this were able to tell us how to access these services. Complaints were handled appropriately and action was taken to improve the service.

Service planning and delivery to meet the needs of local people

- The service manager told us the trust was looking at re-launching the elective care transformation programme. The programme was reviewing the service as a whole from bookings, appointments, cancellations and clinical models of care.
- They were trialling partial bookings for follow-up appointments and felt this practice was effective enough to be incorporated into the re-launch. Partial bookings were when appointments were booked and seven days before the patient's appointment was due a reminder was sent stating the date and time of the appointment and asking the patient to text back if they could not make the appointment.

Access and flow

- The number of new and follow-up outpatient attendances were lower than the national average.
- The trust sent a text reminder to patients seven days before their appointment was due. The overall percentage of new patients who did not attend (DNA) outpatient clinics in 2013 was 7%, which was lower than the national average of 8.5%.
- The trust was achieving the 18-week referral to treatment times for outpatient appointments except for trauma, orthopaedics and neurosurgery. There were

detailed action plans for these specialties. The trust was achieving the two-week waiting time for patients to be seen with suspected cancer. Diagnostic waiting times were within the expected six-week waiting time.

- Consultants would decide and prioritise if a further appointment was necessary for patients who did not attend (DNA) their appointments. When a DNA involved a child, the trust's policy stated that their case notes must be reviewed by a consultant to consider whether there were any safeguarding issues.
- Delays in clinics and waiting times were displayed within the clinic departments and patients requiring ambulance transport were given priority in clinics. Staff told us they supported patients through busy times by ensuring they communicated any problems.
- The service manager told us that delays most often occurred in the orthopaedic, elective and fracture clinics and this was often because patients had to attend the x-ray department before going into their clinic appointment.
- The endoscopy unit was handling a recent increase in the number of referrals by prioritising referrals using referral criteria. These included prioritising cancer patients to ensure that urgent referrals were seen within two weeks.
- Most of the patients we spoke with felt they were seen promptly and kept well informed if clinics were running late. Each clinic had a board that displayed the length of time patients might expect to wait to be seen.
- The number of appointments cancelled by the hospital was below the national average. Of the clinics that were cancelled, about one quarter were being cancelled at short notice (that is, within six weeks). Approximately a third of these were because staff had not notified annual leave appropriately.
- There were one-stop ophthalmology clinics. This enabled patients to attend for one appointment and have screening, tests and consultation at the same time.
- Staff in the chemotherapy outpatients told us that the capacity to administer chemotherapy had increased by 17% since last year.
- Letters were sent to the patient and their GP within one week of their outpatient clinic attendance. Extra clinics held in neurosurgery had meant that clinic letters were delayed by three weeks.

Meeting people's individual needs

- The hospital had a specialist nurse who could be accessed for patients who had learning disabilities.
- The hospital had a dementia specialist nurse who could be accessed for patients who had dementia. Nursing staff and administration staff had attended mandatory training relating to the care of people living with dementia to help them meet the needs of people with dementia.
- Patients gave us positive feedback about how doctors and other staff in the department and the clinics met their individual needs. For example, we spoke with the family of a patient who had a learning disability. They told us they were pleased with the care they had received.
- Staff could access translation services for individual patients if this was required. Language Line could be accessed via the Patient Advice and Liaison Service office.
- Wheelchairs were available in the hospital if these were required.
- There was equipment in place to meet the needs of bariatric patients.
- Hearing loops could be accessed via the Patient Advice and Liaison Service for people who had a hearing impairment, and a small percentage of staff had undertaken sign language training.
- There was written information in English but other languages could be obtained through the Patient Advice and Liaison Service.
- There was a variety of comprehensive leaflets that were given to patients undergoing endoscopy explaining the procedure and the required preparation. The patients we spoke with found this information useful and felt that they were well prepared for the procedure and knew what to expect.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints would be dealt with by the senior sister in charge of outpatients.
- Complaints and concerns were clearly documented and a risk-based approach had been taken to assessing them. The records also detailed the actions that had been taken to rectify the complaint or concern. We could see that, where necessary, the issues were communicated to staff in order that lessons could be learned or further training could be given.

Outpatients

Are outpatients services well-led?

Good

The outpatient service had a strategy to review and transform elective care with the aim of improving the efficiency and responsiveness of services and develop new models of care. There was good local leadership of clinics although this was not apparent in radiology, which had not had a clinical lead for some time and where staff morale was low. Governance arrangements were developed but the service needed to ensure risks were appropriately recorded. Patient feedback was used to improve the service and there was innovation in some service areas, such as one-stop clinics in ophthalmology.

Vision and strategy for this service

- The lead manager for outpatients told us there was no separate vision or strategy for outpatients. However, the vision in the elective care team was to be dedicated to maintaining excellence, respect and integrity in all aspects of their operations.
- The service strategy was now part of the elective care transformation programme to transform and streamline outpatient services, make the services more efficient, develop new models of care and ensure future financial stability.

Governance, risk management and quality measurement

- The business manager for radiology told us that divisional governance meetings took place monthly.
- The lead manager for outpatients told us that quality monitoring arrangements focused mostly on waiting times for the clinics held in the outpatient department.
- The lead manager told us there were no risks on the risk register for outpatients and that risks appearing on the risk register were divisional. Lessons learned from incidents and complaints were appropriately shared.
- There was one corporate risk for outpatients, which related to patients being seen and treated without case notes because case notes had not been tracked. Actions had been taken to address this issue.

Leadership of service

- There was a lead manager for outpatients but there was a vacancy for a lead nurse. A nurse was being seconded to this position in the interim until the post was filled. There was an acting nurse presently in charge of the general outpatient clinics.
- Staff told us there was no clinical lead for radiology and there were leadership problems in the department.
- The lead manager told us there was a new operations manager for outpatients starting in July 2014.
- There was clear local leadership at clinic level for the outpatient clinics we inspected. The outpatient sister was identified as a strong leader.

Culture within the service

- Staff we spoke with spoke positively about the service they provided for patients.
- The staff we spoke with in all the departments we inspected expressed the importance of ensuring patients experienced good care.
- Two members of staff we spoke with told us they felt morale within the radiology department was low and that they felt understaffed and overworked.

Public and staff engagement

- The outpatient department took part in the National Cancer Patient Experience Survey. Results for the 2012/13 survey contained mostly positive comments about the staff and care received in outpatients at the hospital.
- Patients were encouraged to give feedback relating to the service they had received in outpatients and there were feedback boxes with comment cards available in the department.
- The ophthalmology clinic had undertaken a survey in June 2013. The survey looked at service before arrival, signage in waiting areas, promptness and efficiency of appointments, service location and setting, staff and overall experience. Most of the feedback was rated as excellent or satisfactory.

Innovation, improvement and sustainability

- In 2010, the trust entered into a working partnership with a company to support the provision of an ophthalmology service. This had enabled the trust to redesign all pathways at sub-specialist level and increase the number of one-stop clinics, it also ensured delivery of care according to NICE guidelines for glaucoma patients. The trust had also enhanced the nurse's role within the department to maximise their

skill set. This had all led to improved access for patients, increased efficiency and throughput across the outpatient department and theatres, and reduced visits to hospital. The trust reported that patient experience had improved significantly.

- The business manager for radiology told us that the department had invested in a new digital radiography machine, but because of understaffing it was not currently being used.

Outstanding practice and areas for improvement

Outstanding practice

- The ambulatory care unit (ACU) opened in December 2013 and had a positive impact on preventing patient admissions. It was helping to meet the needs of patients in the community who required medical intervention without the need for admission to hospital.
- There were physician associates, who were staff trained to support medical staff with assessment, investigation and diagnosis. One physician associates was trained to complete comprehensive assessments for frail elderly patients.
- The trust had developed initiatives to encourage people living with dementia to eat. They used coloured plates and adapted cutlery, and warmed plates to keep food warm.
- The trust had a 'carer's passport', which was a scheme whereby named relatives could offer their help by coming onto the ward and providing care for their loved one, such as help with eating meals or personal care. The hospital offered named relatives free parking or 10% off meals bought at the hospital.
- Discharge booklets were introduced in all medical wards. These were kept by every patient's bed and were completed by members of the multidisciplinary team (including intermediate care and social services) to record specific outcomes leading towards safe patient discharge.
- A nurse-led early discharge support team was provided for patients with chronic obstructive pulmonary disease. This included home visits and physiotherapy input. The team worked closely with the respiratory ward to ensure longer term management. A discharge bundle had been introduced that included follow-up within 72 hours.
- The Oasis Project identified patients during their pre-operative assessment who may be anxious about surgery. The project consisted of a team of volunteer therapists who had a professional qualification in relaxation. Therapists would talk through any anxieties at that time to provide reassurance to the patient and would make a note in the patient's file to prompt action for when they were admitted for surgery
- The trust had produced a leaflet for relatives and friends inviting them to contact the critical care outreach team directly if they had concerns about their relative.
- The hospital had made significant strides in the recognition and management of sepsis and the delivery of the 'Sepsis Six' care bundle. They had a critical care outreach nurse seconded as a Sepsis Nurse who monitored compliance and had introduced a sepsis recognition tool, sepsis boxes for the wards and stickers to improve fluid balance completion.
- Picture screens were used on the intensive therapy unit (ITU) that depicted, for example, a soothing flower blossom scene. Staff and relatives commented that these were calming and relaxing and gave the patients lovely visual images.
- A special service called 'Providing information and positive parenting support' (PIPPs) was available to give information and positive parenting support to teenage mothers and others who were vulnerable. Midwives developed close relationships with the women and offered additional support, continuity of care and coordinated multi-agency cases conferences involving social services.
- Multidisciplinary networks in children's and young people's services were being developed to deliver care closer to their homes.
- The hospital used the AMBER care bundle, which is a national approach to support advanced care planning when doctors are uncertain whether a patient may recover or be in the final stages of life (months or days). Trained team members acted as champions to drive high-quality care at these times. They encouraged staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about everyone's wishes and putting plans in place should the person die.
- The end of life care team had rolled out care standards to ward areas using a strategy called 'Transform'. Staff were trained to ensure that patients in the hospital had a good experience of end of life care.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Medicines are managed at all times in line with legal requirements.
- There is effective leadership and governance arrangements in the A&E, operating department, maternity and radiology.

Action the hospital SHOULD take to improve

- Safety standards in the A&E department are improved to be in line with current national guidance.
- Parents and Children have information if they have to have long waiting times in the Rose Goodwin observation unit in A&E.
- Care pathways and care bundles continue to be embedded into everyday practice and monitored.
- It continues to reduce the avoidable harms of pressure ulcers, falls, catheter urinary tract infections.
- People living with dementia continue to have consistent care and support in all areas of the trust.
- The Five Steps to Safer Surgery checklist is audited to ensure appropriate and consistent use.
- Patients being 'checked in' for theatre have their privacy and dignity maintained.
- Staffing levels continue to improve (especially in A&E and surgery), and patient care is appropriately delivered by trained, experienced and skilled staff.
- The use of linen drapes in theatres is avoided.
- That all staff use the incident reporting system to report incidents, and that learning from incidents is cascaded and shared.
- Do Not Attempt Cardio Pulmonary Resuscitation orders are appropriately completed so that there is timely documentation of the decision by the appropriate person, and this decision is reviewed if there is a change in a patient's condition, and mental capacity is assessed.
- Radiology services improve so that patients do not experience delays and long waiting times.