The University Hospitals of North Midlands NHS Trust

The County Hospital

Quality Report

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

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Requires improvement
Maternity and gynaecology	Good
Services for children and young people	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The County Hospital is part of The University Hospitals of North Midlands NHS Trust. It was known as Stafford Hospital until 31 October 2014, when it was part of Mid Staffordshire NHS Foundation Trust. In 2013, the foundation trust was put into administration by Monitor. The new trust was created on 1 November 2014, following integration with University Hospital of North Staffordshire NHS Trust.

We inspected this hospital in April 2015 as part of the comprehensive inspection programme. We inspected all core services provided.

We visited the hospital on 23 April 2015 as part of our announced inspection. We also visited unannounced on the trust on Friday 1 May and Tuesday 5 May 2015. Our unannounced visit included A&E and Medical Care Services.

Overall we have rated this hospital as requiring improvement. We saw that services were caring and compassionate. We saw a number of areas that required improvement for them to be assessed as safe and effective. We saw that leadership of services at the trust also required improvement at both a local and an executive level.

Our key findings were as follows:

- **Staff were caring and compassionate towards patients and their relatives; we saw a number of outstanding examples of good care right across the trust.**
  - **There was a strong culture of incident reporting and staff were encouraged and supported by their managers to engage in this. This made staff feel empowered.**
  - **Achieving safe staffing levels was a constant challenge in medical services and there was a heavy reliance on agency and locum staff to support this.**
  - **Systems and processes did not support patients flow through the organisation.**

We saw outstanding work being done on the Specialised Neurological Unit at the County Hospital to improve the outcomes for patients

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

Importantly, the trust must:

- **Review systems and processes to ensure patients flow through the organisation in a timely manner**
- **Implement the end of life individualised care plan as soon as possible so that patients who are actively dying are supported holistically. This would also support the nursing staff to meet all the needs of the patients.**
- **Review systems and processes to ensure staff are engaged with the plans for service integration and communication networks between senior management and front line staff are improved.**
- **Review pathways between County Hospital and Royal Stoke to ensure patients transferred from the emergency department are kept safe and patients who transferred for treatments and procedures are done so efficiently and effectively.**
- **The trust must review systems and processes to ensure staff are engaged with the plans for service integration and communication networks between senior management and front line staff are improved.**
- **Arrangements regarding DNACPR and mental capacity assessments must be improved so that people are safeguarded against decisions being made without their input.**
- **Improve the training opportunities for clinical staff with regard to Dying Matters**

Summary of findings

- **The discharge process for patients who wish to go home so that fast track discharges can be completed within 48hrs.**

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	There was no fast track pathway for patients who needed specialist follow-on care and treatment at Royal Stoke. Patients requiring transferred had to be admitted via the emergency department to Royal Stoke had further waiting in the emergency department there, before finally being transferred or in some instances discharged. Although leaders were well respected and staff felt supported, recent organisational change had had an impact on staff morale, and staff felt uncertain about the future. We saw that people were kept safe whilst they were in the department, Staff were well trained and knowledgeable, they followed policies and procedures which were designed to keep people safe and reduce risk. Staff were compassionate and caring. Patients received treatment which followed recognised pathways. Outcomes were monitored locally in addition to engagement with national audits at trust level.
Medical care	Requires improvement 	Further improvements were required to protect patients across medical services from avoidable harm with medicines management, safe storage of patient records and a lack of continuity for patients due to the high reliance on agency and locum staff. Opportunities for disseminating and learning from incidents and improving the service, through audit and monitoring of the service could be improved. Accessing information could be challenging for staff as neither hospital site could view the other's electronically held records and test results. At times, this led to delays in delivery of care and treatment. We saw that patients were affected by long delays when accessing these services and treatments that were provided at the Royal Stoke site. Care was provided in line with national best practice guidelines and the trust participated in all national clinical audits they were eligible to take part in. Results of national audits for the newly formed trust were not yet available; however,

Summary of findings

results from the former Mid Staffordshire NHS Foundation Trust showed that outcomes for patients were good. The hospital achieved all the applicable targets in relation to referral to treatment times.

Surgery

Good

Patients received compassionate care and staff were kind and caring. Patients' privacy and dignity were respected and outcomes for patients were above the England national average. The standard of cleanliness was good and infection control procedures were followed. There were standardised protocols for elective surgery which were followed and included the five steps to safer surgery checklist. Incidents were reported and learning from these was shared with staff.
Access and flow was not well managed and resources at the County were not optimised. Beds and theatre were not being fully utilised.
Senior clinicians and nurses told us they had good multi- disciplinary working at the County and they felt supported in their roles. Staff did not feel part of the wider trust. They said senior trust management was not visible.

Critical care

Requires improvement

The changes to critical care services had been in place for three weeks at the time of the inspection. As a result of this it was difficult to assess an accurate picture of the responsiveness of the service.
An intensive care consultant was on site Monday to Friday. Medical cover was mainly provided from early afternoon, evening and throughout the night by anaesthetic middle grade doctors with anaesthetic consultants on call from home. This does not meet intensive care core standards.
Staff morale was low and they were concerned about the future of the unit and their on-going employment.
Critical care staff were caring and compassionate. There were sufficient, highly experienced nursing staff available within the critical care unit and within the outreach team at the time of our inspection.
People received effective care, treatment and support that met their needs and achieved good outcomes, promoted a good quality of life and was based on the best available evidence.

Summary of findings

Maternity and gynaecology	**Good**		Overall we found the service good with one area that required improvement. There were many good examples of safe processes including incident reporting systems, audits concerning safe practice and compliance with best practice in relation to care and treatment plans. Policies were based on National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice. The birth to midwife ratio was 1:29. The named midwife model was in place. Midwives told us that they provided one to one care in labour.
Services for children and young people	**Requires improvement**		Inpatient care for children transferred to the Royal Stoke site in May 2015. We saw robust plans in place to facilitate the move and staff were involved. We found some parents were confused over the plans and did not know what services the hospital was planning to provide. Although, we noted there had been several efforts to engage with the public around the closure of the inpatient ward. Care plans and risks assessments were not adequately maintained and contained insufficient detail to care for patients. Parents made comments that the medical staff did not always keep them informed but the nursing staff did. We saw there were a number of issues in maintaining patient and staff safety. There was a lack of correct storage of medicines and hazardous cleaning products were not safely stored. We saw elements of compassionate care and were told staff had taken the children on days out. Parents told us they felt emotionally supported by staff. Staffing levels were found to be of a safe standard.
End of life care	**Requires improvement**		Since the removal of the Liverpool Care Pathway, the hospital had failed to implement an individualised plan of care for the dying patient, with the trust still in the evaluation process for a new pathway. The hospital did not have safe arrangements in place regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The completion of the

Summary of findings

forms was not always done as per trust policy. In addition to this, if a person appeared to lack capacity no associated mental capacity assessment was undertaken to maintain their safeguards.
The local leadership was good; the specialist team were effective once they received a referral. Caring within the service was good; staff were committed, compassionate and emotionally supportive.

Outpatients and diagnostic imaging	**Requires improvement**		Services were safe; there were sufficient staff who were trained and understood their responsibilities. Any incidents were followed up appropriately. Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance. They were treated with dignity and respect. There was potential risk for patients who require treatment at both sites, where records may be unavailable and we also observed that records were not consistently stored securely. There is a clear vision for the service following the integration with Royal Stoke. Although it is still early days, most staff appeared to understand the vision and their role within it. Radiology staff did not feel engaged with integration and are unclear why some services have been moved.

The County Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to The County Hospital

Until 1 November 2014, The County Hospital was known as Stafford Hospital and was part of Mid Staffordshire NHS Foundation Trust. In 2013, the foundation trust was put into administration by Monitor and the Trust Special Administrators (TSA) were appointed to run the trust and determine its future. A number of recommendations about service provision were made and consulted upon regarding what services would continue to be delivered at the hospital.

In November 2014, the hospital integrated with Royal Stoke University Hospital to form the University Hospitals of North Midlands NHS Trust. Since integration, the new trust has been implementing many of the recommendations made by the TSA and at the time of our inspection, some changes had already happened and other were imminent.

The people of Stafford are very passionate about securing the future of their local hospital and some of the planned service moves have caused a great deal of angst amongst the local population.

CQC inspected Mid Staffordshire NHS Foundation Trust in July 2014 as part of the process of ensuring safe and sustainable services. Our report from that inspection is on our website.

Our inspection team

Our inspection team was led by:

Chair: Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

Chief Operating Officer, director of clinical quality, safeguarding children specialist, medical consultants, consultant radiologist, radiology manager, clinical oncologist, speciality registrars, consultant obstetrician and gynaecologist, consultant anaesthetist, consultant paediatrician, specialist nurses, speciality matrons, head of A&E nursing, senior nursing sisters.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Detailed findings

How we carried out this inspection

We inspected this service in April 2015 as part of the comprehensive inspection programme.

We visited the trust on 22, 23 and 24 April 2015 as part of our announced inspection. We also visited unannounced to the trust on Friday 1 May and Tuesday 5 May 2015. Our unannounced visit included A&E, Medical Care Services and Critical Care.

We held two public listening events before the inspection; one in Stafford on 13 April 2015 and one in Stoke on 15 April. These events provided the opportunity for people using services, relatives and members of the public to come and talk to us about their views and share their experiences. Approximately 80 people attended across the two events.

During our visits to the trust we held 14 planned focus groups to allow staff to share their views with the inspection team. These included all of the professional clinical and non-clinical staff. We also held a "drop-in" focus group for any staff unable to attend the other planned sessions. Through these groups we spoke to 232 members of staff.

We met with the trust executive team both collectively and on an individual basis, we also met with ward managers, service leaders and clinical staff of all grades. We also spoke to patients and their relatives and carers we met during our inspection.

We visited many clinical areas and observed direct patient care and treatment.

Facts and data about The County Hospital

The County Hospital has 211 beds, including a free-standing midwifery led unit. The Emergency department is open every day from 08:00am until 10:00pm. In 2013/2014 there were 53,005 inpatient admissions, 297,042 outpatient attendances and 46,761 accident and emergency department attendances.

Data provided prior to 1 November 2014 regarding The County Hospital was from Mid Staffordshire NHS Foundation Trust, which also included Cannock Chase Hospital, which is now part of another NHS trust and we have not been able to disaggregate some of the data.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Inadequate	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at County provided consultant-led emergency care and treatment between 8am and 10pm, seven days a week. Between the hours of 10pm and 8am emergency services were provided by neighbouring hospitals including the Royal Stoke site. Ambulance services in the area were aware of the arrangements and convey patients to the nearest appropriate emergency centre dependant on the location and needs of the patients. Ambulances were on site at County Hospital between 10pm and 8am to transport emergency patients to Royal Stoke should they arrive at County when the department is closed.

Between April 2013 and December 2014 the department had nearly 47,000 attendances, an average of 2,238 per month.

The service did provide services for children and young people but not have a separate paediatric emergency department. A new paediatric emergency care unit was opened in May 2015.

This report relates to our findings of services at County Hospital; however some information used to assess performance was only available at trust level, and often related to County Hospital prior to the integration with Royal Stoke.

In order to make our judgements we spoke with patients or their families or carers. We spoke with clinical and nursing staff and with support service staff such as porters, cleaners, and administrative staff. We visited all the areas within the department and observed how staff interacted with patients. We attended meetings and staff handovers. We spoke with 10 patients and reviewed information from comment cards that were completed in the waiting area.

Urgent and emergency services

Summary of findings

There was no fast track pathway for patients who needed specialist follow-on care and treatment at Royal Stoke. Patients requiring transferred had to be admitted via the emergency department to Royal Stoke had further waiting in the emergency department there, before finally being transferred or in some instances discharged.

The clinical decisions unit (CDU) which was set up as a four bedded unit to support ED patients flow was being inappropriately used with medical and surgical outliers. When we visited the unit we found twelve patients had been accommodated overnight and another was due to be transferred to the unit.

Although leaders were well respected and staff felt supported, recent organisational change had had an impact on staff morale, and staff felt uncertain about the future.

We saw that people were kept safe whilst they were in the department, Staff were well trained and knowledgeable, they followed policies and procedures which were designed to keep people safe and reduce risk.

Staff were compassionate and caring. Patients received treatment which followed recognised pathways. Outcomes were monitored locally in addition to engagement with national audits at trust level.

Are urgent and emergency services safe?

Good

We found that policies and procedures in the emergency department were designed to keep people safe. Staff understood their roles and were knowledgeable and skilled. They were encouraged to raise concern and reports incidents. Incidents were reviewed so that shared learning could take place.

Services were provided in a suitable environment and equipment was available. Staff were responsible for arranging their own mandatory training and we saw compliance was good. Staffing levels were in line with national guidance and where agency staff were used we saw that thorough checks and induction systems were in place.

There was a proactive approach to anticipating and managing risk and where risk was identified appropriate action was taken to reduce or remove the cause.

Arrangements were in place to ensure the continued care of patients in the department and to cater for the needs of patients who might attend and find the department closed, as this was not a 24/7 emergency department.

Incidents

- The trust had systems and processes in place to capture analyse and respond to incidents. Staff we spoke with told us the feedback and discussions which took place regarding incidents helped to prevent similar incidents reoccurring.
- Since the integration, staff reported incidents and 'near misses' through a centralised web-based reporting system (DATIX). This system automatically escalated incidents according to their type and the department affected. All incidents were reviewed by a senior nurse or consultant within the department.
- We were told that when the new system was introduced at County Hospital nursing staff found it was taking them longer to input incidents than the previous system. Staff were now familiar with the system. Staff told us that feedback from incidents had improved with the new system so they felt reporting incidents was now more meaningful.

Urgent and emergency services

- Serious incidents and 'never events' were reported nationally at trust level. Never events were serious, largely preventable patient safety incidents that should not occur if proper preventative measures were taken. During 2014/15 the trust had not reported any 'never events' within emergency services.
- County hospital had recorded two serious incidents between January and December 2014. One incident related to a delayed diagnosis and the second to a retained cannula.
- A total of 272 low or no harm incidents were recorded between 2 November 2014 and the end of January 2015. The majority of these related to recording of pressure sores which were evident when patients were admitted. Seven incidents related to delayed transfer of patients from County A&E to Royal Stoke specialist departments or A&E, delays related to availability of transport. We saw how the hospital had liaised with ambulance services to try to reduce these incidents

Cleanliness, infection control and hygiene

- We found all areas of the emergency department to be clean, tidy and free from clutter.
- All staff in the department observed the 'bare below the elbow principles of infection prevention and control. All staff we spoke with understood the principles and importance of infection prevention and control.
- We saw documentation which demonstrated that Infection control audits had identified that doctors were not always complying with best practice in relation to hand hygiene practices. Audits in November, December and January showed only 85% compliance. Additional training input was provided and in February 2015 compliance had risen to 95% and in March 100% compliance had been achieved.
- The ED Matron had completed an internal patient satisfaction survey in September 2014. Questionnaires were sent to 848 patients who had attended County Hospital ED. 359 patients responded. The results showed that 98% of patients had thought the department was clean.
- Hand cleaning gel and washbasins were available throughout the department, signage had been displayed to encourage people to use them. This included large floor signs reading 'Stop clean your hands' when entering or leaving the department into the main hospital corridor.

Safety Thermometer

- The hospital monitored a number of areas to ensure that performance met patient safety standards, these included;
  - Handover times from ambulance to A&E. Target time for handovers is 15 minutes. National recording of breaches over 30 minutes and over 60 minutes are used as an indicator of performance. County hospital had consistently met the fifteen minute target since integration.
  - Initial assessment and treatment times were all within national targets. For example during March 2015 a total of 3,199 patients attended the A&E, of those 170 or 5% had a total stay in the department of over 4 hours. No patients exceeded the 12 hour reporting rate.
  - No hospital acquired pressure ulcers, falls or catheter associated UTI's were recorded between November 2014 and April 2015.

Environment and equipment

- We found that medical equipment was well marked showing required service dates. Two pieces of equipment a blood pressure monitor and a ventilator had not been serviced within their scheduled service period. Staff had not reported any issues with the functionality of the equipment, but when we pointed these out they were taken out of use until they could be serviced. Other equipment was available which meant staff were not reliant on the items whilst waiting for service. All other equipment was within its current service schedule.
- We saw that resuscitation trolleys were maintained ready for use. Checks were completed regularly and marked in the log books kept with each trolley. Audits for August, September and November 2014 had all showed 100% compliance.
- Treatment rooms and cubicles were well equipped and well lit.
- Access to some areas of the department was controlled by electronic card entry systems. Staff ID badges also acted as their access control. This enabled the trust to restrict access to sensitive areas to particular members or groups of staff.
- Patients were only transferred between hospitals when doctors believe it was safe for them to be moved.

Transfer bags which travelled with the patient, contained emergency equipment and medication that should be checked regularly. We saw that some checks of the bags had not been completed. During the previous six months checks had not been recorded on a total of sixteen days.

- We saw that a linen cage had been left in a small corridor. The corridor was part of a marked fire escape route and would have prevented or delayed the evacuation of patients by bed along that route. This was pointed out to staff and trolley was moved immediately. We were assured that this was not usual practice and all staff would be reminded not to leave obstructions in corridors.

Medicines

- There were systems and processes in place to ensure that medicines and drugs were stored and administered safely. This included security of drugs cabinets and recording of refrigerator temperatures for temperature sensitive drug storage.
- We checked a total of five sets of patient medication charts. All the medication records we checked were found to have been completed correctly.
- The hospital had an on-site pharmacy and pharmacists were available during the day with a call out system in place for emergency cover out of hours.
- We attended a nursing handover in the clinical decisions unit, which formed part of the emergency department. We heard how patient's medication needs were discussed during the handover which enabled staff coming on duty to have an overview of what medication issues people might have.

Records

- We reviewed records relating to the management of the emergency department, auditing of processes and patient notes.
- We found that all written records were concise and accurate and mostly easy to read. Electronic records were complete.
- Individual risk assessments had been completed for patients with specific needs; these included falls risk assessments, Waterlow assessments. We saw that monitoring and updating of risk assessments took place throughout patients stay in the department.
- We had difficulty finding one set of patient notes relating to a patient who was receiving treatment in the emergency department. Staff told us the notes had been taken for review by a medical registrar; however no one knew where the doctor was or how to contact them. The notes were returned about thirty minutes later. This meant that important information about the patient had not been readily available to department staff for a significant period of time. The patient's medical condition was stable and they had not required any interventions during the time the notes were absent, however had they deteriorated the notes may have been required.

Safeguarding

- Staff we spoke with all confirmed that they had received safeguarding training. We saw evidence that as of February 2015, 92% of nursing staff had received level 1safeguarding children training and 90% had received adult safeguarding training. The trust target for this is 95%.
- Seventeen percent of all staff in the emergency medicine directorate had completed level 2 or above training in child protection. This data could not be broken down to site level. The trust told us that directorate managers had not yet determined which staff should undertake this training.
- Staff we spoke with had a good understanding of safeguarding issues, the types of abuse and how to escalate concerns and record incidents.
- The trust had a safeguarding team who provided training for staff and were also available for advice either by phone or through visiting the department. The team ensured that safeguarding incidents were escalated to senior managers where required, and provided regular feedback to individuals and teams who had reported incidents.

Mandatory training

- We saw that 86% of nursing staff had completed their mandatory training, against a trust target of 95%. Recent increases in activity had limited the time available for mandatory training. Managers told us a plan was in place to rectify this.
- We asked the trust to confirm how many staff had completed advanced paediatric life support training at County hospital but this data was not provided.
- Mandatory training was available to staff via computer based training and face to face, classroom based training.

- Staff were responsible for booking their own training and had access to electronic training booking system. Attendance at training was monitored by line managers and department managers, and was discussed during staff appraisals.

Assessing and responding to patient risk

- Recognised pathways of care ensured that patient's acuity was assessed and appropriate treatment provided.
- Acuity tools were used to assess and monitor patients, the national early warning system (NEWS) was used to assess the severity of acute illness.
- Hospital staff received information about patient's on-route by emergency ambulance, so they could alert specialists and teams as necessary. We noted this was a calm, quiet environment where information could be exchanged clearly and assessments made.
- A triage nurse system was used for walk-in patients. Patients told us that they did not wait long to be seen.
- We did see a number of local audits which had been carried out in the emergency department. These included infection control, saving lives, proud to care, family and friends, health and safety and quality document audits. We saw how these had been used to improve services.
- Examples of learning included introduction of green coloured 'I'm Clean' stickers which were placed on equipment after cleaning so that staff could easily identify equipment which was ready for use. Audit of medicines practice had resulted in changes to how keys were managed by staff so that controlled drugs keys were kept separate ensuring that two staff were required to access the cabinets. Documentation audits which were based on national quality assurance guidance, to ensure all documentation was completed correctly and in accordance with trust policies.
- The triage nurse on duty at the time of our inspection told us that she regularly works as triage nurse but had not received training in paediatric and infant resuscitation techniques. This meant that there was the potential for delay in summoning suitably qualified staff in extreme circumstances. We were assured that from 18 May 2015 and the opening of the new paediatric emergency department there would always be staff with the specialist paediatric training.

Nursing staffing

- Planned nursing staff levels were based on NICE guidance. We reviewed the staffing numbers and skill mix for the department. The department sister said that due to the small size of the department it was a challenge to ensure that skill mix was maintained, as they had to draw from a smaller pool of staff. We saw how predicted staffing levels were shown on the electronic system which identified any shortages or skill mix issues in advance. This enabled shifts to be offered to department staff as overtime or passed to agency.
- Nursing staff were also supported by an emergency nurse practitioner (ENP). ENP's were nurses who have taken additional training and were able to take on tasks which previously could only be undertaken by doctors. We were told the ENP's not only reduced workload for the doctors on duty but also provided advice and guidance to other nursing staff.
- The numbers of staff on duty and the name of the nurse in charge were displayed on the notice board in the department.
- We observed as an agency nurse who was not known to the staff on duty arrived at work. We saw how the nurse's registration and identification was checked. The agency nurse was then provided with an induction to the department.

Medical staffing

- Medical staffing skill mix consisted of 27% Consultants, 23% middle grade doctors, 23% registrar and 27% junior doctors.
- Consultant cover was provided between 8am and midnight after which a call out system operated. However consultants advised us that if patients were still in the department after midnight who had not been stabilised and placed on a care plan the consultant would not leave until this had been done. Nursing staff and junior doctors confirmed that consultants often remained in the department for long periods after they had been due to finish.

Major incident awareness and training

- Major incident plans were available on the trust intranet and action cards were kept by senior nurses for distribution in emergency situations. We were shown how policies had been revised when the two hospitals came together as a new trust so that the policies

reflected the new management structures. Staff explained that local procedures had remained the same but escalation and senior management oversight had needed updating.

- The trust had declared its own major incident earlier in the year when in January capacity issues at Royal Stoke had meant that further admissions might prejudice the safety of patients already in the hospital. County Hospital was involved as they needed to restrict transfers to specialist units based at Stoke.
- The trust worked with community based health services and ambulance services to divert patients who did not need emergency treatment. Local media were used to asked people to use other services wherever possible.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The emergency department provided care and treatment in line with national guidance. Recognised clinical pathways were followed.

Patients received timely and appropriate pain relief whilst in the department but concerns were raised with us about pain relief for patients being transferred to Royal Stoke.

Outcomes were audited to ensure treatment was effective, and adjustments made where issues were identified.

Evidence-based care and treatment

- We saw that treatment and care pathways were based on recognised national guidance and best practice.
- Care pathways had been planned which were based on the 'Big 6'. This is clinical guidance pathway for the 6 most common clinical conditions for paediatric patients.
- We saw that policies and procedures had been produced which provided advice and guidance to staff on the procedures to follow during the night.

Pain relief

- Patients we spoke with in the ED told us that they had been asked about their pain and where appropriate pain relief had been provided. The patients we spoke with including some children and their parents were all complementary of how staff had managed their pain and comfort.
- We saw from records we checked that patient's pain levels had been measured and recorded. Patients level of pain and any changes can assist staff identify deteriorating patients along with monitoring other vital signs.
- In the 2014 CQC accident and emergency survey, County Hospital ED scored 8 out of ten when patients were asked if they thought staff had done everything they could to control their pain.

Nutrition and hydration

- Patients were offered food and drink whilst in the department. Where appropriate recognised assessment tools such as the malnutrition universal screening tool (MUST) were used to assess the needs of vulnerable patients.
- We saw healthcare and nursing staff providing drinks to patients and their carers or relatives.

Patient outcomes

- The trust engaged with national audits including College of Emergency Medicine (CEM) Audits, however due to the recent integration with Royal Stoke, there have been no national audits published which include County hospitals data. However, we were able to review data from the 2013 audit, relevant to the former Mid Staffordshire Hospitals NHS Foundation Trust which showed a mixed performance against the standards measured:
  - The former trust was better than the England average for 6 of the 8 indicators with regard to Consultant sign off, but worse than England average for "Reviewed ED notes after discharge" for both Consultant/associate specialist and ST4 or more senior doctor.
  - Audit data regarding the recording of vital signs in majors showed the former trust was in line with other trusts (between the upper and lower England quartile) for all but 5 of the indicators, and better than other trusts (in the upper quartile) for the other 5.

  - For renal colic, the former trust was worse than others (in the lower England quartile) for 9 of the 17 indicators and better than other trusts (in the upper quartile) for 4 of the 17 indicators.
  - For fractured neck of femur, the former trust was worse than other trusts (in the lower England quartile) for 9 of the 15 indicators and better than others (in the upper England quartile) for 4 of the 15.
  - The severe sepsis and septic shock audit data showed the former trust performed well (in the upper quartile) for 4 of the 13 indicators, and in line with other trusts (between the upper and lower quartiles) for the rest of the indicators.
- We saw that the department was engaged with current CEM audits including the fitting child audit, older people care in emergency department and mental health care in the emergency department. The data is collected at trust level and on-going feedback is provided through the 'Blue Light' newsletter which was produced by the trusts clinical audit department.
- Audits of policies had been completed in the department and following the amalgamation with Royal Stoke, most policies had needed to be amended or re-written to account of changes in practice. The new practises had been shared with staff during team meetings and handovers and copies of the policies were available in the A&E department and on the computer systems.
- Mortality review meetings took place monthly to review all deaths which had occurred in the department and identify trends or learning.

Competent staff

- We found that clinical and nursing staff were knowledgeable and understood their role within the organisation.
- All (100%) nursing staff in the department had been appraised during the last twelve months.
- Practice was continually assessed by peers and senior nurses who offered advice and guidance and support by leading by example.
- Medical staff were required to revalidate their registration. Revalidation involves gathering evidence of experience and remaining up to date with current techniques and information. Both nurses and doctors told us they had been supported to revalidate.

Multidisciplinary working

- We saw that multidisciplinary working occurred within the emergency department, both within the main treatment areas and the clinical decisions unit. Specialist nurses and other healthcare professionals were fully involved in and engaged with patient care.
- Effective communication and working with ambulance trusts and with local communities had ensured that patients were transported to the appropriate locations dependant on the time of day and the needs of the patient.

Seven-day services

- Emergency services and associated imaging services were all provided between 8am and 10pm, seven days a week. Where patients were still in the department after 10pm they were provided with appropriate care and treatment, but no cases were admitted to the department after that time.
- Standard operating procedures had been agreed with ambulance services and emergency departments in neighbouring hospitals to transport or accommodate patients during the closed period.

Access to information

- Staff had ready access to information to enable them to provide a comprehensive service to patients. Risk assessments, care plans and comfort rounds were all well documented.
- Staff at County Hospital told us they did not have difficulty accessing computer systems, they believed that there were sufficient terminals to enable them to complete their tasks in a timely manner.
- Trust policies and procedures were available on the intranet and all nursing and clinical staff had access to email and information services via the intranet.
- We saw that situation, background, assessment, recommendation (SBAR) forms were completed for all admitted patients or patients due to be transferred to Royal Stoke. SBAR is a recognised tool used to ensure that all relevant details about a patient were communicated to staff who were escorting or receiving the patient. We checked four forms which had all been completed correctly and had sufficient information to enable staff to continue care.

Consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS)

Urgent and emergency services

- Patients were asked for their consent to care and treatment.
- We did not encounter any patients during our inspection of County Hospital who lacked the capacity to make decisions about their care but staff were able to describe the principles of the Mental Capacity Act and how they would support patients to make decisions based on their best interests.
- Resource packs were available for DoLS and MCA to guide staff.
- Where patients were unconscious treatment was given in emergency circumstances based on the information available such that decisions were made in the patient's best interest. Such decisions were documented and fully discussed with patients or next of kin when the opportunity arose.
- Patients who were conscious and able to engage with staff were told what was happening and asked for their consent prior to care or treatment being given.
- Patients told us that they had been fully informed by staff (both clinical and nursing) about proposed actions and they understood what they were consenting to.

Are urgent and emergency services caring?

Good

Caring in urgent and emergency care was good. Staff were passionate about the care they provided to patients. We observed many instances of good practice during interactions between staff and patients. This included not only nursing and clinical staff but also porters, housekeeping staff and receptionists.

We saw that staff were friendly and courteous; they had a quiet calm and relaxed manner. Patients described staff as friendly and helpful. Patients told us that they were able to influence their care The felt involved, informed and engaged. We saw how patients were supported emotionally in addition to having their physical needs addressed.

Compassionate care

- We observed staff as they provided care and support to patients we saw that peoples dignity was preserved by having curtains pulled around them before care was provided or when sensitive conversations were needed.
- We noted how staff lowered their voices when discussing personal issues or details of care so that patients or relatives in neighbouring beds could not overhear.
- Patients described nursing staff as 'wonderful' and 'really nice'.
- When we talked with relatives of one child they told us how staff had spoken respectfully to their child and asked questions of the child which they had then confirmed with them. They said they had made their child feel special and important which the parent described as 'really nice'.
- During the 2014 CQC accident and emergency department survey County Hospital as part of the previous trust scored well in the majority of patient satisfaction questions and was about the same or better for all of the responses. For the question on d**iscussing anxieties or fears**, the department scored 7.6 out of 10, which was better when compared to similar trusts.
- The Friends and Family Test (FFT) showed that in February 2015, 90.3% of patients were likely or extremely likely to recommend the service. The hospital had scored better than the England average for the preceding three months and the response rate was better than the England average.

Understanding and involvement of patients and those close to them

- Patients told us that they had been fully informed by doctors and nursing staff about what was likely to happen and what options were available for treatment.
- We saw that consent was asked prior to any examination or treatment being given.
- Nursing staff were attentive and listened to patient concerns.
- Relatives of patients told us that they had been able to ask questions and clarify matters in addition to the patient being able to do so.

Emotional support

- Patients and families told us how they had been supported by the nursing staff and doctors. They

Urgent and emergency services

described how staff had remained calm and professional when treating them and speaking with them. They told us how this had enabled them to relax and worry less about their condition.

- We saw how staff in the ED were calm and professional in their approach to patients and their relatives or carers. We saw how this calmness reduced anxiety for patients and how they appeared less agitated after being spoken to. One patient said, "They let you know what's happening so you can concentrate on that instead of just thinking the worst all the time".
- The hospital had a chaplaincy service available seven days per week. Facilities for quiet contemplation were available for all faiths, a quiet room with no religious artefacts and separate facilities for Muslim prayers. Some services were transmitted live over the hospital radio system for those who wish to listen. Patients who were unable to visit the facilities were able to request visits at their bedside.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

The hospital had struggled to achieve the 4-hour waiting time standard, but was improving.

There was no fast track pathway for patients who needed specialist follow-on care and treatment at Royal Stoke. Patients requiring transferred had to be admitted via the emergency department to Royal Stoke had further waiting in the emergency department there, before finally being transferred or in some instances discharged.

We were concerned about the flow of patients through the clinical decision unit, although we were told the volume of patients was unprecedented at our announced inspection, we return to find high numbers were continuing.

Since December 2011, the emergency department had been closed between 10pm and 8am. Between these hours patients would have to seek assistance for other hospitals in the locality. There was no separate paediatric provision and limited access to CAMHS services which impacted on the department's ability to respond to the needs of children and young people; although we were aware there were plans in place to address some of this.

Service planning and delivery to meet the needs of local people

- In December 2011, the accident and emergency department closed overnight. Neighbouring hospitals and ambulances services had been consulted and arrangements put in place so that between 10pm and 8am patients would be taken to neighbouring ED departments dependent upon the location and needs of the patient.
- Staff at County told us that whilst they had not collated figures, they had anecdotal evidence to suggest an increase of patients arriving at the hospital by their own transport. Patients had told them that they would not call for ambulances as they didn't want to be taken to Stoke or other distant hospitals because of travelling for them and their relatives.
- We had been told that on occasions patients had been queuing outside the A&E waiting for it to open at 8am. We visited the department at 7:45am during the inspection and there were no patients waiting.
- Following the integration with Royal Stoke, some specialist services had been moved. This meant that when patients had been seen at County who were identified as requiring specialist on-going interventions they had to be transferred to Stoke. The transferred specialities included, Urology and Consultant led maternity services. We saw challenges across the trust in the ease of movement of patients between County and Royal Stoke site.
- There were no fast track pathways for patients who needed specialist follow-on care and treatment. The specialist services were based at Royal Stoke but patients had to wait in line with other patients to be seen by the County emergency doctor before being transferred. General waiting times at County Hospital were not as long as those experienced at most other hospitals 95% of patients spent less than four hours in the emergency department before being admitted, transferred or discharged. Patients who were transferred to Royal Stoke had further waiting in the emergency department there, before finally being transferred or in some instances discharged with a clinic appointment. The exception being that the County Hospital

gynaecological team would see patients between 9am and 5pm but only after they had been seen by the emergency department doctor, which prevented the need for some transfers.

Meeting people's individual needs

- During our inspections, we noted that whilst the department was busy, all care and treatments had been provided in line with people needs and patients were happy with the care they had received.
- At the time of our inspection the emergency department did not have separate paediatric unit. There was a separate waiting area for children with a child toilet, a consulting room specifically for children and young people and a specifically designed cubicle in majors. After booking in at the reception children and young people used the same waiting areas as adult patients. Adult waiting areas are unsuitable places for children and young people to wait. However, staff assured us that younger children were always prioritised due to their vulnerability and to reduce anxiety for the child and parents or carers.
- Consultants expressed concerns regarding the availability of child and adolescent mental health services (CAMHS). They said they experienced a high volume of young people who required emotional support or specialist interventions regarding eating disorders and similar issues but the CAMHS service which was provided externally, did not usually have the resources to attend.
- Translation services were available in form of telephone interpreter services. We did not see evidence of information being available in alternative languages.
- The trust had a dementia care team who provided training and support to staff. The department did not use overt indicators to identify patients living with dementia or those with other memory issues. Patient notes were marked to indicate to staff which patients were affected. 'This is me' packs were provided to relatives or patients so that they could provide additional information to help staff provide appropriate support and guidance.

Access and flow

- The County Hospital had a higher than average rate of admissions to hospital for patients attending the emergency department. The average admission rate for England during 2014/2015 was 21.9% whilst County's admissions rate was 25.5%. Although this was an improvement on 2013/2014, when the hospital admitted almost 30% of patients. Admitting relatively high numbers of patients increases workload for the department as well as impacting on the rest of the hospital but the downward trend shows improvements in treatment and discharge support.
- National standards require that 95% of patients should be seen, treated, admitted and/or discharged within four hours of arrival at the department. We looked at the daily attendance figures for County Hospital through March 2015. The A&E saw 3,199 attendances of which 170 (5%) exceeded the four hour target. We saw that there was a notice board in the waiting room with waiting time written on it. One patient told us that when they arrived the sign had said 1hour, but whilst they had been waiting this had been updated to 2.5 hours. They said they were unsure where that left them in the queue.
- Patients who leave the department without being treated is a useful indicator of patient satisfaction with waiting times. Between July 2013 and June 2014 294 patients left without being treated, this equates to approximately 1% of patients. The national average for patients leaving without being seen is 3%.
- Following the integration with Royal Stoke, some specialist services had been centralised at Stoke. Two ambulances were available 24-hours a day, 7-days a week to effect transfers of patients who had been seen in County ED but required hospitalisation under the care of specialist consultants. We saw that on average 10 to 12 transfers took place each day. Ambulance staff confirmed that the majority of transfers were to Royal Stoke, however occasionally transfers were made to other neighbouring hospitals.
- Patients who have been treated in ED and need further observations prior to a decision being made to admit or discharge were transferred to the Clinical Decisions Unit (CDU). Staff explained that these patients generally low risk, waiting for discharge home or final test results. These patients remained under the care of the emergency department doctors.
- We were concerned about the flow of patients through the CDU. It had been set up as a four-bedded unit, with additional capacity for up to eight patients. At one point during our visit we found twelve patients on the unit

and that another patient was due to arrive. Managers had moved staff from other areas to manage the workload but they were unfamiliar with the unit and it was chaotic and disorganised.
- We escalated our concerns to the Matron who told us this number of patients was unprecedented, and had been at around six to eight patients in the last few weeks.
- When we returned unannounced, we found twelve patients were yet again being accommodated on the unit. On this occasion we saw that a senior ED nurse had been allocated to the unit and it was being managed appropriately.
- When the department closes at 10:00pm, patients who were in the department continue to be cared for in line with their needs. The department aims to deal with all patients by midnight which is when consultant cover ends. If patients still needed to be seen or monitored then consultants would remain present until all patients had been deal with appropriately.
- On occasions, patients remain on the unit overnight due to lack of beds in other parts of the hospital. In these circumstances, nursing staff and junior doctors are available to meet their needs. Consultants are available on a call out basis if required.

Learning from complaints and concerns

- Complaints and patient experiences were discussed at team meetings and nursing handovers in the emergency department. Staff confirmed that they discussed complaints and gave examples of how the issues raised by patients were responded to. We were shown notice boards which had been purchased and were waiting to be erected. The boards were to be used to display information for patients such as current waiting times and information about staff on duty.
- Staff said that most complaints were in respect of waiting times during busy periods, and people usually understood the reasons when they were explained properly. Other complaints included patients having to ask twice for drinks when staff had been distracted and not responded to earlier requests.
- We saw examples of complaints which had been recorded, investigated and responded to. Where possible explanations had been provided to clarify how or why issues had arisen.
- We saw information about the trust Patient Advice and Liaison Service (PALS) system and how to make a complaint were displayed in waiting areas. We did not see these in any other language than English. Additional information to assist people to make complaints was available on the trust website.

Are urgent and emergency services well-led?

Requires improvement

We observed that team work well together and there is mutual respect. However, staff satisfaction was mixed. Staff did not feel actively engaged or empowered.

There was local public concern that further changes were planned to the ED, managers told us they had worked hard to reassure local people about the future of the department.

The approach to service improvement was not clear, the current focus was on the imminent changes to paediatric provision in the department, but it not appear that any long term plans to develop and improve service delivery had been developed and shared with the staff.

The trust has a clear vision which is understood by leaders in the ED, arrangements for governance and performance management operative effectively.

Vision and strategy for this service

- Local managers understood the trust vision and clearly wanted to develop an excellent service to patients. The vision was communicated to staff through intranet messages and training sessions.
- There was a clear vision for the integration or emergency department teams across the two hospital sites but this had not yet been fully implemented.

Governance, risk management and quality measurement

- Regular management meetings took place. These enabled senior staff to meet and discuss governance and quality issues. Key performance indicators were discussed including items such as compliance with safety thermometer targets, complaints staffing issues. Minutes of the meetings were recorded.

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- New policies and procedures had been drawn up to and amendments circulated to staff to ensure that procedures at both sites were uniform across the trust.
- Audits were completed which assisted managers to assess compliance with targets and policies.
- Proud to care audits were introduced when County merged with Royal Stoke. There were twelve key targets: Dignity, Communication, Infection Prevention and Control, Caring for Patients Compassionately, Pressure Area Care and Mobility, Continence, Bladder and Bowel Care, Nutrition, Principles of Self-care Following Discharge, Personal and Oral Hygiene, Administration of Medicines, Clinical Monitoring and Documentation, and Promoting Health. One key area is assessed each month. County had only just started to engage with the new system and the results had yet to be analysed and fed back.

Leadership of service

- Local leaders understood their role in the organisation and in the emergency department.
- Healthcare workers and nursing staff said they were supported by their managers. We were given an example by a member of staff who had a problem with lifting and handling. They told how managers had supported them and enabled them to continue working. Most staff said they were happy working at the hospital.
- Clinical leadership was good. Registrars' and junior doctors said they were able to approach consultants for advice and felt supported.
- We saw evidence that staff with development needs were supported to improve by leaders in the department.

Culture within the service

- There was a genuine desire from all staff we spoke with to provide effective care and treatment to patients.
- We saw that there was an excellent relationship between the doctors and nurses who were on duty at the time of our inspection. There was a mutual respect for each other's role
- Staff talked to us about their anxieties about recent organisational changes, following integration. Managers told us they had recognised it early in the process and had taken steps to ease staff concerns, they believed that staff were now settling and accepting the new organisation.
- There had been plans to try to integrate the two emergency teams at County Hospital and Royal Stoke by exchanging staff for short periods of time. This had been put on hold because of the unprecedented capacity issues experienced at Royal Stoke. However, we were told that it was hoped to start exchanges later in the year when there would be time to complete proper induction for staff at each site. Managers believed this would help to integrate the teams and reduce the 'them and us' status which some still felt. We were also told that new nursing staff who had been employed since the two sites amalgamated had been recruited on the basis that they could be required to work at either site.
- Some staff expressed concerns about changes to working arrangements at night. If all tasks had been completed and there were no patients requiring support, staff were asked to go off duty (and owe time) or help out in other areas of the hospital or travel to Stoke. This change to working practices had not been well managed in their view and was impacting on staff morale.
- We spoke with the matron about the system and she explained that the trust provided taxi's to ensure staff who moved between sites were safe and didn't have to do so at their own expense. The decision to take time off rather than assisting at Royal Stoke was one of choice for the individual member of staff. Any staff who had travelled to stoke would be expected to return to Stafford in time to end their shift although this was subject to operational need as was the case with any staff.

Public and staff engagement

- Information displayed in the department to show patients and visitors how well the department had performed was very sparse. Only minimal information was displayed in relation to staffing levels, and was not in a position where it could be easily viewed by patients. The management team told us they had plans in place to address this. We were shown notice boards which had been purchased and were waiting to be erected, it was explained how these would be used to provide information for patients and their relatives.
- Information such as employee of the month and 'You said – we did' was already being displayed in the main waiting room.

Urgent and emergency services

- Staff told us they were apprehensive about their future. They said that major changes had taken place and although they understood the changes were for the benefit of patients, staff were told about them at the last minute. This had left an air of uncertainty.
- Managers told us that staff had not been updated about the new paediatric emergency department because it had been thought that the high volume of changes had already caused uncertainty and distress. They wanted to ensure that everything had been authorised and put in place before making any announcements to prevent misinformation of disappointment should the venture not have succeeded. We were told that a staff presentation was planned for the Monday following our inspection at which time staff would be fully aware of what was happening.
- Local community campaign groups had expressed concerns about the transfer of services, including the emergency department. Senior managers told us that they had worked to reassure the local community and pointed to the investment in the new paediatric emergency department as testament of this.

Innovation, improvement and sustainability

- The trust has secured a £250 million financial investment, following the integration of the two hospitals; this will fund capital developments at County Hospital, including the emergency department.
- From May 2015, the emergency department will include a facility for children and young people.

Medical care (including older people's care)

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

Information about the service

Medical services at County Hospital are delivered across six wards: the specialist neurological unit, two respiratory wards, two general medicine wards, an elderly care ward and the acute medical unit.

Between July 2013 and June 2014, the former Mid Staffordshire Hospital received 29,723 medical admissions.

We visited all six wards during the inspection and our unannounced inspection on 1 May 2015. We talked to 12 patients and relatives, 39 staff (including healthcare assistants, therapists, nurses and doctors). We observed care and treatment, and looked at the records of 35 patients on the wards. Before the inspection, we reviewed performance information about the hospital.

We attended nursing and medical handovers and multidisciplinary team meetings.

Summary of findings

Further improvements were required to protect patients across medical services from avoidable harm with medicines management, safe storage of patient records and a lack of continuity for patients due to the high reliance on agency and locum staff. Opportunities for disseminating and learning from incidents and improving the service, through audit and monitoring of the service could be improved.

Accessing information could be challenging for staff as neither hospital site could view the other's electronically held records and test results. At times, this led to delays in delivery of care and treatment.

We saw that patients were affected by long delays when accessing these services and treatments that were provided at the Royal Stoke site.

Ward staff spoke highly of local leadership and felt supported. However, there was a "disconnect" between local teams and trust managers. Staff did not feel engaged in the service strategy and felt more engagement with senior managers was needed.

Care was provided in line with national best practice guidelines and the trust participated in all national clinical audits they were eligible to take part in. Results of national audits for the newly formed University Hospitals North Midlands NHS Trust were not yet available; however, results from the former Mid

Medical care (including older people's care)

Staffordshire NHS Foundation Trust showed that outcomes for patients were good. The hospital achieved all the applicable targets in relation to referral to treatment times.

Staff in the hospital worked well together to provide effective treatment for patients and patients. Staff were caring and kind, treated patients with obvious compassion and respected patients' dignity and wishes.

Are medical care services safe?

Requires improvement

Further improvements were required to protect patients across medical services from avoidable harm with medicines management, safe storage of patient records and numbers of agency and locum staff.

On a number of wards we found patient notes or prescription charts left unattended.

On-going staff vacancy levels resulted in substantial agency usage which permanent staff found difficult as this led to a lack of continuity for patients and a potential reduction in quality of care. Although vacancy levels had reduced from 30% in June 2014 to 11% at the time of the inspection. One week following our main inspection we conducted an unannounced visit during which we inspected the acute medical unit, ward 10 and wards 12 and 12a.

Incidents

- There were no Never Events registered for medical care services from 1 November 2014 to 31 March 2015.Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- In the same period, there were 10 serious incidents which required investigation, including five grade three pressure ulcers, two slips and falls and three ward closures due to outbreaks of diarrhoea and vomiting.
- We saw evidence that all adverse incidents were reported appropriately, investigated and where appropriate feedback was given to staff to improve patient care and reduce risks.
- We were shown examples of two root cause analyses that had been completed after patient harm incidents. Both showed openness, a thorough investigation and that the outcome had been fed back to the staff involved in the incidents. In line with duty of candour responsibilities, patients and relatives involved in these incidents had been kept informed throughout the investigations.
- On the specialised neurosciences unit (SNU) we were shown details of a pressure ulcer that had been acquired while the patient was on the unit. We were

shown that it had been logged using the trust's electronic incident reporting system, that a root cause analysis had been completed; the ward staff had made a safeguarding referral against themselves.
- Staff across all medical wards were encouraged to report incidents to senior ward staff. Many told us they had difficulty accessing the trust's electronic incident-reporting system which had recently been introduced to the hospital and they had not had training in its use. They understood that a 'no blame' culture was promoted.
- Learning from incidents was fed back to staff locally but we did not see any evidence of staff being made aware of incidents from other services within the trust.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care. We were provided with a summary of the results of the monthly safety thermometer audit up to the end of December 2014; however this data was for the whole of medical services for the trust and did not give specific details for County Hospital, this meant that performance against the targets for medical services at The County could assessed.
- Apart from on the SNU, where it was on a notice board, all of the wards we visited had a large LCD screen in a public area showing performance against the trust's own safety and patient satisfaction targets, which included some of the Safety Thermometer information. These targets included numbers of pressure ulcers, falls, MRSA and Clostridium difficile infections, complaints, letters and cards of appreciation and NHS 'friends and family test' responses, and provided a good overview of the wards' safety and satisfaction performance.
- The total number of pressure ulcers reported across medical services from 1 October 2014 to 31 January 2015 was 105, however 97 of these were identified when patients arrived at hospital and only eight were reported as hospital-acquired. Of those eight hospital-acquired pressure ulcers three were reported in October 2014, one in November 2014, one in December 2014 and three in January 2015.
- A total of 163 patient falls were reported across the medical services, excluding emergency medicine, from 1 November 2014 to 31 March 2015. 28 falls happened in November 2014, 37 in December 2014, 36 in January 2015, 31 in February 2015 and 31 in March 2015. We were provided with further details of falls incidents up to the end of January 2015, which included how they were investigated and what the outcomes were for the patients. Up to the end of January 2015 two falls resulted in significant harm to the patients, both of whom suffered a broken bone.

Cleanliness, infection control and hygiene

- With one exception we observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance. Aprons and gloves were readily available in all areas. Hand hygiene audit data supplied by the hospital showed that the medical wards had achieved 100% compliance in the three months preceding the inspection.
- Between 1 November 2014 and 31 March 2015 there was one reported incident of MRSA and seven incidents of clostridium difficile infections across medical services. There was one incident each month during this time apart from in January 2015, when there were four.
- On ward one/two (two wards which have been merged to make one large ward) we saw a junior doctor preparing to insert a cannula into a patient's vein. The doctor was not wearing an apron and did not wash their hands before preparing to carry out the procedure. The tray that the doctor was using contained several packets of equipment and was not a sterile field, so was not compliant with infection control guidelines. A ward nurse intervened before the doctor attempted the procedure.
- All the staff we spoke with were aware of current infection prevention and control guidelines. Across the medical directorate, 90% of non-clinical staff and 75% of clinical staff had completed infection control training. Data just for medical services at The County Hospital was not available.
- There were sufficient hand-washing facilities at the entrance to and inside all medical wards. All the wards we visited were visibly clean and in a good state of repair. On ward 12 we inspected the cleaning records folder and found that it was fully completed and showed a comprehensive daily cleaning regime.

Environment and equipment

Medical care (including older people's care)

- All the wards we visited provided a comfortable, warm environment for patients. There was enough space for effective patient care to be carried out and for equipment and consumables to be stored.
- Resuscitation equipment on wards had been recorded as checked regularly; equipment was in date, appropriately packaged and ready for use.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were available and staff told us they never had any problems getting these quickly when they needed them.
- On the acute medical unit we were told they were trialling a new kind of pressure relieving mattress which combined foam and air sections. Using these mattresses improved care for patients because they did not have to be moved from one mattress to another when they were found to need pressure area care.

Medicines

- On the acute medical unit (AMU) we saw that medicines were kept in a locked room, controlled by a keypad. We were told that it was considered normal practice for other wards to borrow medicines from the AMU out of hours if they were short of stock, which could lead to errors in stock control. One sister told us that if this happened it was mentioned verbally on handover but not recorded in writing and another sister told us that there was a folder containing records of drugs lent to other wards, but while we were on the ward the staff could not find that folder.
- On ward 12 we found ampoules of salbutamol (a prescription-only medicine used for patients with breathing problems) left on top of a cupboard in the ward reception area. We brought this to the attention of the nurse in charge and the medicine was put back in a secure cupboard.
- All ward-based staff reported a good to excellent service from the pharmacy team.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient and regular checks of controlled drugs balances were recorded, in line with good practice.
- Fridge temperatures were regularly checked and recorded, although staff had reported potential problems with digital thermometers that had been supplied to monitor fridge temperatures; they appeared to be reading too high when checked against other thermometers. Staff on ward 12 told us they were waiting for new thermometers to be delivered.
- Patients across most medical wards were prescribed and administered medication as per their prescription charts. The medical notes and patients' wristbands alerted staff when a patient was prescribed a medication to which they were allergic. On AMU we witnessed two nurses checking a drug and patient notes prior to administering it to a patient, then not giving it as the patient was shown to being allergic to it.

Records

- On Ward 12 we found patients' notes left in public view and on wards one/two and 10 we found trolleys containing patients' notes were left unlocked. During our follow up visit to the same ward, we found patients' notes left unattended on a counter behind the nurses' station, a prescription chart left unattended on the nurses' station and a printout of handover notes for all the patients on the ward which had been left on top of a printer.
- We looked at 56 sets of nursing records on medical wards and all were updated regularly and included detailed care plans.
- We saw comprehensive and well-documented wound management plans. These showed that wounds were assessed; treatment records were in place and evaluated to show progress of healing.
- We looked at the records of three patients who were wearing hand control padded mittens to prevent inadvertent removal of their feeding tubes. Their records included a hand control mittens assessment tool and a mitten care plan, all of which were completed appropriately. We saw weekly record to support the multidisciplinary decision to continue with the use of mittens and the care recorded times when the mittens were removed and re-applied twice daily.

Safeguarding

- Staff demonstrated through interviews a good knowledge of the trust's safeguarding policy and the processes involved for raising an alert.
- Staff received safeguarding training at induction, via e-learning and face to face and this was well attended. Across the medical directorate trust wide data showed,

91% of staff had current vulnerable adult awareness training and 90% had current child protection awareness training. Data just for medical services at The County Hospital was not available.

- Staff knew the name of the trust safeguarding lead. They told us they were well-supported and would seek advice if they had safeguarding concerns.
- On the AMU we were told that when patients with existing safeguarding issues are admitted the unit staff were contacted by social services and given information about the situation to allow them to prevent further harm to the patients.
- We saw that safeguarding alerts were completed within the recommended 24-hour timeframe and were relayed verbally during staff handover times to ensure that all staff were aware of patients' safeguarding issues. On the SNU a sister told us that they had reported a safeguarding against themselves after a patient was found to have acquired a pressure ulcer while in their care.

Mandatory training

- The trust provided us with figures for numbers of staff from the medical directorate whose mandatory training was in date however this was not broken down into the two hospitals so we were not able to assess compliance with training for County Hospital staff alone.
- Across the medical directorate, we found that 86% of staff had completed their statutory mandatory combined training

Assessing and responding to patient risk

- Patients' individual risk assessments were completed, however we saw inconsistent quality of these assessments as staff from County hospital were recently introduced to new documentation rolled out by Royal Stoke this resulted in incomplete documentation on wards 12 and 12a for pressure ulcers and falls risk assessments.
- On ward 10 we were told that patients' risk of falls were assessed when they arrived on the ward and they used a system of "cohorting" to reduce the risk of falls in higher risk patients. This meant that patients who were considered to be more likely to fall were nursed close together, in the same bay on the ward if possible, and that more staff were allocated to that area so that they were able to monitor patients more effectively.
- Patient handovers took place at the beginning of every shift change. Patient information sheets were given to each member of staff.
- Nurses routinely attended ward rounds, making communication of nursing and medical information efficient and enabling nursing and medical staff to respond to patients' needs in a timely manner.

Nursing staffing

- There were adequate levels of nursing staff across most medical wards, however senior nurses told us that up to a third of the nurses on weekends could be agency staff, and that local managers did not have any input into which agency staff were sent to work on their wards. Managers and nurses told us this had a negative impact on quality of care being delivered as agency staff did not always complete documentation and new agency staff were unfamiliar with individual patient needs. On the AMU a ward manager told us that on most days about 20% of the nurses working on the ward were agency staff but data to support this was not available.
- High numbers of agency nurses and locum doctors on all the wards we visited meant that staff could be working in unfamiliar areas and that permanent staff would have to spend time away from their own duties to mentor, supervise and assist agency and locum staff. The trust told us that the number of nursing vacancies across County Hospital had reduced by 50% in the last six months.
- During an unannounced visit to AMU and ward 9, the SNU, we saw staffing levels were adequate to meet the needs of patients and both wards were well managed.
- Ward managers were not counted in the daily staffing rota and their role was supernumerary. However, it was not uncommon for ward managers to work as part of the staffing numbers to cover unfilled shifts which could be several times per week. This resulted in reduced time to carry our managerial ward duties. Nursing staff on wards 12 and 12A told us that they felt well supported by senior staff in the hospital but that they felt stretched due to vacancies and the numbers of agency nurses. When we carried out the follow up visit to these wards during a late evening we found that half of the qualified nurses on ward 12 were agency staff. ,
- Wards 1 and 2 had recently been merged to make one large ward with 40 beds. There was only one ward manager for the whole of this newly combined ward. The manager told us that four band six nurses have

been appointed to supervise smaller sections of the ward. However, the ward manager's duties were stretched across two wards which made day to day working difficult.
- On ward 10 we were told that the ward manager 'block booked' agency staff so that the same staff worked on the ward for longer. This improved continuity of care and reduced risks as the agency nurses got to know the patients, environment and other staff.
- We talked to three agency staff who told us when they are booked they are orientated to the ward, given a verbal handover and also a handover sheet. There was no formal induction for agency staff as nurses told us there was not enough time.
- We observed nursing handovers on AMU. Handovers were comprehensive, with oncoming staff being told about all details of the patients' care and their conditions. Handovers took place within sight of the patients but far enough away that patients and visitors could not overhear confidential information.

Medical staffing

- Most of the time there were adequate staffing levels of doctors and consultants across most medical wards to assess and treat patients. However, this was largely due to the use of locum doctors and nursing staff told us that doctors sometimes had to work 'flat out' to treat patients. They told us they felt that there was high use of locum doctors up to consultant level and nursing staff sometimes had no idea how many doctors would be on duty or who they were, until they arrived.
- Nursing staff reported satisfactory medical cover across all wards, with minimal delays when requested to assess patients whose condition had deteriorated.
- Junior doctors covered weekends and had access to medical registrars as required. We spoke with three junior doctors who told us that they felt unsupported on nights and weekends and often had problems getting advice from more senior medical staff who were at Royal Stoke.
- Senior nurses on AMU told us some consultants were permanently based at the hospital but some floated between there and Royal Stoke. Senior nurses on AMU also told us that not all of the locum doctors carried hospital pagers so they sometimes had difficulty contacting them when they were needed on the ward.
- On ward 12A nurses told us that the medical staff were all locums which led to a lack of decisions being made about patient discharges and sometimes patients stayed on the ward longer than they needed to.
- A doctor on ward 12 told us that they were supposed to have two registrars (a type of middle-grade doctor) but they only had one locum middle grade doctor and one junior doctor.
- Two doctors on ward 10 told us that the cover by middle grade doctors was inconsistent and locum doctors were often used. We were provided with figures for forecasted agency and locum doctor use across medical wards from October 2014 to March 2015 and during that time 31% of doctors' hours were planned to be covered by agency or locum doctors. Details of actual locum and agency doctors' hours were also provided but they were not separated into the two hospitals so a direct comparison could not be made.
- On the AMU a senior nurse told us that the night medical cover for the hospital was two middle grade and two junior doctors.
- We observed a medical staff handover meeting on AMU, which was attended by a consultant, a middle grade doctor, a junior doctor and a critical outreach practitioner (a member of staff from another ward where higher dependency patients are cared for). The medical staff were supportive of each other and the junior staff were able to speak freely and contribute to the handover.

Major incident awareness and training

- Major incident training levels were recorded as 100% attendance.
- The major incident response plan was in place and written with reference to the NHS Emergency Planning Guidance 2005.
- The plan provided detailed information for how the trust would respond to a major incident, including primary and secondary command centres and local action cards specific to each division and department.

Are medical care services effective?

Good

Care was provided in line with national best practice guidelines and the trust participated in all national clinical

audits they were eligible to take part in. Results of national audits for the newly formed University Hospitals North Midlands NHS Trust were not yet available; however, results from the former Mid Staffordshire NHS Foundation Trust showed that outcomes for patients were good.

Patients were well-supported with nutritional needs, hydration and effective pain relief by well-trained, competent staff.

Staff in the hospital worked well together to provide effective treatment for patients and patients had access to nursing, and medics seven days per week and therapists Monday to Friday.

Accessing information could be challenging for staff as neither hospital site could view the other's electronically held records and test results. Consequently, this led to delays in delivery of care and treatment at times.

Evidence-based care and treatment

- Hospital policies and procedures were developed in line with national guidance; they were available for all staff to access on the hospital's intranet site.
- We saw evidence that the National Institute for Health and Care Excellence (NICE) guidance, such as the clinical guidance on the prevention and management of pressure ulcers was followed across medical wards.
- Staff understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies.
- On the SNU, we talked to a ward sister who told us they were piloting enhanced one-to-one care for patients with complex needs as a result of their brain injury aligned to NICE head injury guidelines. They were using games and electronic activity-based gaming consoles to promote recovery for patients with this condition, and healthcare support staff had been given training to recognise patients who might benefit from this therapy soon after they were admitted to the ward. It was too early to fully evaluate the outcomes for patients receiving this care but initial results had shown improvements in patients' recovery time and quality.

Pain relief

- Patients were generally administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels.
- Patients we spoke with on the wards were satisfied with their pain relief and told us it was normally provided when they asked for it and it was effective.
- On ward one/two a sister told us of instances where pain relief had not being given to patients in a timely fashion because the controlled drugs cabinet had only been kept on one of the original wards which meant quick and easy access to drugs was problematic.

Nutrition and hydration

- All patients at risk of malnutrition had cards by their bedside to alert staff that assistance to eat was required. On ward 10 we talked to six members of staff, including some agency staff, and they were all aware of the cards and what they meant for the patients.
- On the SNU we saw an information display board for relatives which described the differences between various types and textures of diet that may be needed for patients who have problems swallowing. This information was presented in a clear and helpful way.
- Staff on all wards told us that patient referrals to dieticians were carried out promptly when required.
- The majority of patients told us that the food and drink was tasty and enjoyable, that portion sizes were adequate and there was a variety to choose from.
- One patient on ward 10 told us that he needed small sloppy portions of food but that the catering team didn't always supply this for him. He told us that the dietician on the ward was working hard to get him the type of food that he needed.
- Hot and cold drinks were offered to patients at regular intervals and fluid balance charts were recorded appropriately.

Patient outcomes

- Individual wards held performance data to measure the quality of care, quality of patient documentation and any patient harm incidents.
- Overall, the standardised risk of readmission was lower for County Hospital's elective patients.
  - The 2012/13 Heart Failure Audit showed County hospital, when it was part of Mid Staffordshire NHS Foundation Trust was in line with England averages,
- The Myocardial Ischaemia National Audit Project (MINAP) audit for 2013/14 showed that the hospital was above the average in almost all measures when it was part of Mid Staffordshire NHS Foundation Trust. For

example; 97% of patients with ST segment elevation myocardial infarction (nSTEMI – a form of heart attack) were seen by a cardiologist, compared to the national average of 94%. Patients admitted to the cardiac unit or ward scored significantly better at 87% against a national target of 55% and patients that were referred for or had angiography (heart procedure involving widening of the arteries) scored 87% against the national average of 79%.

- The former Mid Staffordshire NHS Foundation Trust scored higher than the England median in 16 indicators in the National Diabetes Inpatient Audit (NaDIA).
- The former trust also scored better than the national average for elective patients at County Hospital regarding length of stay.
- Since 1 November 2014, medical services conducted 13 local audits to measure quality and performance across a range of clinical conditions. According to the trusts audit register, results were in the process of still being collated and not yet completed.

Competent staff

- We observed clinical practice, attended staff handovers and MDT meetings and saw that staff across all medical services were competent and knowledgeable within their chosen wards.
- We saw records of staff training and assessment which showed they were competent in specialist areas. For instance on the SNU we saw training folders that were held for every member of ward staff, in which the stored certificates from the Stroke Training and Awareness Resources ('STARS') competencies .
- Most staff told us they received appraisals from their line managers. Up to the end of December 2014 the trust told us that 89% of non-consultant staff had had an appraisal against a target of 95%.
- On the Acute Medical Unit, two Advanced Nurse Practitioners told us that they did not have a line manager identified to do their appraisals, and were unable to structure their own development as they did not know what the plan for their role was.
- Staff we talked to on ward 10 told us they completed their mandatory training but the ward was too busy for them to actively seek more training to develop their skills and knowledge.
- Healthcare support staff on SNU were being trained in medical note-writing to improve the information that was recorded about their patients.

Multidisciplinary working

- Within the hospital staff demonstrated good multidisciplinary working across medical services. Doctors, nurses and therapists worked well together and treated each other with respect. This ensured good communication of patient information at handovers, ward rounds and multidisciplinary team meetings.
- On ward 10 we were told that staff held a multidisciplinary meeting every morning involving doctors, the nurse co-ordinator, occupational therapists, physiotherapists and social care and dementia liaison leads. Each patient was discussed during these meetings and the nurse co-ordinator then passed the information on to the nurses dealing with individual patients.
- On ward one/two a sister told us that they experienced delays in visits from experts at Royal Stoke when they were needed to assess patients at County Hospital, which caused delays in appropriate treatment being given to patients.
- We spoke to a specialist anticoagulant nurse while we were in AMU. Anticoagulants are a medicine that change the way blood clots, and are used to treat some heart conditions and problems where blood clots form inside blood vessels. The nurse told us that they visited all the wards in the hospital regularly to assess and reassess patients in need of anticoagulant therapy. They told us they regularly spoke with colleagues at Royal Stoke and other nearby hospitals and this worked well.
- We spoke with members of the discharge liaison team who told us that they worked in partnership with Royal Stoke and other nearby trusts.

Seven-day services

- All medical wards had seven-day consultant cover. At night a team of two junior doctors and two middle-grade doctors covered all wards in the hospital.
- Junior doctors covered weekends, with access to medical registrars and on-call consultants when required.

Access to information

- Doctors and senior nurses on AMU told us that there were communication problems between Royal Stoke

and County Hospital because neither site can view the other's records and test results. This leads to delays in discussing patients because staff have to photocopy notes and fax them to Royal Stoke. This process also takes time away from care and treatment of other patients on the ward.

- Agency nurses and locum doctors were unable to access IT systems so were not able to obtain some test information for their patients and had to ask for assistance from permanent staff to obtain information.
- One senior nurse on AMU told us that a patient had been transferred from that ward to Royal Stoke, and then discharged home with a diagnosis of an infection. When the patient was readmitted from home to County Hospital some days later staff at AMU were unable to get the patient's test results from Royal Stoke and had to ask the patient's GP to fax them a copy of the discharge letter from Royal Stoke.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated through interviews they had good knowledge of the Mental Capacity Act 2005 and understood issues relating to deprivation of liberty safeguards and when to raise an alert. On ward 10 we spoke with a staff nurse who demonstrated a good understanding of the Mental Health Act and how it should be implemented. We also spoke with three healthcare assistants who had a basic understanding of the Act.
- We were provided with a copy of a "Standard Operating Procedure for the use of hand controlled padded mittens to prevent inadvertent removal of feeding tubes and other essential lines". Use of mittens is a form of deprivation of liberty. Information for patients and relatives about the Mental Capacity Act was displayed at each ward.

Are medical care services caring?

Good

Staff were caring and kind, treated patients with obvious compassion and respected patients' dignity and wishes.

Patients and relatives were supported physically and emotionally on all of the wards. .

All the patients and relatives we talked to across medical services spoke very highly of the staff and the care they provided.

Compassionate care

- Patients across all medical wards were satisfied with the quality of service they received and all the patients we talked to told us they had no complaints.
- We talked to three patients on AMU who told us that the staff frequently came to check if they needed anything, and that nothing could have been done better. They described staff as attentive and caring.
- A patient on ward 12A told us they were admitted to AMU when they first arrived at the hospital and said staff on AMU were lovely and couldn't do enough for them.
- We saw patients being cared for in a genuinely compassionate way on all the wards we visited but especially on AMU, the SNU, and ward 12.

Understanding and involvement of patients and those close to them

- Patients told us that details of their care and treatment were explained to them without them having to ask, but that staff were happy to answer questions if they were asked.
- A patient told us that the nursing took time to have proper conversations with them and had built a good rapport with patients, which put them at ease.
- The family of an elderly patient told us they were very happy with the way that they were involved in management of the care of their relative.
- Excellent patient involvement was seen on the SNU where staff paid special attention to patients who had complex needs resulting from brain injuries. The sister told us that relatives were asked to be involved in multidisciplinary team meetings on the ward about the best interests of patients who weren't able to make their own decisions.
- A relative of a patient living with advanced dementia told us that their family had received good communication about the patient from doctors and nurses and described them as excellent.
- We saw relatives of a patient ask nurses a question while the nursing handover was taking place. The nurses stopped the handover and answered the question in a supportive, empathetic and caring manner before carrying on with their task.

Medical care (including older people's care)

- The Friends and Family Test (FFT) showed that in February 2015, 95% of patients were likely or extremely likely to recommend the service. The hospital had scored just below the England average for the preceding three months.

Emotional support

- One patient told us that they had been really worried about leaving their wife and children to come into hospital but that staff had supported him and it had not been as bad as he expected.
- On ward 10 we saw information about an Independent Mental Capacity Advocate who visited and was able to assist any patients who had no family or other support outside the hospital.
- The trust provided a chaplaincy team to support the needs of patients with different religions; we saw them engaged with patients at the bedside and they provided comfort through quiet conversations which we saw put patients at ease.

Are medical care services responsive?

Requires improvement 

The hospital achieved all the applicable targets in relation to referral to treatment times

Following implementation of the Trust Special Administrators (TSA) recommendations some services had been transferred from County to Royal Stoke. This meant patients requiring certain tests or procedures had to transfer to Stoke to have these carried out. We saw that patients were affected by long delays when accessing these services.

The Ambulatory Care Unit demonstrated responsive admission and discharge planning, however it was largely used as an overspill area for AMU and floor space was limited.

Patients' individual needs were generally met; however, further improvements could be made for patients living with dementia or a learning disability.

Service planning and delivery to meet the needs of local people

- In December 2013, the Trust Special Administrators (TSA) recommended that a physician led inpatient service for adults with medical care needs should remain in Stafford which will manage acutely unwell patients locally, however, complex medical care would no longer be provided on site. A number of the changes needed to facilitate this new model of care have been implemented and we recognise that the service is still in the process of change.

Access and flow

- National standards state that 90% of referred patients who were admitted to hospital and 95% of referred patients who were not admitted to hospital should start consultant-led treatment within 18 weeks of referral.
- During November and December 2014 only gastroenterology and clinical haematology treated people as inpatients. Both achieved 100% in November 2014. In December, clinical haematology maintained 100% against the target but gastroenterology did not meet the target, achieving a score of 75%.
- For non-admitted patients, all seven specialties provided at the hospital reported that they had achieved or exceed the 18 week referral-to-treatment target. These were general medicine, gastroenterology, endocrinology, clinical haematology, nephrology, neurology and geriatric medicine.
- Staff told us patients at County Hospital who required treatment or procedures such as angiograms, perfusion tests and pacemaker treatment were transferred to Royal Stoke as these services were no longer provided at County, following integration.
- We saw delays in transferring these patients for example one patient had waited four days to be transferred to Royal Stoke, the ward manager told us if the patient had been admitted to Royal Stoke direct this procedure would have been carried out within 24-48 hours.
- Nurses told us about a patient who needed a test for a heart condition that until recently they would have been able to carry out on site, and which would have taken about 30 minutes to perform. As they no longer had the equipment to perform this test the patient and a nurse had to travel to Royal Stoke where they waited for nine hours before the test was performed. We asked the trust for data on the number and length of delays experienced by patients but this was not available.
- Medical teams tried to make timely internal and external referrals to other healthcare professionals to ensure that

patients were seen by the right person at the right time, however three junior doctors told us that they experienced difficulties referring patients to specialised wards at Royal Stoke University Hospital (Royal Stoke) at night and could sometimes spend up to four hours on the telephone trying to get their patients accepted there.

- Staff on the Ambulatory Care Unit, which was intended to look after day case patients, told us that the unit was used as an overflow for inpatients from AMU when AMU did not have enough space. They told us that this had a negative effect on flow of patients through the department and meant they were less able to assist with patients being referred from other departments such as the emergency department.
- Two senior nurses on AMU told us that GPs continued to refer patients in to that unit for conditions such as heart and abdominal problems which County Hospital was no longer able to assess or treat. Patients such as these then spend longer waiting to be transferred to Royal Stoke than they would have, had they gone straight there, as they were already in hospital they were considered to be less at risk.

Meeting people's individual needs

- There were not enough side rooms to care for infectious patients or to allow privacy for families of patients who were dying. We were told that the area has been subject to redesigned and that the new plan aims for 40% of the beds to be in side rooms.
- There were no activities specifically provided for patients living with dementia or learning disabilities to stimulate or occupy their time. A dementia liaison team was present however staff on ward 10 told us that all the team were able to do was spend time talking to patients living with dementia as there were no equipment or activities available.
- Three patients on ward 12A told us there were no activities for them to take part in and that they were very bored. We observed and were told that nursing staff on the wards were very busy and this sometimes hampered their ability to meet people's individual needs. For example, a patient told us that sometimes he had to wait 10 minutes for help after using his call bell. He told us that the staff were "really good but just too busy".

Learning from complaints and concerns

- Every ward we visited had information on how to make a complaint prominently displayed.
- We were told that all complaints were discussed during monthly ward meetings and learning from complaints was discussed during this time, although we did not see any meeting minutes.
- On ward 10 we were shown a formal record of complaints which was kept by the ward manager. Most complaints related to continuity of care and communication from bank and agency staff. In response to these complaints, the agency staff booking and management procedure had been changed to book staff for longer periods.
- There were 37 complaints registered by the trust relating to medical services at County hospital between November 2014 and April 2015, of which 27 were upheld. There was no information available as to the nature of these complaints.

Are medical care services well-led?

Requires improvement

Ward staff spoke highly of local leadership and felt supported. However, there was a "disconnect" between local teams and trust managers. Staff did not feel engaged in service strategy and more engagement with senior managers was needed.

Opportunities for disseminating and learning from incidents and improving the service, through audit and monitoring of the service could be improved.

There was a strong team ethic amongst staff and they supported each other very well. They were passionate about giving a good service but felt unsupported in achieving this.

Vision and strategy for this service

- Staff were clear about their role in contributing to the overall goal of their respective wards and were determined to provide a good service to patients.
- However, there was no recognition of a strategy, vision or values across medical services. Staff were unable to articulate a common vision or plan. One member of staff

thought that there may be a plan to move specialities from County Hospital to Royal Stoke, another thought that services were winding down and the future of services at County Hospital was "bleak".

Governance, risk management and quality measurement

- Reporting incidents was imbedded across medical services front line staff, and we saw evidence of staff receiving feedback on individual incidents they had raised.
- However, lessons learned from across the medical directorate were not consistently shared with front line staff to ensure improvements in practice. There was little routine shared learning to improve services.
- Governance initiatives were carried out monthly to measure risk and quality of care on medical wards. These included patient safety thermometer and a monthly metric to audit areas of potential risk to include: falls, pressure ulcer prevention, infection control and record keeping.

Leadership of service

- The majority of nursing staff spoke highly of senior sisters as local leaders and told us they received good support.
- Senior managers and executives were not visible. Staff were aware of some members of the executive team but felt they were not approachable and described the overall trust management style as "uncaring".
- Staff told us they felt support and leadership from senior management was lacking, with limited communication and they did not feel respected or valued.
- Two senior nurses told us they had no idea who they should speak with to raise concerns about nursing HR issues such as long term sickness reviews and referrals to occupational health as their manager was on long term sick and they had no replacement manager to escalate queries to.
- During our unannounced inspection we were concerned about the leadership and support arrangements for one very busy ward where concerns had been escalated but support did not appear to be available for the team. We passed on our concerns during the visit and were reassured that support had been offered at the time but it had been a particularly busy day for that ward. The management team agreed to review the leadership issues we raised with them and we saw an action plan was developed as a result.

Culture within the service

- In general we found staff across all medical wards were dedicated and compassionate. We found staff were hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed how dedicated they were.
- However, many staff told us that morale was low and staff felt despondent about the future of the hospital. Nurses across medical wards told us how deflated they felt. One nurse told us "It's really sad, the heart has been ripped out of this place, the main focus is Royal Stoke, we're just a second thought", another nurse said "everyone is leaving or have left, there's no support or leadership and we can never get enough staff to want to work here".

Public and staff engagement

- Staff felt disempowered to improve practices as there they felt there was little opportunity or encouragement from senior management to engage with staff to listen to their concerns or hear their opinions.
- The percentage of patients who completed the Friends and Family test across all medical services was 65% in February 2015. This test measured patients who were likely or extremely likely to recommend the trust.

Innovation, improvement and sustainability

- The opportunity for clinical excellence to flourish across medical wards depended on individual team's workload.
- Many staff we talked to reported little encouragement or opportunity from senior management to engage in innovations in practice and front line staff's focus was purely on delivering patient care.

Surgery

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

Information about the service

In February 2015, all acute surgery activities at The County Hospital moved to the Royal Stoke site. Surgical services on the site are now provided sole on a day care basis.

The day care unit at Stafford provides elective surgery for specialties such as general surgery, gynaecology, urology and upper gastric and orthopaedic surgery. Between July 2013 and June 214 there were 10,300 surgery spells at the hospital and day cases accounted for 44%.

We inspected the trust over three days between 22 and 24 April 2015. A further unannounced inspection took place on 1 May 2015 as part of the inspection process.

We visited the operating theatres, recovery areas and, the day care unit. We spoke with nine patients, 28 staff which included senior doctors, theatre assistants, nurses, healthcare assistants and nurse managers.

We observed care and treatment and looked at 13 care and associated records. We followed three patients to the operating theatres in order to gain a better overview of the patients' journey who were undergoing elective surgery. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Patients received compassionate care and staff were kind and caring. Patients' privacy and dignity were respected and outcomes for patients were above the England national average. The standard of cleanliness was good and infection control procedures were followed. There were standardised protocols for elective surgery which were followed and included the five steps to safer surgery checklist. Incidents were reported and learning from these was shared with staff.

Access and flow was not well managed as resources at the County were not managed effectively. Beds and theatre were not being fully utilised.

Senior clinicians and nurses told us they had good multi-disciplinary working at the County and they felt supported in their roles. Staff did not feel part of the wider trust. They said senior trust management was not visible.

Surgery

Are surgery services safe?

Good

There were standardised protocols used in the assessment of patients and to support the staff in the selection and appropriateness of patients for day care surgery. The five steps to safer surgery checklist was used to identify patients who were at risk of deteriorating.

The unit was clean and well maintained, infection control procedures were followed and infection risks were monitored and regular audits completed. Staff followed national safety guidance on the prevention and management of pressure sores, blood clots, falls on the unit.

Medicines were managed safely although patients encountered long delays for medicines to be dispensed from the pharmacy. Emergency equipment was available, checked regularly to ensure they were fit for purpose.

Patients told us they felt safe and did not have any concerns about current or previous care they had received at the hospital. Safeguarding training was available to the staff. They were aware of the procedure for managing major incidents, and fire safety incidents.

Incidents

- There were no "Never Events" attributable to surgical services in 2014. Never events are serious, largely preventable patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers.
- The surgical day care unit exceeded the national target of 95% for New Harm Free Care via the "Safety Express" point-prevalence survey of care.
- During the Month of November 2014 data, there were 97.3% of all patients recorded as receiving harm free care and year-to-date is 97% against a target of 95%.
- Staff were aware of their responsibility and the process to report incidents that may be to the detriment to the patients. There was a positive reporting culture and staff were supported by their managers. Staff said they had low level of incidents due to the type of patients they currently cared for.

Safety thermometer

- The surgical day care unit had measures in place and risks to patients were identified by the NHS Safety Thermometer. This was being managed appropriately.
- Safety Thermometer information provides a means of checking on harm and used alongside other measures, for improvement in patients' care.
- Safety thermometer data was clearly displayed on the surgical day care unit when we visited. Patients, visitors and staff could access Safety Thermometer information at the entrance of the unit. This included information about falls, venous thromboembolism (blood clots), catheter use with urinary tract infections, and pressure ulcers. There had been no incidents of avoidable harms reported.
- The day care unit undertook a monthly audit as their "safety thermometer". This was an audit of the occurrence of avoidable harms, including pressure ulcers, venous thromboembolism (VTE), and falls.
- Assessments of risks were considered and six patients records contained assessments such as fall, Waterlow (a recognised tool for assessment of pressure risk), and VTE.
- Senior nursing staff told us they had a process in place for reporting and investigating serious incidents, which included root cause analysis (RCA), action plans developed and these are shared with staff as part of learning.
- Records showed that national safety guidance was followed on the prevention and management of pressure sores, blood clots, falls on the unit.
- There were systems in place to ensure that patients' nutritional and hydration needs were identified and met.

Cleanliness, infection control and hygiene

- The day care unit was spacious, airy and visibly clean. Overall standards of cleanliness in the areas we visited were good.
- Patients said they were very impressed with the standards of cleanliness and a patient commented the staff "wash their hands or they use the gels frequently, which is very good".
- We observed surgical and nursing staff followed infection control practices by washing their hands or used hand gels between patients, and the bare below elbow policy was adhered to.

- Patients admitted for elective surgery were screened for methicillin resistant staphylococcus aureus (MRSA) when they attended the pre-assessment clinics.
- Personal protective equipment (PPE) for the prevention and control of infection, such as gloves and aprons, were available and used by staff as per trust policy.
- Hand sanitizing gels were prominently located and at the entrance of the ward and in the bays and side rooms, as well as hand wash basins.
- Daily cleaning logs were seen and cleaning was completed by all staff.
- The safe working staff bundle and cleaning and decontamination care bundle were in use and the day care unit had achieved 100% compliance following their audits in April.

Environment and equipment

- Staff followed the trust's procedure for the checking of resuscitation equipment, for use in emergency, to ensure this was fit for purpose.
- The resuscitation trolley was checked daily and records were maintained. Appropriate resuscitation equipment was available in all the theatre areas and the day care unit we visited.
- In theatres sterile equipment was well managed, three autoclaves were in place and accredited.
- Bariatric equipment such as operating tables was available in theatres which could accommodate patients up to 360kg.
- In theatres flammable solutions were not maintained safely in fire proof cabinet as required and this was brought to the attention of senior staff at the time of the inspection.
- The anaesthetic room was in need of refurbishment and storage for anaesthetics equipment was lacking.

Medicines

- Medicines were stored safely and securely and staff monitored the temperature of the medication fridge.
- Pharmacy service was available Monday to Friday 9-5pm and until 1pm on Saturday.
- An electronic drug prescribing system was used, some of these prescriptions were completed in theatre prior to the patient returning to the unit; but this was not consistent for all patients. The prescriptions were printed and sent to the pharmacy via their pod system. The electronic medicines charts were signed by the prescriber on line.
- Staff were able to track progress with the prescription on line. Staff and patients raised concerns about the long delays in waiting for medicines to be dispensed from the pharmacy. Comments were "it took hours" and patients were left waiting around.
- There were some stock medicines which were available on the wards out of hours. Nursing staff had undertaken training, followed by competency assessments, to enable them to dispense medicines from stock to patients. However staff were only allowed to dispense these medicines out of hours; although staff told us patients could benefit if they were able to dispense their medicines from stock at other times.
- CDs were kept securely and the registers were appropriately maintained in the day care unit. Staff were aware and followed the procedures as required.

Records

- Pre-operative assessments were completed and these included risks such as VTE and falls.
- The five steps to safer surgery checklists (based on the WHO Surgical Safety Checklist) was used at each stage of the surgical pathway, from when a patient was transferred to theatre until they returned to the unit. The latest WHO checklist audit showed 99% compliance in March 2015.
- Other issues related to the electronic records at one hospital which could not be read on the computer systems of the other. Records were not always available including reports of scans which impacted on patients' care.
- Patients care records were not locked; these were kept at close proximity to the nurses desks and there was a risk of other patients may pick these up.

Safeguarding

- Most staff had completed safeguarding training and they had clear knowledge of what constituted abuse and the steps they would take to protect patients in their care.
- Policies and procedures relating to the safeguarding of adults were available.
- Staff said they were confident to approach senior management for advice and support and felt they would listen and take action as required.
- Information about safeguarding included leaflets and folder to support the staff.

Mandatory training

Surgery

- Staff said training was good and they were supported to attend training as part of their role and personal development.
- There was an induction training programme for all new staff when they joined the trust. Staff were complimentary about the induction programme and felt well supported when they started working in the trust. They were able to describe induction arrangements and what was included in their induction.
- Nurses and healthcare support workers we spoke with told us they had completed their mandatory training and yearly updates were undertaken as required. Information we have indicated as at December 2014, 83% of all staff were up to date with statutory and mandatory training

Assessing and responding to patient risk

- Pre-operative assessments were carried out before surgery and patients we spoke with were complimentary about their pre-operative assessments. Patients told us the staff were "excellent" and they were made to feel at ease and their questions were answered. Staff were aware of agreed indicators for determining patients' selection for day surgery.
- The World Health Organisation (WHO) five steps to safer surgery checklist was in place. Staff followed the recognised WHO Surgical Safety checklist to ensure required pre- and post-operative safety checks were completed.
- Access for clinician input to manage the deteriorating patients was available. Care of patients undergoing day surgery was consultant led. Help could be accessed from the accident and emergency staff after 5pm as an emergency.
- Staff had raised concerns that there was no surgical cover out of hours. This could impact on the care of patients because an increasing number were staying until midnight or later. Senior clinical lead managers assured us there was a middle grade anaesthetic cover 24/7 at the County hospital.

Nursing staffing

- The trust used the national safer nursing tool to assess the nursing numbers in providing safe care and identified minimum staffing levels.
- We saw the required and actual staffing numbers were displayed as required and met. Staffing rotas demonstrated that safe staffing levels (registered nurse to patient ratio) of 1:8 during the day were exceeded.
- Staff said they had adequate staff and they worked flexibly to meet the demands of the unit. Comments were staff worked "very well as a team and they supported each other'"

Surgical staffing

- Patients care was consultant led. Patients were admitted under a named consultant who was available out of hours although they were not on site.
- There were standard operating procedure for access of consultants out of hours for the continuing care and treatment post operatively.
- Data showed that the proportion of junior doctors was similar to the England national average.

Major incident awareness and training

- There was a trust major incident plan and senior staff had roles in it and would be called out in an emergency.
- There had been no major incident exercises. Staff said this may be because they have few patients and are not considered an acute centre. However senior staff were able to tell us the actions they would take to move patients to safe areas.
- Emergency plans and evacuation procedures were in place.
- Staff told us about the hospital's business continuity plans and relocating patients to other sites.

Are surgery services effective?

Good

Elective surgery care pathway was followed as per NICE guidance.

From February 2015, the County Hospital only provided surgery on a day care basis. Data regarding patient outcomes was not available for the current service. We looked at data for the former trust and found that patients' outcomes against a number of indicators were similar to England national averages. Patients were assessed pre -operatively and information shared including pain control.

. Access to information was not effectively managed as patients' information was not always available when they were assessed at the other site. Staff had an understanding about Mental capacity and protecting people's rights.

Evidence-based care and treatment

- The elective day care case pathway was in use for all patients admitted to the day care unit at the County Hospital.
- The pathway was used as a selection process for inclusion as day care. The aim is to enhance the quality of care by assessing risk and promoting patients safety.
- Senior clinical staff said the pathway for selection was adhered to and this worked well.
- The trust participated in relevant national clinical audits for surgical procedures. There was also evidence of a trust-wide audit and unit-based audit programmes that were used to monitor the quality of care.
- Results of audits were disseminated at the clinical governance meetings.
- Staff told us they received feedback of audits from the manager and matron on their unit and were "very proud" to achieve high compliance ratings.

Pain relief

- Patients were assessed pre-operatively for post-operative pain relief and patients' preferences were discussed.
- Patients told us they were provided good information on pain control and they had no worries about receiving appropriate pain control. Another patient said they had a procedure a few months ago and everything including pain management was to their satisfaction.
- Pain control medicines were available from the unit medicines stock and could be dispensed out of hours if needed. This meant patients were provided with appropriate pain control on discharge.

Nutrition and hydration

- Patients were asked what they wanted to eat and arrangements were in place for food and fluids post operatively.
- Patients were offered a choice of meals and hot beverages were available at all time from the unit's kitchen.
- We saw a selection of sandwiches and desserts had been delivered for patients who were having surgery in the morning.
- Feedback from patients' survey identified food choice as area which could be improved.

Patient outcomes

- From February 2015, the County Hospital only provided surgery on a day care basis. Data regarding patient outcomes was not available for the current service. We looked at data for the former trust as a guide to the effectiveness of current services.
- The former Mid Staffordshire Hospitals NHS Foundation Trust took part in national audits, for example, the elective surgery Patient Reported Outcome Measures (PROM) programme, National Hip Fracture Database.
- Data from the national hip fracture database (NHFD) and clinical programme audit published in September 2014 showed the former trust recorded a 30-day mortality rate of 7.4% which was better than the average of 8.35%.
- Out of the 10 measures in the hip fracture audit the County was better than average in seven standards measured.
- PROM scores for improvements in general health and condition-specific indicators after procedures were the same as or slightly better than the England average.

Competent staff

- Staff said they had access to regular training and support, although they had not attended any recent training due to integration, which had presented a period of uncertainty amongst the staff.
- Clinical staff had completed training in cannulation, blood taking, mentorship and catheterisation. They said they felt "very well supported" and the manager was "very hot" on training and provided support.
- There was a programme for yearly appraisal and staff confirmed this occurred regularly. Although staff were not able to tell us about clinical supervision. Senior nurses told us they did not have a structured programme for supervision.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within surgical specialities rated their overall satisfaction with training as similar to other trusts.

Multidisciplinary working

Surgery

- We observed a multidisciplinary team working and clear communication between members of the team and discussion about patients order on the list. Patients were involved and kept informed about when they would be going to theatre.
- Senior clinicians and nurses told us they had good multi- disciplinary working at the County and they felt supported in their roles.
- There was pharmacy support Monday to Friday during the hours of 9-5pm and until 1pm on Saturday.

Seven-day services

- The day care unit did not provide seven day service. Patient care was consultant led and they were contacted out of hours for support and treatment.

Access to information

- Access to information was not effective as patients who attended pre assessments clinics at Royal Stoke did not always have their records when they came to the County for their surgery. This was because the electronic patient records systems on each site were unable to communicate with each other and staff had to use paper records.
- Patients scheduled for surgery at the County required a new assessment which impacted on the service, as their records were not available.
- A copy of the record of medication dispensed to patients was given to them on discharge. Discharge summaries for patients were sent to GPs, but they were not always sent immediately when the patient was discharged from hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust was following the process for the Deprivation of Liberty Safeguards (DoLS). A senior member of staff told us they had completed training in MCA and DoLS and staff would contact the lead nurse for advice and guidance. Among the nurses the knowledge of MCA and DoLS was limited.
- The trust had clear policy and procedures about DoLS application which was available to the staff.
- Patients were consulted and consents forms were fully completed in all six records seen. A section of the consent form also included if a translator was used to ensure informed consent and practice was adhered to.

Are surgery services caring?

Good

Patients were treated with care, compassion and staff respected their wishes. Patients were involved in their care and they had opportunities to discuss their care with their consultant and nurses caring for them. Patients were complimentary about the care and support they received.

Staff ensured confidentiality was maintained and promoted patients privacy and dignity when providing care and support. Feedback relating to patients care was actively sought to improve care provided.

Compassionate care

- During our inspection we observed patients being treated with compassion, dignity and respect. On admission to the day care unit, patients were taken to a private area to complete the admission process. This ensured sensitive information was not overheard by other patients.
- Staff ensured the patients' dignity was maintained, curtains were drawn when patients were transferred onto the theatre trolleys.
- Data from the NHS Friends and Family Test showed patients were satisfied with the care they received. In February 2015, 98% of patients were likely or extremely likely to recommend the service. This was better than the England average.
- We observed interactions between staff of all disciplines and the patients they cared for; patients appeared comfortable in the presence of staff.
- Patients were encouraged to provide feedback and this was analysed to improve the care provided.
- A sample of 18 patients' surveys cards for the day care unit was seen. This showed patients expressed a high degree of satisfaction with the care and treatment they received. Comments included that care was outstanding. Staff were described as "compassionate, very attentive and easy to approach".

Understanding and involvement of patients and those close to them.

Surgery

- All patients we spoke with confirmed they had a pre-operative assessment completed. They said the doctor had explained the procedure thoroughly and they knew "what to expect".
- Patients felt fully involved in their care. Opportunities to speak with the consultant were available on admission to answer any queries.
- Staff were able to tell us of ways to involve patients and seek support if patients were unable to fully participate in their care.

Emotional support

- Patients told us staff were 'excellent' and they were 'fantastic at putting patients at ease'.
- Patients commented that coming in for any surgery was very stressful; however they felt staff supported them and took time to explain things and did not feel rushed and helped them to relax.

Are surgery services responsive?

Requires improvement

Since February 2015, the hospital provided surgical service on a day care basis only; this was in line with the model recommended by the Trust Special Administrators (TSA). Since the changes to services the hospital was not working at full capacity in relation to elective surgery where theatre hours, beds and equipment were underused.

The day care unit did not have facility to accommodate patients overnight. Patients requiring overnight care would be transferred to the emergency department at Royal Stoke to wait for a bed to become available. Staff raised concerns that some transfers were happening late at night and patients could be subjected to long waits on arrival at Royal Stoke. Patients were confident that complaints would be addressed in a timely manner. Information from complaints was reviewed and acted upon. Information on how to make a complaint was available to patients.

Service planning and delivery to meet the needs of local people

- The Commissioners have been involved in the integration and planning of services. This includes the transfer of acute surgery, gynaecology, trauma in February 2015. The need for supporting anaesthetic cover for consultant-led obstetrics and emergency surgery meant that the transfer of these services during January and February were managed together.
- As part of the changes to services, the trust had involved the Clinical Commissioning Group (CCG) and quality and impact assessment were undertaken looking at any inequality created by the changes, transport issues the changes may bring to specific high-risk and vulnerable patients. There were plans to develop the orthopaedic service at the County hospital. A new theatre was being commissioned and the plan is to provide major surgery for hips, knees and shoulders.

Access and flow

- The day care unit did not have facility to accommodate patients overnight. There were procedures developed for transfer of patients out of hours. The consultant was responsible for all referrals of patients who required admission from the day care unit to Royal Stoke.
- The original plan was for patients to be sent directly to the surgical admission unit at the Royal Stoke. However, a letter from the chief executive in February 2015 instructed staff to transfer patients straight to the emergency department (ED) at Royal Stoke and not to wait for a bed to be found. Staff told us post- operative patients were left waiting for long periods for a bed to become available. Additionally, staff raised concerns about the timing of some transfers. In March 2015 seven patients were transferred to Royal Stoke after 10 pm.
- In November 2014, the day care unit was opened on six occasions to accommodate day care patients overnight. In December and January this had increased to 25 days which included weekends.
- At the time of our inspection, the County hospital was not operating to optimal levels. Theatres were achieving 34% utilisation. For the gynaecology and orthopaedic specialties the theatre sessions were not filled, we saw that in May some theatre sessions had only one patient booked. Senior staff had raised concerns with the executive team, as they felt patients who could be operated on at The County were not being sent from Royal Stoke. This was frustrating as the trust was failing to meet targets and staff at the County felt they could contribute.
- Staff told us of poor communication from Royal Stoke and they were not informed when surgery cases were planned or changes made

Surgery

Meeting people's individual needs

- Patient information leaflets and details about surgical procedures were available. Leaflets were only available in English. Staff told us they could access translation service if needed.
- Staff felt they had appropriate training to enable them to care for people in the unit. They were able to access link nurses for dementia; however not all the staff were clear about whether there was a learning disability link nurse.

Learning from complaints and concerns

- Patients were aware about how to make a complaint and told us they had no complaints about their care and treatment.
- Staff said complaints were escalated to the nurse in charge to enable them to resolve it if possible at the time. Process on how to make a formal complaint would also be shared with complainant as appropriate.
- Information related to complaints was reviewed at unit level and action plans developed and used as part of learning.
- Staff told us complaints were discussed at team meetings and helps to develop practice.
- Staff said they would direct patients to patient advice and liaison service (PALS) if they were unable to deal with concerns directly.
- A log was maintained and response provided to complainants as needed.

Are surgery services well-led?

Good

The surgical unit and theatres were well led. Staff felt supported by multi-disciplinary team, joint working and strong clinical leadership. There was a disconnect with the wider trust and staff felt isolated and undervalued. Staff told us the senior leadership team for the trust was not visible and they did not feel part of the wider trust.

The trust had in place a development plan for orthopaedic major joint surgery at the County.

There was good engagement with patients; these were through patients' satisfaction surveys and the friends and family test. These showed patients and their relatives were positive about the services they received.

Vision and strategy for this service

- The trust has a development plan looking at the long term provision of care for the local community and development of orthopaedic care at the County site.
- Staff did not know what the trust's vision and values were as they felt disengaged from the wider trust's management. Staff were not aware of longer term plans for surgical services at County Hospital.

Governance, risk management and quality measurement

- The surgical division had a quality dashboard for each of its services and the day care unit. Dashboard data included performance information against quality and performance targets.
- There were risk registers for each surgical clinical service and these identified relevant risks. Key risks were escalated to the trust's organisational risk register and reviewed by the trust board.
- Senior staff told us they attended operational management meetings; however there were no minutes for these and this had been raised with the trust.

Leadership of service

- The unit had a manager who provided day-to-day leadership to members of staff on the day care unit with the support of matron who was part of the team. Nursing staff told us their immediate manager and matron operated an open door policy and worked as a team on the unit and they had excellent support.
- Senior management was not aware of any strategy in managing underused beds and theatre capacity for elective surgery.
- There was an associate director for surgery who staff told us was "not visible".

Culture within the service

- The culture at the County was mostly positive and some staff told us it was it was "an excellent place" to work. They supported each other and felt the service provided in the day care unit was good and with high degree of patients' satisfaction.
- There was a perceived divide between the two sites and surgical and nursing staff did not feel they belonged in the wider trust and worked "in silos".

Surgery

- Staff told us they did not feel whistle- blowing was confidential in the trust and they would not be confident to raise their concerns with the trust. However locally they felt well supported by their immediate managers.
- Senior clinicians who worked solely at the County told us they felt opportunities for shared learning did not happen.
- Feedback we received was that the process of integration was not working well and had been the source of low morale and stress among the staff. Comments included “Feels second class and we have moved backwards”.

Public and staff engagement

- Patients felt there had been some public engagement in relation to the changes at the County hospital.
- Concerns were raised from patients we spoke to about “stripping of services”. Although the trust held public consultation, patients felt they had not been heard.
- Patients were encouraged to complete the satisfaction surveys in the day care unit and they told us they felt it was “a very good thing” and they were happy to contribute to these.
- We viewed 18 responses which had been recently received and patients expressed a high degree of satisfaction with the care and treatment in the day care unit.
- The response rate to the friend and family test at the County was 33% and similar to the national rate and twice as high as the Royal Stoke.
- The latest friend and family test from NHS England showed 99% of inpatient would recommend this hospital for care, 61% of staff would recommend the County as a place to work.
- Information was displayed in the day care unit. These included incidents such as falls and infection control audits and staff said these were reviewed and action plan developed as required to address any shortfalls.

Innovation, improvement and sustainability

- Senior managers told us of their plans to develop staff’s training and education to raise the skills of nursing and support staff on the unit.
- Theatre staff were positive about the development of the orthopaedic service at the County.

Critical care

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

Information about the service

The County Hospital had 10 critical beds which included both level three and level two beds until 31 March 2015.

Following the recommendations of the Trust Special Administrators, on the 1 April 2015 the unit became a high dependency unit with four level two beds (high dependency beds, but non-ventilated patients) only. Patients were admitted to the high dependency unit from the emergency department, theatres, wards and departments in the hospital. Patients who required level three care may be stabilised either in the emergency department or on the high dependency unit until the transfer to another hospital with level three unit.

The critical care unit had admitted 423 patients between 1 April 2014 and 31 March 2015.

We visited the high dependency unit (HDU) during our announced inspection on 23 April 2015 and our unannounced inspection on 5 May 2015. We spoke with three patients and nine staff: nurses, doctors, domestic staff and managers. We observed care and treatment, and looked at the records of three patients on the HDU. Before the inspection, we reviewed performance information about the hospital.

Summary of findings

The changes to critical care services had been in place for three weeks at the time of the inspection. As a result of this it was difficult to assess an accurate picture of the responsiveness of the service.

An intensive care consultant was on site Monday to Friday. Medical cover was mainly provided from early afternoon, evening and throughout the night by anaesthetic middle grade doctors with anaesthetic consultants on call from home. This does not meet intensive care core standards.

Staff morale was low and they were concerned about the future of the unit and their on-going employment. Staff were caring and compassionate. There were sufficient, highly experienced nursing staff available within the high dependency unit and within the outreach team at the time of our inspection.

People received effective care, treatment and support that met their needs and achieved good outcomes, promoted a good quality of life and was based on the best available evidence.

Critical care

Are critical care services safe?

Requires improvement

There were appropriate systems in place to highlight risks, incidents and near misses, although these systems were not fully utilised. Incident reporting needed to be improved to provide assurance that required actions will be taken in response to staff concerns and to ensure that lessons were learnt. There was a need to ensure that patients' deaths were reviewed to ensure that patients had consistently received high quality patient care and appropriate lessons were learnt.

Medical arrangements met the needs of patients accommodated, although this will require further review to ensure that they meet patient dependency. There was a need for effective communication between intensive care consultants and anaesthetists who were both responsible for patient care within the HDU.

Staffing levels and skill mix were set and reviewed to keep people safe and met their needs at all times.

There were appropriate arrangements in place to respond to deteriorating patients. There was a need to ensure that staff maintain their competence to care for critically ill patients should they require stabilisation prior to their transfer to a level three critical care unit. The high dependency unit was clean and there were appropriate systems in place to minimise the risk of cross-infection. The availability and use of equipment including emergency equipment was found to safely meet patients' needs. Medicines and intravenous fluids were safety stored and administered

Incidents

- No never events were linked to critical care. A never event is a serious largely preventable patient, safety incident that should not occur if the preventative measures have been implemented.
- There had been no serious incidents requiring investigation reported to the Strategic Executive Information System (STEIS) from 1 November 2014 and 31 March 2015.
- The trust had an established system for reporting incidents and near misses through a computerised reporting system. Following the changes to the management of the trust and to ensure consistency of incident reporting the high dependency unit had changed to the reporting system used by the new trust. The unit had reported 13 incidents between 1 November 2014 and 31 March 2015. Each incident submitted was reviewed and graded by a senior nurse or consultant and the investigation was proportionate to the grading and any harm to the patient involved.
- Staff told us they had completed an incident report under the previous trust but not under the new system. Although staff said they would report untoward incidents we found this was not always the situation. We spoke with a doctor who raised concerns about another division and a delay in review of a patient and referring them for further treatment. This doctor told us that they had not completed an incident report.
- The ward manager told us that they did not report mixed sex breaches (patients of both sexes accommodated in the same area and using the same toilet and bathroom facilities when they were medically fit to be on a general ward). A failure to report incidents may mean that actions may not be taken to ensure that lessons were learnt.
- Incidents were reviewed by medical and senior nursing staff depending upon the nature of the incident. Incidents were discussed at the monthly clinical governance meetings. Feedback on the outcome of investigations and learning was given by email or in person to staff.
- Mortality and morbidity meetings had taken place monthly but there had been no meeting held since October 2014. There was a need to ensure that there were effective arrangements in place to review patient deaths.

Safety thermometer

- The safety thermometer was in use within the HDU and was displayed on the unit for patients and relatives to view. The information on display showed the number of complaints, compliments, falls, pressures ulcers and infections within the last month and also the accumulated annual total.
- The trust used a management tool which contained information about each ward or unit's performance against agreed targets. It included: staffing information (such as sickness, vacancy rates and bank and agency staff usage), incidence of infections, incidence of pressure ulcers, slips, trips and falls, patient feedback

and compliance with mandatory training. The unit had mostly performed well compared to the rest of the trust In relation to pressure ulcers, mandatory training, patient feedback and patient falls.
- There was a trust target of zero patient falls. The critical care service had met this target from November 2014.
- We reviewed ten patient records which showed that risk assessments for pressure ulcers and venous thromboembolism (VTE) were being completed appropriately on admission. We observed that staff had taken appropriate actions to reduce any identified risks.

Cleanliness, infection control and hygiene

- We observed that the HDU was clean and well maintained. There were cleaning plans in place, which included the frequency that cleaning should take place. Staff did not sign to confirm that they had cleaned identified areas and this was confirmed by domestic staff. We saw that weekly audits were undertaken to check the cleanliness and maintenance of the unit and when required appropriate actions were undertaken. However improvement was needed to provide assurance that all areas were cleaned at the required frequency.
- We saw cleanliness audits were undertaken weekly by a senior manager. The average cleanliness scores between November 2014 and January 2015 were between 96% and 100%.
- We observed that staff washed their hands appropriately and wore appropriate personal protective equipment (PPE). Effective hand washing and use of gloves and aprons reduce the risk of cross-infection.
- HDU staff compliance with hand hygiene was audited monthly by a senior nurse. The target for compliance was 95% and a warning risk of below 90%. A hand hygiene audit in October 2014 identified a compliance rate of 88%. We saw information that showed that staff had been made aware of this poor compliance and risks to infection control, staff were reminded when hand washing was required. Since the hand washing audit in October 2014 subsequent monthly audits had identified 100% compliance.
- Hand sanitising gel was available at the entrance to the unit, at each bed space and throughout each unit. Signs to remind both staff and visitors about hand hygiene were visible throughout the unit.
- The trust target for MRSA bacteraemia infections was 0%. There had been no patients who tested positive for MRSA within the unit since before April 2014. Information provided by the trust showed that incidents were investigated, with root cause analysis (RCA) undertaken. When needed, required actions were identified such as an independent investigation of the infection.
- The trust had a 100% target for MRSA screening. Staff told us, and this was confirmed by records we looked at, that all patients were screened for MRSA infection.
- The trust had a target of 0% of patients with Clostridium difficile within critical care services. There had been no critical care patients with Clostridium difficile.

Environment and equipment

- The ward manager told us that critical care equipment was being standardised across both hospitals within the trust. Staff were being trained in the use of new equipment. This will ensure the safe and appropriate use of equipment.
- We saw that the resuscitation equipment was regularly checked and, when needed, restocked. There was a record of when someone had undertaken this check, as well as whom it was. The trust target for compliance with the checks was 95%. We saw that an audit of the checks on the resuscitation trolley was undertaken monthly and identified compliance between 95% and 100%. The audit results were displayed in the main corridor for both staff and visitor information.
- A buzzer system was used to enter the HDU, to identify visitors and staff, and ensure that patients were kept safe.

Medicines

- We found that medicines including intravenous fluids were securely stored. We observed that medicines rooms and cupboards at patients' bed spaces were locked.
- We saw that an audit of the storage of medicines and intravenous fluids in the critical care service had been undertaken during October and November 2014. It was positive to see during our inspection that the required improvements such as appropriate medicines storage had been made to ensure that medicines were safely and securely stored.
- We found that all controlled medication, high risk medication and associated paperwork was appropriately and safely stored. The trust identified a target of 95% compliance with the controlled drug

records, storage and administration. The critical care unit had scored 100% between November 2014 and March 2015 with the exception of December 2014 when 96% was compliance was identified and appropriate actions addressed the findings.

- The medicines fridge temperatures, including the minimum and maximum temperatures were recorded daily. A regular check on temperature provided assurance that medicines were stored safely, and their effectiveness was not adversely affected.
- The HDU used a paper-based medical prescribing and medication administration record system for patients. We saw that nursing staff signed to confirm that medicines had been given or the reason they were not given.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- There was a senior pharmacist available for the unit to advise doctors on medicines. There was a top up service for ward stock and other medicines were ordered on an individual basis. Staff told us that there was an effective on-call service, out of hours. This meant that patients had access to the medicines they needed.

Records

- The unit used a combination of computerised and paper records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient, their treatment and care needs.
- We looked at three patients records during our announced visit. We saw that the records were clear and identified the treatment that patients had received and any further treatment or follow-up plan within critical care.
- Within the HDU, paper-based nursing documentation was present at each bed space alongside computer records. Patients' observations and risk assessments were recorded electronically with an alert when review was required. Risk assessments included pressure ulcer risk, nutrition risk, coma scale, and delirium assessments. We saw that observations were checked and recorded at the required frequency and any deviation from expected results was escalated to medical staff.
- The trust has an electronic clinical results reporting system that was available in the high dependency unit.

Safeguarding

- The trust policies and procedures were in place for safeguarding children and vulnerable adults.
- Staff that we spoke with knew how to access safeguarding policies and procedures on the trust's intranet.
- Records we saw confirmed that 100% of HDU staff had received safeguarding vulnerable adults training. Staff confirmed that they had received safeguarding vulnerable adults training, and confirmed actions that would be undertaken to keep people safe.

Mandatory training

- Nursing staff confirmed that they received annual mandatory training in areas such as: infection control, moving and handling, fire, blood transfusion and information governance. Records we saw identified that 100% of HDU staff had received required mandatory training.
- Mandatory training attendance for nursing staff was monitored by the unit manager and professional development nurse lead nurse.

Assessing and responding to patient risk

- The hospital used the modified early warning score (MEWS) to identify acutely ill patients.
- There was one critical care outreach team member available 24 hours a day, seven days a week for the management of critically ill patients in the hospital. A patient's MEWS was calculated from each observation recorded on the patient's records. The score then identified deteriorating patients who required input from the critical care outreach team. The team then assessed the patient and a decision was made in relation to their ongoing management.
- There was an identified plan for patients who were admitted to accident and emergency or who had deteriorated whilst an inpatient in the hospital requiring escalated including level three management. The escalation plan involved the stabilisation of patients both in accident and emergency and HDU, use of the outreach team and the need for a registrar to accompany the patient to transfer to a level three hospital.
- The critical care outreach team undertake a ward visit within 12 hours of a patient's discharge from the HDU. The team also provided advice to wards when they had

concerns about patients who were deteriorating and ensured appropriate actions were undertaken However there was a risk that with time nurses will lack the capability to care for deteriorating patients and when required to stabilise those who are critically ill before their transfer to another hospital with a level three critical care unit.

Nursing staffing

- The required and actual number of nursing staff on duty for each shift was displayed on the HDU. During our visits (both announced and unannounced) the required number of staff were on duty.
- We found that nurse staffing numbers met core standards for intensive care units. The unit could accommodate up to four level two patients. The unit had two qualified nurses on duty 24 hours a day, with the ward manager available 8am to 4.30pm Monday to Friday and a health care assistant also available on most shifts. This met core standards for intensive care units.
- When shifts could not be fully staffed from their own staff working their contracted hours, HDU staff could worked additional hours on the hospital bank.
- The ward manager told us that that although the unit had not had to use agency nurses they would probably have to in the future. This was due to the reduction in the number of staff employed it and the number of staff on each shift (two staff). We saw that the unit had an induction checklist that provided agency nurses with essential information about the hospital and the unit.
- Nursing handovers occurred at least twice a day, during which staff communicated any changes to ensure that actions were undertaken to minimise the risks to patients.

Medical staffing

- An intensive care consultant from the Royal Stoke University Hospital was available in the HDU between 08.30 am and 2.30pm Monday to Friday. The ratio of one consultant to four patients meets intensive care core standards.
- Consultants rotated to the County Hospital and each worked five day blocks to aid continuity of patient care. At night, a staff grade doctor or equivalent anaesthetist was on duty with a consultant anaesthetist on call from home with the support and advice available from intensive care consultants at the Royal Stoke University Hospital. Consultants and junior doctors expressed concerns that these arrangements could potentially be unsafe.
- If patients required level three care the registrar would accompany the patient to another hospital, usually the Royal Stoke University Hospital, otherwise another hospital which had level three facilities.
- If medical staffing was not adequate (for example, due to sickness), locum support was generally provided by doctors who were currently working, or who had previously worked on the units.
- The doctors within the HDU had handovers twice daily with a daily ward round. This meant that patients' health and recovery was regularly assessed to ensure they received appropriate and timely treatment.
- New admissions were reviewed by a consultant within 12 hours of admission. However, as the intensive care consultants only work Monday to Friday, a patient admitted at the weekend may not be seen within 12 hours. This meant there was a risk that patient's may not receive timely review and appropriate care.

Major incident awareness and training

- There was a major incident policy and business continuity plan; although this had not been updated since the creation of the new trust. The major incident plan identified different types and levels of incidents and responses required by the hospital's staff. Staff told us that there were key staff who they would report to. If staff were off duty alerts would be on local radio and they would ring the hospital to check if they were needed to come on duty.
- The trust was reviewing the daily escalation plans to ensure that any fluctuations in demand and capacity were managed safely and effectively, along with managing the associated clinical risk, within acceptable limits.

Are critical care services effective?

Good

People received effective care, treatment and support that met their needs and achieved good outcomes, promoted a good quality of life and was based on the best available evidence.

Critical care

Arrangements were in place to ensure that nursing staff had appropriate training and development opportunities. There was multidisciplinary but limited seven day working. Staff had mixed understanding of their responsibilities around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- The high dependency unit used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine (FICM) and Nursing and Midwifery Council (NMC) guidelines to determine the treatment it provided. Local policies were written in line with this.
- There were appropriate and timely arrangements in place for deteriorating patients to be reviewed by the critical care outreach team. The availability of the outreach team and timely review of patients meets the requirements of NICE guidance using the local guideline modified early warning score CG35 Prediction and Detection of Impending Critical Illness in Adults. Records we looked at showed that critical care outreach staff responded quickly to deteriorating patients.

Pain relief

- A standardised pain scoring tool was used in the HDU and could be used for patients who were unable to express pain. The pain assessment included a check on non-verbal responses, or changes to the patient's observations.
- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us staff ensured they had the pain relief they needed and they were kept comfortable.

Nutrition and hydration

- Should the unit have patients who were at risk of dehydration or poor nutrition there were appropriate arrangements in place to highlight the risk of dehydration within the HDU.
- Policies were in place to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds until they could be seen by a dietician. This meant that patients were protected against the risk of malnourishment.
- Patients we spoke with said that the food was tasty and appropriate for their needs. We observed that drinks were accessible for patients and that, when needed, nursing staff provided appropriate assistance.
- Staff told us that dieticians provided individualised dietetic advice using their expertise in food, nutrients, drug interactions, and enteral feeding when required.

Patient outcomes

- Critical care services contributed data to Intensive Care National Audit and Research Centre (ICNARC). The last ICNARC report dated 2013/14 used data relating to the previous trust. The hospital critical care mortality rates were higher than expected (60 deaths in comparison to 56 that were expected) but was not an outlier.
- The critical care unit, prior to the recent changes had performed worse than other comparable hospitals for out of hours discharges and delayed discharges but performed better than other comparable trusts for unplanned readmissions within 48 hours.
- The units collected data for a local audit of central venous catheters. The results were displayed for staff, patients and their relatives and showed 100% compliance (satisfactory compliance was 95%).

Competent staff

- The HDU had 64% of nurses with a post registration qualification in critical care and met the required standard of at least 50% of nursing staff with this qualification.
- The HDU did not have any new staff since changes to critical care arrangements within the trust. However staff confirmed that new nursing staff would have both a hospital and local induction in critical care and at least four weeks supernumerary experience.
- All nurse competencies were checked against standards identified by the critical care network. This meant that there were assurances in place to ensure appropriate staff practice and competency.
- The practice development lead nurse at Royal Stoke told us that there were arrangements in place for a practice development nurse to support nurses at County Hospital when required. The practice development nurses told us that they were reviewing the components of mandatory training to ensure that HDU nursing staff at County Hospital received all required training.

Critical care

- At the end of April 2015, 100% of staff had had an appraisal. All staff we spoke with confirmed that they received an annual appraisal.
- Medical cover since the changes to critical care services was mainly provided by consultants from Royal Stoke, where their practice was validated.

Multidisciplinary working

- Staff told us that physiotherapists, a dietician, speech and language therapists and microbiologist visited the unit when required to provide specialist patient care.
- There were visits to the HDU five days a week by a pharmacist during which the patients' medication needs were reviewed. At other times, staff could obtain telephone advice. This meant that advice was provided which reflected changing recommendations and immediate changes could be made in response to national guidelines.
- The critical care outreach team was available 24 hours a day seven days a week. Staff told us that the outreach team also had an additional role when required to support level three ventilated patients until their transfer could be arranged.
- Doctors raised concerns about the lack of support they felt they received from other medical specialities especially when patients were ready for discharge. Doctors told us that on occasions this had increased the length of both critical care and hospital stay. For example, during our inspection there was one patient who was ready for discharge and had been waiting 4 days to be seen by the medical team.

Seven-day services

- The service was available seven days a week, 24-hours a day. There was an intensive care consultant present in HDU between 8am and 2.30pm five days a week. Consultant cover outside this time was provided by the hospital on call anaesthetic consultant with advice also available from intensive care consultants at Royal Stoke.
- Records we saw identified that one reason for the down grading of the unit to a high dependency unit had been concerns around access to medical cover. We found that medical staff arrangements were suitable for the current dependency of patients.
- Physiotherapy was mainly available Monday to Friday. A limited physiotherapy service was available over the weekend.
- Radiology and radiography services were led by a consultant who was available for urgent x-rays and scans seven days a week and during the evening and overnight.
- The hospital pharmacy was open seven days a week, although for shorter hours over the weekend. Staff told us that they were able to obtain patients' medicines seven days a week.
- Speech and language therapists and dieticians were available Monday to Friday.

Access to information

- On the critical care units nursing notes were kept at the patient's bedside and were accessible by staff at all times
- Staff could access electronic care and treatment policies and procedures at all times.
- The ward manager attended senior sister meeting with the critical care matron and shared the outcome of these meetings with staff. Staff meetings had previously been held but the ward managers said that mostly information was shared face to face or by email.

Consent and Mental Capacity Act

- The trust had a consent to treatment policy. This policy included: the process for consent, consent refusal and lasting powers of attorney guidance.
- Nursing staff told us they had received some training about the Mental Capacity Act 2005, as part of their safeguarding vulnerable adults training but had mixed understanding of their responsibilities under the Act and the assessment and recording of 'best interests' decisions.

Are critical care services caring?

Good

Patients said that staff were caring and compassionate and they were happy with the care they had received within critical care.

All critical care patients who had completed the NHS Friends and Family Test said that they would recommend the service. Staff built up trusting relationships with patients and their relatives by working in an open and supportive way.

Critical care

Patients were given good emotional support, and throughout our inspection we saw patients treated with compassion, dignity and respect.

Whenever possible patients and relatives were consulted and informed about the treatment they or their relative would receive.

Staff provided good care by understanding what was significant to patients, and making arrangements to ensure they retained what was special in their lives.

Compassionate care

- Patients were positive about staff and the care they received on all the units. One person told us: "The staff have been lovely. I have never been in hospital before and I can't believe how good they (the staff) all are".
- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. We saw that nurses ensured that curtains were fully closed before any care was provided
- Privacy and dignity arrangements for patients were acceptable. Privacy curtains were closed and staff were seen to ensure they remained closed to maintain patients' dignity.
- We observed staff talking to patients and relatives in a respectful and friendly manner.
- All critical care patients who had completed the NHS Friends and Family Test said that they would recommend the service.

Understanding and involvement of patients and those close to them

- Patients told us that they had been informed of their care needs and options for their treatment. Patients told us that staff had explained their treatment to them and they had been asked to provide their consent to their treatment and staff had acted in accordance with their wishes.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open and supportive way. Patients and relatives were given good emotional support.
- The ward manager told us that after admission, a meeting between the consultant covering the unit and the patient or their relatives would be arranged to update them on the patient's progress. When necessary, further face-to-face meetings were organised.
- A chaplaincy service was available, which provided valuable support to patients and relatives.

Are critical care services responsive?

Good

The changes to critical care at County Hospital had been in place for three weeks at the time of the inspection. As a result of this it was difficult to assess an accurate picture of the responsiveness of the service. Whilst we found that the service delivered was in the main responsive to planned needs there was need for improvement to address the accommodation of both male and female patients in the same area.

There were appropriate visitor facilities available. Within the HDU, support for patients living with physical and learning disabilities, dementia, or those who had communication difficulties was available.

Service planning and delivery to meet the needs of local people

- In December 2013, the Trust Special Administrators (TSA) recommended that a small critical care unit should be retained at the hospital in order to support the acute medicine and elective surgery services. It was recommended that the unit would provide 'level two' (high dependency) care and a 24/7 rota of anaesthetists at the hospital who could deliver 'level three' advanced respiratory support.
- On the 1 April 2015 the unit became a high dependency unit with four level two beds (high dependency beds, but non-ventilated patients) only.
- Patients were admitted to the high dependency unit from the emergency department, theatres, wards and departments in the hospital. Patients who required level three care might have been stabilised either in the emergency department or on the high dependency unit until their transfer to a hospital with a level three unit.

Meeting people's individual needs

Critical care

- Support for patients living with physical disability, learning disability or dementia was available if needed. Staff told us that they usually received assistance from families.
- There was a visitors' room with tea and coffee making and overnight facilities. Other rooms were available for sensitive and difficult conversations such as breaking bad news.
- Regular meetings were held with the patient and family members to ensure they were included in treatment decisions and, where necessary, interpreters/translation services were arranged.
- The Department of Health required all providers of NHS funded care to confirm by 1 April 2011 that they were compliant with mixed sex accommodation except where it was in the patient's best interests or reflected their choice. A breach of 'mixed sex accommodation' refers not only to sleeping arrangements but also bathrooms and toilets and the need for patients to pass through areas for the opposite sex to reach their own facilities.
- When we visited the HDU we observed that male and female patients who did not required or no longer required high dependency care were accommodated in the unit. The ward manager was not aware that mixed sex breaches should be reported, as the unit had only been open in its current configuration for three weeks. We told the trust about our concerns about mixed sex breaches.

Access and flow

- Staff told us that most potential admissions to the HDU were discussed with an intensive care consultant prior to their admission.
- County Hospital was downgraded from a level three critical care unit to a level two unit at the end of March 2015 and now provided high dependency beds only. This meant that patients admitted into accident and emergency or who deteriorated whilst at the hospital had to be transferred to another hospital that provided level three care.
- Changes to the provision of critical care services at County Hospital had required that four level three patients were transferred on 30 March 2015 to other hospitals with a level three unit.
- There were agreed protocols in place to transfer level three patients. In the three weeks since the changes to the critical care service six patients had been transferred to other hospitals. Two patients were transferred to Royal Stoke, and the remainder were transferred to three other hospitals within the critical care network.
- Five operations were cancelled due to the lack of availability of a high dependency bed between 1 November 2014 and 31 March 2015.

Learning from complaints and concerns

- There had been one complaint about critical care services at County Hospital since 1 November 2014. We discussed this complaint with the ward manager and found that it had been investigated and required action had been taken.
- Staff told us that if a patient or relative wanted to make an informal complaint, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Information on how to raise concerns and make a complaint was on posters displayed within high dependency care unit and visitors room.

Are critical care services well-led?

Requires improvement 

The critical care unit had reconfigured its services three weeks prior to our inspection. This meant that the service configuration was still new and staff and managers were still clarifying how services fitted together.

Governance arrangements were in the process of change but there were a number of risks that had not been clearly identified and mitigated. Shared arrangement for medical leadership was unclear.

Staff morale was low and they were not clear on the future plans for the service. Senior managers were not visible and they felt there could have been more support during the recent changes.

Vision and strategy for this service

Critical care

- The vision for the service was to reconfigure services in accordance with the plans outlined by the Trust Special Administrators. This had included the change of critical care from a 10-bedded level three critical care unit to a four bedded high dependency unit.
- Whilst staff were working with the changes to the unit they were unsure of the ongoing future and plans for the unit as this was still so new to everyone involved and it was not clear how services all fitted together. Staff told us they felt disengaged from the wider trust's management.
- Staff felt demoralised and demotivated however still wanted to provide quality and safe care for patients.

Governance, risk management and quality measurement

- The ward manager told us that they attended the monthly governance meetings at Royal Stoke where complaints, incidents, audits and quality improvement projects were discussed. The outcomes of these meetings were fed back to critical care staff at County Hospital in person or email.
- There was a risk that there was no strategy in place to ensure that County Hospital critical care staff maintained their skills and competence to care for level three patients if in an emergency situation they were required to.
- Some, but not all, risks inherent in the delivery of safe care, were identified on the risk register. However, the lack of timely actions, to address the risks identified, did not provide confidence that actions were being taken to protect people from harm.
- The ward manager confirmed that a root cause analysis would be undertaken following a serious incident.

Leadership of service

- The ward manager (a band seven nurse) was supernumerary between 8am and 4pm Monday to Friday.
- The HDU had a matron and deputy matron who were based at Royal Stoke.
- The ward manager told us that the deputy matron (based at Royal Stoke) visited the unit weekly to provide managerial support. The ward manager told us that they met the matron at the monthly band seven meetings at Royal Stoke.
- Nursing staff told us that managers above the ward manager were not visible and had generally not provided sufficient support to them during what they described as a difficult time.
- Medical leadership was confusing and was shared between intensive care consultants at Royal Stoke and a consultant anaesthetist on call at County Hospital. We found that communication between the two medical specialities was not effective, for example there were policies in place for escorting a level three patient by a registrar which had been shared by critical care doctors however the anaesthetic registrar on duty at the time of the inspection was not aware of this.

Culture within the service

- Staff working on the HDU spoke positively about the service they provided and had previously provided for patients.
- Staff morale was low; staff were tearful when they discussed the changes to the services. Staff felt they had not been adequately supported by senior managers from outside the unit during the changes to the unit.

Public and staff engagement

- The trust used a combination of direct emails, and intranet messages to engage with staff.
- Critical care staff at County Hospital confirmed that they had been informed about the changes to the services although did not agree with this decision.
- Staff had been given the choice to either go to work in critical care at Royal Stoke or to remain in County Hospital in the high dependency unit. Staff confirmed that they had the opportunity to visit the critical care unit at Royal Stoke before they made this decision.
- The public had been informed about the changes to critical care services at County Hospital. People told us that they were unhappy to the changes to critical care services.

Innovation, improvement and sustainability

- Critical care had a quality improvement plan which demonstrated a commitment to quality care while obtaining best value for money. This included the standardisation of equipment across both sites and the sale of decommissioned equipment.

Critical care

- The ward manger told us that they were proud of their computer records which had been tailored to their needs and included appropriate response to patient observations. However the ward manager was uncertain that this system would be retained by the trust.

Maternity and gynaecology

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

Information about the service

On 1 November 2014 the services previously managed by the former Mid Staffordshire NHS Foundation Trust (MSFT) were transferred to the management of University Hospitals of North Midlands NHS Trust (UHNM).

Following the recommendations of the Trust Special Administrators (TSA), the maternity and gynaecology services were one of the first services to be relocated on January 19th 2015. Staff transferred to either the Royal Stoke or the Royal Wolverhampton University NHS Trust. We recognised that this was a service that had undergone massive change and that staff were still in the process of adapting to new ways of working.

In line with the TSA recommendations, a free standing midwifery led unit (FMU), day assessment unit, antenatal clinic and community midwifery remained at the County Hospital.

The FMU promoted a 'home from home' experience, where partners could stay overnight, for low risk women who wished to have the comforts of a home birth with the added reassurance of being in a hospital. They offered a birthing pool, home furnishings and specialist equipment such as beans bags, mattresses and birthing balls to promote the comfort of women in labour.

Between July 2013 and June 2014 1,652 babies were born at the former Mid Staffordshire Hospital. Since the service was reconfigured, 17 babies had been born at the new FMU.

Seventeen babies had been born in the FMU since integration on January 19th 2015. The FMU was only offering birth for women who had a baby before. This was because of recommendations made by the Royal College of Midwives (RCM) that the unit should adapt to providing care to women who have had normal deliveries in the past before accepting first time mothers who had a higher risk of transfer in labour.

Community midwives worked in partnership with GPs, health visitors, family nurses, children's centres and lifestyle services to promote good health during pregnancy and early days following a baby's birth. Five teams of community midwives provided care in GP surgeries, health centres and during home visits including antenatal care, parent education classes, home births and postnatal care.

A team of gynaecologists worked across the two hospital sites to provide clinics, day care and assessment facilities. At the time of our visit, renovations were underway to create a gynaecology unit adjacent to the midwifery led unit.

We visited all the wards and departments relevant to the service. We spoke with 18 midwives, six student midwives and four support workers. We spoke with five nurses and three support staff who care for gynaecological patients. We met and spoke with three medical staff that work across both the maternity and gynaecology services. We were unable to speak with any patients during our inspection as none were using the service at the time.

Maternity and gynaecology

Summary of findings

This was a new service that had only been in its current format for a few months; however, based on our findings we rated the service as good. There were many good examples of safe processes including incident reporting systems, audits concerning safe practice and compliance with best practice in relation to care and treatment plans.

Policies were based on National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice.

Are maternity and gynaecology services safe?

Good

There were clearly defined systems and processes to keep people safe. Eight serious incidents were reported to STEIS between January and December 2014. These were monitored and the action plan reviewed at weekly risk meetings. All areas providing maternity and gynaecology services were seen to be clean but despite refurbishment still looked tired. We saw that all resuscitation equipment was checked as per policy.

The named midwife was model was in place and midwives told us that they provide one to one care in labour.

The planned staffing levels were displayed at the entrance to each ward. We did not see actual staffing displayed.

Incidents

Staff told us that they were able to raise concerns and were confident that their concerns would be listened to.· Escalation of risk was identified through a computer based incident reporting system (Datix). The trust used the RCOG trigger list for inputting Datix forms. This meant that incidents were identified, investigated and that necessary learning could take place.

- The hospital reported a total of 117 incidents between November 2014 and January 2015 for maternity and gynaecology.
- Eight serious incidents were reported to the NHS strategic executive information system (STEIS) by maternity services between January and December 2014.
- Following every reported serious incident, a full investigation would be undertaken. This would include a root cause analysis (RCA) review and a report would be developed. Review meetings would be held, minuted and attended by senior management team. Any learning from the incident investigation would be disseminated in meetings and via a newsletter. We saw examples of RCA reports completed and presented for both maternity and gynaecology incidents.

Cleanliness, infection control and hygiene

- All areas of the FMU were seen to be clean and well maintained. A cleaning schedule was displayed in all areas.
- Sluice areas were clean and had appropriate disposal facilities, including disposal of placentae.
- Compliance with the trust infection control policies and procedures was evidenced in the maternity hand hygiene audit for 2014 demonstrated 100% consistently throughout the year.
- Staff were seen using hand gel and protective clothing. Bare below the elbow policy for all staff was adhered to.
- We looked at the birthing pool and saw that it was well maintained. Staff we spoke with knew the pool cleaning procedure.

Environment and equipment

- We saw that all resuscitation equipment was checked as per policy.
- Midwives had access to the equipment they needed to confirm the health and well-being of mothers and babies. We saw that equipment such as hand held Dopplers, vital sign observation monitors and rescusciatiares had been maintained and stickers applied to confirm that checks were up to date.
- Staff were able to tell us about the procedure to evacuate a mother from the birth pool in the case of an emergency
- We observed that the antenatal clinic had been relocated to accommodation alongside the FMU. Refurbishment was in progress and the consulting rooms looked tired and contained a mixture of furniture. Privacy and dignity was maintained with privacy screens for consultations.

Medicines

- We saw that medication was stored in locked cupboards within clinical rooms. Controlled drugs were checked twice a day in all areas.

Records

- We saw that records were kept secure and away from public view.
- On the FMU we saw the individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born.
- The hospital has its own patient notes and hospital numbers and IT systems. This could be a risk to patient care if notes were required for consultation at Royal Stoke. Managers assured us that plans were in progress to integrate the medical records systems.
- Minor gynaecological surgery was undertaken on the surgical day unit. There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's (WHO) 'Five Steps to Safer Surgery' guidelines. The checklists we looked at showed that all the stages were completed correctly.

Safeguarding

- All ward staff followed the trust's safeguarding policy and reporting procedure. Staff reported that safeguarding support has reduced since the safeguarding midwife relocated to the Royal Stoke. She visited the FMU once a week to offer support to midwives and was available by telephone in between visits.
- Ninety-five percent of staff had completed level 1 child protection training. Across the obstetrics and gynaecology directorate, 18% of staff had completed child protection training at level 2 or above. This data could not be broken down to site level. The trust told us that directorate managers had not yet determined which staff should undertake this training.
- The safeguarding midwife met the link safeguarding midwife attached to each community team every 4- 6 weeks to discuss concerns. Community midwives had regular safeguarding supervision to support them in the care of vulnerable

Mandatory training

- Mandatory training for midwives was provided over three days and covered subject matters including; maternal and neonatal resuscitation, electronic foetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Overall completion of mandatory training was high. Safeguarding was recorded at 95%, infection control 89%, health and safety 99% and patient handling 92%.

- Community staff told us that on occasions backfill is not available to attend training which meant they could not attend the training and the risk is that they could miss updating on current care issues.

Assessing and responding to patient risk

- All staff were required to undertake annual new-born life support training and adult resuscitation training as part of the mandatory midwifery training day.
- All staff working on the FMU had additional training stabilization of the newborn based on the Newborn Life Support (NLS) course. This was developed under the auspices of the Resuscitation Council (UK) to provide clear practical instruction in airway support and the theoretical background to illustrate its importance in resuscitation of the newborn.
- Women that required extra monitoring in pregnancy were reviewed on the Maternity Assessment Ward and could be transferred to the Royal Stoke to be reviewed by the obstetric staff if necessary.
- Were told that some tests were not consistent across the trust. For example beta human chorionic gonadotropin (HCG) assays (HCG is a hormone excreted during the development of an embryo or foetus and is used in the diagnosis of ectopic pregnancy). This meant that if a woman attend the EPU at County and then required follow up out of hours at the Royal Stoke, blood tests could not be compared. We were told that this was in the progress of being resolved at the time of our visit.
- Staff told us that accessing blood results in the community was very challenging. They were not getting results back in a timely manner. This meant that they could not fully assess a woman's condition. For example providing timely treatment for anaemia in pregnancy.
- The trust has provided an emergency ambulance that is available 24 hours a day to transfer women who experienced difficulties in labour to the consultant unit at Stoke.

Midwifery staffing

- The planned staffing levels for the FMU were one Band 7 midwives and one maternity support worker for each shift. An additional midwife was called if a woman was in labour. A community midwife was on call 24 hours a day to provide this support. An additional two community midwives were on call from home to support in times of high activity.
- The midwife-to-birth ratio was 1:29 (one midwife to 29 births). Midwives told us that they were able to provide one to one care in labour but this was not formally audited so was difficult to demonstrate.
- We saw that Maternity Support Workers (MCAs) were on duty the community and on the FMU to provide additional support according to their training and designated responsibilities.

Nursing staffing

- Appropriately qualified nurses cared for gynaecology patients in the EPU and Gynaecology assessment unit and in the day surgery unit.
- We saw that there was one staff nurse on duty to support the gynaecological outpatients clinic, 1.4 whole time equivalent nurses working in the Early Pregnancy Unit, two nurses and a support worker working in the Colposcopy and Hysteroscopy service and a one nurse attached to the surgical day unit that cared for gynaecological patients.

Medical staffing

- There were two consultant gynaecologists based at County Hospital. Consultants from Royal Stoke held clinics. There was 'always' a consultant present on weekdays but out of hours, or if they were busy in theatre, junior staff and nurses called the consultant on call for gynaecology at the Royal Stoke.
- There was on-call registrar at County Hospital between 9:00am and 5:00pm Monday to Friday. After 5:00pm and on weekends there is no gynaecology emergency service at County Hospital. This meant patients had to go to the Royal Stoke for assessment and treatment.

Major incident awareness and training

- Staff were aware of the major incident policy and senior staff knew of the business continuity plans.

Are maternity and gynaecology services effective?

Good

People have good outcomes because they receive effective care and treatment that meets their needs. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice.

Maternity and gynaecology

Staff had access to and were using evidence-based guidelines to support the delivery of effective treatment and care.

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and outcomes were used to improve care.

Staff were competent in their roles and received performance reviews and supervision.

We saw good examples of multi-disciplinary team (MDT) working on the FMU. Staff worked collaboratively as part of the multidisciplinary team to serve the interests of women using the maternity service.

Women were provided with information which helped them to understand their treatment and care before consenting to this.

The FMU was a low risk midwifery unit and there were no doctors on site. Access to medical support was available seven days a week from the consultant led unit at Royal Stoke.

Two community midwives were on call 24 hours a day to facilitate the home birth services and 1 midwife was available to support birth in FMU.

Evidence-based care and treatment

Maternity

- Policies were based on National Institute of Clinical Excellence (NICE) and Royal College of Obstetric and Gynaecology (RCOG) guidelines so the best clinical outcomes were promoted.
- Staff had access to guidance, policies and procedures via the trust intranet. The guidelines from University Hospital of North Staffordshire NHS Trust had been archived and the guidelines from University Hospitals of North Midlands NHS Trust were adopted when the new trust was formed.
- At the time of our visit, policies and guidelines were in the process of being reviewed after integration so that they are consistent across the trust. One cross trust meeting had been held and more were planned.
- Staff raised particular concerns around the guidelines for babies born before admission. Since integration and adoption of the Royal Stoke guidelines, women had to be taken to hospital in an ambulance instead of the midwife going to the home, assessing the situation and providing care in the home. This could cause a woman and her family an unnecessary journey to hospital and negatively affect her birth experience.
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included for example; having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- The care of women using the maternity services was also in line with RCOG guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to; the organisation, safe staffing levels, staff roles and education, training and professional development. In addition to the facilities and equipment to support the service.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse. However, services had been centralised at the Royal Stoke and this meant vulnerable women had to access service away from their locality.
- We were told that it was Royal College Midwives guidance around only accepting second-time mothers to the FMU. Managers felt staff needed time to settle down and not to experience problems in the early

stages of integration. They were expecting to be admitting first-time mothers from early summer. We were told three different dates for this to happen, May June and July.

Pain relief

- On the FMU we saw a variety of pain relief methods available to women including TENS machines, Entonox and opioids. A birth pool was available so women could use water emersion for pain relief in labour.

Nutrition and hydration

- The FMU promoted breastfeeding and the important health benefits now known to exist for both the mother and her baby. Their aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how they will feed their baby.
- Women experiencing problems with breast feeding were invited to the FMU for on-going support.
- In relation for food and drink, women were able to choose from a varied menu, which also met their cultural needs.

Patient outcomes

Maternity

- There have been seventeen births at the FMU since it opened.
- Two women and two babies (not the babies of the two women) required transfer to the Royal Stoke for on-going care and treatment. This meant a transfer rate of 35% which is higher than expected for second time mothers which a recent study showed was 10% (Birthplace in England Study, 2011).
- The trusts results for the former Staffordshire General Hospital in the National Neonatal Audit Programme (NNAP) Annual Report, 2013 showed that they were below the NNAP standard on two questions. These were the proportion of babies born under 33 weeks who were receiving breast milk on discharge form hospital and whether a senior neonatologist had discussed the baby's care and treatment with the parents within 24 hour of birth.

Gynaecology

- There was a colposcopy and hysteroscopy service that saw 3000 patients a year. Eight sessions a week were held and two consultants attended these. We were told that consultants from Royal Stoke had begun to hold clinics at the hospital.
- Direct referrals were made by GPs or clinics if abnormal smear tests were found. Patients were sent an information leaflet and a history form to complete before being seen by the nurse who completed the history, the patient then saw the doctor or nurse practitioner. Patients could choose to have treatment under general or local anaesthetic. Women had the choice to see a female consultant.
- The nurse-led gynaecology assessment clinic was run by two staff. Ninety percent of the EPU work concerned pregnancy issues but they also saw walk in patients referred by GP or the emergency department with conditions such as urinary tract infections or ovarian cysts.
- Almost all referrals were from GPs, midwives or accident and emergency but they did accept self-referrals from women with a history of ectopic for example. We were told the 'vast majority' of patients seen the same day.

Competent staff

- We were told that the lead midwife education and development had undertaken the Maternal Acute Illness Management (AIM) at another provider. The course was developed following the most recent Confidential Enquiry in to Maternal Death (CMACE, 2011). The report outlined key priorities related to managing acute illness in this patient group which included identifying and managing deteriorating illness. Learning from the course will be implemented in the near future.
- We were told that training days had been developed in response to incident reporting. For example, it was noted that there was a problem with documentation relating to antenatal screening and a session was planned for community midwives in July 2015.
- Community staff told us that on occasions backfill is not available to attend training which meant they could not attend the training and the risk is that they could miss updating on current care issues.
- Appraisal rates for midwifery staff were provided for us and these demonstrated that 90% (248 out of 272) had been appraised.

Maternity and gynaecology

- The band seven midwives rotate to Stoke hospital to work on labour ward to maintain their skills. Community midwives all rotate throughout the Midwifery Birthing Centre at Stoke Hospital.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- Supervisee ratios were 1:15, which is the ratio recommended in the Midwives Rules and Standards (2012).
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.

Multidisciplinary working

- Communication with community maternity team was efficient. In the community we were told of effective multidisciplinary team work between Health Visitors, GP's and social care.
- The gynaecology wards and departments ensured patients discharge arrangements were appropriate.

Seven-day services

- Out of hours services were not available for Gynaecological patients who had to go to the Royal Stoke for assessment and treatment.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- We found that the notes, IT systems and hospital numbers used by the two trusts had not been amalgamated which meant that staff did not always have the information they required to treat patients effectively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- County Hospital had a policy on the Mental Capacity Act (MCA) and this was adopted as the policy for the newly formed trust.
- With the limited activity at the newly configured unit, we were unable to test this in practice.

Are maternity and gynaecology services caring?

Good

Although we did not speak directly to any patients during our inspection, feedback from people who use the service and those who are close to them was positive about the way staff treat people.

People were involved and encouraged to be partners in their care and are supported in making decisions. Patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

Staff responded compassionately when people need help and support them to meet their personal needs and those of their babies. People's privacy and confidentiality is respected.

Staff helped people and those close to them to cope emotionally with their care and treatment. People's social needs are understood.

Compassionate care

- Maternity Services were added to the Friends and Family Test (FFT) in October 2013. The October 2014 FFT achieved the following results:
  - How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? A score of 100% was achieved compared to the national average of 95%.
  - How likely are you to recommend our labour ward/ birthing unit to friends and family if they needed similar care or treatment? A score of 100% was achieved which is above the national average of 96%.
  - How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment? A score of 96% was achieved compared to the national average of 92%.

  - How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? A score of 100% was achieved compared to the national average of 96%.
- The latest CQC maternity survey from December 2013 surveyed women who gave birth in February 2013. A total of 152 women returned a completed questionnaire. It showed that all measures were similar to national average, with care in hospital after the birth better than the national average.
- We observed caring and compassionate interactions between staff and patients. We also observed supportive and caring attitudes between the staff.

Understanding and involvement of patients and those close to them

- We saw that processes were in place to offer women choice in their place of birth.

Emotional support

- Midwives observed women for anxiety and depression levels. They referred as necessary to the mental health team.

Are maternity and gynaecology services responsive?

Good

People's individual needs and preferences were mostly considered when planning and delivering services. The maternity service is flexible and provides choice and continuity of care.

Women had access to a team of specialist midwives who could support vulnerable patients and staff had access to the team for support. The individual care needs of women at each stage of their pregnancy was acknowledged and acted on as far as possible.

Translation services could be arranged as required.

The maternity and gynaecology services were recently integrated with the Royal Stoke and processes were on going to reconfigure parts of the gynaecology service in order to improve access and flow.

Complaints were investigated and responded to when raised.

Service planning and delivery to meet the needs of local people

- In December 2013, the Trust Special Administrators (TSA) recommended that a Midwife Led Unit should be established in Stafford to provide an opportunity for low risk births to be delivered locally and that the unit should be managed in a maternity network with other providers. In the public consultation, 72% of respondents opposed this recommendation.
- We asked the midwives on the unit what were the views of women on the changes to the service. They told us women were accepting of the changes but some women did not want to birth at the FMU because they were concerned about the transfer time to the consultant unit and the fact that there is one no doctors on the FMU.
- Women could access the maternity services via their GP or by contacting the community midwives directly
- A range of information leaflets were seen to be available across the service a leaflet, 'Developing services for mothers to be in Staffordshire', was available on the trust website. This comprehensive leaflet outlines the services offered and explains the options available for birth.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and where necessary doctors. The Red Book was issued on discharge from the FMU and facilitated on-going care and monitoring of the baby until five years of age.
- We were told that a coordinated approach to the gynaecology service was in the process of development since integration of services with Royal Stoke.

Access and flow

- We were told about and saw written documentation which confirmed women were supported to make a choice as to the place to give birth. This decision was made at 34 weeks and information was provided to assist in making their choice. We saw that there were specific risk factors, which needed to be considered and would lead midwives to advise a hospital birth, rather than home or a midwifery-led unit.

Maternity and gynaecology

- A Maternity Assessment Unit (MAU) provided care to women with concerns such as such as reduced foetal movements and also triaged women referred by community midwives or those who self-referred.
- Midwives were competent in examination of the newborn which enabled efficient discharge of low risk babies.
- Bed occupancy for maternity for at the former Stafford Hospital during July, August and September in 2014 was 80% compared to the England average of 59.9%. This indicated that women were having shorter stays in hospital in comparison to the other trusts.

Meeting people's individual needs

- Women with complex requests or needs were said to be discussed with the supervisor of midwife and a plan was then developed. We saw evidence of detailed recordings where a woman had made specific requests around the birth of their baby, for example, a first time mother wishing to birth at the FMU.
- Vulnerable women or those with complex needs requiring specialist services such mental health, foetal medicine and combined obstetric and neurology clinics, female genital mutilation (FGM), diabetes and, substance and alcohol misuse had to attend clinic at Royal Stoke.
- The antenatal and newborn screening midwife visited the FMU weekly to provide support to midwives and see women with concerns.
- Partners were able to stay on the FMU following the birth of the baby.
- Women had a choice regarding the management of the termination of a pregnancy. For example when there was a miscarriage women could choose medical or surgical termination or await the natural expulsion.
- For ectopic pregnancies the choice was either medical or surgical. Information leaflet was available to help women in making their choice in addition to discussion with staff.
- We saw that there was a translation service both face to face or via telephone.
- Privacy and dignity was protected by the use of privacy screens.
- Supervisors of midwives (SoMs) were available to help midwives provide safe care the mother, baby and her family. SoMs are experienced midwives, with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met the mother's needs.
- Women have a choice of medical or surgical management for spontaneous abortion.
- The Early Pregnancy and Gynaecology Assessment Unit was cramped. There were three scan rooms and a smaller room for consultations. There is a definite plan to move to new rooms adjacent to the FMU later this year. This accommodation will contain a designated scan room for the early pregnancy unit which will be separate from the room used for antenatal scans. This will provide suitable accommodation for women with suspected pregnancy loss.
- Currently the stroke unit is accessed through the EPU scan area so many people walk-through which does not provide the necessary privacy for women waiting for treatment.

Learning from complaints and concerns

- Complaints were managed by a centralised team who investigate the complaint, including asking staff to review the letter of complaint. The team then prepare a response letter that was reviewed by the divisional manager for factual accuracy.
- We saw an information leaflet for patients informing them of how to raise concerns of make complaints. The leaflet entitled 'Compliments Concerns Complaints' had a rear of section that could be used to put in the Patient Advice and Liaison Service box in the unit.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology services were the first services to be integrated, following the creation of the new University Hospitals of North Midlands trust. Integration took place on 19 January 2015. Following consultation staff were relocated to Royal Stoke or to the Royal Wolverhampton University NHS Trust. We recognized that this is very much a service in transition.

Maternity and gynaecology

All the maternity staff we spoke to were disaffected by the changes and felt they lacked on-going support to adapt to new ways of working.

The governance arrangements facilitated discussion and review of quality and safety matters, with dissemination of learning. There was oversight of quality and safety at the Trust Board.

Vision and strategy for this service

- We were told the maternity strategy is in line with the overall trust strategy. The directorate wanted to develop services to meet people's needs. We saw that renovations were underway to create a woman's centre that would encompass the FMU, antenatal and post natal clinics and gynaecological services in one area.
- The FMU will take women who are first time mothers in the future. The date for when this change will happen was cited as somewhere between May and July 2015. Senior managers told us they were aiming for 200 births per year in the FMU.

Governance and risk management

- We saw that robust clinical governance and risk management arrangements were in place.
- All incident reporting forms were reviewed by the Head of Midwifery, the Deputy Head of Midwifery, clinical matrons and ward managers. Staff told us they recieved feedback if they had completed an incident reportng form.
- Staff told us that they recieved feedback in various ways. Specific issues were taken up with the individual. A Quality and Risk newsletter was available electornically and in hardcopy.

Leadership of service

- We were told that the senior management team felt confident that the integration with County Hospital had been managed effectively. Following consultation, integration champions were established amongst the staff to support colleagues through the changes.
- Staff told us they were concerned that the focus was on the future and that the trust was running too fast and not allowing integration to settle.
- Senior staff told us that support was given to the staff and spends lots of communication around integration. We asked about the level of support staff felt they had received and were told there 'is a perception of what people think is support and what is provided'.
- Staff told us that the Head of Midwifery visited the FMU weekly. Midwifery staff spoke positively about the deputy head of midwifery, who had an office on site, and her support in general.
- Staff told us that members of the trust board are not visible.
- Gynaecology staff were positive towards the change. Staff told us they wanted to stay and work at County Hospital and continue the service there. They felt that the trust was supportive of the service at County.

Culture within the service

- The trust promoted a positive safety culture and encouraged incident reporting.
- A junior doctor told us consultants are already always happy to give advice I can always approach the consultants.
- Staff in the gynaecology unit told us 'those who stayed signed up and they are learning from each other'.
- From our observations and talking to staff there was a strong commitment to meeting the needs of and experiences of people using the service. In particular midwives were keen to normalise the birth experience and to ensure that appropriate support was available following delivery.

Public and staff engagement

- Staff felt unprepared for the integration. They received individual written information but it was left on the unit and not sent to home addresses which meant staff on annual leave did not receive timely communication. They said 'We were given the opportunity to express our choices but we felt the decision had already been made'.
- Staff at the County Hospital told us that felt they had not been involved in developing guidelines. They told us 'we have a lot of expertise but have been made to feel we don't matter'.
- There was input from an external consultant midwife to prepare the staff for changing to midwifery led unit but we were told the meeting was not well publicised so the attendance was poor. Staff felt they missed a valuable opportunity to be more prepared for changes in practice

Maternity and gynaecology

- We saw evidence that women were not fully informed of the changes. One woman said 'I had to do my own digging and found out that Stoke did antenatal classes.'

Innovation, improvement and sustainability

- The integration with Royal Stoke enabled a review of how the trust provided maternity and gynaecology services. There are plans in place to offer enhanced services but at the time of our visit, these were 'plans in progress'.

Services for children and young people

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

Information about the service

At the time of our inspection, services for children and young people at the County Hospital were provided on Shugborough ward and in outpatient clinics. The ward had 28 beds in total, six adolescent beds, four high dependency care beds, five medical care beds, six surgical beds and six cubicles. The outpatients department had clinics across areas of respiratory, rheumatology, diabetes, allergies, endocrinology, ear nose and throat, ophthalmology, surgery, urology, psychology, epilepsy and dental.

From May 2015, the hospital no longer provided an inpatient children's service as recommended by the Trust Special Administrators. This service integrated with the Cheethams children's centre at Royal Stoke and The Royal Wolverhampton Trust.

The Cheethams children's centre plans to add another children's ward which will initially have eight beds but will have the capacity to open up to 30 beds depending on demand.

The County Hospital opened a nurse led emergency paediatric assessment unit in May available from 8am to 10pm daily. If the patient requires a bed they will be transferred to Royal Stoke or Wolverhampton. A paediatric consultant will run an appointment only rapid access clinic. The outpatients department will not change.

We inspected the service by interviewing staff, reviewing records and undertaking observations. We received comments from patients who contacted us to tell us about their experiences and we reviewed performance information about the trust. We reviewed data submitted by the trust.

During our inspection we visited the ward and spoke with six nurses, four doctors and five supporting staff including allied health professionals and managers. We spoke with nine parents and children currently using the service. We reviewed six patient care records.

Services for children and young people

Summary of findings

Robust plans were in place to facilitate the transfer of services from County Hospital to Royal Stoke and staff were involved.

We found some parents were confused over the plans and did not know what services the hospital was planning to provide. Although, we noted there had been several efforts to engage with the public around the closure.

Care plans and risks assessments were not adequately maintained and contained insufficient detail to care for patients. Parents made comments that the medical staff did not always keep them informed but the nursing staff did. We saw there were a number of issues in maintaining patient and staff safety. There was a lack of correct storage of medicines and hazardous cleaning products were not safely stored.

We saw elements of compassionate care and were told staff had taken the children on days out. Parents told us they felt emotionally supported by staff. Staffing levels were found to be of a safe standard.

Are services for children and young people safe?

Requires improvement

We saw a number of areas in relation to patient safety that needed to be improved.

There was a risk to patient safety that had not been identified and properly dealt with. Due to the lack of correct storage of medicines nine children were required to be recalled by the trust as they had received a vaccine that was not correctly stored at the optimum temperature.

We found hazardous cleaning products that were not safely locked in a cupboard as per the trust policy.

We noted care plans were not adequately maintained and contained insufficient detail to care for patients. Admission assessments, food and fluid balance sheets were partially completed and discharge plans were not always clear. Risks assessments such as nutritional state, pain assessments and skin assessments were not always completed.

Safeguarding procedures were understood and followed. A paediatric early warning score (PEWS) system was used to enable the early detection of any deterioration in a child's condition. We found staffing levels to be of a safe standard.

Incidents

- Staff reported incidents via electronic information systems, managers were clear about their responsibilities for reviewing and escalating incidents. One medical staff told us they had recently been injured on the ward and burnt their hands, they told us nothing had been investigated or fed back. We raised this with the management team who demonstrated that it had been investigated and actioned.
- Nursing staff told us they always received feedback from incidents and learning was disseminated through e-mails and ward meetings.
- Reports provided by the trust showed that a total of 23 patient safety incidents had been reported between October 2014 and January 2015. We saw evidence all incidents had been reviewed by managers and action had been taken in order to reduce harm to the patient and details of lessons learnt.

- The ward manager stated there had been no recent trends in incidents and no risks had been identified on the risk register during the 12 months proceeding to our inspection.
- We were told the normal protocol after a medication incident is that the nurse would be suspended from giving any medication for 48 hours whilst an investigation had been carried out and statements had been made by all staff involved. The nurse would then undergo supervision for a period of three months. We saw this was actioned in one of the incidents we reviewed as detailed above.
- There had been no 'Never Events' or serious incidents reported. The manager confirmed this during our interview although had not mentioned the incident of the doctor burning their hands.
- The trust monitored monthly harms on all wards as per national guidance, we saw from the results there had been no pressure ulcers, falls or infections from urinary catheters from February 2014-January 2015.
- Paediatrics Mortality Data submitted by the trust revealed that mortality rates were within expected ranges based on the case mix and activity.

Cleanliness, infection control and hygiene

- All the areas we visited were clean, we observed housekeeping staff cleaning on the wards and in the departments throughout our visit. The domestic staff told us that staff were available out of hours if anything needed to be cleaned immediately or deep cleaned. Cleaning schedules were well maintained and up to date.
- We noted Control of Substances Hazardous to Health (COSHH) product records were detailed and appropriate information was recorded. During inspection the cupboard which contained harmful cleaning products was unlocked. We were told it was normally locked. We found this a risk due to the nature of the ward caring for young people with a medical history of self-harming. We checked this again later and the cupboard was still unlocked. Staff were informed to ensure it was locked and remained locked.
- Hand washing facilities and hand sanitising gel were available and we observed staff adhering to the trust's policy on 'bare below the elbows' policy.
- There were no episodes of methicillin-resistant staphylococcus aureus (MRSA) or Clostridium difficile (C.Diff) attributable to children's services between the period of October 2014 to March 2015.
- Monthly infection control audits and hand hygiene audits were undertaken; in the sample that we reviewed the areas were fully compliant.
- Personal protective equipment, such as gloves and aprons, were available for use by staff in clinical areas, we observed this equipment being used appropriately by staff.

Environment and equipment

- Equipment, such as monitors and electrical equipment had been checked in line with their testing requirements. We noted that labels were in place to confirm the last check date.
- Age appropriate resuscitation equipment was available and there was evidence it was checked regularly. Staff audited all equipment within the resuscitation trolley on a monthly basis; staff stated they were 100% compliant with what equipment and products were required in the trolley.
- Staff had assessed the environment in February 2014 and had identified a number of items and fixtures that needed replacing and repairing. We saw the area needed to be redecorated and painted in some places although due to the closure this was not deemed to be a priority.
- Children's toys were cleaned and checked for damage on a daily basis.

Medicines

- The medicines fridge temperatures were routinely recorded as being outside of the safe range. Staff recorded temperatures outside of the accepted safe range and there were no actions to address this issue. Medication was not stored at the correct temperature meaning some children that had received vaccines were required to be recalled by the hospital. We immediately informed the Medicines Safety Officer when we found this, they took action to condemn the fridge and make arrangements to recall patients.
- Copies of the medicines fridge temperature charts for March and April revealed that the temperature had been out of range for at least two months. There was only one record of an action taken to inform the ward manager of the temperature disparity.

- The ward manager told us they had raised the temperature discrepancy with the ward pharmacist and that the pharmacist had not raised any further action. We saw records of this in the pharmacy action plan in April, held by the pharmacist, no actions had been taken. We found a lack of escalation in line with trust policies and governance awareness placing patients at risk.
- When asking staff to locate certain medication guidelines, staff did not know how to access these.
- We reviewed random medicine charts and found them to be completed appropriately.
- We noted that all other medicines were stored safely, including the safe storage of controlled drugs.

Records

- We reviewed six case notes and care plans from the wards. We noted care plans were not adequately maintained and had insufficient detail such as, activities of daily living, how the child fed and what their toileting requirements were, in some cases these we not completed at all. We discussed this with staff who told us management did not encourage further detail.
- Admission assessments, food and fluid balance sheets were partially completed and discharge plans were not always clear for those who had been in some time. Daily nursing notes lacked detail, were medically focused and did not include an overview of the child's health.
- We reviewed a care plan for a patient with complex needs and noted that basic information about the child such as communication, sleeping, eating and drinking had not been recorded as assessed since the admission, 10 days ago. When asking staff it became apparent that they knew the child's needs but had become complacent with long term patients care plans. We highlighted that this was not best practice for a number of reasons, for example patient safety, continuity of care and especially for new staff such as student nurses that don't know the patient.
- We asked the management team if care plan audits had been maintained, they told us they could not be certain and that this was the responsibility of the ward manager.

Safeguarding

- Safeguarding policies and procedures were in place. Staff understood their safeguarding responsibilities and knew what to do if they had concerns. Ninety-three percent of staff had completed standard children's safeguarding training and 91% had completed vulnerable adults awareness training.
- We asked the trust to tell us how many staff had undertaken additional child protection safeguarding training. Data provided showed that across the children's directorate 51% of all staff have completed this training. The trust have not identified which staff required this training so we cannot assess whether this is compliant with trust targets.

Mandatory training

- The ward manager told us staff were up to date with their training and staff we spoke to confirmed this.
- Mandatory training information was available for the whole service and was not available for just County Hospital. However, the data showed that 95% of staff had completed mandatory training.
- The data also showed that 26% of staff had completed conflict resolution, 71% equality and diversity, 46% hospital resuscitation, 62% blood transfusion, 84% information governance, 75% fire, 74% health and safety (including manual handling theory), 75% infection control (clinical), 83% infection control (non-clinical).

Assessing and responding to patient risk

- A paediatric early warning score (PEWS) system was in place on the children's ward, based on the NHS institute for innovation and improvement PEWS system. This tool supported early identification of children at risk of deterioration.
- PEWS assessments had been completed in the six care records we reviewed.
- Staff were able to explain the process of reviewing the scores, and what to do when there were changes in the score, which indicated that a child's health was deteriorating.
- Risk assessments such as nutritional status, pain assessments and skin assessments were not always completed.
- For patients who were at risk of self- harming, they were assessed and monitored closely either directly opposite the nurses' station or on a one to one supervision. The ward staff were aware of the risks involved with accepting and caring for children with mental health issues. Staff were aware of which national risk assessments and guidelines to follow when accepting

admissions. Staff were aware of the risk of absconding and what protocol to follow if such incidents were to occur. Staff worked closely with Child and Adolescent Mental Health Services (CAMHS).

- We found evidence that staff were able to manage admission pressures appropriately. We noted on one occasion during winter pressures the ward was full and admissions were diverted to other neighbouring hospitals.
- We observed staff respond rapidly to a deteriorating patient. We noted they were very supportive and caring in their responses making both the patient and parents feel comfortable and provided reassurance.

Nursing staffing

- Staffing levels were adequate, as was the required skill mix on the day of our inspection. Staffing levels conformed to the Royal College of Nursing (RCN) guidance. We were told by the manager that they had no issues with staffing levels and had a low turnover. The staff we spoke with had been there for a number of years.
- Staffing levels were planned in order to cover annual leave. Staff worked flexibly to cover each other's shifts during periods of sickness.
- We were told the ward did not require the use of agency staff.
- Planned and actual nursing staffing levels were clearly displayed on status boards on the wards.
- Some staff had recently left due to the ward closure and some told us they were planning on working in the assessment unit.
- Parents agreed that the ward always appeared to be well staffed.

Medical staffing

- The medical staff that we spoke with confirmed they were fully staffed and told us they felt supported by the consultant and senior medical staff. They did not see skill mix as an issue of concern. All medical staff told us they received clinical supervision and regular appraisals which they considered to be robust.
- There were two handover sessions per day for the medical teams. We saw the consultant was late for the morning handover, medical staff told us this has happened before. We noted he had missed the discussion and handover of most patients. We found this was poor practice due to the impact it could have on patient's treatment and management plans as well as the lack of support for junior medical staff.
- Out of hours medical staff cover was found to be adequate and the number of locum medical cover was found to be infrequent.

Major incident awareness and training

- Staff were aware of the major incident and the business continuity policy, and understood their roles and responsibilities within a major incident.

Are services for children and young people effective?

Requires improvement

The environment did not support mental health patients, we saw they were not adequately distracted or engaged in therapeutic activities. There was no evidence for staff training around mental health care for children and we saw this was a gap in meeting the needs of this patient group.

We noted children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH).

The child psychologist based all care and treatment on best practice and national guidelines. We found knowledge of pathways and protocols to be of a good standard which ensured patients' safety was paramount.

Children and young people were able to choose what they wanted to eat from a menu. We received positive comments about the quality of the food but parents also mentioned the concern around small portion sizes for older children. We were told this had been escalated to the catering department but nothing had been adapted or improved.

Staff commented that they received good training opportunities, regular appraisals and clinical supervision.

Evidence-based care and treatment

- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH).
- Appropriate care pathways were in use and were in keeping with the relevant NICE clinical or nursing guidance.
- Policies, procedures and guidelines were available to all staff via the trust intranet. Staff knew how to access them when necessary.
- There was a planned approach to monitoring compliance with the NICE guidance. Compliance with the NICE guidance was reviewed centrally therefore none of the staff we spoke with were able to tell us if there were any issues with compliance.
- The management team told us the service was involved in a range of local and national audits but did not provide us with any evidence of this.
- The child psychologist based all care and treatment on best practice and national guidelines. We found their knowledge of pathways and protocols to be of a good standard which ensured patients' safety was paramount.
- Parents felt the environment did not support their children and we saw they were limited therapeutic activities to distract or engaged them. Parents told us that their child wanted to recover but felt they were not supported to do so. One child was frequently readmitted with attempts of self-harm and we saw there were no long term goals or care plans to reduce attempts to self-harm or readmissions.

Pain relief

- Pain was assessed and managed appropriately. We observed a number of age-specific tools in use and the appropriate national guidance was followed. Nursing staff utilised a 'comfort round' tool to ensure the assessment of the child's comfort. We reviewed comfort round assessments and saw they were incomplete. However parents told us that staff did regularly ask if the child was in any pain.

Nutrition and hydration

- We found children's nutritional status was not always assessed and food and fluid records were incomplete. We noted examples of children on the ward that had poor intake and issues with constipation where these should have been recorded.
- Children's likes and dislikes regarding food were not identified and recorded as part of the nursing assessment on admission.
- Staff told us portion sizes did not vary depending on the age of the child so older children did not always have a larger portion leaving them hungry. We were told this had been escalated to the catering department but nothing had been adapted or improved.
- Children and young people were able to choose what they wanted to eat from a menu. We received positive comments about the quality of the food but parents also mentioned the concern around portion size.
- Staff held a parents group some months ago in order to engage with families one of the issues parents fed back on was the limited choice for vegetarian children. Staff told us they had actioned all the suggestions including introducing more choice onto the menu.

Patient outcomes

- There were emergency readmissions after elective admission at the former Mid Staffordshire NHS Foundation Trust among patients in the 1-17 age group between June 2013 and May 2014. However no treatment speciality reported six or more readmissions.
- Hospital Episode Statistics (HES) data for 2013/2014 showed that the trust had a higher than average readmission rate for paediatric readmissions following emergency admissions.
- Readmission rates for children and young people with epilepsy were slightly better than the England average for July 2013 to June 2014. However, for asthma and diabetes the readmission rate was slightly worse than the England average.
- From data submitted by the trust almost a quarter of children aged 1-17 admitted to the former Mid Staffordshire Trust for diabetes had multiple admissions. We reviewed this data with the diabetic nurse specialists on the ward and noted the readmissions were young adults who were non-compliant with their diabetic medication.

Competent staff

- Data submitted by the trust showed that 84% of staff had an appraisal in the last 12 months. Six out of 38 staff were yet to receive their appraisal this year.
- The medical staff we spoke with all confirmed that they had received an appropriate induction when they started work and had an appraisal planned to identify

training needs. They told us that they received good training opportunities, and access to clinical supervision. Nursing staff told us they recently had training on caring for children with asthma.
- There was no evidence for staff training around mental health care for children and saw this was a gap in meeting the needs of this patient group.

Multidisciplinary working

- There was evidence of multi-disciplinary team working. We saw evidence of external engagement with other agencies such as social services and CAMHS.
- The clinical psychologist worked closely with medical and nursing staff for children with complex needs.
- Handovers were multidisciplinary to ensure that all staff had up-to-date information about the needs of children within the service.
- There was a section for multidisciplinary notes in the care plans, however these were not consistently completed.

Seven-day services

- Following the closure of Shugborough ward, a seven day service will be provided by the emergency assessment unit but it will not be open overnight. A child requiring overnight care would have to be transferred to a neighbouring hospital.

Access to information

- Policies and protocols were kept on the hospital's staff intranet so that all staff had access. Parents had access to their child's care plan although as previously noted these were inconsistently completed.

Consent

- We spoke with staff, who confirmed that patient and parental consent would be sought prior to any procedures or tests being undertaken.

Are services for children and young people caring?

Good

We saw elements of compassionate care and were told staff had taken the children on days out.

Parents told us that the medical staff did not always keep them informed but the nursing staff did. Parents were able to feedback to the staff, we noted staff listened to their suggestions and made several changes based on the feedback.

Parents felt emotionally supported by staff. We saw children who had mental health problems were not fully emotionally supported by all staff at all times.

Compassionate care

- We noted a number of thank you cards from parents to staff with an array of positive comments. One letter described the care as "Excellent".
- We observed care provided by staff for two patients and saw staff were kind and polite.
- One parent told us the staff were understanding and empathetic when they were upset.
- Staff took children on days out, the past year they had been abseiling, canoeing and participated in workshops around team building. We noted 14 thank you cards about the days out, we saw comments such as: "It was fantastic", "Invaluable", "Loved it" and "Confidence building".

Understanding and involvement of patients and those close to them

- Parents told us they felt well informed by some doctors, they told us it was dependent on which medical staff were working although the nurses were consistent with their engagement and involved parents.
- Parents told us all staff spoke with the child and explained things in an age appropriate manner.
- Staff held a parents group some months ago in order to engage with families. Staff told us parent's fed back that the parents' beds were uncomfortable, children had said it was noisy at night, there was not much choice for vegetarian children and the parents' room needed redecorating. Staff told us they had actioned all suggestions and the trust invested in better beds for parents, to reduce noise at night they bought soft close bins, more choices were introduced onto the menu and the parents' room was redecorated.
- Parents and children were able to complete online survey's using their patient televisions providing the staff with feedback. We were told these results were displayed for parents to see.

Emotional support

Services for children and young people

- Parents we spoke to gave us examples of how the staff had always emotionally supported them.
- We received positive feedback about the support from the child psychologist but on the wards there was a lack of consistent support for children with mental health issues. We spoke with one patient who told us there was nothing to occupy them and that they spent their time pacing up and down the ward.
- Staff and patients told us nurses would go out of her way to sit and spend time with children with mental health issues. This helped to get to know the patient and built a rapport with them.

Are services for children and young people responsive?

Good

Service planning had taken place and assessments had been made to ensure the delivery of care to paediatric patients. Although local people who use the service were disappointed with the closure of the ward, we saw there were plans in place to manage a safe transfer, adequate access and flow had been considered.

Parents of mental health patients were told us they were not effective in meeting their needs.

We were told by one parent about one complaint that had not been dealt with appropriately and parents were not informed of the process of how to complain should they need to.

Service planning and delivery to meet the needs of local people

- From May 2015 The County Hospital no longer provided an inpatient children's service as a recommendation by The Trust Special Administrators. This service integrated with the Cheethams children's centre at Royal Stoke and The Royal Wolverhampton Trust. The Cheethams children's centre plans to add another children's ward which will initially have eight beds but will have the capacity to open up to 30 beds depending on demand.
- A nurse led emergency paediatric assessment unit opened at County Hospital in May, available from 8am to 10pm daily. Staff will continue to see patients in outpatient clinics. If the patient requires a bed they will be transferred to an inpatient facility.
- We were told a paediatric consultant would run an appointment only rapid access clinic and the outpatients department would continue to run as normal.
- The nurse led emergency assessment unit would be supported by adult emergency care medical staff. We were told the paediatric consultant running the rapid access clinics on site would be able to provide a consult or advice should the adult medical staff require.

Access and flow

- Under current arrangements, parents with children with long term conditions were able to directly access the ward. They could phone at any time to speak to a doctor who would then decide if the child needed to come in to hospital. Parents told us this was reassuring and made for a seamless admission process. Patients could also be referred to the ward by GPs and the emergency department.
- Bed occupancy levels had slowly been declining over the past months as GPs and paramedics directed care to the other hospital sites. There were eight inpatients on the day of inspection.
- Concerns were raised by staff and families over the length of time taken to travel to the other hospital sites for emergency care after the closure of The County Hospital. However we saw there was plans in place which ensured a safe transfer of critically ill children.
- The children's acute transport service provided a retrieval service in which they would go to the patient's home to start care so treatment was not delayed. We were told all transport systems would liaise with the hospitals and decisions would be made if the child required a bed they would be taken straight to Royal Stoke or Wolverhampton.
- GPs would be able to directly access the rapid access clinic for a local paediatrician consult. We were told it would be a next day appointment service.

Meeting people's individual needs

- Nursing staff utilised a 'comfort round' tool to ensure the assessment of the children's comfort. It reviewed whether the child needs to be repositioned, their pain score, any action taken, access to a drink, fluid balance is up to date, toilet or nappy changing needed, call bell in reach, environment was safe, medication up to date and family aware of current plan of care. However these assessments were not consistently completed.

Services for children and young people

- Some parents told us staff knew their child well and felt they had built up a good rapport.
- Staff told us they had 120 admissions of children with mental health needs in the last year. Parents of children with mental health needs were grateful that the hospital would accept them on admission and care for them but told us they were not effective in meeting their needs. We did not see evidence of adequate planning to improve the patient's wellbeing.
- Staff had been preparing long term patients for the closure and had gained their preferences on where they would prefer to be cared for.
- Staff had educational days for children with diabetes in order for them to better understand their treatment. Staff engaged with school teachers, training and educating them around the children's needs.

Learning from complaints and concerns

- From information received by the trust the children's services had five complaints from November 2014-February 2015. Most of which were regarding lack of communication with the families. In the information sent to us by the trust there was no details of dates when actions were taken. Staff documented on the action plans that one complaint was not upheld and two were only partially upheld.
- We spoke with one parent that had complained about a member of nursing staff being unprofessional and argumentative. The parent told us nothing had been followed up or discussed with the nurse nor had they received an apology. The parent felt as though the complaints system was not a formal process and was not happy that the issue was not investigated.
- Other parents we spoke with told us they did not know how to complain should they need to.

Are services for children and young people well-led?

Good

The directorate management team developed an integration panel in order to strategically plan the move of County Hospital paediatric services and staff and integrate them into Royal Stoke.

The integration panel involved staff from both hospital sites in order to ensure staff were engaged and informed. However medical staff from both sites did not feel involved. Junior medical staff thought that there were no plans in place for the move.

We found some parents were confused over the plans and did not know what services the hospital was planning to provide. Although, we noted several efforts to engage with the public around the closure of the ward.

Vision and strategy for this service

- The vision for the service was to reconfigure services in accordance with the plans outlined by the Trust Special Administrators. To facilitate the move of services, the management team had developed an Integration Panel oversee the strategic plans of the move of County Hospital paediatric patients and staff and integrate them into The Royal Stoke site.
- The integration panel involved staff from both hospital sites in order to ensure staff understood, were engaged and felt informed. We saw the management team were eager to engage with staff.
- The panel oversaw progress against the strategic plan to ensure key milestones were achieved so that the planned date for the actual move could be achieved.
- The management team informed us that senior medics had been invited to these panel meetings but the medical staff did not choose to engage.

Governance, risk management and quality measurement

- Services for children and young people are part of the Women's and Children's division at the trust. The management team for children's health has a clinical director and senior nursing team who work across both hospitals.
- There were monthly clinical governance meetings where incidents, mortality data, development of guidelines, complaints, risk and other issues were reviewed.
- We noted staff were unaware of their compliance with the NICE guidance as it was reviewed centrally and was not disseminated and therefore are missing out on learning or driving changes. We saw this as an area for improvement.

Services for children and young people

- The head of housekeeping and infection control lead conducted an environmental audit in which they regularly scored 95-100% in outpatients department and on the ward. We saw they detailed an action plan of areas that needed improvement.
- During our inspection, we noted that the temperatures of refrigerators used to store medicines were being recorded as unsafe but no action was being taken. This raises concerns that governance protocols were not being adhered to and staff had not been made aware of their responsibilities in this area.
- The risks associated with the integration of services had been highlighted on the risk register.
- The management team told us the service was involved in a range of local and national audits but did not provide us with any evidence of this.

Leadership of service

- Nursing staff stated that they had been supported during the impending closure of the ward and that there has been clear leadership and direction from the ward manger. Nursing staff felt supported by their line management in general and told us there was an open door policy and that mangers were visible and approachable.
- Medical staff told us they felt supported by the consultant although we saw a lack of leadership during the closure of the ward.
- We were told by management that one paediatric consultant had been invited to several meetings but did not engage. We saw this disadvantaged the junior medical staff and they thought that there were no plans in place for the move. The consultant confirmed there had been little engagement with the management team.

Culture within the service

- Staff told us morale was low. Although parents told us the staff had been very professional throughout a time which they thought must be difficult for them.
- Staff commented it was a positive place to work. They were disappointed to see the ward close. All staff told us that they felt they worked well together as a team and supported one another.
- We noted 13 thank you cards from student nurses commenting that that it was a “Welcoming team”, “Fantastic” and “Confidence building”.

Public and staff engagement

- From the integration panel, managers developed the role of integration champions whose responsibility it was to answer questions, alleviate fears and disseminate information to other staff. This aimed to engage and involve as many of the staff as possible, during the move.
- The trust had engaged with the public in the move. We saw extensive evidence that staff were engaging with the public through community evenings, the media, visiting stakeholders and meeting with local GPs preparing for the imminent changes. However, when discussing the closure of the ward with parents, we found that most families were unclear about the plans.
- When discussing engagement with staff they felt the engagement with the public has not been adequate and people remained confused.

Innovation, improvement and sustainability

- We requested information for improvement although audits had been archived due to the pending closure so we did not see evidence of this.
- Plans were in place for sustainability of the children’s service to be carried out at the Royal Stoke hospital.

End of life care

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

Information about the service

End of Life Care Services were provided across the hospital. Referrals were made to the specialist palliative care team (SPCT); this consisted of two consultants and three Clinical nurse specialists, plus two occupational therapists. There were other members of the extended SPCT also. Referrals were made by staff to the team to support patients who were identified as palliative, or end of life and who required additional support such as symptom control from the SPCT.

There were 409 deaths at County Hospital between April and December 2014.

During the inspection we visited six wards, spoke to 12 staff and one family. We reviewed patient notes and care plans, which included nine Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records.

Summary of findings

Since the removal of the Liverpool Care Pathway in July 2014, the hospital had failed to implement an individualised plan of care for the dying patient, with the trust still in the evaluation process.

The hospital did not have safe arrangements in place regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The completion of the forms was not always done as per trust policy. In addition to this, if a person appeared to lack capacity no associated mental capacity assessment was undertaken to maintain their safeguards.

The local leadership was good; the specialist team were effective once they received a referral. Caring within the service was good; staff were committed, compassionate and emotionally supportive.

End of life care

Are end of life care services safe?

Requires improvement

When Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders were put in place discussion with families always took place, and this was recorded. There recording of review dates was not consistent.

The trust was still using an interim pathway document to support palliative and end of life patients, having guidelines for staff which did not appear to be well embedded.

The processes around incident reporting and investigation appeared robust, however we saw examples of where this may not always be the case. Staff were aware of their responsibilities around reporting incidents and learning took place.

Incidents

- No 'Never Events' had occurred within the palliative care service since November 2014.
- The incidents were reviewed by the local leadership to ascertain if they involved any patients receiving palliative care. These were then reviewed further to identify if an investigation was required and any learning actions were to be taken.
- The incidents documented since November 2014 were recorded across both The County and Royal Stoke sites. We noted 48 incidents; eleven relate to medication or equipment, four to discharge arrangements and eight to adverse staffing arrangements which either had, or had the potential of a negative effect on patients. For example, one pertained to a palliative care patient whose discharge was delayed because their take home medication had not been dispensed. This occurred at Royal Stoke Hospital but was reviewed for learning opportunities by the SPCT leadership.
- We did see documentation of investigation following an incident which occurred before the formation of the new trust. The process demonstrated that a clear timeline of events was recorded which enabled the hospital to identify where deviation from protocol or additional learning opportunities needed to be offered. The investigation documents clearly described the actions required and delivered following the incident to reduce the likelihood of its repeat.
- All staff had access to the electronic form to enable them to complete incident forms.
- Staff told us of learning which had resulted from incidents; this involved the use of syringe drivers and the recommendations for priming them. We saw that written advice had been produced and shared with staff.
- On Ward 10 during the unannounced part of the inspection there were a number of incidents which related to staffing and missed doses of medication. These were not recorded as incidents at the time. Following the inspection the trust confirmed that incident forms had been raised and a full investigation would be undertaken.

Environment and equipment

- Common equipment used for palliative care patients were syringe drivers. The Graseby syringe driver had been discontinued for use, as per national guidance and the hospital was using an alternative. We noted that a few times lack of syringe drivers had been reported as incidents; also local managers confirmed that more syringe drivers would be beneficial.
- Patients who were in the last few days of life were all cared for on pressure relieving mattresses.
- All equipment in use had been maintained and PAT tested for their safe use.

Medicines

- The trust had identified the most commonly required medication for symptom control. An algorithm of most common medications for symptom control was available for staff at the hospital.
- We noted that one patient who had been identified as end of life and referred to the SPCT had not had any anticipatory medications prescribed. Staff thought that the Consultant or the Clinical nurse specialists (CNS) within the SPCT would prescribe them.
- There was an identified pharmacist who worked as part of the extended SPCT.

Records

End of life care

- Patient care plans had space for relatives to write their opinions about their relative within it. We observed that this was used by relatives although we saw two completed by a relatives.
- We reviewed the arrangements for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). Where community DNACPR's were in place the patients views were honoured. The community one was red in colour but was not to be acted on if it was the only one in the patient's notes. However the community forms were not legal within the hospital, so the hospital recognised form needed to be in place.
- We reviewed nine DNACPR orders within the hospital. In all of the cases we noted that discussions with families had taken place and were documented in the notes. The orders had been signed by appropriate senior medical staff.
- There was inconsistency regarding reviews. Some DNACPR forms had associated documents indicating the date of the next review. The review dates were dependent on the acuity of the patient. Some forms had no dates indicating when the next review was due.
- Notes were accessible, however we noted on the wards that they were either unsecured or unlocked, or they were not able to be locked, being of a design which it was not possible to lock. They were not always attended which meant that an information breach could occur.
- Risk assessments and care plans were completed and regularly reviewed and updated with patient care needs in the vast majority of cases.
- When members of the SPCT visited patients they documented their visit and recommendations in the patient's notes.
- Documents used for safety rounds, handovers and ward rounds were in use and accurate. They contained up to date summary information about patients. These were updated on a daily basis and given to staff as they came on duty.
- The hospital had a resuscitation policy which was due for review May 2015. It was specific to County hospital. It contained guidelines regarding the actions staff should take making reference to the Human Rights Act 2000 and Mental Capacity Act 2005.
- Since the withdrawal of the Liverpool Care Pathway, over two years ago, the hospital has been using an interim measure of guidance document. It detailed the care and treatment most commonly required for a person nearing the end of their life. Including common symptoms and their treatment. However it had not yet been fully implemented.
- The normal care plans were in use for patients, no other care plan was available at the time and this was in line with the guidance document in place.
- The AMBER care bundle had been previously used within the hospital but we did not see any patient with it in place. Both staff we spoke to and the local managers agreed it needed further support to embed its use with staff. There were a number of staff who did not know what this was. Members of the SPCT felt the use of it was personality-led and that doctors had not really signed up to its use.

Safeguarding

- We spoke with two members of the SPCT at County. They confirmed that they had undertaken Safeguarding Adults training level 2. They were able to describe their responsibilities and actions they would take.
- We were unable to verify the completion rate for the SPCT specifically as the trust did not supply us with that information specific for this team. We were able to see that at the time of the inspection Medical and Dental staff completion rate was 63% and Nursing and Midwifery was 97%. The trust target was 97%.
- The trust had a policy for Vulnerable Adults which was due for review September 2016. It included contact details and a flow chart and the expectation of staff to attend mandatory training regarding vulnerable adults.

Mandatory training

- We were unable to verify the completion rate for the SPCT specifically as the trust did not supply us with that information specific for this team.
- The SPCT should deliver mandatory training to the clinical staff groups; the end of life training was required to be repeated every three years. Mandatory training delivered by the SPCT was zero for 2015 due to staffing pressures. In 2014, 21 staff confirmed they should have attended training, but were not noted as having completed the training.
- The trust had a policy which identified the different staff groups and the training they were to undertake. It had been ratified in 2013 and was not due for review until

2016. It still had as part of the training offered to medical, dental, nursing and midwifery staff end of life care including the Liverpool Care Pathway, this therefore needed updating.

Management of deteriorating patients

- Due to the patient's conditions, ceilings of care were identified and shared with all the staff involved in with their care and treatment. Therefore interventions which control symptoms would always be offered but more invasive treatment would not be offered.
- Modified Early Warning Score (MEWS) were maintained for patients and we saw evidence of escalation undertaken when scores indicated it necessary to do so.
- Risk assessments were in place for patients and where these directed additional support it was provided. For instance, for patients who no longer took fluids orally, two to four hourly mouth care was administered.
- Patients we observed appeared to be comfortable.
- The SPCT received referrals to offer additional advice to patients, family and staff. This was to help ensure the patients were kept comfortable during the end of their lives.

Nursing staffing

- The SPCT consisted of three clinical nurse specialists.
- Within documents supplied to us by the trust all the wards should have at least one palliative care lead. During this inspection we did speak with two who were on duty. These were not members of the SPCT but formed a link to that team and supported staff on the wards to recognise the dying patient.
- The number of referrals was falling at this hospital. Some members of the SPCT were working in other clinical areas to meet their contractual hours.
- Within the hospital for the months of November and December the agency use for nursing averaged 32%. This was a high number of staff who may not have the experience of caring for the dying or have received the end of life mandatory training.
- During the unannounced part of the inspection we saw that care was not delivered to an optimum level. The ward area was short staffed, and as a result patient admissions and risk assessments had not been fully completed for people.

Medical staffing

- The medical support was consultant-led, of which there were three, which equated to 1.4 WTE in the team. They work across both sites supporting patients at both hospitals. At the time of the inspection there was an outstanding vacancy for one full time consultant.

Major incident awareness and training

- The hospital had a major incident planning policy. The chaplaincy team had a designated role within it. This is seen as good practice in line with the NHS Chaplaincy guidelines 2015.
- There was clear advice and guidance for mortuary staff regarding a major incident within the policy.

Are end of life care services effective?

Requires improvement

The lack of effective care planning and delivery systems meant that patients ran the risk of not receiving the care and treatment they required. Although the hospital had previously endeavoured to ensure the staff were competent in recognising the dying patient by offering training to both medical and nursing staff , this had fallen by the wayside recently and was having a detrimental effect.

The arrangements regarding DNACPR and patients who appeared to lack capacity was not sufficient to safeguard patients.

The SPCT was a multidisciplinary team and as such when supporting referred patients all contributed to their care and treatment.

Evidence-based care and treatment

- The hospital failed to achieve all seven of the organisational key performance indicators (KPI's) for the National Care of the Dying Audit results (NCoDA results July 2014) and five of the ten clinical KPI's.
- An action plan had been produced to address the areas where the hospital had not achieved the NCoDA KPI's. All of the organisational KPI's within the action plan had no date of completion. However, all of these would be resolved by the integration and use of the individualised plan of care and additional training.

End of life care

- The trust did not use the Liverpool Care Pathway (LCP) since its withdrawal. The County Hospital did not have formal policy for care of the dying patient.
- The trust had developed the individualised care plan for the last days of life to replace the LCP. This was to be used in conjunction with the last days of life guidance. The care plan was in the evaluation stage after being trialled on five wards within Royal Stoke Hospital. The guidance had not been implemented yet and was still in draft format.
- As an interim measure the trust used a guidance document for both medical and nursing staff which was an aide memoire for the care and treatment needs of the dying person. However we did not see these present in patients care documents.
- The AMBER care bundle provides a systematic approach to manage the care of hospital patients who are at risk of dying in the next month or so. It was developed by an NHS trust and has been adopted by a number of other NHS providers.
- AMBER care bundles could be used on all wards at this hospital. However, we found that where we identified patients who appeared to require such intervention this had not been initiated. For AMBER to be more effective it needed more on-going support from the team. Staff had left the hospital and taken their knowledge with them. This meant unless new staff were trained to understand the bundle they did not recognise when to implement it.
- One member of the SPCT told us its use within the hospital had stopped around June/July 2014. Other staff were aware of it but confirmed it was not used systematically.
- NICE quality standards number six relates to Holistic support - spiritual and religious for EOL care. We saw that the chaplaincy team felt they were well utilized. They received the vast majority of their referrals from the SPCT. However, the hospital did not achieve the KPI for assessment of spiritual needs, achieving a score of 18% against the national average of 37% (NCoDA).
- The hospital did not use the gold standard framework.
- Following the Leadership Alliance for the care of Dying People recommendation June 2014, the trust had adopted the five Priorities of Care. This was promoted within the hospital and three staff we spoke with were able to describe the five key areas.
- We noted that each clinical area had an End of Life folder, these varied in the information which was contained within it. We also noted that some still contained the LCP protocol.

Pain relief

- Patients we saw appeared to be comfortable and pain-free. When we spoke to family members they confirmed their relatives were pain-free.
- The hospital failed to achieve the KPI for the prescribing of anticipatory medication, scoring 32% where the national average was 50% (July 2014 NCoDA).
- We observed one patient who had not been prescribed anticipatory medication. Staff told us it was the responsibility of the CNS or doctors to do this.
- During the unannounced part of our inspection we noted that on ward 10 two patients' medication charts were missing. One of the patients was an end of life patient who required their pain relief medication. They appeared to be uncomfortable, having not had their medication from 17:00hrs to 00:15hrs, which was when they eventually received their medication as the chart had been located.

Facilities

- When doctors and/or nurses needed to inform families of the poor prognosis of family members, these difficult conversations took place mostly in offices on wards and day rooms and staff rooms. This was not ideal, although staff said that when they did use day rooms, other people using it did vacate the room.
- The hospital had facilities to meet patient and families spiritual needs, offering a chaplaincy service. Doctors sometimes met with families in the family areas by the bereavement offices.
- The mortuary had three bariatric fridges and a foetal fridge, as well as the 32 regular fridges. There was an arrangement in place to use the other fridges at Royal Stoke if required.

Nutrition and hydration

- Assessments of patient's hydration and nutrition needs were assessed. Families were informed and understood when their relatives who were actively dying had a reduced interest in food and drink; this was included in medical notes.

Patient outcomes

End of life care

- The hospital needed to improve the recognition of the dying person. Staff expressed that since the withdrawal of the LCP they felt they lacked guidance of what to do to support patients and families effectively.
- The NCoDA demonstrated that the hospital did not achieve the KPI of communicating the patient's plan of care in the dying phase, achieving 46% where the national average was 59%.
- The hospital did not support patients to achieve their preferred place of death as this was not routinely asked and recorded. Local leadership said it was often not asked as patients were not ready to accept they were dying. The SPCT used the Somerset software which had a place to record patient's preference regarding place of death. However, staff told us they recorded preferred place of care, which was also recorded on the Somerset tool which we observed.

Competent staff

- A member of the SPCT confirmed that training for hospital medical and nursing staff had been cancelled the last three times they had been scheduled. The reason had been that the priority was to staff the wards.
- Members of the SPCT were suitably qualified to meet people's needs. Documents supplied by the trust indicated that every member of the team was qualified to degree level. All of the SPCT had advanced communication skills training. One of the team was qualified to deliver cognitive behaviour therapy.
- The SPCT saw their role as offering formal training to staff via both mandatory training and specialist training which they offered, but to also support staff informally whilst in the ward areas. We were told by a member of the SPCT that due to the lower number of referrals, they were not getting the same number of opportunities to train staff in the ward areas. This was confirmed by local leaders.
- Equality and diversity training was part of the training, which was mandatory for all staff.
- Appraisal rate for medical division nursing and midwifery was 66% April –December 2014.

Multidisciplinary working

- The SPCT had within it medical palliative care consultants and CNS's. In addition to this the team had two occupational therapists, clinical psychologist, chaplains, social worker, bereavement staff, pharmacist, discharge liaison and administrative support.
- Documents supplied and minutes of meetings confirmed that weekly meeting of the MDT took place where patients referred to the SPCT were discussed. The Somerset Cancer database was used as a tool so that uniform information was collected and discussed at each meeting. Patients who were newly referred or had uncontrolled symptoms, or those with complex discharge needs were discussed. The minutes were shared with the treating physician and placed in the patients' medical notes.
- The hospital integrated with the local hospice which facilitated patient's wishes. The medical members of the SPCT also worked within the hospice to better support their patients.

Seven-day services

- The SPCT worked Monday to Friday from 9:00am through to 5:00pm. During this time staff would visit all the patients referred to them in the ward areas. Outside of these times telephone support was offered by the local hospice. Staff on the wards had the contact details for the hospice and said they would use it if they needed.
- Consultant cover included weekends; we saw they were identified on an on-call rota which included weekends.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A current mental capacity assessment tool was available at the hospital via the intranet. However we did not see this used as part of the DNACPR discussion where patient's capacity was in question. We spoke with local leadership where there was mixed views with regard to when a mental capacity assessment should be undertaken. One manager was very clear that where the doctor had reason to believe capacity was lacking, an assessment should be undertaken. The other thought it was the doctor's decision. In every case where the DNACPR had identified that the patient lacked capacity, there was no associated mental capacity assessment.
- Where the patient appeared to lack capacity, the doctors completing the form would tick this option. The form then prompted them to complete three other Yes / No questions and in all of the cases these were left blank. The questions related to if an advanced decision had been made, whether a welfare attorney had been

End of life care

appointed and if any other person involved in the patient's welfare had been consulted. The hospital policy requires that if any of the questions are not applicable the form should be marked with N/A.
- The trust supplied us with their current mental capacity act policy published April 2014 which stated "If there is evidence to suggest that a person may lack capacity then an assessment of capacity must be carried out." However the DNACPR policy was not as clear and could lead to confusion.
- We observed staff prior to any interaction with patients gaining their consent where the patient was able to communicate.

Are end of life care services caring?

Good

Staff delivered the service and we saw that members of the SPCT were committed to delivering good quality care when interacting with patients, relatives and staff. This was also true of the extended SPCT such as the bereavement office staff and chaplaincy.

Compassionate care

- We observed members of the SPCT interacting with patients; they demonstrated exceptional communication skills, both verbal and non-verbal. Their listening skills were noted as very good. Staff on the wards we saw were respectful to both patients and family members.
- One family of relatives we spoke to mentioned that they were offered drinks whilst visiting a dying relative for extended periods. However one family who had a recently deceased relative did not have an opportunity to speak with staff, this was due to staff shortages, but this was not acceptable.
- The bereavement team displayed compassion to relatives. One member of staff said, "the patient and their families come first, we always provide a service".

Understanding and involvement of patients and those close to them

- We saw in the notes that discussions with family members took place. Relatives we spoke to mostly felt well informed.
- Visiting times were completely open, allowing relatives to spend as much time with their loved ones as they needed.

Emotional support

- We noted that where patients had been referred to the SPCT they were routinely asked about spiritual support requirements and referred to the chaplaincy service.
- Counselling was available to patients if required.
- We observed that most patients who were actively dying had family members with them, so they could support their relatives and start the grieving process.

Are end of life care services responsive?

Requires improvement

We found the service was responsive but still required improvement. The hospital failed to have enough impetus to ensure that people died in their preferred place. The fast track discharge process was not fast enough.

Referrals were responded to in a timely fashion, but they were often coming too late to offer patients and their families all the options. Also a face-to-face service was not being offered seven days a week.

When palliative or end of life patients were admitted to via the emergency department SPCT staff supported patients within that department.

Service planning and delivery to meet the needs of local people

- National care of the dying audit results were reviewed and the main points from the review had an associated action plan. We saw that one of the areas which had been completed was the availability of leaflets within the bereavement office which we observed. Some of the outstanding actions were the ability to offer seven day service, but it was felt after the merger with Royal Stoke this would be postponed. This had originally been for completion March 2015. Education was also highlighted on the action plan, but there was no date for its completion. Regarding the development and implementation of specific care plans to be used for the dying patient, again there was no date for completion on the action plan.

- Parking passes and free parking was available for relatives which allowed them to visit for extended times. However, we did speak to some relatives who were not aware of this as they had not been informed. One family said they had been visiting their dying relative for three weeks before they were told they could access free parking.
- The SPCT received referrals from many specialities within the hospital, with the medical division being the largest user.
- The trust did not record the number of patients dying in their preferred location. Staff said one of the reasons for this was that sometimes patients were not fully aware of their prognosis so staff did want to ask. Local leadership confirmed it was an area of improvement for the trust.
- Clinical areas had End of Life folders. These contained information/guidance for staff and we found that these were uniform, containing the same information regardless of the clinical area.
- Post mortems no longer took place at County; bodies were transported to Royal Stoke for this to take place. The post mortem could be two to three days before being performed, whereas staff told us when they were undertaken at County they were usually done the next working day. They went on to describe other delays because there was no longer a pathologist at County since the merger of the two hospitals.

Meeting people's individual needs

- Palliative care and end of life patients were offered side rooms when they were available. During the inspection we did see patients who were being cared for on the main wards
- The hospital had a leaflet with frequently asked questions in it regarding CPR for patients and family.
- Staff confirmed the use of interpreters, saying it was mostly eastern European languages which were required. The bereavement office staff mentioned using Google to translate for one family.
- Patients admitted via the emergency department when identified as palliative or end of life were supported by members of the SPCT within the unit.
- The SPCT received referrals which are checked three times a day. Referrals are responded to usually within one working day. Urgent referrals can be requested via a bleep. However members of the SPCT had observed that referrals were arriving later in the patient's condition, which reduced the number of options the team were able to offer the person and their families. This could be because staff were not recognising the dying person soon enough to request an intervention and support.
- Staff told us the circumstances under which they would make a referral; they described symptom controls and pain relief.
- We observed the CNS supporting patients who had complex needs and they utilised appropriate members of the SPCT to access specialist input for patients, such as counselling and occupational therapy.
- We saw that patients who were living with cognitive impairment had "this is me" document in their nursing notes. This enabled staff to better understand their communication requirements to improve their experience of the hospital environment.

Access and flow

- The discharge process was not responsive where patients wanted to go home to die. We spoke with one family member who recounted the experience of their relative who had wanted to die in their care home. However the discharge was delayed and when the transport arrived after a few days, doctors reassessed and said they were too ill to leave. Staff confirmed that patients waited up to a week, even when they had been identified as requiring fast track discharge. Fast track discharge was for patients who were expected to die within a few days or hours and could have their needs met at home if that was their preferred place to die.
- Local leadership and members of the SPCT confirmed that referrals at County were decreasing.
- The team worked with a discharge liaison person who was based predominantly at the local hospice, which meant they had good links and support from that provider.
- Discharges to the hospice care could be same day or next day, being a much more responsive service.
- If the patient needed to move to new nursing home staff told us this could take weeks, as families needed to be happy with the choice offered.

Learning from complaints and concerns

- Complaints regarding end of life care were reviewed at the End of Life Operational Group. Minutes seen from the April 2015 meeting, which was attended by staff from both sites, identified one complaint relating to end

of life care. The SPCT had an input in responding to the complainant. Local leadership confirmed that additional learning input had been implemented to reduce the likelihood of an occurrence.

Are end of life care services well-led?

Inadequate

There was no overall strategy or vision for end of life care. The leadership have not demonstrated sufficient urgency in the implementation of appropriate care pathways for both palliative and end of life patients since the removal of the Liverpool Care Pathway in July 2014. There has been a failure to recognise the importance of supporting this work with training and in identifying timelines for its completion.

Governance processes and risk management was not robust. Staff felt that the executive team did not fully understand the uncertainty about the future of the service at County Hospital and that local leaders could do more to support them during the process of change.

Vision and strategy for this service

- The strategy had not been fully agreed, due to trust integration. An away day had been held in November and part of the reason for this was to achieve better integration. Members from both sites attended. It was agreed that policies needed to be harmonised and that both teams needed to work together.
- When we spoke to staff they told us there was no current strategy, but also told us about their role and how this should improve the dying experience for patients and their relatives. However, members of the SPCT were working in other clinical areas due to the lack of referrals and this caused some uncertainty regarding their future.

Governance, risk management and quality measurement

- We noted within the EOL Committee minutes Feb 2014 that the AMBER care bundle was due for a re- launch at County, but was not mentioned at all in the April meeting.
- Staff within the bereavement service were working without a manager and they felt this was detrimental to them with the number of changes which had occurred since the merger.
- The NCoDA demonstrated that the hospital had not met a number of KPI's, but the action plan associated with it was not a robust document with a number of actions without completion dates.
- July 2013 'More care, less pathway – An independent review of the Liverpool Care Pathway' recommended the phasing out of the LCP over the following 6-12 months and then the implementation of individual plans of care. At the time of the inspection this was not fully in use at the hospital. The delay in the implementation of the individual plan of care meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have the plan of care in place.
- Within the minutes of a document supplied to us by the trust we noted that SPCT staff had misgivings about the implementation of the individualised plan of care being launched without being fully resourced to support staff acceptance and use. This could result in a barrier to use and patients could potentially not receive the standard of care required.
- The current practice regarding DNACPR and mental capacity was not uniform; the trust policy regarding DNACPR was not clear and could mean that both undertaking and not undertaking a mental capacity assessment is acceptable. However the trust Mental Capacity Policy was very clear that the expectation was that if capacity was in question a mental capacity assessment should be undertaken. We did not see any mental capacity assessments undertaken for the DNACPR decision.
- AMBER care bundle was not used within the hospital with staff expressing lack of knowledge of its benefits and implementation. Additional education support of staff was required to fully integrate this into the service.
- Information governance risks were seen, as most of the notes trolleys we saw were unlocked or not able to be locked. This meant the notes were vulnerable to being removed or tampered with.
- The risk register was a corporate document rather than local and site based. The risk is that patients may not receive the required amount of pain relief. An action plan was due to be produced for June 2015. The risk register had identified a number of controls which were already in place.
- We noted that a number of other risks were not present in the risk register, such as more improvement of the

fast track discharge process, which could be classed as a moderate to high risk. However, a potentially higher rated risk is the need for recognition and wholesale implementation of care pathways such as the individualised plan of care and the AMBER care bundle to ensure patients receive the highest quality of care.

Leadership of service

- Within County Hospital staff were vocal about the failings of the executive leadership.
- For the care pathways of AMBER and individualised plan of care to be successful, staff felt there needed to be more support from the trust leadership.
- SPCT knew who the non-executive director was and the executive lead was for end of life services within the trust. Local leaders confirmed that they felt very well supported by the trust leadership.
- The SPCT appeared to be a strong team; staff told us they felt supported by their local leadership and by the executive team. However, they did not feel they were fully appraised of the changes taking place at the hospital.
- The End of Life leads on the wards we spoke to felt well supported by the SPCT; they met with the SPCT once a month.

Culture within the service

- NHS Staff survey 2014 showed that staff within the hospital valued team work and felt well supported by their leadership.

Public and staff engagement

- The SPCT had not achieved the KPI for the NCoDA for obtaining feedback. We saw an action plan that the trust was planning to undertake feedback with patients and/or their families in 2015 by taking part in the National Bereavement survey (VOICES).

Innovation, improvement and sustainability

- The SPCT wanted to make sustainable improvements but the transitional phase the hospital was undergoing at the time of the inspection made this difficult. However, there were plans to implement the individualised plan of care for dying patients, but that was not going to be in place fully for another 12 months.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department is open Monday to Friday, 8 00am to 6 00pm and 9.00am to 1.00pm Saturdays.

The trust offers a range of diagnostic imaging services including; general radiology, fluoroscopy, dental, ultrasound, CT and MRI scanning, breast scanning, orthopaedics, and obstetric ultrasound.

The trust manages the breast screening services for the whole of South Staffordshire. A new £1.2m MRI scanner is due to be installed at County Hospital which will enable over 6,000 patients to be seen locally.

Between July 2013 and June 2014 there were a total of 294,683 outpatient appointments at the former Mid Staffordshire trust. The hospital had a lower than England average rates for patients who did not attend their appointment (DNA rate).

During the inspection the team attended a variety of clinics including: fracture clinic, orthopaedics, chemotherapy and haematology, orthopaedic plaster room, audiology (children's).

We spoke with a range of staff including, healthcare assistants, nurses, consultant radiologists and trainee doctors, sonographers, advanced practitioners, clinical nurse specialists, receptionists, administration staff, managers in outpatients and imaging.

We also spoke with nine patients accessing the services, and three relatives/carers.

Summary of findings

Services were safe, There were sufficient staff who were trained and understood their responsibilities. Any incidents were followed up appropriately.

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance. They were treated with dignity and respect

There was potential risk for patients who require treatment at both sites, where records may be unavailable and we also observed that records were not consistently stored securely.

There is a clear vision for the service following the transition to the new trust. Although it is still early days, most staff appear to understand the vision and their role within it. Radiology staff did not feel engaged with the transition and are unclear why some services have been moved.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We found that outpatients and diagnostic services were safe.

Staff understood and fulfilled their responsibilities to report incidents. Incidents were followed up, action taken and lessons learnt. Staff were also able to demonstrate their responsibilities for recognising the signs of abuse and reporting it appropriately. Staff had received training on safeguarding along with other safety systems. Staffing levels were sufficient to keep people safe at all times.

There was potential risk for patients who require treatment at both sites, where records may be unavailable and we also observed that records in outpatient and imaging were not consistently stored securely.

Incidents

Outpatients

- We found incidents in the outpatients department were reported in line with the trusts policy. A new electronic reporting system had been introduced at the beginning of April 2015 but only senior staff had received training to date. Three further training days on the new system had been arranged. All staff interviewed in the imaging department reported they were using the new electronic reporting system.
- Examples of incidences that had been reported and actioned were seen on staff notice boards. For example, a patient living with dementia was found to have a grade one pressure area on their heel when their plaster was removed. The patient was admitted for observation and a new external fixation was applied to prevent any further damage to the patient's heel.
- No never events had been linked to outpatient specialities at the hospital.
- Between January and December 2014, one serious incident had been linked to outpatient specialities at the hospital. This was in relation to an MRSA bacteraemia.

Diagnostic Imaging

- We saw that notifications of incidents relating to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were sent to CQC as required. These were usually incidents where a patient received exposure to radiation much greater than intended and greater than diagnostic reference levels. The incident notifications gave details of the action taken, including investigating the cause of the incident and explaining to the patients.

Cleanliness, infection control and hygiene

- We observed all areas of the outpatients department and imaging. These included clinical areas, waiting areas and office areas. All these were clean and tidy and both staff and patients commented that cleanliness had improved since the integration of the two hospitals.
- Hand gel dispensers were seen to be well placed throughout the departments to encourage safe hand hygiene.
- Compliance with regular hand washing audits and infection control audits were seen and infection control information was displayed clearly on notice boards in the outpatients department.
- We observed safe clinical waste handling practices in the outpatients department.
- Outpatients had assigned link nurses for the promotion of infection control.

Environment and equipment

- We observed the children's area within the outpatients department was secure. We were approached by staff when observing the environment as we did not have accompanying children. This was part of their safeguarding procedure.
- We saw the daily log for cleaning the toys and were told by staff that a play specialist completed weekly safety checks of the toys.
- All cardiac resuscitation trolleys had been checked daily. The trolleys were locked and well stocked. The clinical areas had coded locks and fridges were seen to be locked
- We found waiting areas had plenty of seating including bariatric seats and were divided off into specialist clinics.
- All equipment seen in the plaster room had been serviced and PAT tested in the last 12 months or as the service logs required.

Outpatients and diagnostic imaging

- Imaging had clear evidence of equipment maintenance and handover records. We also saw good room cleaning logs in imaging.

Medicines

- Medicines were stored securely in locked cupboards with access restricted to nurses and doctors.
- FP10 prescription pads were stored in locked cupboards in the department. Nursing staff ordered all medicines through the hospital pharmacy.
- Patient's GPs were informed by letter of any medication changes.

Records

Outpatients

- Patient records in outpatients were not always stored securely. Records were placed in open containers behind the clinic reception desk which meant that there was a confidentiality risk of patient's records and personal details being seen or removed by people in the reception areas.
- Outpatients at Royal Stoke were moving towards a paperless system and medical notes were scanned into an electronic system which was accessible across the Royal Stoke site. At the time of our inspection, this system had not been rolled out to The County site.
- Some patients may be required to access The Royal Stoke and County sites in the course of their treatment and/or care pathway. This meant that they had two sets of medical notes, for example stroke patients. This created patient safety issues when both sets of patient's notes were not available for each of the consultations at the different sites. Until the paperless system was rolled out to the outpatients department at the County hospital then this would continue to be a risk for patients.
- When paper records were unavailable clinic staff could access current letters, path lab results, prescribed drugs, X ray on line through a different system and this did mitigate some of the risk but did not provide staff with information about a patient's medical history if needed

Diagnostic Imaging

- In the imaging department, we observed that referral forms were being placed on the reception desk and personal details were visible to other staff and the public. Computer screens in the imaging reception area could also be seen and read by both staff and public raising a risk of confidentiality.

Safeguarding

- We were told all professional and receptionist staff in this area had undertaken safeguarding training to level three as part of the mandatory training within the trust.
- Staff were able to demonstrate that they were aware of their role and responsibilities and knew how to raise matters of concern regarding safeguarding.
- We saw training records in the outpatient department showing that 100% of staff had completed both adult and children's safeguarding training.

Mandatory training

- We observed staff mandatory training records displayed in outpatients and imaging areas. Overall, 80% of staff were up to date with their training. We noted that the proportion of staff who had completed infection control training had increased from 76% in January 2015 to 83% in March 2015. Compliance with CPR training, aseptic technique, manual handing and hand hygiene was all above 80%.
- Staff told us that they now have access to online training which had improved access, enabling them to keep up to date.

Assessing and responding to patient risk

- There were emergency procedures in each clinic to alert other staff and resuscitation equipment was available. Staff had received training in emergency life support.
- Staff carried out observations of patients as required, such as pulse and blood pressure. If patients were having treatment or tests.

Nursing staffing

- The trust employs 32 (19.16 WTE) nurses in the outpatients department. There are no vacancies for qualified nursing staff. The department does not use agency staff, if additional staff are required for extra clinics outpatients nursing staff covered them.
- Staff told us and we observed there were sufficient staff available during the clinics to provide a safe service.

Outpatients and diagnostic imaging

- Staff told us there was some internal rotation of staff taking place between the two outpatient sites specifically in fracture clinic and imaging. This provided staffing flexibility as well as developing skills.
- The imaging department had a rota system in place for advanced practitioners working across the two sites.

Medical staffing

- Outpatient clinics were arranged by consultants to meet the needs of their specialities.
- Consultants were supported by trainee colleagues in some clinics, where this was appropriate.
- We were told by staff that locum doctors do see patients in outpatients and their induction was organised by the speciality they were working for.
- Staff we spoke to in the clinic confirmed that clinics were cancelled on occasion but it was usually because there was no doctor. The trust were unable to supply us with data regarding the number of cancelled clinics.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal. There were good examples of staff working collaboratively to meet patients' needs.

Evidence-based care and treatment

- Guidance from the National Institute for Health and Care Excellence (NICE) was used to determine the care and treatment provided to patients
- NICE and best practice guidance was available to staff through the trust's intranet.
- There were local protocols in place which were followed by staff.
- In the imaging department we observed the World Health Organisation (WHO) checklist for interventions was completed but had not been audited. There was no evidence seen of regular embedded practice. Two records were looked at, one WHO record was completed correctly and the other was found to be incomplete.

Pain relief

- We observed that FP10 prescription pads were available in clinics and were told by staff that prescriptions for pain relief were recorded in patients' notes and changed to meet patients' needs.

Patient outcomes

- Since 1 November 2014, the out patients department overall Friends and Family results have scored well over 90%.
- The Radionuclide Protection Audit Report from April 2015 noted there was a good standard of radiation protection within Nuclear Medicine and that the majority of action points from the previous report have been addressed.
- We saw evidence of compliant cannulation audits in imaging.

Competent staff

- Staff we spoke to confirmed that they had annual appraisals. Trust data showed that 98% of all staff in outpatients had completed their appraisal. Band six and seven staff had monthly one-to-ones with their line managers. Clinical supervision was in its infancy, some supervision took place but it was not recorded.
- We were told by staff that the matron and outpatients sister had an 'open door' policy and staff felt they could request professional support at any time.
- New staff had a trust induction and a local induction arranged by the senior nurse in the department.
- The imaging department were seen to have effective clinical supervision and mentoring systems in place for staff and they were proud to tell us they regularly developed their own staff.
- We saw imaging had competency frameworks for equipment use and nominated key trainers for each item of equipment.

Multidisciplinary working

Outpatients and diagnostic imaging

- We observed effective multidisciplinary working in both the outpatient and diagnostic imaging departments. Staff reported to us that they had team meetings, newsletters, and could ask for guidance from other professionals.
- Letters were sent to GPs regarding their patients and a summary of consultations, treatments and investigations for the outpatient clinics.

Seven-day services

- The outpatient departments was open from Monday to Friday 8 00 am to 6 00 pm and 9 00 am to 1.00 pm Saturdays.
- Diagnostic imaging ran a 24 hour service over 7 days to cover the hospital. The imaging staff reported to us that they managed their own 'out of hours' services and consultants carried out diagnostic reporting when required.

Access to information

- All patient records were transported in boxes from the central record store on the Royal Stoke Hospital site the day before each clinic is due to beheld. The transport went between sites at least four times a day and missing records could be requested on the day of clinic.
- A bar coding system was used to track records. This was demonstrated to us by tracking down a patient's records from the clinic.
- Staff told us they had access to all policies and procedures on the trusts' intranet.
- X ray and diagnostic imaging results were available electronically which made them promptly and readily accessible to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking consent from patients. Verbal consent was observed in the plaster room and the orthopaedic outpatient clinic.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity. Staff knew the procedures to follow, including involving other professionals.

Are outpatient and diagnostic imaging services caring?

Good

People were supported and treated with dignity and respect and were involved as partners in care.

Staff were approachable, open and friendly. Staff were observed to be discreet and kind when individuals were upset.

We noticed staff being as discreet as possible when calling patients names out in clinic as electronic patient call system was not used. We observed the staff supporting patients, they were offered a quiet place to sit after being given bad news and spent time with them.

Compassionate care

- Feedback from patients in the clinic indicated that staff were kind and polite to them and they were happy to be attending the hospital. The clinics were seen to be undertaken in a calm, professional manner. Patients and relatives who spoke with us before the inspection were also positive about staff in the outpatients department.
- Patients reported to us that the car parking was not an issue on the County Hospital site as they could pay on leaving the hospital.
- In the plaster room waiting area we witnessed that all consultations between the doctor and patient could be overheard; there was only a curtain dividing the consultation area and the waiting room. This highlighted a privacy and dignity issue for patients attending clinic.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved and well informed about their care and treatment.
- Patients told us treatment was discussed with them and they were involved in the decision making process. We observed this and saw evidence in patient records.

Emotional support

- Patients gave us examples of how staff had emotionally supported them through a diagnosis and treatment. Patients told us staff were caring, supportive and professional.

Outpatients and diagnostic imaging

- Staff were observed by us supporting a distressed patient and family and taking them to a quiet area.
- Patients told us staff were reassuring and kind.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Some people are not able to access services for assessment, diagnosis or treatment when they need to due to long waiting times. Cancer waiting times were constantly fluctuating and referral to treatment time targets were not being achieved. The diagnostic waiting times had been higher than England average but were seen to be improving. A significant number of patients were waiting for follow up appointments.

The trust had plans in place to refurbish the outpatients department to ensure it met the needs of the local population and supported service delivery.

Service planning and delivery to meet the needs of local people

- The trust provided a range of outpatient clinics to meet the needs of local people. This included general surgery and medical specialities.
- Signage to outpatients and diagnostic imaging services was clearly displayed at the main reception and in corridors.
- Patients treated for fractures at Royal Stoke Hospital can present themselves with their A&E card to County Hospital Fracture Clinic for follow up. This is responding to local need as there is a fifteen mile distance between the two hospital sites.
- No notice boards were available in the outpatient areas for giving information to patients regarding doctors or nurses running the clinic or delays in waiting times. Some consulting room doors had doctors' names on.
- We saw, and were told about, the good planning and vision for the installation of a new MRI scanner.
- The management team for outpatients told us that a capital programme for the refurbishment for County Hospital outpatients was to commence shortly. They were currently working with external contractors to develop a fit for purpose model that met the standards required for the growing outpatient services. The service will include the repatriation of outpatient activity from Cannock Hospital back onto the County Hospital site.

Access and flow

- The national standard for NHS trusts is that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral.
- The number of follow up appointments will have a bearing on how many new patients can be seen and so will have an effect on meeting the 18 week standard. For both of the predecessor organisations the ratio of follow up to new patients was consistently below the England average.
- The overall rates for the trust for patients who did not attend, (without prior cancellation) for their appointment was better than the England average. Patients who did not attend were referred to the consultant for a decision about whether to offer another appointment.
- Data supplied by the trust showed cancer waiting times for both hospital sites were constantly fluctuating for all 2 week urgent GP referrals, 31 days and 62 day targets since 2013.
- Referral to treatment times (RTT) for patients at the trust with incomplete pathways had been consistently worse than the England average since April 2013. RTT for non-admitted patients had also been inconsistent since April 2013.
- The diagnostic waiting times for the trust had been higher than the England average but were seen to be improving. This demonstrated that targets were not being met month -on-month by the trust.
- The electronic booking system (Medway) for the County Hospital did not link with the Royal Stoke electronic booking system (IPM). All booking and scheduling of County Hospital clinics was actioned at a central hub based at Royal Stoke.
- Staff told us that clinics were susceptible to cancellation at short notice and on the day, as doctors had not been available to run the clinics. The trust were unable to supply is with data regarding the number of cancelled clinics at County Hospital.
- Following the last clinic cancellation due to doctor availability, each booking system had been supplied with a list of doctors' rotas for each site and who was available to run clinics. This had improved processes.

Outpatients and diagnostic imaging

- We were made aware of an issue with a neurology patient. The patient had a diagnostic scan in September 2014 but had not had a review since. Several appointments have been cancelled on the day of the clinic. Staff in the clinic had liaised with the specialist directorate to try and rearrange appointments. After our site visit it was confirmed that the patient had had their appointment.
- We were informed that the trust had a project plan in place to move all booking of clinics across the trust over to same system at Royal Stoke by April 2016.
- At the time of our inspection, the trust had in the region of 28,000 patients who are waiting for a follow up appointment and that appointment is overdue. If these, approximately 10,000 are less than 4 weeks overdue (which the trust allows as a tolerance for patient choice of appointment). These leaves a backlog of 18,000 patients who have gone more than 5 weeks past their due appointment date. The trust have implemented a number of actions to address this including clinical validation led by the clinical leads and working with the local CCGs to facilitate a joint clinical review of selected patients.
- During our listening events with patients, we were told that some clinics book a number of patients for the same time; this is called block booking. During the inspection this was confirmed to us but our observations and from talking to staff. This means all the patients arrive at once, and provide a poor patient experience.
- Staff in fracture clinic told us that they block book to manage activities like removal of plaster and x rays.
- We also noted this practice occurred in the urology clinic. For example, six patients were booked for 1:00pm on 17 April 2015 to see the consultant and on 23 April 2015, clinics were block booking four patients at a time to see two doctors.

Meeting people's individual needs

- Outpatient staff were seen to be participating in the "my name is" initiative and had badges that gave their names in large print. Staff in imaging were not wearing name badges.
- It was observed at some reception desks patients had to queue to "book in". This meant that people with mobility issues or other disabilities had to stand in line to speak to the receptionist before they could sit down. Conversations could also be overheard by others in the queue. Wheelchairs were accessible at the main entrance to the hospital but very few were available.
- We saw evidence that a standard operating procedure had been introduced at County Hospital which will ensure that patients waiting for ambulance and private transport, after the outpatient clinic has closed were transferred to the discharge lounge to wait.
- There was no multilingual information in diagnostic imaging areas or in the outpatient department, but staff reported they could access interpreters if required and would book them for the clinic appointment with the patient.
- The clinics we visited provided waiting areas with sufficient space and seating, accessible toilets, and water or a drinks machine available.
- There were rooms available in clinics for discussing sensitive issues or breaking bad news to patients and their relatives / carers.
- We were told, and we saw that the imaging services had developed storyboards for patients having CT colonography. This was sent out with the patient preparation letters and the process was currently being audited
- The outpatient department had a selection of patient leaflets that were available in clinics or handed out to patients with verbal instruction, e.g. plaster room. There was no evidence of patient's information in imaging post procedure and some patients stated they had not received any procedure information with their appointment.

Learning from complaints and concerns

- There were two complaints linked to the outpatients department at The County Hospital since November 2014.
- An example of a complaint sent to CQC and seen by us made reference to a child seeing nine different consultants during her care in fracture clinic at County Hospital.
- Leaflets on how to make a complaint were available in the outpatient clinic areas. However, there were no such leaflets in the diagnostic imaging outpatient areas.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Requires improvement

There is a clear vision for the service following the transition to the new trust. Although it is still early days, most staff appear to understand the vision and their role within it. Staff working in radiology do not feel engaged with the transition and are unclear why some services have been moved.

There was evidence seen of multidisciplinary working in outpatients and diagnostic imaging services and both have an integration champion as part of the service development across sites

Vision and strategy for this service

- Since the transition of services in November 2014, the outpatients department at The County had been part of a new directorate. Staff told us that they had had some involvement in the vision for the service and areas of work to focus on. There were regular newsletters and the Spring newsletter was included the new management structure and vision.
- Staff reported to us that they do see the Matron and directorate manager on site and feel they could approach them with a concern.
- Diagnostic imaging were observed to have good integrated leadership and vision at a senior level. There was evidence seen of staff meetings and regular newsletters for the department.

Governance, risk management and quality measurement

- The outpatient management team had weekly meetings with the associate directors of each division to discuss issues. We saw comprehensive minutes of meetings which showed governance and quality issues were discussed.
- The outpatients risk register identified the issues relating to using two electronic clinic booking systems across the two sites, concerns relating to patient notes availability and cancellations due to overbooked clinics or doctors absence.
- Senior staff explained to us that the directorate had their own governance meetings and activities from outpatients were presented and discussed at the meeting, e.g. cancellations of clinics had been escalated to these meetings.
- It was reported to us that not all staff were trained on the electronics incident system. A new system was introduced on 1 April 2015 and staff were still waiting to have training in some clinic areas. Three days of training has now been arranged at County Hospital.
- We were told by staff that national audits were carried out as required to meet government targets. “In house” audits were carried out on a monthly basis e.g. family and friends, infection control, cancellation of clinic (two in April 2015) and cannulation.

Leadership of service

- Most staff we talked to felt it had been a positive move to bring in an outpatient matron to lead the changes taking place across outpatient’s services. The fact that she was also an integration champion for the service had helped.
- Some staff told us that they felt they were “second class” to staff at the Royal Stoke outpatients as new technology had been introduced there first.
- We were told by both senior and junior staff in imaging that they felt aggrieved at the merger. When doing rotation across sites they “felt like poor relations”. They also expressed that they felt remote from the directorate.
- We saw a well-integrated PACS team in imaging.
- The integration lead in imaging told us about the overview of the trust's integration in imaging and that they had five champions to engage with teams. We saw documentation to move imaging to a temporary area while the new MRI scanner was installed. This information had been shared with staff.
- We saw the nursing staff communication folder for outpatients which included sketches of the new outpatients unit and it asked for comments.
- Some staff reported to us that senior management were not visible “on the floor” in imaging.

Culture within the service

- Some outpatient staff stated to us that they still felt disenfranchised over the way changes to staffing and

services had been managed. Others felt very unclear regarding the services they deliver and how it will fit into the current proposed capital programme planned for County Hospital.
- Staff told us that they did support each other and worked as a multidisciplinary team in the outpatient clinics.

Public and staff engagement

- Staff told us they were keen to engage with patients and the public to improve the patient experience and asked for verbal feedback.
- We saw minutes of the monthly outpatient's operational meetings. January 2015 discussed the ongoing work involved with the paperless audit and highlighted three complaints whereby patients had been left in the department waiting areas.

Innovation, improvement and sustainability

- Staff in outpatients and diagnostic imaging confirmed to us that they were aware of the major redevelopments in the pipeline for the services e.g. new MRI scanner. Outpatient staff can see the new outpatient plans in the staff communication file and have had the opportunity to make comments. Plans to move imaging to a temporary area while the new MRI scanner is installed have been discussed with staff.
- The Integration champions were visible and staff stated that they were receiving more information via newsletters and staff meetings than before they had the champions.

Outstanding practice and areas for improvement

Outstanding practice

We saw outstanding work being done on the Specialised Neurological Unit to improve the outcomes for patients, this included innovative practice using Wii technology to stimulate and engage with patients, provided medical note writing training for support workers to enhance understanding and quality of documentation. Training for support workers to identify which patients would benefit from specific therapy.

Areas for improvement

Action the hospital MUST take to improve

- The trust must implement the individualised care plan as soon as possible so that patients who are actively dying are supported holistically.
- The trust must improve the discharge process for patients who wish to go home to die so that fast track discharges can be completed within agreed timescales so that patient's preferences regarding place of death can be met. This information should be routinely recorded and monitored.
- The trust must review pathways between County Hospital and Royal Stoke to ensure patients transferred from the emergency department are kept safe and patients who transferred for treatments and procedures are done so efficiently and effectively.
- The trust must ensure that arrangements for medicines that require storage in fridges are done so safely and effectively. All fridges must be maintained and/or replaced to ensure medicines are stored at the correct temperature. Plans should be in place in order to monitor the fridge temperature on a daily basis and clear actions taken when temperatures are not within agreed limits.
- The trust should ensure that all staff are suitably trained and knowledgeable about the Mental Capacity Act 2005 and their responsibilities around it to ensure that patients who lack capacity are protected from decisions being made about their care and treatment without their input and their capacity is appropriately recorded.

Action the hospital SHOULD take to improve

- The trust should review and reframe the 2025 Vision to ensure staff at all levels of the organisation can understand it and be clear how they fit into the wider plans for the new integrated organisation.
- The trust should ensure that all patient records are stored securely at all times to protect privacy and confidentiality
- The trust should review theatre utilisation at County Hospital to ensure resources are being used effectively.
- The trust should review arrangements for access to patient records and information across both sites to ensure staff are able to access records as needed and care is not compromised. The trust should also ensure that patient records are kept secure and confidential at all times.
- The trust should ensure that suitable arrangements are in place to address and when needed report mixed sex breaches of ward-able patients in critical care.
- The trust should ensure that hazardous cleaning items are safely stored and kept locked away from vulnerable children and young people.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care for patients at the end of their lives was not person-centred as care and treatment was not designed with a view to achieving their preferences and ensuring their needs were met. Regulation 9(2)(b) HSCA 2008 (Regulated Activities) Regulations 2010 Person-Centred Care