

Burton Hospitals NHS Foundation Trust

Queen's 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



Accident and emergency

Requires improvement



Medical care

Inadequate



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and family planning

Good



Services for children and young people

Requires improvement



End of life care

Requires improvement



Outpatients

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

Queen's Hospital is part of Burton Hospitals NHS Foundation Trust. The trust serves a population of more than 360,000 people in Burton upon Trent and surrounding areas, including South Staffordshire, South Derbyshire and North West Leicestershire.

The trust provides services from three locations. Queen's Hospital is the largest of these. The trust also took over the management of the treatment centre in 2011, which is based on the Queen's Hospital site providing day-case and ophthalmology services to the immediate area and beyond.

The trust employs over 3,000 staff and has 496 inpatient beds across all three locations. Queen's Hospital, Burton Upon Trent provides accident and emergency (A&E) services, medical and surgical services for adults and children, it has a critical care unit and a maternity unit. It also sees over 300,000 outpatients each year.

The trust carries out 47,000 planned and emergency operations and undertakes around 13,000 day-case procedures annually. In the last 12 months there were more than 60,000 accident and emergency attendances.

The trust has a stable board with only two of the executive directors having been appointed in the last 18 months.

We inspected Queen's hospital on 24 and 25 April 2014. We undertook an unannounced inspection on 6 and 7 May 2014.

Before and during our inspection we heard from patients, relatives, senior managers and other staff about some key issues that were having an impact on the service provided at this trust. We also held a listening event in Burton where patients and members of the public were given an opportunity to share their views and experiences of all the trust locations.

Why we carried out this inspection

The trust had a significantly higher than expected mortality rate from April 2012 to March 2013. As a result, the trust was included in Professor Sir Bruce Keogh's review of trusts in 2013. The overview report Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England is available on the NHS Choices website.

The review identified a number of areas of good practice. However, the report identified a number of areas of concern, such as no systematic approach for ensuring the collection, reporting and action on information about the quality of services. It also found that there was a lack of support for junior doctors, medical staffing levels and skill mix was not appropriate, and equipment safety checks had not been carried out.

We inspected this hospital as part of our in-depth hospital inspection programme. Burton Hospitals NHS Foundation Trust was considered to be a high-risk service. When we inspected the trust in April 2014, 14 of the 61 recommended actions following the Keogh inspection had still to be completed.

Overall, Queen's Hospital, Burton Upon Trent was rated as requires improvement. We rated this hospital as requires improvement for providing safe, effective, and responsive care, and good for being caring, but we rated it as inadequate for being well-led.

Our key findings were as follows:

- Ward staff were committed to the delivery of high quality care and saw patient experience as a priority.
- Recruitment is a recognised challenge for the trust, with some wards below establishment. Bank, agency and locum staff were used to fill vacant posts and some staff worked additional hours. In some areas there was a high dependency on temporary nursing staff.

Summary of findings

- The significant number of medical outliers is contributing to patients experiencing several bed moves during their inpatient stay. Between January and March 2014, 7% of inpatients spent time on three or more wards during their time in hospital.
- Dementia care was not delivered consistently across the trust. While nurse and healthcare assistant 'dementia champions' were available on some wards to support patients with dementia and initiate the most appropriate care for them, this was not available in other wards.
- Incident reporting systems were in place. However, learning was not always shared across the trust and staff use of the system was variable.
- Not all staff had appropriate knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected.
- The trust's end of life provision was not clearly defined and information relating to the service was not used to inform resources. There was a designated board lead, but there were no clear lines of accountability and assurance of delivery of end of life care.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) paperwork was not fully completed and there was a lack of guidance for staff to follow on the action they should take if they suspected that a person lacked mental capacity.
- The current Resuscitation Council Guidelines were not reflected in trust's resuscitation policy or in the resuscitation department's staffing levels. The resuscitation committee had not met since November 2013.
- Not all policies reflect national guidance or best practice. For example the trust's safeguarding policy was not in line with best practice set out in Working Together to Safeguard Children (March 2013).
- Not all medical and nursing staff delivering care to children and young people were trained to the appropriate level in paediatric life support and also safeguarding children.
- There was no identified high dependency area to stabilise children on the paediatric ward and not all relevant staff were trained in paediatric life support.
- There were systems and processes in place to reduce the risk of infection. Most staff followed the trust's infection control policy, including being bare below the elbow, observing hand hygiene and wearing personal protective equipment, such as aprons and gloves, when appropriate.
- There was no clear ownership of the risks on the risk register and little sense of pace about making improvements.
- Patients we spoke with told us that they'd experienced long delays for appointments in the outpatients department.
- Action was not always taken to ensure staffing was in line with national guidelines. This includes staffing in the neonatal unit, which did not currently meet the requirements of the British Association of Perinatal Medicine (BAPM), and the numbers of junior doctors on the labour ward between midnight and 7am did not meet guidelines as set out in Towards Safer Childbirth.

We saw the following areas of outstanding practice:

- The maternity services were recognised in May 2014 as providing excellent care by an independent provider of healthcare intelligence and quality improvement.
- The service was one of the only maternity services nationally to use the enhanced recovery programme for women following a caesarean section, if it was clinically appropriate for them. The aim of the programme was to speed up the recovery process, so that women could be discharged the day after a post-elective caesarean section if it was safe to do so.
- There was a seven-day therapy service available from 7am to 7pm, with a focus on patient care within medical services.
- A tool developed by a nurse and a pharmacy colleague that assessed the impact of certain medicines in contributing to the risk of falls had been shortlisted for a national award. This tool was used on wards and had significantly reduced the number of falls.
- The orthopaedic team had introduced an enhanced recovery pathway for hip and knee replacements, which had reduced the length of stay. National data demonstrated that their hip and knee revision rates were significant lower than other trusts.

Summary of findings

- The bereavement office participated in the doctors' training programme, delivering joint training with coroners on a range of issues, including completion of death certificates. This significantly reduced the number of death certificates that were completed incorrectly.

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

- Complete the 16 outstanding actions from the Keogh review that had not been delivered and were overdue in April 2014.
- Ensure that all relevant staff in the trust are trained in paediatric life support and staff in the neonatal unit are confident in neonatal resuscitation.
- Review the arrangements and facilities for the stabilisation of high dependency children on the paediatric ward.
- Review the arrangements for junior doctor cover on the labour ward between midnight and 7am, to ensure it meets nationally recommended guidelines as set out in Towards Safer Childbirth.
- Review which staff require training to Level 3 in child protection and provide this training.
- Review staffing in the neonatal unit and ensure that it meets the requirements of the British Association of Perinatal Medicine of one nurse per nursery.
- Review the resuscitation committee and consider whether the current frequency of meetings is sufficient to mitigate the risks.
- Ensure that all resuscitation trolleys are easily accessible in an emergency and that all oxygen cylinders are in date and fit for use.
- Ensure that the trust's resuscitation policy reflects current best practice.
- Review the Do Not Attempt Resuscitation (DNA CPR) paperwork currently in use and take action on the findings to ensure that this is fit for purpose and that staff are trained to complete this paperwork.
- Review the pathway of care for patients at the end of their life and ensure that all nurses know who to contact and when.
- Review bed capacity to reduce the number of medical outliers and minimise the number of times patients are moved during their stay in hospital.
- Take action to ensure that the care for people living with dementia is embedded in all divisions across the trust.
- Take action on the findings of the WHO surgical safety checklist audit and strengthen the assurance process.
- Review the training provided to staff in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards, as not all staff had appropriate knowledge of these areas to ensure that patients' best interests were protected.

In addition the hospital should:

- Consider reviewing the maternity targets, such as the numbers of women having either elective or emergency caesareans and the maternity dashboard, as the current targets are not stretching.
- Consider developing and using a tool to monitor the quality of paediatric services.
- Review and amend the hospital's safeguarding policy so that it is in line with best practice set out in Working together to safeguard children (March 2013).
- Take action to mitigate or resolve risks identified on department's risk registers in a timely manner.
- Review capacity in outpatients to minimise the long waiting times for patients when attending outpatient appointments.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Accident and emergency

Requires improvement

Rating



Why have we given this rating?

Overall, the A&E unit required improvement. People were generally receiving effective care and there were numerous policies and procedures in place to keep people safe. People we spoke with were positive about the service and numerous aspects of the service had been specifically designed to be responsive to the needs of the local population and provide an efficient service.

However, there were areas where the governance of the department could be developed to help improve the service. These included the services for children as some of the processes and procedures needed to keep them safe were not always effective or undertaken.

It was also noted that the service was currently experiencing challenges in transferring patients to wards and this was impacting on the length of time people spent in the department.

Medical care

Inadequate



Patients were often moved around the hospital to accommodate new admissions, feedback from clinical staff was that their clinical input and judgement was often ignored and overruled, resulting in patients being moved inappropriately. Clinical staff who had experienced this practice told us that they were concerned that these decisions could compromise patient safety.

There was not always a consistent approach to discharge. The discharge lounge environment was inappropriate and could not meet the needs of patients or the hospital as it doubled-up as a medical day care service. This dual purpose meant that neither of the functions of the unit could be adequately met.

The nursing staffing levels on some wards were below their establishment figures; however there were processes in place for ward leaders to make sure that appropriate staffing levels were maintained. Senior nurses were heavily relied upon to carryout non-clinical tasks and this reduced their capacity to support junior grade staff. Nursing staff we spoke with in the Acute Assessment Centre (AAC) expressed concerns about risks to patient safety due

Summary of findings

to the administrative demands on their time. They told us that they spent most of their time away from patient bedsides completing computer records. Support for people with dementia was not embedded across the trust.

Surgery

Requires improvement



Medical outliers had impacted negatively on the use of surgical beds. This included some post-operative surgical patients being moved to other wards to accommodate new elective admissions, due to medical patients using surgical beds. Surgical staff worked as part of multidisciplinary teams to ensure patients received the best care possible. We observed that the service was responsive to the needs of people with a learning disability and dementia. The enhanced recovery programme for knee and hip surgery was in place which reduced the length of stay for patient. We saw that discharge planning commenced when the patient was admitted.

There was ward level leadership provided by the senior sisters who led enthusiastic staff. Staff told us they had not seen or rarely saw the executive team and not all wards had seen board members. The staff told us that areas of the trust worked in silos so staff didn't always know what was happening in another part of the hospital.

Critical care

Requires improvement



Staff were appropriately qualified and had assessed to supervision and appraisals. The unit had recently recruited new staff, but pressure on staffing levels remained and there were limited resources for accessing extra staff when capacity in ICU increased. The resuscitation department, part of the critical care unit, was not staffed appropriately in line with the Resuscitation Council (UK) guidelines, which impacted on the amount of training provided. There was a multi-disciplinary approach to the delivery of care and treatment to ensure the patients' needs were met. We saw that people's needs were assessed care and treatment was planned and delivered utilising evidenced based practice to meet their individual needs. The ICU does not have a side room facility and cannot isolate patients. This issue has been recorded on the critical care risk register but action to address this issue had not been taken. There was no specific strategy for

Summary of findings

Maternity and family planning

Good



vision for developing the ICU, development was led by the corporate vision. There was strong nursing and medical leadership at a local level with staff feeling engaged.

There were systems in place to ensure that women and their babies were treated in a safe, well equipped environment by suitable numbers of qualified staff. Some areas were cluttered and some emergency medication was not stored securely, this was a trust wide issue and senior management were aware.

Services were planned to meet the needs of the local population. Feedback from women, commissioners and third party organisations had been used to inform the service's development strategy. We found evidence that incidents were reported, investigated and learning was shared through a variety of forums. Staff felt engaged and were supported to be innovative in order to constantly improve the service.

All the women we spoke with and their partners could not compliment the staff enough. They had felt well supported, well informed and well cared for.

Services for children and young people

Requires improvement



We found that staff were caring and compassionate and responded to children's needs. Staff in children's services considered they worked in a supportive team. The number of inpatients was relatively low and children did not have complex conditions.

We had multiple concerns regarding children's safety which were not seen as a priority. Not all staff had completed the appropriate level of safeguarding training; some staff were delivering care to children without having an appropriate level of knowledge of Paediatric Life Support (PLS) and inconsistent response to Paediatric Early Warning Scores (PEWS). There was no dedicated room with suitable equipment in which to provide high dependency care on the children's wards if needed. It was common practice to transfer children from theatre to the ward without oxygen and suction. There was no system for sharing information about children known to social services who missed outpatient appointments and not all treatment guidelines systematically updated in line with national guidelines.

Summary of findings

Staffing levels in the neonatal unit were below standards recommended by the British Association of Perinatal Medicine (BAPM) and the Central Neonatal Network of which the unit was part. The nursing and medical staff did not operate as a unified team, setting out a vision and giving leadership to staff. The children's department did not share in the trust's wider vision of improving quality.

End of life care

Requires improvement



The trust's end of life provision was not clearly defined and is fragmented. Basic information such as the number of inpatients who are receiving end of life care as inpatients is available, but staff do not routinely use it effectively. Patients receiving end of life care could be admitted and discharged without seeing a member of the end of life team resulted in some patients not receiving appropriate support. The referral criteria was not understood by staff on the wards as there was no clear definition regarding who was to be called when a patient was at the end of their life. Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) paperwork was not fully completed and this led to confusion and raised safety concerns for patients. There was no guidance for staff to follow on the action staff should take if mental capacity assessments found an individual lacked capacity. The trust's resuscitation policy did not have parity with the DNAR CPR form used and led to further confusion.

Outpatients

Requires improvement



Equipment was maintained and regularly checked, and the areas were visibly clean and uncluttered. Staff had completed mandatory training and had opportunities to access further appropriate training. There was evidence of multidisciplinary meetings and shared learning with other departments and organisations. Most patients had access to outpatient services within the national guidelines. We found that there were significant waiting times for patients attending appointments in some clinics. The organisation reviewed care and treatment through local clinical audits and monthly performance dashboards by division. All the staff we spoke with felt supported by their immediate manager. We saw evidence of the

Summary of findings

middle management working well to improve links between senior and lower grade staff. However, it was evident that the executive board had not reached all the staff within the trust.

Requires improvement

Queen's Hospital

Detailed findings

Services we looked at

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

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Detailed findings from this inspection

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Detailed findings

Background to Queen's Hospital

Queen's Hospital, Burton Upon Trent became a foundation trust in 2008. It provides accident and emergency (A&E) services, medical and surgical services for adults and children; it has a critical care unit and a maternity unit. It also sees over 300,000 outpatients each year.

The trust carries out 47,000 planned and emergency operations and undertakes around 13,000 day-case procedures annually. In the last 12 months there were more than 60,000 accident and emergency attendances.

It is one of three of Burton Hospital NHS Foundation Trust locations. The trust also provides services from Sir Robert Peel Community Hospital and Samuel Johnson Community Hospital.

The trust had 496 inpatient beds across the three locations.

The trust has a stable board with only two of the executive directors having been appointed in the last 18 months.

Our inspection team

Our inspection team was led by:

Chair: Brigid Stacey, Director of Nursing and Quality NHS England (Central)

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission

Inspection Lead: Fiona Wray, Inspection Manager, Care Quality Commission

The team included CQC inspectors, analysts, doctors, nurses, midwives, patients and public representatives, experts by experience and senior NHS managers.

How we carried out this inspection

In the planning of this inspection we identified information from local and national data sources. Some of these are widely in the public domain. We developed 117 pages of detailed data analysis which informed the inspection team. The trust had the opportunity to review this data for factual accuracy, and corrections were made to the data pack from their input.

We sought information in advance of the inspection from national and professional bodies for example the Royal Colleges and central NHS organisations. We also sought the views from local commissioners and Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event on 23 April 2014. This was held to inform the thinking of the inspection team. Over 32 local residents and service users attended the listening event, and each had the opportunity to tell their story, either in small groups or privately with a member of the inspection team.

We received information and supporting data from staff and stakeholders both before and during the inspection.

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

We undertook further unannounced inspections on 6 and 7 May 2014 when we inspected A&E and ward areas.

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

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

The inspection team inspected the following core services:

- Accident and emergency (A&E)

Detailed findings

- Medical care (including older people's care);
- Surgical care
- Critical care
- Maternity & family planning
- Services for children and young people
- End of life care
- Outpatients

What patients say

We received 83 comments cards across the three trust locations. The majority of these were positive and related to the good or excellent care that patients or relatives received while having treatments at the trust. Many comments related to the fact that the trust was always found to be clean. However, the negative comments were about poor communication between staff and patients/relatives.

Facts and data about Queen's Hospital

Burton Hospitals NHS Foundation Trust was formed in 1993 and became a Foundation Trust in 2008.

The trust serves a population of over of approximately 360,000 in Burton upon Trent and surrounding areas including South Staffordshire, South Derbyshire and North West Leicestershire.

The trust provides services from three locations: Queen's Hospital, Sir Robert Peel Community Hospital and Samuel Johnson Community Hospital. In 2011, the trust took over the management of the Treatment Centre based at the Queen's Hospital providing day case and ophthalmology services to the immediate area and beyond.

The trust employs about 3,000 staff over three sites.

The trust carries out more than 47,000 planned and emergency operations and carries out around 13,000 day case procedures annually. In the last 12 months the trust had more than 60,000 A&E attendances and 70,000 minor injuries unit attendances.

On average, 97% of the trust's population are registered with a GP. The life expectancy is worse than average for men and better than average for women in East Staffordshire. This is similar to the England average for Lichfield and Tamworth.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Accident and emergency

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

Information about the service

In 2013/14 the Emergency Departments across the Burton Hospitals NHS Foundation Trust saw around 130,000 patients in total. Of these approximately 60,000 attended the Accident and Emergency (A&E) department at Queen's Hospital and of these 20-25% were children.

The A&E has dedicated children's waiting area and major's treatment area as well as a clinical decision unit where patients needing ongoing assessment could be admitted. The department aims to meet the national target of treating and admitting, transferring or discharging patients within four hours of arrival.

This report refers to the A&E department at Queen's Hospital. The Trust's Emergency Departments also includes two minor injuries units. The data we received from the Trust sometimes refers to the Emergency Departments (ED) as a whole, and sometimes individual units. We have made it explicit where the information relates to an individual unit or the department as a whole.

We visited the A&E department during the day as part of our announced inspection, but also returned unannounced within ten workings days to observe and speak to staff on night duty.

Summary of findings

Overall, the A&E department required improvement. People were generally receiving effective care and there were numerous policies and procedures in place to keep people safe. People we spoke with were positive about the service and numerous aspects of the service had been specifically designed to be responsive to the needs of the local population and provide an efficient service.

However, there were areas where the governance of the department could be developed to help improve the service. These included the services for children as some of the processes and procedures needed to keep them safe were not always undertaken and effective.

It was also noted that the service was currently experiencing challenges in transferring patients to wards and this was impacting on the length of time people spent in the department. However, the department was achieving the A&E target on most days, and the majority of patients were being seen, treated, transferred or discharged within four hours.

Accident and emergency

Are accident and emergency services safe?

Requires improvement



There were suitable numbers of appropriately qualified staff on duty to meet the needs of people who use the service. Care and treatment took place in clean environments with appropriate equipment available. There were procedures in place to reduce the risks and for staff to learn from incidents that occurred.

Some of the records and paperwork relating to children were not fully completed. Improvements needed to be made in training and awareness about mental capacity and consent, though this was acknowledged by senior staff.

Incidents

- Between December 2012 and January 2014 the ED reported six incidents through the Strategic Executive Information System (StEIS). We spoke to senior staff about the two of the incidents which involved retained cannulas on discharge and they were able to describe the actions and learning for nurses to prevent reoccurrence.
- No never events had taken place (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the last 12 months.
- 127 incidents were reported through the National Reporting and Learning System (NRLS) between March 2013 and February 2014 to have taken place in A&E, of which two of these were deaths and the majority were classified as 'moderate'.
- Staff in the department kept records of accidents and incidents that occurred. There was a process in place for these to be reviewed and for changes to be made to departmental policies and procedures as appropriate.
- Staff we spoke with were able to describe improvements that had been made following the review of incidents and how they had improved safety levels within the department.

Cleanliness, infection control and hygiene

- Infection control audits were conducted on a quarterly basis. These included compliance with the hand hygiene policy and the cleanliness of the environment. A review against the trust's infection control standards in March 2014 reported a 97% level of compliance in the department.
- In March 2014 hand hygiene compliance was below the trust's target at 89%.
- There was a policy and procedure in place for what needed to be cleaned by staff, including frequency, and we saw records of this taking place. However, we observed that there were areas where cleaning could be improved on the unit and these were raised with staff during our inspection.

Environment and equipment

- A central log was kept of all the equipment held in the department. This contained details of when the equipment had last been serviced and when its' next service was due. All the equipment we checked had stickers indicating when their next service was to take place and no equipment checks were overdue.
- All the sterile equipment and supplies we reviewed were in date and fit for use.
- Staff had been trained in what to do in emergency and received regular update training.
- Emergency drugs and equipment were available and these were regular checks to ensure that they were in date and fit for purpose.
- During our inspection we observed one resuscitation call. All staff, from both within the A&E and externally, attended promptly and were aware of their roles.

Medicines

- Medications in the department were stored securely and the actual stock of medications matched the records held.
- The major and minor case records we looked at showed that medication charts were completed appropriately and those patients had been provided with their medications at the prescribed time.
- Patient Group Directions (PGDs), protocols that had been developed so that nurses who were not independent prescribers could provide some medications without direct authorisation from a doctor, were in use and facilitated patients receiving medication in a timely manner.

Accident and emergency

Records

- We reviewed a selection of records on the unit. Appropriate assessment and treatment plans were recorded, as were ongoing nursing observations. There were also recorded details of discharge plans.
- It was noted that the medical documentation for children lacked specific prompts. At all locations factors specifically relevant to children, such as immunisation history or whether they were known to social services, were not requested or documented by staff.

Mandatory training

- There was a programme of mandatory training which staff said they were able to complete. This included areas such as basic life support and safeguarding training.
- In February 2014 85% of mandatory training had been completed by nursing staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act and how the provisions within the act could relate to the protection of vulnerable adults. However, they were not aware of broader issues relating to capacity and consent, such as the procedure to follow if someone refused treatment.
- Senior staff we spoke with acknowledged that Mental Capacity Act and Deprivation of Liberty Safeguards training needed to be improved for all staff. There were no plans or timescales for this training to be reviewed and improved.

Safeguarding

- Staff we spoke with were aware of the signs of possible abuse and how to report their concerns.
- Staff told us they had attended training in safeguarding adults and children, and that they were expected to attend refresher training on a regular basis.
- During our inspection we requested information about what level of safeguarding training staff were expected to complete and how many staff had completed this training. However, this information was not provided by the trust. Therefore we were unable to assess how many staff had completed this training and if it was at the appropriate level for their position.

Management of deteriorating patients

- The department used the Modified Early Warning Score (MEWS) and the Paediatric Early Warning Score systems (PEWS) to monitor patients and identify any deterioration in their condition.
- The records we reviewed showed that MEWS and PEWS were being used and completed appropriately.
- When people first attended the A&E staff used the Manchester Triage System to assess their condition. This assessment was used to direct the patient to the most appropriate member of staff in a timely way.
- All staff who were responsible for the triage of patients had received specific training in the Manchester Triage System.
- During our inspection we observed more than one instance where a patient with a potentially serious condition was referred directly to senior healthcare staff once the seriousness of their condition had been established.
- Following the initial triage adult patients had a risk assessments completed to ensure that they would be safe while in the unit. This included, nutritional screening, a falls risk assessment and a mobility assessment as appropriate. The records we reviewed showed these had been completed appropriately.

Nursing staffing

- At Queen's Hospital nurses and nursing assistants worked shifts of 07:00-19:30, 11:30-00:00 or 19:30-07:30. During the early part of the day there were seven nurses and one nursing assistant, two registered nurses joined the team later in the day and seven nurses and one nursing assistant worked the night shift. Staff told us these staffing levels usually met the demands of the department.
- The skill mix of nurses included two registered children's nurses and three emergency nurse practitioners. We were told these numbers and the skill mix was appropriate to the volume and medical condition of the majority of people who attended.
- However, it was not clear whether there was specific provision for a member of staff with Advanced Paediatric Life Support to be on site at all times.
- In the internally commissioned follow-up report to the Keogh review, undertaken in January 2014, the team noted the significant improvements in nursing staffing which had reduced the vacancy level in the A&E unit to zero.

Accident and emergency

Medical staffing

- The numbers and skill mix of doctors was appropriate to the volume and medical condition of the people who attended the A&E department. Seven Whole Time Equivalent (WTE) consultants worked in the unit, nine WTE middle grades and six WTE junior grades.
- The College of Emergency Medicine survey established that the mean average number of WTE Consultants in an ED in England is 4.39 with a typical attendance of over 60,000 patients per annum (The College of Emergency Medicine workforce recommendations April 2010). However the view of the College is that such rotas require a minimum of 10 WTE Consultants in every ED.
- Two of the consultants had a speciality in paediatric A&E medicine.
- There was a vacancy for one middle grade doctor as well as one trainee doctor. It was unclear from the evidence provided by the trust if these posts were being actively recruited to at the time of our inspection.
- One consultant was on-call for each 24 hour period, including weekends. During the week consultants would cover the department through a morning and an afternoon shift.
- One consultant covered the department in an afternoon-evening shift during the weekend. Junior and middle grade doctors covered the department 24 hours a day with between two and four doctors on at any one time during the week, and between two and three doctors on over the weekend.
- A further middle grade doctor was being used to cover a late shift on Fridays, Saturdays, Sundays and Mondays as part of the department's plan to relieve the extra pressure placed on the unit over the winter months. As the department continued to operate under pressure, it was planned for this role to continue.
- There were protocols in place for doctors to be asked to attend A&E from other areas of the hospital, such as surgical specialities, to assist the A&E team meet demand if there was a marked increase in the number of patients attending the department. In the follow-up Keogh review the team described the consultant cover in the A&E Department as 'adequate'.

Major incident awareness and training

- There were policies and procedures in place for what action staff should take in the event of a major incident.

These policies set out specific tasks for individual members of staff and resources and equipment were kept on site to ensure they could be accessed in a timely manner.

- Staff we spoke with reported that they participated in mock major incident response exercises in the past 12 months. They said that following the exercise a review had taken place and that the exercise had been positively evaluated.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

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

The trust had previously participated in several College of Emergency Medicine audits including ones into assessment and treatment of feverish children, fractured neck of femurs and vital signs relating to 2013 and before. However, we were not provided with more recent results of these audits. Relevant National Institute for Health and Care Excellence (NICE) best practice guidelines were followed and these were reviewed by the department's clinical director who passed any specific guidelines to staff or made changes to policies and procedures as necessary. Staff were supported in training and development.

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

Evidence-based care and treatment

- The A&E department at Queen's Hospital used sepsis and stroke treatment pathways that followed national guidelines.
- It was noted that in the resuscitation bays, there were some guidelines and procedures on the walls which were out of date and did not reflect current best practice. This included the guidance on paediatric resuscitation.

Accident and emergency

- In April 2013 the hospital opened an Acute Assessment Centre (AAC) in which the A&E's Clinical Decisions Unit (CDU) was based.
- The trust had a National Institute for Health and Care Excellence (NICE) committee. Senior staff in the A&E department reported that the committee kept them up to date with relevant new guidance produced by NICE.
- Relevant NICE guidelines were reviewed by the department's clinical director who passed any specific guidelines to staff or made changes to policies and procedures as necessary.
- The trust had previously taken part in several College of Emergency Medicine audits including ones into assessment and treatment of feverish children, fractured neck of femurs and vital signs. However, these all related to care prior to April 2013.

Patient outcomes

- The unit monitored specific areas of the service and participated in audits to ensure it was providing effective care and treatment. This monitoring included the number of emergency readmissions; the findings of this monitoring did not highlight any particular risks within the trust.
- The unit conducted monthly "ward assurance audits" that looked at performance in undertaking appropriate risk assessments when people arrived at the unit. Recent audits did not identify any ongoing significant issues. The audit results were displayed at the entrance to the main A&E department.
- Other audits the trust participated in included national audits of fractured necks of femurs and severe sepsis and septic shock. However, we were not provided with the results of the most recent audits, only those relating to care and treatment prior to April 2013.

Hydration and nutrition

- Patients said that they had been given food and drinks where appropriate.

Competent staff

- When staff first started working in the unit they received an induction to the working environment and the local policies and procedures.
- Staff we spoke with were positive about the training and supervision they received. At the time of our inspection the annual appraisal process was underway, but we were not provided with figures about how many staff had had an appraisal.

- Staff with specific paediatric training were available on most shifts in A&E at Queen's Hospital.

Multidisciplinary working

- There was a written strategy for working with the paediatrics department which included a protocol for accessing staff when there were possible delays in children being seen. The staff that we spoke with were positive about working with the paediatric department.
- The ED had access to a broad range of other facilities at Queen's Hospital including surgical, medical and imaging services.
- Staff told us that they had good working relationships with the AAC staff who they felt had been instrumental in helping improve their performance and the care and treatment people received.

Seven-day services

- At the time of the inspection the unit was piloting the use of physiotherapists on dedicated shifts seven days a week. We were told that this was having a positive impact on patient care but this had not yet been formally evaluated.

Are accident and emergency services caring?

Good



People using the service spoke highly of the staff and said they had been well looked after. We saw numerous examples of this taking place. Patients told us that they understood what their care and treatment involved. The NHS 'Friends and Family' test results showed that people rated the department above the national average.

Compassionate care

- The majority of the 20 patients and relatives we spoke with during our inspection were positive about the staff and the way they had been cared for and treated. They described staff as "nice", "lovely" and "helpful".
- Some people did report that the unit could get very busy at peak times and they had to wait longer for care and treatment.
- We observed numerous examples of care, treatment and support being provided by staff members. In all cases patients were treated with patience and respect.

Accident and emergency

- People's privacy and dignity were maintained as curtains were closed around cubicles as appropriate.
- In the NHS Friends and Family Test, where patients are asked if they would recommend the service to other people, conducted between October 2013 and January 2014, an average of 73% of people said they would recommend the department. This was above the England average of 56%. The average response rate to this survey for the trust was 17.1% compared to a national average of 15.4% over the same period.

Patient understanding and involvement

- The people we spoke with said that they were kept informed and they understood what their care and treatment involved.
- Patient information leaflets were available and how the Patient Advice and Liaison Service (PALs) could be contacted, these were in the waiting rooms and the main ward areas of the AAU.
- There was a suggestions box also in the waiting room. However, we were not told how this information was used or about any changes to practice that had occurred as a result of patient feedback.
- Several of the nursing staff participated in the trust's 'Ask Me' campaign and wore their badges. The aim of this initiative was to encourage patients and relatives to ask staff questions.

Emotional support

- Staff reported that they had access to different religious persons at patients' requests.

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

Good



There were policies and procedures in place to help patients move through the department and to receive treatment in a timely manner. In April 2013, the trust had introduced a new model for how people were cared for and treated within the department, which had significantly improved their waiting times. The department was appropriately organised to meet the needs of people using the service and there was a process for learning from complaints.

However, we noted at the time of our inspection that the department was experiencing some delays in meeting the national four-hour target due to a lack of available beds in the hospital. In addition, we observed that there was no separate 'minors' area for children and that they would be accommodated with adult patients.

Service planning and delivery to meet the needs of local people

- Senior staff reported that they had taken several actions to relieve the pressure the unit was experiencing at the time of the inspection. They stated the main cause for delays and capacity issues was a lack of available beds across the hospital for patients to be admitted.
- At Queen's Hospital there was psychiatric cover from 09.00 to 15.00 on weekdays. There was no psychiatric cover outside these times until the psychiatric crisis team were available after 17.00 on weekdays and at the weekends.
- Staff reported that at times there was insufficient cover for patients who needed to be seen by psychiatric staff in a timely manner. They reported that out of hours it could take up to three hours or more for a patient to be seen. Staff told us that this risk had been included on the department's risk register but no action had been taken to address it.
- Paediatric psychiatric cover was 9am to 5pm seven days a week.
- For those people who did not speak English as their first language, translation services were available on request.

Access and flow

- The department's performance figures demonstrated the positive impact of opening the AAC on reducing waiting times in the A&E. Between April 2013 and March 2014, the emergency department as a whole was performing well in achieving the A&E target that 95% of patients will be seen, treated and discharged within four hours. This was contrary to the national trend during this period.
- In January 2014 the hospital requested an assessment to follow-up the actions that resulted from the Keogh review. In this staff described a number of positive examples in A&E of effective team working, both internally and in partnership with local GPs, to avoid inappropriate patient admissions.

Accident and emergency

- However, between January and March 2014 the A&E had been experiencing problems with patient flow. While 95% of patients continued to be initially assessed within 15 minutes, there was a reduction in the number seen by a doctor within one hour.
- When patients first attended A&E, the time of their arrival was noted and their details were entered on to the department's computer system. This was then used to log what stage the patient's treatment or assessment was at and what the anticipated next steps were.
- The unit worked to the national standard of patients being seen and admitted, treated, discharged or transferred within four hours of arrival. The progress of each patient's treatment was flagged on a computer screen in the department so that their progress could be monitored in real time. This data was used to produce ongoing reports detailing the pressures on the department.
- There was a specific policy in place for what staff should do if a patient was in danger of breaching this four-hour target to try and speed up their treatment.
- There was also a policy in place to help reduce crowding in the department at times of higher attendance. Staff in the A&E told us that to reduce crowding, they would place low-risk patients on trolleys in a corridor with a dedicated member of staff to look after them, and there was a rapid assessment and treatment room which could be used if necessary.
- Specific consideration had been given to what pressure the department was likely to experience during winter and plans were in place to address this.
- In the documentation used by the department there were specific checklists to be completed before patients were transferred or discharged. These asked for relevant details about whether patients were stable enough for a transfer, or if written guidance had been provided to patients being discharged.
- There were two separate waiting departments in the A&E, one for adults and one for children. The children's waiting room had toys and books for children to use while they waited to be seen.
- There was a separate paediatric bay in the majors section of the A&E. However, there was no separate area for children in the minors section and they were care for with adults.
- During our inspection it was noted that there was an appropriate amount of seating in the A&E. Some patients did report that it could be very crowded and busy at peak times.
- People had access to a range of services to meet their specific needs. The AAC had facilities for GPs to see patients, as well as the CDU where patients could be admitted from A&E for ongoing observation and treatment if it was required for longer than 4 hours.
- The A&E department had facilities for dealing with major and minor injuries, including an ophthalmology room, a plaster casting room, and physiotherapy services.
- There were adult and child resuscitation bays also equipped for trauma patients.
- The protocols developed between the A&E, the CDU and the AAC for working together were in line with current best practice on how to involve GPs in supporting the care and treatment of people attending EDs.
- However, we were provided with one example where, six months prior to the inspection, a patient with dementia had been discharged from A&E to the discharge lounge. However, they were not suitable for discharge to this area as defined by the trust's policy and there was an incident where an oxygen cylinder was thrown towards staff.

Learning from complaints and concerns

- There was a complaints policy and procedure in place.
- Recent complaints that we reviewed predominantly referred to poor communication. The responses made by the department were noted to be appropriate.
- Senior staff told us that the department usually received between five to 15 complaints per month.

Meeting people's individual needs

- There were an appropriate number of bays in the majors, minors, resuscitation and the CDU areas of A&E to accommodate the volume of patients seen most of the time and plans were in place for when demand was higher than capacity.
- There was not always a clear sight-line from the nursing station to patient bays; however, there were two-hourly comfort rounds where patients were checked.

Accident and emergency

Are accident and emergency services well-led?

Requires improvement



Staff were generally aware of the visions and values of the trust and displayed these values in their interactions with patients. There were positive relationships between all members of the team, as well as senior staff at the trust. However, whilst there were some arrangements in place for governance, risk management and quality measurement, these could be improved and important areas of quality and performance were not analysed and acted on routinely (which senior staff recognised). In addition, whilst the department received feedback from patients, this was not always collected and analysed in a systematic way and there was a risk that important improvement information and opportunities for learning could be lost.

Vision and strategy for this service

- We spoke with numerous staff members in the A&E department, both junior and senior staff, clinical and non-clinical, all staff spoken to were aware of the trust's vision and quality strategy.

Governance, risk management and quality measurement

- The department collected data using a range of mechanisms to monitor safety and effectiveness. This included information relating to infection control, safety of the environment, time taken to be seen, as well as audits on compliance with national pathways.
- However, this data did not always regularly cover the breadth of topics normally expected to be covered in the quality assurance reporting of an emergency department. Lead clinical staff had been identified as being responsible for a range of quality assurance topics in the A&E. We noted that each member of staff was allocated several areas which would be difficult for any one staff member with clinical commitments to cover. Senior staff we spoke with stated that they recognised that, while they had the "basics" in place, further development of their governance structure was needed.
- Staff maintained the risk register and were able to describe what the department's risks were and how they were being mitigated.

- The unit provided a monthly performance report to the directorate board where their performance was discussed with senior staff from across the directorate.
- Staff attended external meetings with staff from the local Clinical Commissioning Group and local GP practices to discuss issues of relevance to the local area and how these could be addressed.
- Junior staff told us they were aware of the aims of the department and where senior staff had made changes to working practices to improve services.

Leadership of service

- Senior staff we spoke with described positive relationships with members of the trust board who they said had visited the department and listened to their concerns. Junior staff were also aware of who senior staff and trust board members were and said they visited the department.
- During our inspection it was noted that there was a regular presence throughout the daytime of senior staff in A&E. The senior consultant with nursing staff undertook comfort rounds every two hours to review the patients in the department.

Culture within the service

- During the inspection, where appropriate we raised challenging questions or concerns about aspects of the service in the department. The majority of staff were already aware of these issues and were open about the challenges. They were able to articulate where particular challenges and where actions had been or were currently being taken to address. Staff recognised areas where further work was required.
- All interactions we observed between staff and patients were undertaken in line with the trust's values.







Public and staff engagement

- Senior staff reported that there were numerous ways to receive feedback from patients. These included the complaints process and their responses to it, as well as other written feedback they received.
- Staff stated that they also obtained patient feedback through the NHS Friends and Family Test, from the Patient Advice and Liaison Service, by email, from feedback cards and from the rating of the department by use of voting tokens near the A&E department exit.
- The department did not systematically seek feedback from other wards within the trust using the trust's Inpatient Survey.

Accident and emergency

- Staff recognised that, while significant individual issues such as complaints were acted on, the full range of patient feedback was not brought together in one place and systematically reviewed.
 - The senior staff we spoke with described the various meetings and discussions they had with junior staff where they could feed back information on complaints or accidents and incidents, but also where they could seek feedback from junior staff on how to improve the service.
 - The junior staff we spoke with were positive about their working environment. They stated that senior staff were supportive and they felt able to engage with them, make suggestions and were sure that these would be listened to.
- Innovation, improvement and sustainability**
- Senior staff reported that since April 2013, with the introduction of the AAC they had made significant improvements to their performance, which was reflected in their performance statistics.
 - The unit was piloting the use of a physiotherapist and had recently brought in a new, recognised triage system to replace their previous self-developed one.

Medical care (including older people's care)

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

Information about the service

The trust provides a range of inpatient services, including acute stroke, respiratory medicine and medical day care services.

We visited five of nine wards as well as a surgical ward that was supporting medical patients, the discharge lounge, the acute assessment centre (AAC) and the medical equipment library. We spoke with 25 patients and relatives, 48 members of trust staff, including domestic staff, porters, nursing and medical staff and we looked at 26 sets of patient records. We observed the delivery of care and assessed the division's quality assurance processes as well as its local leadership, staffing and performance against both national and internal measures.

Summary of findings

Patients were often moved around the hospital to accommodate new admissions, feedback from clinical staff was that their clinical input and judgement was often ignored and overruled, resulting in patients being moved inappropriately. Clinical staff who had experienced this practice told us that they were concerned that these decisions could compromise patient safety.

There was not always a consistent approach to discharge. The discharge lounge environment was inappropriate and could not meet the needs of patients or the hospital as it doubled-up as a medical day care service. This dual purpose meant that neither of the functions of the unit could be adequately met.

The nursing staffing levels on some wards were below their establishment figures; however there were processes in place for ward leaders to make sure that appropriate staffing levels were maintained. Senior nurses were heavily relied upon to carryout non-clinical tasks and this reduced their capacity to support junior grade staff. Nursing staff we spoke with in the Acute Assessment Centre (AAC) expressed concerns about risks to patient safety due to the administrative demands on their time. They told us that they spent most of their time away from patient bedsides completing computer records. Support for people with dementia was not embedded across the trust.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement



Medical and nursing staffing levels and skill mix were risk-assessed and there was sufficient planning to maintain safe levels and mitigate risks. However, the lack of clerical and discharge nursing support resulted in clinical staff being taken away from patients' bedsides to answer telephone calls to the ward and facilitate discharge. Nursing staff in the AAC spent the majority of their shift away from patient bedsides completing patient records. Observations were recorded by nursing assistants who passed the information to the nurses to transfer to electronic records.

Of the staff groups across the division, 15 of the 26 staff groups were not compliant with mandatory training targets. Hand hygiene and infection control practices were not always followed by staff.

Incidents

- Between March 2013 and February 2014 the trust submitted 874 incidents to the National Reporting and Learning System (NRLS). Medical specialities accounted for the majority of incidents (241 incidents or 30% of the total number reported). Of these patient incidents, 93% were categorised with a moderate degree of harm.
- In the six months prior to our inspection, a serious incident occurred when an oxygen cylinder was thrown towards staff in the discharge lounge by a patient living with dementia. The patient's condition meant that they were not suitable for this area as defined by the trust's policy. However, they were inappropriately transferred to the lounge from the emergency department.

Safety thermometer

- The division used a ward assurance tool to audit quality and safety on wards. The tool requires ward leadership to produce an action plan if the ward scores below 95% overall each month to address identified failings.
- The data provided across medicine showed that the performance of wards 3, 5, 8 and 44 had declined every month between January and March 2014.
- We saw consistent evidence of the use of falls mapping on wards to identify trends and manage risk, and evidence that this had reduced the number of falls on wards.

- In April 2014 ward assurance for wards 3, 8 and 44 had shown an increase in performance with only ward 3 still flagging as red on the red, amber and green rated performance data. As data for ward 5 was not available, we were unable to assess if their performance had improved.

Cleanliness, infection control and hygiene

- We observed three instances of inappropriate infection control practice, including poor hand hygiene and temporary staff not using aprons and gloves as appropriate.
- There was no correlation between what was highlighted by ward self-assessment audit and then what was reviewed by the infection control audit. The lowest self-assessment score for the environment for February and March 2014 was recorded by ward 3, but the team did not audit the ward 3 environment when they audited in either month.
- Throughout our inspection, wards were visibly clean and domestic staff were present.
- Equipment and curtains were visibly clean, hand-washing facilities, aprons and gloves and anti-bacterial wipes and gels were accessible. A domestic cleaning colour-coded system was in place and adhered to.

Environment and equipment

- All staff we spoke with told us that they did not experience delays in obtaining equipment. The hospital had a medical equipment library where staff could access equipment and could sign-out equipment as needed out of hours.
- Resuscitation trolleys were checked by day and night staff and signatures were recorded to validate the checks. There was no resuscitation trolley in the discharge lounge or medical day care service, a resuscitation box was available which was checked and sealed by the anaesthetic department.
- During our announced inspection, we were told about an expected delivery of new resuscitation trolleys across medicine. When we returned to the trust on our unannounced inspection we saw that these trolleys had been delivered and staff had received training in their use before they were placed on the wards.
- Generally the environment was maintained appropriately, with access areas kept free and equipment stored appropriately.

Medical care (including older people's care)

Medicines

- Medicines were stored and handled appropriately. Pharmacists were available to review patient medication across the division. The medical team told us that a pharmacist visited all wards, five days a week, to review patient medication.

Records

- Across the medicine wards at the Queen's Hospital site, we found that records were completed appropriately and accurately and that risk assessments triggered the development of appropriate care plans. Monitoring information and observations were recorded as appropriate.
- On Ward 44 we found a contrast in record-keeping standards with the rest of the hospital. One example was a patient who had sustained an injury during their stay on the ward. Staff were not able to provide documented evidence of how and when they sustained the injury or the date for when the dressing on the injury needed to be changed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff knowledge of the Mental Capacity Act 2005 was not embedded across medicine. This was particularly evident on ward 44 where capacity was not assessed in line with the guidance.
- We spoke with one patient on ward 44 who had made a complaint about being moved four times during their eight-week stay at the hospital. We were told by a member of nursing staff that this person lacked capacity. However, this patient was able to tell us when they were admitted, how long they had been an inpatient and their experience of being moved around the hospital. There was no documented ongoing assessment of capacity or any assessment of their capacity to make a specific informed decision.
- We found another example on ward 44 where an assessment had not been carried out when required.

Mandatory training

- Mandatory training compliance across medicine as of March 2014 was 84% which was below the trust's expected target of 90%. Fifteen of the 26 training groups across medicine were not compliant with the mandatory training target.

- On the whole, nursing training rates were around the target percentage, but the division was failing to meet doctor training targets, with junior gastroenterology training at 69%, junior general medicine training at 59% and senior cardiology training at 70% compliance.
- Training compliance rates for respiratory medicine were below the expected level for all staffing groups, with compliance rates of 53%, 76% and 80% for senior, junior and nursing staff respectively.
- Nursing staff told us they were up to date with their mandatory training, but that they often had to complete mandatory training in their own time.

Management of deteriorating patients

- Track and trigger records, used to monitor a patient's condition and manage pain, were completed correctly and accurately across medicine. We saw that doctors had been involved when assessments required them to be made aware of the patient's condition. A modified early warning score was implemented and used to assess a patient's condition and identify deteriorating patients.
- On wards where patient acuity meant they were at greater risk of a deterioration of condition, appropriate monitoring equipment was used to manage and support patients.
- With the pressure for beds on wards such as the acute stroke ward, we observed clinical decisions being made by senior nurses that ensured new patients were admitted to the ward that could monitor their condition. Patients who no longer needed to be monitored were risk-assessed for their suitability to be moved. However, it was a theme of our inspection that nursing staff across medicine told us that sometimes clinical decisions were overruled, and patients were moved against the advice of nursing staff by non-clinical staff.

Nursing staffing

- We saw evidence that nursing staffing levels were risk assessed and that weekly challenge and planning meetings occurred to maintain safe levels.
- The trust had a high dependency on temporary nursing staff across medicine, all the nursing staff we spoke with told us that, when the agency was used, it was often the same nurses supporting wards.

Medical care (including older people's care)

- A matron and other nursing staff told us that, by using the same temporary staff where possible, they had been able to give them IT access and the necessary skills for the ward, enabling them to be more effective in their role.
- The trust had introduced a pay initiative approximately 12 months ago to encourage its own staff to cover extra shifts. Nursing staff told us this had led to more of the trust's own staff covering shifts as bank (overtime) staff.
- Recruitment was a recognised challenge for the trust, with wards below establishment. Nursing staff were frustrated by the failure to recruit to vacant nursing posts.
- The acute stroke ward was significantly below establishment with 5.2 full-time equivalent positions not filled at the time of our inspection. While the skills mix on wards was satisfactory based on the care needs of the people and their acuity, nursing staff were being taken away from patients' bedsides for considerable periods to undertake administrative duties. For example, senior nurses were involved in discharge and clerking and were regularly being supported by newly qualified nursing staff; therefore, the care was not delivered by senior staff.
- Nursing staff we spoke with in the Acute Assessment Centre (AAC) expressed concerns about risks to patient safety due to the administrative demands on their time. They told us that they spent most of their time away from patient bedsides completing computer records. We visited in the early hours of the morning to find that nursing staff were sitting at computer terminals, unable to see newly admitted patients while nursing assistants carried out observations and provided the information for trained nurses to record.

Medical staffing

- Prior to our inspection, a risk to patients had been identified relating to the under-establishment of consultants for respiratory medicine. We saw evidence that medical staffing was risk-assessed and found that two new respiratory consultants had been employed by the trust in March and April 2014.
- The number of medical staff observed during our inspection suggested appropriate cover for wards. Medical staffing rotas for a six-week period prior to and after our inspection showed that cover had been provided and planned for.

Are medical care services effective?

Requires improvement



We saw some examples of effective risk management including a project led by a senior nurse which had significantly reduced the number of falls on their ward. The tool they used had been shared and implemented across medicine. Despite sharing this good practice, other tools used to manage risk and improve quality, such as the ward assurance tool, were not consistently used to affect improvements on wards.

Findings from the national stroke audit demonstrated the trust was performing poorly in this area. Support from therapies and multi-disciplinary working was well established across the division with effective support and input provided as appropriate, throughout the patient journey. There was a seven day therapy service available from 07.00-19.00 with a focus on patient care.

Pain relief

- Consultants in one of our focus groups shared with us that they were concerned that the acute pain team had no support from ward staff when visiting patients. We were told that, often when they visit patients, the team who made the referral were not present, and did not offer a history. It was left to the acute pain team to find and read patient notes, and speak with nursing staff.
- The track and trigger document used by the trust helped to manage patients' pain, and when a doctor's input was triggered by the ongoing assessment, people were seen and the intervention was recorded.

Nutrition and hydration

- Patients' nutrition and hydration needs were risk-assessed and monitored. Food and fluid monitoring charts were in place as necessary and people's intakes and outputs were appropriately monitored and recorded.

Patient outcomes

- There was evidence that the trust participated in 46 of the 51 national audits they were eligible for in 2012/13 including the National Diabetes Inpatient Audit and Sentinel Stroke National Audit Programme (SSNAP).
- The SSNAP allows comparison of key indicators that contribute to better outcomes for patients. Overall

Medical care (including older people's care)

performance is rated from A (highest, which no service achieved) to E. It is acknowledged by the audit that very stringent standards are set; however, data from 1 October to 31 December 2013 shows that the trust achieved a grade D overall.

- However, the trust is performing the same as other trusts in its region.
- Where the trust is falling well below national performance is against the domain of specialist assessment.
- For the proportion of patients assessed by a stroke specialist consultant physician within 24h of clock start, the hospital's percentage was less than half of the national figure (31% compared to 75%).
- For the median time between clock start and being assessed by stroke consultant, the hospital's time was 29 minutes compared to a national time of 14 minutes.
- For the median time between clock start and being assessed by stroke nurse, the hospital's time was over seven minutes compared to a national time of around two minutes.
- The trust was within the expected range for the Myocardial Ischemia National Audit Project for data collected from 1 April 2012 to 31 March 2013.
- For three key indicators for the 2012/13 Myocardial Ischaemia National Audit Project the trust performed similar to expected for one indicator and tending towards better than expected for the other two.
- These were the proportion of eligible patients with a discharge diagnosis of nSTEMI who were seen by a cardiologist or member of their team. - Similar to expected.
- Proportion of eligible patients with a discharge diagnosis of nSTEMI who were admitted to a cardiac unit or ward - tending towards better than expected.
- Proportion of eligible patients with a discharge diagnosis of nSTEMI who were referred for or had angiography - tending towards better than expected.

Competent staff

- Band 5 nursing staff told us that they felt well-supported and that, in the 12 months following qualification, they had been able to complete relevant training and build on their competencies.
- Nursing staff across medicine and in our focus groups felt there were good development opportunities provided by the trust, including access to leadership programme.

- An allied health professional fed back in one of our focus groups that they had access to training and professional development.
- Regular agency staff were provided with training to enable them to be more effective members of the nursing team.
- We were told by doctors that revalidation was taking place as necessary.

Multidisciplinary working

- All staff we spoke with felt they had good access, support and input from occupational therapists, physiotherapists and other allied healthcare professionals.
- Feedback received in our focus groups was that the role of therapies was promoted and there was effective partnership working with no professional boundaries.
- Therapies were integrated across medicine and allied healthcare professionals were involved in a range of meetings, including ward rounds.
- Ward 3 had respiratory nurses who identified and reviewed patients who were being cared for on medical wards each morning. One respiratory nurse we spoke with told us that they begin these rounds at 8am and that they also met with allied healthcare professionals on ward rounds.
- Doctors we spoke with in focus groups felt that there was a good working relationship between consultants and managers and that issues were resolved in a timely manner.
- Doctors and nurses did not carry out joint ward rounds on medicine wards. Staff in one focus group raised a concern that, when doctors went on so-called 'safari' rounds to see outlying patients, they were not always attended by a nurse. Staff felt this meant that the doctors may not be made aware of important patient information.

Seven-day services

- There was a seven-day therapy service available from 07.00 to 19.00, with a focus on patient care.
- The critical care outreach team, medical and surgical staff were available out of core hours. Including a gastric bleed rota to ensure patients were treated promptly in an emergency.
- Diagnostic scoping for emergency cases was performed out of hours in theatre if necessary.

Medical care (including older people's care)

Are medical care services caring?

Good



Nursing staff showed they had their patients' interests foremost in their minds, and patient feedback from the Acute Assessment Centre was that patients felt involved and informed.

The trust's 'Ask Me' initiative which encouraged patients and relatives to ask staff questions was embedded across medicine, and staff felt that its introduction had engendered more patient interaction and feedback.

Several patients on ward 44 raised concerns that they were not informed and involved in decisions about their care and treatment.

The trust performed within the expected range for the 2013 Adult Inpatient Survey and above the England average for the Friends and Family Test (October 2013 to January 2014).

Compassionate care

- Nursing staff across medicine demonstrated a compassionate nature and conveyed that they cared about their patients. Nursing staff shared with us where they felt patient safety might be compromised, and gave examples of when the trust was not responsive to patients' needs.
- The patient experience for some patients, particularly elderly people, did not always reflect a compassionate approach. The pressures on staff and beds meant that patients were not always treated compassionately.
- Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results had been used to formulate the NHS Friends and Family Test. For the inpatient test, the trust scored above the England average for all four months reported between October 2013 and January 2014. The results were formulated from an average of 476 respondents for the period.
- The trust performed within the expected range for the questions asked in the CQC's 2013 Adult Inpatient Survey.
- We observed on Ward 44 that there was no apparent urgency from nursing staff to respond to call bells.

Patient understanding and involvement

- The trust introduced an 'Ask Me' initiative which meant that staff wore badges encouraging patients and relatives to ask them questions. Across medicine nursing staff felt that this had been a positive initiative and that patient and relative queries had increased.
- On ward 44 we spoke with three elderly patients who each expressed that they did not feel informed and involved. This included one patient who was waiting to be discharged who told us that they were concerned that the support they were going to need when they arrived home wasn't in place. Another patient told us they had been moved four times during their inpatient stay and that on each occasion they had received no prior notice, were not informed where they were being moved to and that the first thing that they knew about being moved was when the porters arrived to move them.
- Patient feedback from the AAC was that patients felt involved and informed.

Emotional support

- Wards had access to a community psychiatric nurse but we were told that response times could vary from one to five days to see patients.
- Feedback from nursing staff aligned to stroke medicine was that professional clinical psychology support wasn't available to patients.

Are medical care services responsive?

Inadequate



Appropriate care and support for patients living with dementia was not consistently provided or appropriately resourced. Patients discharged from the hospital received an inconsistent and often insufficient response to their needs as they were discharged from all parts of the hospital. The discharge lounge was an inappropriate environment for patients as it doubled-up as a medical day care service and therefore not many patients could be accommodated by the lounge during opening hours.

Patient bed moves happened during the night and there were a significant number of medical patients on surgical

Medical care (including older people's care)

wards or in medical beds designated for other specialties. Evidence showed that some inpatients experienced multiple bed moves which increased the risk of them not receiving appropriate continuity of care.

As of 02 May 2014, the trust had failed to provide a full response within its own target of 35 working days to 43% of complainants.

Meeting people's individual needs

- Coordinated care for patients with a diagnosis of dementia was not embedded across the division.
- A senior nurse in charge on one ward wasn't able to explain how they made sure that the needs of people diagnosed with dementia were met.
- Despite signs on wards detailing who the lead dementia nurse contacts were, the majority of band 5 nursing staff we spoke with did not know who to contact.
- The dementia nurses we spoke with talked us through some good practice and good patient outcomes where they had been able to intervene to improve the patient experience. They also showed us holistic reviews that they had carried out when they had visited patients on wards to make sure there was a coordinated approach to their care.
- However, while some medicine wards felt they had good support and used the dementia leads effectively, other wards didn't find the dementia leads as visible and there was a feeling among nursing staff that dementia leads were under-resourced.
- The dementia leads shared some examples of where their intervention had enabled patients to achieve positive outcomes. However, they were only resourced to be able to reach a small number of the patients diagnosed with dementia and so their input was not consistently available.
- There had been no evaluation of the dementia team's input and impact to date which could provide shared learning and assess if there was a need to provide further support to the team.
- Feedback at one of our focus groups from staff was that the trust met the government target for the number of required dementia champions, but not all wards had a champion. Staff said there was an identified need for more dementia training for nurses.
- Nursing staff we spoke with on some wards confirmed that they did not have a dementia champion on their ward.

- On ward 44 we found that the reminiscence room, designed to provide for the needs of patients with dementia, was inaccessible due to equipment being stored in this room.
- As well as the dementia lead nurse; we did see other elements of good practice on wards. This included the use of a 'pat dog' on wards, including Ward 44. There was good provision for bariatric patients on wards in the division.
- The discharge lounge was not an appropriate environment for the discharge of patients. The room doubled-up as a medical day care services ward and, on the day we visited, day patients occupied the majority of the space available. We were told by staff that elderly patients were often required to be received on beds in the discharge lounge, but beds were often not available as they were being used by day care patients.
- We were told by staff on medical wards that patients were not routinely repatriated to their specialist ward when beds became free, unless their condition deteriorated or unless the bed they were in took priority for another patient.
- Care plan records on Ward 44 did not show how patients' personal care needs were being met.
- The medical team told us that stroke patients had access to the next computerised tomography scan slot and there are also designated slots for stroke patients to avoid delays in scanning and commencement of treatment.

Access and flow

- Between October 2013 and December 2013 the trust's bed occupancy was 83.9% compared to the England average of 85.9%
- On the first morning of our inspection, the trust reported that around 10% of the hospital's total beds were taken by medical patients placed on surgical wards.
- The trust's bed occupancy rates have been on an upward trend since July 2013. Every bed was being used by a patient in the AAC and the medicine wards we visited throughout the announced part of our inspection.
- On Ward 3 which focused on respiratory medicine, there were 12 out of 32 non-respiratory medicine patients in beds on the ward. Ward 8, which focused on stroke

Medical care (including older people's care)

medicine, had six beds which nursing staff told us were regularly used for general medical patients. When we visited the ward unannounced, we found that 12 non-stroke medical patients were in beds on the ward.

- We were told by staff members in medicine that night transfers of patients were not unknown. When we visited the hospital unannounced, we found that one patient had been moved from the AAC to a surgical ward at 23.30, and another patient had been moved from the AAC to another ward at midnight. Night porters told us that they regularly moved patients in the middle of the night.
- The trust told us that night transfers do occur from the AAC (a 24-hour facility) when another medical ward is a more appropriate location in the hospital for patients.
- At our listening event, someone who had used the service told us that they had experienced three moves in the space of 24 hours as an inpatient. We were told by a patient on Ward 44 that they had experienced four moves in the eight weeks of their inpatient stay.
- At one of the focus groups we held during our inspection, a member of staff told us of a patient who had been moved seven times in five weeks during their stay, adding that their relatives were not informed about the move and that their consultant changed each time they moved.
- There was evidence that nearly 7% of inpatients from January to March 2014 had stays on three or more wards. In the same period a small number of patients experienced between three to eight moves during the course of their inpatient stay.
- We observed patients attending for medical day care services experiencing long delays due to medicines not being provided in a timely manner.
- Admissions for day cases commenced at 08.00 the day we inspected. We saw that medicines were requested for three patients over the telephone, a prescription was written by a junior doctor at 09.58 for the three patients and their medicines were not made available for treatment until after 12.00. One patient's treatment did not begin until 13.00. This meant that patients attending for a planned one-hour treatment could experience a six-hour stay.
- We were told by consultants that IT systems allowed patients to be discharged without a discharge letter

being produced before they left the ward. We saw six sets of notes on one ward, waiting for a discharge letter to be produced, and all these notes were patients who had recently been discharged from the ward.

- The trust performs within the expected range for referral to treatment times under 18 weeks for the admitted care pathway.
- The trust performs within the expected range for diagnostic waiting times for patients waiting over six weeks for a diagnostic test. Ward managers and ward staff told us that diagnostic turnaround times were satisfactory but we were not provided with any exact times for the completion of these tests.

Learning from complaints and concerns

- The trust sets a target response timeframe of 35 working days for complaints requiring a written response. As of 2 May 2014, the trust had failed to provide a full response within this target to 43% of those complaints.
- In January to March 2014 the trust received 53 complaints relating to the medicine division which required a written response.
- The trust told us that, as part of the ongoing review of their complaints response times, work is underway to address and respond to the percentage of complaints that have exceeded their target, and that they are liaising with families to ensure they are kept informed of the status of their complaint. The trust told us that this work is being monitored through the director of nursing's office, and the governance, risk and assurance committee.
- Feedback from our staff focus groups was that mechanisms were not in place for sharing information about complaints.
- One member of staff at a focus group told us that they were on the patient experience board and so knew about complaint outcomes, but they told us that, if they were not on the board, they would not know about progress on complaints as this information was not cascaded.
- Feedback received at one focus group was that, due to a high number of complaints about discharge letters, an audit had been carried out on the quality of letters, which was then re-audited to monitor improvements. We were told that the results of this second audit had not been shared.

Medical care (including older people's care)

Are medical care services well-led?

Inadequate



In August 2013, the trust disbanded an acute assessment unit for the frail elderly and was directing all patients through their new AAC. The trust is currently reviewing the efficacy of this decision as well as their frail elderly care pathway.

Patient safety was at risk of being compromised by decisions to overrule local clinical advice on patient bed moves, which have been made based on a patient acuity and patient need. Similarly, there were risks to patient safety due to the demand placed on trained nurses in the AAC to complete electronic records, keeping them away from patients' bedsides.

The vision and principles of the trust's 2011 dementia strategy have not been delivered, and the investment in dedicated nursing support is insufficient to meet the needs of the patient group.

Some areas of good practice were shared across the division but the implementation and compliance with the principles of the Mental Capacity Act were inconsistently applied.

We observed good local leadership on most medicine wards and staff talked positively about their role and told us that they felt supported by local leaders. Staff told us that learning was shared sporadically but was improving. The management of the risk and improvement agenda was not effectively managed to ensure consistent performance and continued improvement across the division.

Vision and strategy for this service

- The trust's dementia strategy is that "Burton Hospitals will ensure that the needs of patients living with dementia are met, in a way that maximises their potential, makes them feel valued, protects and supports those that are vulnerable". We found evidence this had not been implemented.
- In November 2011 a strategic steering group was formed to deliver this vision and the underlying strategic principles. The trust was failing to deliver on many of these strategic principles three years later.

- We were told that the 'forget-me-not' scheme was being introduced to support patients with dementia in the weeks after our inspection. The 'forget-me-not' scheme has been present in some trusts for many years.
- We carried out a number of staff focus groups during our inspection. Feedback received from senior staff was that the trust's values were discussed as part of the appraisal process. However, feedback from many of the students and nursing assistants we spoke with was that they were not aware of the trust's values.
- The AAC and short stay unit (SSU) were integrated in terms of the care pathway for patients, but the SSU currently resides in another part of the hospital. We were told by staff that there were plans underway to accommodate the SSU next to the AAC.
- Throughout our inspection we observed that elderly patients who were not acutely unwell presented to the A&E and were also referred by GPs to the AAC and often occupied beds in the AAC and the SSU.
- In August 2013 the trust disbanded an acute assessment unit for the frail elderly and directed all patients requiring assessment of this kind through the newly opened AAC.
- At a presentation by the trust to our inspection team the day before our inspection, the director of operations suggested that the trust was considering reviewing this decision and whether it needed to re-examine the need for a dedicated unit for frail elderly patients.
- We were told that the trust was currently reviewing the frail elderly care pathway.

Governance, risk management and quality measurement

- We were told that the decision to move patients was based on a patient's acuity, and we saw examples of these decisions being effectively made by senior nurses in the internal management of their own wards. However, we heard throughout our inspection that the clinical decisions of ward leaders and senior nurses were commonly overruled when decisions were made about patient bed moves.
- While challenge was built in to manage the risks associated with nurse staffing levels, the risks associated with the resourcing of clerical staff and discharge liaison nurses had not been mitigated.
- Similarly, there were potential risks to patient safety in the AAC due to the demands placed on trained nurses to record information passed from the emergency

Medical care (including older people's care)

department and information in preparation for patient stays on other wards, such as the SSU. This information had to be recorded electronically and away from patients' bedsides.

- There were improvements in quality and safety through the use of the ward assurance tool on some wards. However a decline in performance on some medical wards month after month in early 2014, including repeat failures highlighted in the same areas, showed that use of the tool was inconsistent.
- We saw evidence of falls mapping on some wards with trends in falls being assessed to predict and mitigate risks.
- However, not all of the good practice we observed was embedded across medicine which, along with declining ward assurance tool scores for some wards in the first three months of 2014, suggested that the effectiveness of risk management was determined by ward level leadership.
- Prior to our inspection, the trust told us that they had made all of their band 7 ward managers supervisory based on the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report). However, nurse feedback across wards was inconsistent, with some nursing teams telling us their ward manager was supervisory and others telling us their ward manager was involved in the hands-on delivery of care.

Leadership of service

- We saw good local leadership on most wards from senior nurses and ward managers. Some senior nurses and ward managers had led by example on patient safety and risk management. We saw that there was a strong and effective ward manager in place in one area previously identified as high risk.
- Feedback received from our focus groups was that many staff did not know who the trust's most senior lead for therapies was.
- We also received feedback in focus groups that the majority of the senior team were visible and that the board made regular visits to wards.
- Several senior nurses stated that their clinical judgement was 'overruled' and their view ignored when it was being decided which ward a patient should be

cared for on. A clinical specialist told us that they felt undervalued when they were unable to challenge decisions made by bed managers to place one of their patients on a non-specialist ward. We were told by these nurses that the decision to overrule sometimes came from the bed manager but often came from the head nurse or others in senior positions.

- One patient felt bullied to move wards and that their views were not taken into account. They did not want to and said so. However, after their relative went home, a senior manager came and told them they were being moved.







Culture within the service

- Nursing staff and doctors spoke positively about their day-to-day work, the development opportunities available to them and the support provided to them.
- There were opportunities provided in nursing for staff to challenge senior staff and feedback.
- Nursing staff told us that they had recently attended a 'clear the air' event where they could raise concerns about working on their wards. We were told that one concern was that the initial forum for this session was too big for everyone to be able to share their views; in response, local 'clear the air' sessions were facilitated.

Innovation, improvement and sustainability

- We were told by one matron in medicine of a new group that had been introduced where all staff could attend to hear about learning from incidents and complaints. The group was called the 'care group' and had recently been rolled out. The group was set-up as an open-house session for all staff.
- We were given examples of learning from incidents being shared with staff, but shared learning was inconsistent in the division. Also, while some staff received an initial update, further progress updates were not always provided when an ongoing project of work was in place to make improvements to care quality.
- Feedback in our focus groups was that sharing learning and cascading information was improving, but de-briefing was not as effective as it could be.

Surgery

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

Information about the service

Surgical procedures were carried out on two sites. 136 surgical beds were available at Queen's Hospital including five day case beds in urology. There were nine theatres. The Treatment Centre based at the Queen's Hospital provided 40 trolley spaces for day case and ophthalmology services. Annually the trust carries out over 47,000 planned and emergency operations and 13,000 day-case procedures

We spoke with 24 patients, 40 qualified staff, 16 staff, five managers and eight relatives. We looked at 14 sets of medical notes. We observed care and spoke with staff and patients on five surgical wards including general surgery, orthopaedics, ENT and gynaecology. We visited the anaesthetic rooms, theatres and recovery areas to observe care provided both pre- and post-operatively. We spoke with staff and patients in the endoscopy unit, breast care unit and day care units.

Summary of findings

Medical outliers had impacted negatively on the use of surgical beds. This included some post-operative surgical patients being moved to other wards to accommodate new elective admissions, due to medical patients using surgical beds.

Surgical staff worked as part of multidisciplinary teams to ensure patients received the best care possible. We observed that the service was responsive to the needs of people with a learning disability and dementia. The enhanced recovery programme for knee and hip surgery was in place which reduced the length of stay for patient. We saw that discharge planning commenced when the patient was admitted.

There was ward level leadership provided by the senior sisters who led enthusiastic staff. Staff told us they had not seen or rarely saw the executive team and not all wards had seen board members. The staff told us that areas of the trust worked in silos so staff didn't always know what was happening in another part of the hospital.

Surgery

Are surgery services safe?

Requires improvement



Surgical specialities accounted for 19% of the serious incidents reported. The rate of cancelled operations was similar to that expected. The readmission rate was lower than expected.

Medical outliers had impacted negatively on the use of surgical beds. Post-operative surgical patients had been moved to other wards to accommodate new elective admissions, due to medical patients using surgical beds. Enhanced recovery initiatives in joint replacement enabled some patients to have a shortened post-operative stay in hospital. However, due to some patients being moved to other surgical wards, staff suggested that this impacted on the effectiveness of the pathway.

Incidents

- One Never Event had been reported between March 2013 and February 2014 in surgery. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. During time in theatre a patient was subject to a medication error by the maladministration of a potassium-containing solution which is on the list of Never Events as defined in the Never Events Framework An update to the Never Events Policy (DH 2012).
- A second incident occurred where the same patient received a blood transfusion with no evidence that a mental capacity assessment was undertaken at this time. As a result of this incident, a second investigation was conducted to review the governance arrangements in theatres. The subsequent death is subject of a HM Coroner's inquest in the future and depending on the findings surrounding the administration of potassium, this may be re categorised as a national never event. To prevent similar events occurring in the future, new trust-wide protocols and procedures had been implemented.
- This incident was not reported immediately and escalated as a serious incident and never event. There was a lack of awareness on Trust policy and procedures. Concerns relating to the administration of potassium were not escalated appropriately by theatre staff.

- The Keogh mock review in January 2014 identified improvements in the serious incident process were recognised however the need for improved divisional engagement was noted.
- In July 2013 the Keogh review identified that the trust had a rate of patient safety incident reporting of 9.5 which is very high when compared to the national average for similar sized trusts of 6.5. The trust had a rate of 1.58 for incidents reported as either 'moderate, severe or death' compared to a national average of 0.43. Therefore the trust has more patient safety incidents per 100 admissions than the median rate for similar small acute trusts.
- Data identified that between March 2013 and February 2014 the trust submitted 159 incidents of moderate harm within surgical wards, two cases of abuse were reported and nine incidents of severe harm. The trust had developed and implemented action plans for each of these incidents to reduce the risk of a recurrence.
- The trust's quality board reviewed the progress of the implementation of each action plan.
- Data received from a whistle-blower prior to the inspection indicated that there was a lack of understanding about incident reporting. However, all clinical staff we spoke with were aware of the electronic patient safety reporting system and were confident to report any incidents.
- We were told that some staff did not report all incidents as they did not always receive a response on the progress or feedback from their report.
- Some staff stated that they received feedback from their matron, and incident themes were discussed at the weekly manager's meetings.
- Staff told us that the trust senior management were slow to finish and close incident investigations.
- Mortality and morbidity meetings did take place. The ward staff were unsure of the frequency of the meetings and outcomes were not communicated to them.

Managing risks associated with surgical procedures

- All patients were invited to attend a pre-operative assessment clinic prior to coming in to hospital to ensure they are in optimum health and fully informed. This assessment is an essential part of the planned care pathway which enhances a patients care and recovery.

Surgery

- Some patients experienced a delay between this assessment and being admitted for surgery due to medical outliers reducing capacity in the surgical wards. This resulted in a need for this assessment to be repeated.
- We found that appointments were generally offered within six weeks of the planned theatre date. On occasions the time between the assessment and theatre date exceeded this. Patients were recalled for mini assessments to ensure their safety and suitability for surgery.
- The Keogh mock review held in January 2104 found that the current winter pressures led to medical outliers was a concern raised by staff, despite the acknowledgement that this had improved notably from last year. Concerns raised in a focus group suggested that patient care was at risk of being compromised by the number of medical outliers and agency staff. However, observational visits did not support these concerns and examples of mitigating plans to ensure the safety of patients were seen.
- The WHO surgical safety checklist was used for all 12 of the patients having surgery we looked at, minimising common and avoidable risks that could endanger the lives and wellbeing of these patients.
- Theatre audits were carried out in November and December 2013 to ensure WHO checklists were completed and equipment was available. The results showed that the anaesthetic room check achieved over 50% compliance; with the remaining results indicating that standards were not met over a three-week period. 'Team brief', 'stop moment' (this is part of the checklist when the team reflect on the case) and 'sign out' and 'documentation' all scored less than 50% compliant.
- The WHO checklist action plan was commenced in February 2014 with final completion planned for August 2014. Actions included team brief starting earlier, a surgeon led team brief, a team leader identified for each list and the re-launch of 'sign out'. Surgeon guides were to be up dated, staffing allocations reviewed and a clinician with an interest in the WHO checklist to be identified as a link person for training and advice. Re-audit was planned for April 2014 with final completion by the end of August 2014.
- The outreach sister visited the wards daily to assess unstable patients; nurses could refer patients directly to them. Their role was to review outlier patients and ensure their tests and follow-up consultations were being actioned. They also identified patients who could be moved back to their appropriate ward. For example, a patient being moved back to respiratory ward.
- The lack of capacity on medical wards resulted in some surgical patients being moved to other surgical wards, not linked to their specific condition, to ensure that elective patients could be admitted to avoid cancelling their surgery. The number of cancelled operations was similar to other trusts nationally.
- The high numbers of medical patients being cared for on surgical wards was impacting on the surgical team's ability to fully implement the enhanced recovery programme, which aimed to reduce the length of post-operative stay.
- Pressure-relieving equipment was used for those patients with a high Waterlow risk-assessment score, who had been identified as being at risk of developing a pressure score. The orthopaedic wards were trialling two types of pressure-relieving boots to avoid pressure ulcers occurring.
- The theatres used pressure-relieving equipment, including anti-embolism stockings and Flowtron therapy, a clinically effective, non-invasive therapy which uses intermittent pneumatic compression to treat a wide variety of vascular, circulatory and lymphatic conditions were used in theatre.
- Bed rail assessments were completed and, where necessary, bed rail bumpers were used to protect the patient from harm. High/low beds and sensor mats were seen to be in use to reduce patient falls in the ward areas.

Safety Thermometer

- Safety Thermometer (the NHS local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care) information for falls, new venous thromboembolism (VTE or blood clots), catheter use with urinary tract infections and new pressure ulcers was displayed at the entrance to each ward.
- The trust Safety Thermometer monitoring results showed that performance was in line with or better than the national average for all areas monitored.
- Two of the medical outlier patients VTE scores, recorded on the surgical ward, were increased due to not being prescribed anti-coagulants on admission.

Surgery

- All patients admitted to surgery wards were risk-assessed and those identified as being at high risk of falls, had action plans implemented to mitigate the risk.

Cleanliness, infection control and hygiene

- Staff were noted to be to 'bare below the elbow' and regularly washed their hands and used hand gel in between seeing patients in line with the trust's infection control policy.
- MRSA and *Clostridium difficile* (C. difficile) rates for the trust were within expected limits.
- Patients were screened for MRSA on admission to the wards. Patients who were MRSA positive were, where possible, were nursed in a side room to prevent cross-infection. When a side room was not available for a patient with an infection, the infection control nurse would be asked by the ward staff to assess if the patient was suitable to be 'barrier nursed' on the ward.
- Surgical site infection rates were not audited. We were told that infection rates were low, and for that reason staff stated that they were not monitored.

Environment and equipment

- All ward and department areas we visited were visibly clean. We saw that cleaning audits were reviewed as part of the matron's weekly ward round.
- The Keogh mock review in January 2014 identified that some noticeboards were observed that were cluttered, and included out of date information. Since then 'Clutter champions' had been identified to ensure ward areas were free from trip hazards and that noticeboards held relevant, up-to-date information.
- The equipment library at Queen's Hospital ensured sufficient, well-maintained equipment was available. There was adequate equipment on the wards and this was appropriately checked and cleaned regularly.
- Ward resuscitation trolleys were checked on a daily basis and staff signed to confirm that all equipment was present.

Medicines

- Pharmacy technicians visited the wards daily to support the management of patient medicines and stock control.
- Patients' own medicines were stored on the ward and re-issued on discharge to prevent delays.

- Intravenous fluids in the wards and theatres were stored in locked cupboards. Entry to the medication rooms was by swipe card only.
- Pharmacy stock in theatre was kept in locked cupboards, also accessible by a swipe card.

Nursing staffing

- Patient handovers took place at the start of each shift and were recorded on a handover sheet. We observed at handovers that all patients were discussed, including high-risk patients, potential issues and staffing levels.
- Mandatory training had been identified for all staff groups. Evidence seen during our inspection demonstrated that all surgical areas scored above 90% compliant for staff completing mandatory training.
- Ward sisters were responsible for ensuring staffing levels were safe. Low staffing levels and sickness were reported to the matron which was covered by bank staff, overtime or agency staff was employed to cover. Agency staff were inducted to the ward and given a ward tour to ensure they were familiar with the environment.
- We noted that, during the first quarter of the year, to ensure appropriate staffing levels in trauma orthopaedics, a high number of agency staff had been employed. Evidence provided during our inspection demonstrated that there was a correlation between high agency usage and a marked increase in patient falls, which reduced once agency usage decreased.
- Staffing levels were regularly reviewed to ensure patient needs were met. For example, the orthopaedic ward had increased its establishment by one nurse and a healthcare assistant in the afternoon to meet the needs of the patients.
- Skills mix was organised by the ward and department manager. Band 5 and 6 nurses were allocated areas to work with the support of nursing assistants.
- On one ward, there were 25 patients and the ward sister was in a supervisory role and therefore not included in the staff numbers. There were five qualified staff and two nursing assistants on duty in the morning. There were four qualified staff and two nursing assistants on duty in the afternoon and two qualified staff and one nursing assistant on night duty. Student nurses were not included in the staff numbers. These numbers were sufficient to meet patients' needs.

Surgery

- The theatre staffing establishment was five staff below the Association for Perioperative Practice recommendations. This risk was recorded on the department's risk register and staffing levels were met by bank and agency staff.
- An overseas recruitment programme had commenced which staff anticipated would address the shortfall in permanent staff in theatre and wards.
- Nursing staff on the surgical wards had not received any medical nursing update to ensure they provided appropriate care to medical patients on their ward.

Medical staffing

- Medical staff were visible on the wards reviewing, admitting and discharging patients as part of their multidisciplinary role. We saw medical staff present at staff handovers and multidisciplinary team meetings.
- There was availability of 24-hour, consultant-led care and came in if required to perform surgery. Registrars had a shift system to supply out-of-hours cover.
- Staff told us they were well supported with out-of-hours cover for weekends and nights.
- The site practitioner attended medical and surgical handovers and was alerted to any issues regarding lack of cover. Locum doctors were arranged by the consultants and operations manager.
- Staff at focus groups and on the wards told us that medical outliers were reviewed by the medicine team daily. However, we were also told that some medical patients were not reviewed by the medical teams.

Records

- Care plans and care pathways were in place with individual risk assessments for each patient.
- Nursing care records were kept at the end of the patient's bed and were completed appropriately.
- Care plans were stored on the computerised system.
- The patient records we looked at included a record of discussions that had taken place with patient and relative.

Consent and Deprivation of Liberty Safeguards

- Patients told us they were fully informed about their operation before signing the consent form. They had been told how long they should be in hospital and any risks to having the operation.

- Staff had attended training in deprivation of liberty and safeguarding. Information provided during our inspection showed that overall above 90% of staff had attended safeguarding training.
- Nursing staff we spoke with were competent in mental capacity issues through training and information booklets.

Safeguarding

- The matron told us that staff were encouraged to report safeguarding concerns. Staff we spoke with told us that they reported their concerns during multidisciplinary team meetings and raised a safeguarding alert when necessary.

Mandatory training

- Mandatory training was overseen by the ward sisters and they had a responsibility to report their data to the matron at matrons ward rounds.
- Staff told us they had sufficient time to complete e-learning or attend their mandatory training.
- Mandatory training was recorded at 92% compliant on Ward 19 and in theatre.

Management of deteriorating patients

- Modified early warning system documentation ensured timely escalation of issues by nursing and medical staff to the specialist outreach team. This assessment was in use to identify the acutely ill patient.

Are surgery services effective?

Good



Surgical staff worked within multidisciplinary teams to ensure patients received the best care available. Patients told us they were treated with respect. The enhanced recovery programme for knee and hip surgery was in place which reduced the length of stay for patients. Staff were suitably trained and supported by the senior staff and ward sisters.

Evidence-based care and treatment

- The trust was registered with the National Joint Registry and submitted data on all hip, shoulder, elbow and knee replacement operations, which was then compared with other trusts nationally.

Surgery

- Data showed that the need for revision of a knee or a hip replacement was significantly less than the national average.
- Patient Reported Outcome Measures (PROMs) questionnaires were completed for all hip or knee replacements, varicose vein surgery, or groin hernia surgery. This information was used to measure the trust's performance. The PROMs performance dashboard we saw during our inspection showed that the trust performed well across all aspects of the dashboard. Patients completed a questionnaire before and after their operations to assess the improvement in their health and quality of life.
- Policies were based on National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines. This included care being provided in line with NICE CG50 for acutely ill patients and CG83 for rehabilitation after critical illness.
- We saw evidence that staff adhered to local policies and procedures such as complaints and patient risk assessments being completed on admission.
- Ward audits took place and monthly data results were displayed on the noticeboards. The senior ward sisters took responsibility for ensuring audits were completed and the findings were discussed with the matrons at managers' meetings.

Pain relief

- Pain management was part of the surgical care pathway. It included the use of specific pain tools for some patients. The Abbey Pain Scale was a tool used to support patients on the dementia care pathway.
- Patients were given pre-physiotherapy pain relief and its effectiveness was monitored.
- Requests for analgesia were managed appropriately. For example, we saw that a request for pain relief had been noted on a comfort round and the medication had been offered within an acceptable timescale.
- Assessments for post-operative pain relief were considered at pre-admission clinics.
- We were told there was no dedicated pain team; the outreach team and anaesthetic team were contacted to address individual patient pain issues.

Nutrition and hydration

- We saw that nutritional risk assessments were recorded. Some patients had been assessed to have their fluid intake and output recorded and monitored.

- Every two hours staff undertook comfort rounds during which general observations, fluid and food intake and pain management were all considered and all interventions were recorded.
- Patients had access to a call bell and they told us that the staff responded in a timely way. Patients told us they would recommend the hospital and they felt safe.

Patient outcomes

- The trust's surgical readmission rate was among the lowest nationally. Data showed that there was 'no risk' to patients being readmitted following elective or emergency surgery.
- The enhanced recovery programme which aims to reduce the length of stay for each patient where possible was in place. We saw that, on the orthopaedic ward, the length of patient stay for an enhanced recovery programme knee replacement had been reduced from six days to three days. This was not always achieved when these patients were not nursed on the orthopaedic ward due to medical outliers being placed in these beds.
- Ward meetings were held to review the results of the ward assurance tool and to discuss ways to improve the scores. The ward assurance tool measured patient care relating to observations, pain, continence, infection, environment and assessments including venous thromboembolism (VTEs or blood clots). It also measured manual handling, tissue viability, falls risk, nutrition, discharge, and resuscitation equipment and medication storage. In February 2014 the ward assurance for the surgical division scored 95.1% overall.
- Participation and performance in national audit was evident. The trust was part of the national PROMs programme, joint registry and fractured neck of femur database. The fractured neck of femur audit results were within expectations.
- The National Bowel Cancer Audit aims to improve the quality of care and survival of patients with bowel cancer, and meets the requirements as set out in the NHS cancer plan, NICE guidelines and the report of the Bristol Royal Infirmary inquiry. Information in the audit includes audit participation by NHS trusts and data completeness for key fields, measures about the process of care given to patients and information about care outcomes and treatment. The trust's performance for two of the five National Bowel Cancer Audit

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indicators were better than expected and the other two were within expectations with only one indicator, the reporting of CT scans being worse than expected at 66%, the national average was 88%.

- Hip fracture audit data showed that the number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database showed no evidence of risk.
- Data showed no evidence of risk regarding emergency readmissions. The trust was continuing to focus on improving discharge planning, engaging the multidisciplinary team to ensure that patients were discharged safely when they are medically fit and linking this with their expected date of discharge.

Competent staff

- Staff were encouraged to develop professionally – for example, link nurses attended study days, staff had been funded to complete degree courses.
- Annual appraisals at which staff's performance was assessed were completed for the majority of staff. The NHS Staff Survey 2013 showed results to be within expectations.
- We were told that the doctors met weekly at the education centre for training and the orthopaedic nurses had been invited to join this training for their personal development.
- Revalidation and clinician outcomes were assessed and monitored by the deanery.

Multidisciplinary working

- We found that multidisciplinary teams were working effectively in the trust. We observed that the consultant, occupational therapists, physiotherapist and social workers supported the ward nurses and patients to ensure patients received appropriate care in a timely manner.
- Multidisciplinary meetings were held daily, seven days a week. Staff used the meetings to discuss patients, including post-operative progress, mobility, and plans for discharge.
- Specialist surgical nurses worked with the general surgery on call team to support junior doctors, ward staff and patients.
- Multi-condition alerts were raised appropriately on a patient's admission. This ensured that other specialist services were involved to support a patient's wellbeing.
- The multidisciplinary team worked with the ward staff to promote early safe discharge of patients.

- Transfers between sites were arranged to rehabilitation wards at other sites. Handover of patients between wards was organised by the nursing staff.

Seven-day services

- The critical care outreach team, medical and surgical staff were available out of core hours.
- Consultants were present out of hours when required to attend by the registrar's discretion. Daily wards rounds were arranged for all patients. New patients were seen at weekends when necessary.
- Out-of-hours imaging, pharmacy and physiotherapy were available.

Are surgery services caring?

Good



Patients told us they felt well cared for and staff were attentive to them. Protected meal times and visiting hours were advertised at the ward entrance. Comfort rounds were completed to ensure that they were being well cared for and their needs met. Clinical nurse specialists were available in some specialities.

The NHS Friends and Family Test for surgery generally scored above 85%. Results were displayed on the quality boards at the ward entrance. People told us they were happy with the care and would recommend the hospital to their friends and family.

Compassionate care

- All 28 patients and eight relatives we spoke with were positive about the caring, friendly staff. We saw staff speaking with patients to alleviate their fears.
- Comfort rounds undertaken every two hours provided an opportunity for nurses to enhance patient care, involve patients and improve communication. Comfort rounds highlighting and providing evidence of patient pain relief effectiveness, oral care, and pressure area care, bed-side charting was up to date, drinks were at hand, the bedside was free from clutter and the patient was receiving the care prescribed in the nursing and multi-professional care pathway.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. We observed call bells to be answered within reasonable timescales.

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- Patients we spoke with told us: “The staff have been very kind. They look after me well” and “they come to me reasonably quickly when I call them; they are very busy but I am happy with the care I have received”.
- We saw doctors introduce themselves to patients and relatives, and saw that curtains were drawn to maintain patient dignity.
- Visiting times were displayed outside each ward; however, flexible visiting was arranged depending on the patient’s needs.
- Protected meal times were advertised and some people did support their relatives with their meals. Patients told us that they thought the meals were good and they had a choice.
- We saw that nutritional risk assessments were recorded. Some patients had been assessed to have their fluid intake and output recorded and monitored.
- The Keogh mock review in January 2014 identified the information on noticeboards did not show whether the ward/department was improving or deteriorating in its performance against its KPIs. The Friends and Family Test results were cited as needing further clarification to be meaningful. It was also not clear from the boards what action the ward was taking where results were below target.
- At this inspection the NHS Friends and Family Test scores showed that the trust had performed above the England averages in four months from October 2013, with the majority of respondents stating they would recommend the hospital to friends and relatives. The ward’s scores were displayed on the quality board for surgical wards. For example, Ward 20 scored 88 for March 2014 and 94 for in-patient experience.
- The CQC Adult Inpatient Survey 2012, looking at areas such as delayed discharges, reported that the trust performance was similar to other trusts.
- We observed that there was a wealth of ‘thank you’ cards displayed around the wards and a patient feedback ‘word cloud’ had been designed to display on each ward’s quality board.
- We observed caring attitudes of staff towards patients, and patients we spoke with confirmed this.
- The 2013 Cancer Patient Experience Survey that seeks patients’ feedback reported that the trust was in the top 20% nationally for 18 questions. (The survey asks questions such as were patients treated with dignity, and if they were given appropriate levels of privacy.)

Patient understanding and involvement

- Patients told us that the ward sisters were visible and available to speak with. Patients said they felt involved in their care.
- The name of the patient’s consultant and discreet information was written above the patient’s bed to ensure their individual needs were met.
- Patients told us that communication with hospital staff was good and their questions had been clearly answered.
- The endoscopy user group meetings attended by patients were held by specialist nurses to enhance the patient experience.

Emotional support

- We saw patients being reassured by the nursing staff and heard explanations of their care being given. We saw information/advice leaflets and posters around the wards.
- We were told that staff were encouraged to emotionally support patients when they were distressed or confused.

Are surgery services responsive?

Good



Patients were cared for in single sex wards and bays to provide privacy and dignity. We observed that the service was responsive to the needs of people with a learning disability and dementia. We saw that discharge planning commenced when the patient was admitted. A discharge date was identified and planned for by the multidisciplinary team. Minutes from ward meetings showed us that patient histories were discussed, as well as learning from complaints.

Service planning and delivery to meet the needs of local people

- The service dealt with busy times through a review of the service at capacity meetings which were held several times a day. The service was aware of their busier time and pre-planned an increase in staff to accommodate this.
- Capacity bed meetings were held daily to monitor the bed availability in the hospital; they reviewed planned discharge data to assess future bed availability.

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- There were clinical nurse specialists in some areas such as urology, oncology, and breast care. The gynaecology and urology services had advanced nurse practitioners.
- The orthopaedic team performed a high number of hip and knee replacements in response to the needs of the local population.
- Wards were organised, including single-sex accommodation, to promote privacy and dignity.
- A 'reminiscence pod' (pop-up reminiscence rooms that provide a therapeutic and calming environment) had been purchased in some wards to be used as an activity tool. The pods are designed to help relieve boredom, work as a meaningful 'fun' activity and build better care bonds between staff and their residents, helping to raise care standards.
- Patients were assessed for anxiety and depression and referred to the psychiatric crisis team for review if necessary.
- Counselling services were available for all patients including oncology. The Royal National Institute of Blind People supported ophthalmology referrals.

Access and flow

- The trust's bed occupancy between October and December 2013 was 83.9%; this is lower than the national average.
- Admission processes were either directly on to the ward from the GP via the surgical assessment unit, elective admissions on to the ward or through accident and emergency.
- To avoid appointment cancellations, the trust developed a forward predictor tool which gave an early indication of where there could be pressures in the system relating to elective bed availability.
- The trust cancelled 50 operations in the last quarter, January to March 2014. This number was similar to the number cancelled by other similar trusts. The reasons for operations being cancelled varied from 'no bed available', 'list running late', 'emergency case took preference', to 'surgeon not available'.
- The backlog of endoscopy patients, due to a consultant leaving, was being addressed by additional Saturday and backfilled lists. This issue had been logged on the risk register due to an impact of a delay for patients on the cancer pathway and compliance with the Joint Advisory Group (JAG) accreditation.
- The pre-assessment unit saw, on average, 240 patients a week. The unit was split into several areas with the

waiting area in a corridor, resulting in a lack of privacy, confidentiality, and health and safety issues. These issues had been raised as a concern and placed on the risk register. As yet no action had been taken.

Discharge planning

- The service took a proactive approach to discharge planning, starting this process at the patient's admission. The orthopaedic wards had a designated discharge nurse based on the ward to facilitate timely discharges. The service also worked closely with local GPs to support their patient flow and ensure support on discharge.
- To avoid delayed discharged due to patients awaiting medications to take home with them, staff regularly checked what was required. When a patient's own medicines were on the ward they were locked in their bedside cabinet ready for discharge.
- We saw that self-medication care pathways were in place and some people had been risk assessed as suitable to administer their own medication while on the ward. They held a key to their personal medicine locker. Staff checked during comfort rounds to ensure they had taken their medication.
- Medical outliers impacted on the enhanced recovery programme in orthopaedics as orthopaedic patients were frequently moved to other wards sometimes disrupting their shortened stay in the hospital.
- Patient information leaflets were available for patients being discharged to alleviate any fears they may have and they were encouraged to contact the ward if they had any concerns once home.

Meeting people's individual needs

- Nurse and healthcare assistant 'dementia champions' were available on each ward to support patients with dementia and initiate the most appropriate care for them.
- We saw a learning disability patient with their own 'health passport'. This document held all the relevant individual patient health details and personal choices, for use when they were unable to tell medical and nursing staff themselves.
- A translation telephone service was available so that patients who did not speak English as a first language were able to communicate with staff.

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- Patient information boards were sited around the hospital. These displayed a range of information including the latest NHS Friends and Family Test results, Patient Advice and Liaison Service (Pals) details, visiting hours and latest trust news.
- Volunteers were sited around the hospital to signpost patients to the correct ward or department.
- Care pathways were instigated for all new admissions to support their needs and keep them safe. The pathways alerted staff to complete risk assessments and request certain equipment or support to aid their comfort and recovery.
- Patients' individual needs and preferences were noted in their care plan and at all times confidentiality issues were considered.
- Patients with multiple, 'complex' health needs were supported by the outreach team of specialised nurses and doctors. Staff told us, for example, that a patient may have been admitted with a fracture but also have other health conditions which they have reviewed while in hospital.
- There was a relative's room or day room available on the wards, used for private conversations when necessary.
- Patients had access to a call bell and they told us that the staff responded in a timely way. Patients told us they would recommend the hospital and they felt safe.
- To reduce the number of falls reported on the wards, several initiatives had been introduced including sensor mats, one-to-one care when necessary and the orthopaedic wards had purchased non-slip footwear for patients.
- Protected meal times were advertised, and some people did support their relatives with their meals. Patients told us that they thought the meals were good and they had a choice.
- Staff attended meetings to share experiences and make requests for change. Changes made included mobile trolleys for staff to write up care records in patient areas.
- Complaints were handled in line with the trust's complaints policy. This included responding to complaints within 28 days. We were not provided with information regarding how many complaints were responded to within this timescale.
- We were told that patient and relative communication at ward level had improved and, as a result, complaints were being reduced as issues were being addressed informally.
- To improve complaints handling, changes to the process had recently been made. The ward sisters were given a timescale to respond to the initial complaint and an acknowledgement letter was sent to the complainant. Management then decided, if necessary, who else would need to be involved and a new timescale was then set to address the outstanding issues.
- Complaint posters were visible around the wards along with Patient Advice and Liaison Service leaflets.
- The Patient Advice and Liaison Service offered confidential advice, support and information on health-related matters. They provided a point of contact for patients, their families and their careers.

Are surgery services well-led?

Requires improvement



There was ward level leadership provided by the senior sisters who led enthusiastic staff. Staff told us they had not seen or rarely saw the executive team and not all wards had seen board members.

Medical outliers in surgical beds impacted on the service overall and had a negative impact on staff morale. Incidents and risks were followed up with an action plan to address the issue. Staff felt that the executive were slow to respond to the action plans and close them off. The staff told us that areas of the trust worked in silos so staff didn't always know what was happening in another part of the hospital.

Learning from complaints and concerns

- We were told in the orthopaedic wards that they had introduced the Listening into Action (LiA)[™] strategy (a comprehensive, outcome-oriented approach to engage all the right people in quality outcomes) to improve the patient experience.
- Staff on the orthopaedic ward told us they attended LiA meetings to share experiences and make requests for change. We saw one of the suggested changes in place; a mobile writing trolley. These trolleys allowed staff to write up care records in patient areas therefore increasing patient observation and staff visibility.

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Vision and strategy for this service

- We were told that further action was required to meet all the recommendations highlighted in the Keogh Mortality Review report.
- The trust had a quality strategy, but not all ward staff were aware of this.
- Staff told us their clinical areas had been inspected several times over the previous year. However, they were seeing the benefits of these inspections and morale was improving.
- There was no evidence that there was a systematic approach in place for ensuring collection, reporting and action on information on the quality of services.
- Patients and staff felt that the trust board needed to improve communication with them.

Governance, risk management and quality measurement

- We saw information boards containing governance data to inform patients, staff and visitors of the clinical audit results month on month.
- The trust had submitted 15 abuse notifications from March 2013 to February 2014. Eight occurred within inpatient areas, all of which were under medical specialities. One incident that was listed as 'unknown' and categorised as 'patient abuse', by staff/third party, related to an ongoing issue with inappropriate medical outliers. Two incidents were categorised as disruptive, aggressive behaviour, including patient-to-patient, whereas the majority of all incidents were categorised as 'patient abuse', by staff/third party. There was no evidence that action had been taken to address the risks associated with medical outliers.
- The divisional risk register included an action plan for identified risks, with timescales for completion. Staff told us that, at times, the progress to resolve identified risks felt slow and ineffective.
- Staff told us that the impact on surgical patients as a result of significant numbers of medical outliers had not been identified as a risk on the risk register. Therefore, no action had been taken to resolve the issue.

Leadership of service

- There were identified lead professionals in all areas, including a supervisory band 7 ward sister on all wards who provided local leadership, an identified clinical lead for each of the surgical specialities and a divisional lead.

- The senior sisters, lead nurse and matrons were visible in the ward areas supporting staff, ensuring training was completed and undertaking audits.
- There was evidence that medical leadership was in transition due to vacancies of the surgical director and clinical lead posts.
- Ward staff reported a 'disconnect' between middle management and themselves which required addressing to be an effective team.
- Nurses told us they regularly saw the director of nursing who was enthusiastic and supportive, and that the CEO occasionally visited the wards, but they were unsure who the other managers were.
- Board to ward visits had commenced but, at the time of our inspection, not all wards had been visited.
- Staff told us that board executives and non-executive members do not make themselves available on a regular basis to see the quality of services for themselves.
- In the General Medical Council's National Training Survey 2013, trauma and orthopaedic surgery were performing 'worse than expected' in two areas; 'overall satisfaction' and 'study leave'.

Culture within the service

- The trust supports the Nursing Times Speak Out Safely campaign, which encourages any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.
- Staff we spoke with told us that quality and patient experience was a priority and strong team work resulted in a better patient experience.
- Staff were encouraged to share good practice and support each other when things went wrong.
- Staff felt that some areas worked in silos and were not being effective in moving forward and improving the service.
- Resolutions of complaints were not always fed back to staff on the wards.

Public and staff engagement

- Patient feedback was positive. Patients we spoke with told us they felt safe and well looked after.
- A staff magazine was distributed, updating staff on current issues. However, staff told us they felt that, although communication had improved in recent times, they didn't always know what was going on, or changes that were being planned in the trust.







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Innovation, improvement and sustainability

- To celebrate the outstanding achievements of hard-working individuals and teams across the trust, staff attended the annual PRIDE awards ceremony (celebrating the trust's vision of Passion, Responsibility,

Innovation, Drive and Empowerment). One award went to the enhanced recovery pathway in orthopaedics. A staff award had been given to the surgical nurse practitioner role in recognition for their work in supporting wards and junior doctors.

Critical care

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

Information about the service

The critical care unit (CCU) at the Queen's Hospital, Burton Upon Trent has eight beds. It consists of two geographically separate areas the intensive care unit (ICU) with four intensive care beds, and a separate high dependency unit (HDU) with four high dependency care beds. If capacity is exceeded, the ICU can use another two beds for level 3 care. Patients who have a potentially life-threatening illness can be admitted to an intensive care bed; they receive one-to-one nursing care, or those patients too ill to be cared for on a general ward can be admitted to a high dependency bed. The unit had around 500 patients admitted per year. From January to March 2014 there were 136 patients admitted.

The hospital had a combined critical care outreach and acute pain team of four nurses they assisted with the management of critically ill patients on wards and departments and supported pain management across the hospital. The critical care outreach and acute pain team work between the hours of 08.30 and 19.00 during the week. At the weekend, they provide cover between 08.30 and 16.30. Out-of-hours cover is then provided by clinical site practitioners. A modified early warning system (MEWS) is used to manage the deteriorating patient, promoting early detection and intervention.

We spoke with one patient, four relatives, 18 staff including, nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment, we also reviewed care records. We received

comments from our listening events, and from people who contacted us to tell us about their experiences. Before and during our inspection we reviewed performance information from, and about, the trust.

Critical care

Summary of findings

Patient mortality outcomes had improved following the Keogh review and were now within the statistically expected limits when compared to similar units. Staff were appropriately qualified and had access to supervision and appraisals. The unit had recently recruited new staff, but pressure on staffing levels remained and there were limited resources for accessing extra staff when capacity in ICU increased. The resuscitation department, part of the critical care unit, was not staffed appropriately in line with the Resuscitation Council (UK) guidelines, which impacted on the amount of training provided across the hospital.

There was a multi-disciplinary approach to the delivery of care and treatment to ensure the patients' needs were met. We saw that people's needs were assessed, care and treatment was planned and delivered utilising evidenced based practice to meet their individual needs. The ICU does not have a side room facility and cannot isolate patients with. This issue has been recorded on the critical care risk register but no action to address this issue had been taken. There was no specific strategy for developing the ICU, development was led by the corporate vision. There was strong nursing and medical leadership at a local level with staff feeling engaged.

Are critical care services safe?

Requires improvement



The patient and relatives that we spoke with praised the nursing and medical staff. Patients in vulnerable circumstances were well supported and staff put the patient at the centre of their care. Patient mortality outcomes were within the expected limits when compared to similar unit. The nursing establishment had increased as new staff had been recruited, there was pressure on staffing levels and limited resources for accessing extra staff when capacity in ICU increased. The ICU does not have a side room facility and cannot isolate patients with infections or those patients needing reverse barrier nursing. This issue had been recorded on the critical care risk register.

Incidents

- The Intensive Care National Audit and Research Centre (ICNARC) data for ICU in 2012 identified a higher than expected mortality trend in benchmarking data. The issue was escalated for further evaluation and reviewed externally.
- The trust acted on the review recommendations and the latest ICNARC data for January to June 2013 release showed that mortality data is back within statistically expected limits.
- The external review resulted in learning and facilitated change which included clinicians visiting other ICUs within the network, resulting in changes to local practices. These changes included the timing and structure of handovers between shifts. Consultants now have more involvement in returning data to ICNARC with regard to initial diagnosis.
- Mortality and morbidity meetings were held monthly and all deaths on the ICU were reviewed and the findings reported to the Mortality Assurance Review Group.
- Staff we spoke with felt that the changes following the external review of mortality and morbidity have been a driver for improvement.

Safety Thermometer

- The ward assurance performance dashboard and Safety Thermometer, local improvement tool for measuring, monitoring and analysing patient harms and 'harm free'

Critical care

care, results and information were displayed on a noticeboard in the corridor outside of the ICU. The information was accessible for relatives and members of the public to see.

- The ITU had developed and implemented an action plan to facilitate changes in practice in response to the ITU not achieving above 95%, the level set by the trust for all areas to achieve on the assurance performance dashboard. This had resulted in improved compliance rates in March 2014; ICU achieved an overall compliance score of 98.2%.

Cleanliness, infection control and hygiene

- Monthly infection control audits were undertaken on the ICU by the infection control link nurse team. The results of the infection control audits were displayed for the public in the corridor outside the ICU.
- The staff had access to the infection prevention and control link group meeting minutes which display all results and collated evidence. We were told that the unit had no cases of methicillin resistant staphylococcus aureus (MRSA), methicillin sensitive staphylococcus aureus (MSSA), Escherichia coli (E. coli) and Clostridium difficile (C. difficile) in the past four months.
- All staff we saw during the inspection adhered to the 'bare below elbows' policy, as well as using appropriate protective equipment, such as gloves and aprons to carry out procedures and personal care activities.
- The ICU was participating in a hand hygiene trial. All hand gel dispensers in patient bays had a sensor that logged how many times hand hygiene was undertaken.
- Results for the hand hygiene audit recorded on the ward commendation scheme from January 2014 showed a compliance score of 93%. The results of the same audit for February and March 2014 were not recorded on the scheme; it was therefore not possible to make a comparison to monitor any changes in the compliance score.
- The cleaning schedule for the unit was accessible for all to see.
- The ICU and HDU were visibly clean and tidy, cleaning services were provided in house by the trust.
- The ICU and HDU did not have a side room facility and cannot isolate patients with infections. This issue had been recorded on the critical care risk register and was being reviewed on an ongoing basis. However, to date no action had been taken to resolve this issue.

- The only option that staff had to barrier nurse infectious patients in the main ICU area was to keep the adjacent bed to the infectious patient empty, but if another patient was admitted the bed was used.
- We were told that staff did not display the required infection control signs or codes; the rationale for this was concern about repercussions from relatives of the patients and confidentiality breaches.
- The sluice was small, cluttered and had boxes stored on the floor which could impede effective cleaning of the area, as well as compromise the cleanliness of equipment stored there.

Environment and equipment

- The resuscitation trolley was checked daily and we noted that a signature was recorded after each check.
- We were told that the trust takes part in the National Cardiac Arrest Audit, a clinical audit for in-hospital cardiac arrests. We were not provided with the trust's results for this audit and were therefore unable to assess if any areas for improvement had been identified and action taken.
- The ICU had a designated technician who manages the equipment, and is responsible for the induction and training of doctors and nurses, as well as training for new equipment.
- All equipment we checked was found to be in date for portable appliance testing (PAT) training or external company servicing.
- A new medical equipment policy had recently been introduced. There was a rolling equipment replacement programme in place for the ICU for the next five years, in line with the rest of the trust.

Medicines

- All medicine cupboards were noted to be locked and secure.
- Controlled drugs checks were completed at least daily, sometimes twice a day; there was no stipulation on the checking sheet to confirm the required frequency.
- The drug fridges were locked, however, daily temperature checks were not completed and the records showed several gaps.
- The critical care pharmacist attended the unit daily to review each patient and their medications to ensure that they were suitable and within prescribing guidelines.

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- Drugs administered using the aseptic non-touch technique were given using designated trays specifically for each patient.

Records

- The ICU used an electronic patient record system care plan. The system followed a systematic approach which included a treatment plan, physiological assessment, resuscitation status, as well as regular updates of the nursing care plan throughout each 24-hour period.
- Specific risk assessments were also recorded on the hospital information support system, such as skin assessment bundle, venous thromboembolism (VTE or blood clots), falls, as well as manual handling risk.
- The unit had an expectation that relatives of patients admitted to ICU were greeted within 15 minutes of arrival and spoken to within two hours of admission. The electronic patient record was updated when this action had been completed. We reviewed this on one set of patient electronic records and found that it had been completed within the agreed timescale.
- We reviewed one observation chart for a ventilated patient who was receiving one-to-one nursing care. The staff member showed awareness of guidelines and protocols and was able to demonstrate knowledge about tracheostomy and ventilator care bundles.
- There was a structured approach at staff handover and from feedback in the main multidisciplinary ward round, the focus centred on management of each patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an adult safeguarding policy that staff could access on the intranet.
- We were told staff knew how to escalate and refer for issues pertaining to the Mental Capacity Act (2005) and its associated deprivation of liberty safeguards.
- For patients who needed to be reviewed, a consultant and nurse examined the patient after 24 hours to assess whether deprivation of liberty safeguards were necessary.
- Mandatory training for safeguarding adults had been undertaken by the majority of staff and was recorded on the ICU training matrix.

Mandatory training

- The ICU had a structured critical care mandatory training programme that ran monthly, with dates scheduled up until December 2014. The programme comprised of specific core skills required within the critical care environment.
- Mentorship training was provided and all band 5 staff nurses were required to undertake a teaching/mentorship course.
- Compliance with mandatory training for ICU staff was recorded as being 94% in February 2014. We spoke with the lead nurse for education who explained how students and new members of staff were allocated mentors with whom they worked, and this allowed their development and learning to be monitored and supported.
- Newly appointed staff to the unit had a period of between four to six weeks supernumerary status. There was a critical care competency document that newly appointed staff nurses have up to one year to complete, signed off by their mentor.
- The resuscitation department, which is part of the CCU, had raised issues including the staffing levels of resuscitation officers for a number of years, Resuscitation Council (UK) guidelines recommend for the trust size an establishment of 3.5 WTE; we were told that staffing levels have been as low as 1.5 WTE, and there were currently two WTE. It was reported that staffing levels were impacting on the quantity of training and teaching that the resuscitation department were able to provide as well as other duties within the role.

Management of deteriorating patients

- There was a combined critical care outreach and acute pain team of four nurses that covered the hospital and provided a service between 08.30 and 19.00. Weekend cover was provided between 08.30 and 16.30. Outside these hours, the service was provided by the clinical site practitioners.
- The trust has implemented the modified early warning score (MEWS) for any patient deemed at risk of deterioration; the system standardises the assessment of acute illness severity, and indicates when senior staff should be contacted. Referrals were made predominately to the admitting team and the outreach critical care team would liaise with the critical care consultant providing cover.

Critical care

- There was no face-to-face handover of patients monitored on the modified early warning system (MEWS) between the critical care outreach team and the clinical site practitioners.

Nursing staffing

- The nursing establishment for the ICU was 39.94 whole time equivalent (WTE), there were also two nursing assistants at 1.8 WTE. Currently there were 18.4 WTE registered nurses with a post-registration critical care course, which is approximately 46% of the total nursing establishment. This is below the 50% recommended by the core standards for intensive care units (2013).
- However, a further two staff nurses will complete their post-registration critical care course in July 2014.
- We were told that staff recruitment had been an ongoing issue, recorded on the critical care register. The ICU had recently recruited new staff but they had not yet started on the unit. We were told by senior staff that there would be pressure on staffing levels on the May 2014 rota, due to staff leaving and new staff starting.
- On 25 April 2014, the unit was extremely busy admitting new patients. Due to staff sickness. We observed one member of staff caring for two level 3 patients. This was not an isolated incident as later in the day we observed a second nurse on the same shift caring for two level 3 patients. These patients required a high level of care and national standards state one nurse should care for only one level 3 patients, Therefore this staffing arrangement were not in line with the core standards for intensive care units and placed the patients at risk of not receiving appropriate care.
- There was a standardised handover procedure at shift change for all nursing staff. After this staff were allocated to a specific patient and received handover at the bedside for each individual patient they would be caring for. Shift leaders' recorded information on a standardised sheet over a 24-hour period, including daily treatment plans from the multidisciplinary ward round.
- The ICU did not routinely use agency staff on a regular basis. Currently a 'bank system' was used which involved ICU staff doing bank shifts.
- There was also a 'banked hours' system in place, when ICU activity allows, staff were given 'on call' duties. The on-call hours were paid back when the workload of the unit increased. This system allows the ICU flexibility to admit patients when the unit is busy.

- The ICU used bank staff from their own nursing establishment to cover busy periods. The unit had recently recruited up to establishment, although not all nurses were yet in post.

Medical staffing

- The consultant-to-patient ratio on the ICU was 1:8, which was in line with national guidance.
- A consultant intensivist leads the multidisciplinary clinical ward round, Monday to Sunday.
- There were six consultants: each week there was an identified consultant who covered 24 hours per day;
- A second consultant covered mornings and part of the afternoons to allow for support of the outreach team in the morning and to see referrals.
- In response to the Keogh review some changes to medical staffing had been implemented. These included the introduction of a standardised handover procedure for shift changes between medical staff, a consultant intensivist leading the multidisciplinary clinical ward round.

Major incident awareness and training

- There were major incident planning processes and systems in place, such as regular tests of the system including local communication exercises

Are critical care services effective?

Good



There was a multidisciplinary approach to the delivery of care and treatment to ensure the patients' needs were met. We saw that people's needs were assessed and care and treatment was planned and delivered using evidenced-based practice. The unit actively participated in clinical audit.

Staff were appropriately qualified and had been assessed through supervision and appraisals.

Evidence-based care and treatment

- We saw evidence that ICNARC data was reviewed and used to make improvements for patients using the service.
- Care bundles were used including those for tracheostomy and ventilation.

Critical care

- The unit participated in a range of clinical audits including monitoring of compliance with National Institute for Health and Clinical Excellence (NICE) and other professional guidelines.

Nutrition and hydration

- The records that we reviewed both electronic and those at the patient's bedside, showed that those patients unable to take food orally were assessed for their nutritional needs.
- Patients had a completed nutritional assessment, using the malnutrition universal screening tool.
- Nurses referred patients to the dietician following a feeding protocol and nutritional assessment score. Patients received nutritional support either enteral (through the stomach) or parenteral (through bloodstream) to ensure adequate nutrition to aid rehabilitation.
- When possible patients were fed orally. We spoke with a patient who had had a swallowing assessment and was then able to eat normally.
- The ICU observations charts recorded intravenous infusions and parenteral nutrition and the patients' fluid balance, enabling staff to monitor the patients' nutrition and hydration status.

Patient outcomes

- The mortality ratio was 1:14, which was within statistically expected limits.
- The trust was performing the same or better than similar units for outcomes such as discharges, length of stay and infection rates according to the most recent ICNARC data.
- Mortality meetings were held monthly and all deaths on the ICU were reviewed and the findings reported to the Mortality Assurance Review Group.

Competent staff

- Annual appraisals were completed between April and June 2014 for all staff.
- Appraisals were completed within mentor groups, led by the band 6 sister responsible for the staff in the group.
- The current completion rate for appraisals for nurses up to February 2014 in critical care was 80%. However, new staff had been appointed and therefore had not completed the appraisal process.

- Medical staff we spoke with confirmed that they were up to date with their appraisals. Electronic reminders were sent out when appraisals were due and a letter from the medical director was sent once a doctor's appraisal was overdue.
- The resuscitation officers, who were part of the CCU, did not have the required support from the paediatric department to ensure there were enough trainers to provide the number of Paediatric Immediate Life Support (PILS) courses necessary to meet the trust's training requirements.

Multidisciplinary working

- We were told that the ICU had changed the format of how the multidisciplinary ward round was conducted. The changes occurred over the last year, and feedback from staff we spoke with was positive.
- The main ward round took place at 11.00 led by the consultant and attended by junior medical staff, the sister in charge and the critical care pharmacist and other members of the multidisciplinary team, including physiotherapy, dietician and microbiology participated.
- The outreach team also attended the daily ICU multidisciplinary team ward round. This aided continuity of information, as well as liaising about potential patients to be discharged from the ICU to the ward and creating beds for unwell patients on the wards.
- Patients discharged from ICU were supported by the outreach team; they monitored the discharged patient on the modified early warning score for 24 hours. Those discharged at the weekend were supported by the clinical site practitioners.

Seven-day services

- Consultant cover was provided 24 hours a day. They were supported by more junior members of staff.
- The physiotherapist, dietician, microbiology and pharmacist provided a seven-day-per-week service. The critical care pharmacist is available on Saturday from 09.00 until 12.00; there was an on-call service for advice outside these hours and on Sunday.

Critical care

Are critical care services caring?

Good



Feedback from a survey on friends', relatives' and carers' experience of the CCU was positive about how patients were cared for. We observed that staff treated relatives and patients with dignity and respect.

Staff were kind and showed a caring and compassionate attitude, building positive relationships with the patient, family and friends.

Compassionate care

- Throughout our inspection, we witnessed patients being treated with care, understanding and respect. We observed both the nursing and medical staff engaging with patients who were able to understand them, ensuring as far as possible participation and engagement.
- Relatives we spoke with praised the care and devotion shown to patients. They told us "care and information, superb". They were told what was happening to their relative, they felt involved.
- From November 2013 to December 2013 the CCU undertook a survey of friends, relatives and carers on their experience of the CCU. The results of the survey concluded that, overall, the outcome of the survey was positive. It also identified that there were recommendations for areas of change that would be addressed.

Patient understanding and involvement

- One of the four patients we spoke with felt that generally care was good and that they were treated with respect by most of the staff. But, they said that, occasionally "the nurses get frustrated and a bit sharp at times".
- For other patients who were ventilated and therefore not conscious, we were told that where possible, their views and preferences were taken into account and the staff involved their families.

Emotional support

- The ICU used a guide for patients and relatives who have been admitted to intensive care, a STEPS booklet. It gave advice and information about experiences and patients' recovery.

- Following admission to the unit, the relatives we spoke with had been seen by a consultant. They were able to ask questions and be kept informed about changes and progress in the patient's condition.

Are critical care services responsive?

Good



The unit took a proactive approach to managing admission and discharges to and from the ICU. The staff met the individual needs of patients and, as far as possible, facilitated relatives or carers of patients with complex needs staying with the patient.

The ICU engaged with patients, family and friends to address any complaints or concerns. They provided feedback and were willing to learn and to take action to ensure a resolution.

Service planning and delivery to meet the needs of local people

- There was a bed management and escalation policy which included that, if necessary, ICU patients would take priority to be transferred to the ward. This ensured that there was a bed available for emergency or elective admissions on the unit.
- By working with the local critical care network, the unit told us they were able to deal with capacity issues. We noted significant capacity issues while on inspection.

Access and flow

- The number of patients admitted to the ICU from January 2013 to June 2013 was 263. Of these, 77 were planned elective or scheduled surgical patients, 26 were emergency surgical admissions, and the remaining 160 patients were non-surgical patients.
- The unit had a bed occupancy rate of 96.3% which was above the national average.
- Processes for surgical patients being admitted to the ICU or HDU included liaison between the anaesthetist and the unit. Nursing staff also completed a diary of expected surgical admissions; this information was entered as soon as they were informed by the surgical team that a patient would require ICU bed post theatre.

Critical care

- We noted that from data that 20% of patients had delayed discharges of four-hours or more, between the time they were ready for discharge and time of discharge.
- Data showed that 6% of patients were discharged out-of-hours, after 17.00.

Meeting people's individual needs

- We spoke with the relative of a patient with complex needs, and they told us that the staff were supportive and that they were kept up to date with information.
- The unit's aim was, as far as possible, to facilitate relatives or carers of patients with complex needs staying with the patient. They were incorporated into the care process as they know the patient's needs.
- To meet the needs of patients or relatives who do not speak English as their first language, the ICU used a laptop to communicate and translate text.

Learning from complaints and concerns

- The ICU matron told us about the process for patients or relatives wanting to make a complaint. If the patient or relative wanted to make an informal complaint, they would speak to the shift leader.
- Informal concerns were documented in the first instance in the nursing notes. The senior sister spoke with the person concerned; this conversation and the outcome was recorded in the notes.
- If the issue or concern were not resolved satisfactorily they were directed to the Patient Advice and Liaison Service. If the issue or concern was still unresolved, the person would be advised how to make a formal complaint.
- There was no evidence of learning from complaints being shared with other divisions in the trust.

Are critical care services well-led?

Requires improvement



There was no specific strategy for developing the ICU, development was led by the corporate vision. There was identified nursing and medical leadership at a local level with staff feeling engaged. Staff were supported to develop and most staff had an appraisal and personal development plan.

The resuscitation department, part of the critical care unit was not staffed appropriately in line with the Resuscitation Council (UK) guidelines, which impacted on the amount of training provided. There had been no meetings of the resuscitation committee since 15 November 2013.

Vision and strategy for this service

- We were told that the strategy for the ICU was the corporate vision of the trust. Staff we spoke with emphasised the importance and commitment to caring for patients.

Governance, risk management and quality measurement

- The critical care unit had frameworks for monitoring the quality of its service.
- The matron and senior sister performed a monthly quality round, visiting the clinical areas to meet with relatives, as well as reviewing the nursing environment and looking at patient care. This also provided relatives with an opportunity to ask questions and give feedback.
- It was reported that the risks associated with the paediatric department not supporting the resuscitation officers to ensure there were enough trainers for the Paediatric Immediate Life Support (PILS) courses necessary for staff training were being addressed.
- The critical care unit's risk register included issues such as nurse staffing vacancies.

Leadership of service

- There was identified medical and nursing leadership on the unit. The matron and senior sister worked closely together, complementing the overall strategic management of the service as well as supporting the clinical staff on a daily basis.
- Staff were updated with events happening in the trust at staff meetings. There was a template for these meetings, the purpose being to ensure that staff were kept up to date with changes on the ICU and results from audits.
- There had been no meetings of the resuscitation committee since 15 November 2013.

Culture within the service

- Staff were positive about the quality and care that they gave to their patients.
- We observed that staff worked well together and showed respect for each other.
- There was a structured staff development within the appraisal and personal development plan that each staff member had to complete as per trust policy.

Critical care

- Staff have raised concerns about the number of nursing staff available to meet the current high patient activity levels. They felt that, although the issue was raised, there has been little response.

Public and staff engagement







- The recent critical care unit survey of friends, relatives and carers, was conducted between November 2013 to December 2013, and 16 of the 25 questionnaires distributed were returned. Most responses were positive. However, there were areas for improvement, including the need to address communication breakdown, and relatives should be encouraged to take a more active role with basic if they wished to do so.
- There were regular staff meetings where all staff could participate. Feedback was given with outcomes for ward assurance and service improvement.

- Consultants had increased involvement in returning data to ICNARC to benchmark results and the data accuracy had improved.

Innovation, improvement and sustainability

- Recent changes in the handover and the timing of the multidisciplinary ward round had enabled changes in clinical management, there was professional support for staff we saw this on the ward round and reviews of patient treatment.
- There were opportunities for staff to access professional development through post-registration courses in critical care. However, some staff felt that they did not have the opportunity to develop further within their current role. They stated the senior nurse did not look at opportunities for their development.

Maternity and family planning

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

Information about the service

In 2013, Burton Hospitals NHS Foundation Trust delivered 3,381 babies. Maternity services at the trust are provided over two sites, Queen's Hospital in Burton and Samuel Johnson Community Hospital in Lichfield. The maternity unit at Samuel Johnson is a midwifery-led unit for women who have been assessed as having a "low risk" pregnancy. The maternity unit at Queen's Hospital consists of a maternal foetal assessment unit (MFAU), an antenatal clinic, triage rooms, an antenatal ward, a labour ward with seven en-suite delivery rooms and a postnatal ward. There are two dedicated obstetric theatres adjacent to the labour ward.

We spoke with 12 women, their partners and 38 staff, including domestic staff, care assistants, midwives, nurses, doctors, consultants and senior managers. We observed care and treatment and looked at 16 care records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

We also inspected the midwife-led unit at Samuel Johnson Community Hospital, which delivers approximately 250 babies annually and is detailed in the Samuel Johnson Community Hospital report.

Summary of findings

There were systems in place to ensure that women and their babies were treated in a safe, well equipped environment by suitable numbers of qualified staff. Some areas were cluttered and some emergency medication was not stored securely; this was a trust wide issue and senior management were aware of this medication issue.

Services were planned to meet the needs of the local population. Feedback from women, commissioners and third party organisations had been used to inform the service's development strategy. We found evidence that incidents were reported, investigated and learning was shared through a variety of forums. Staff felt engaged and were supported to be innovative in order to constantly improve the service.

All the women we spoke with and their partners were very complimentary of the staff. They had felt well supported, well informed and well cared for.

Maternity and family planning

Are maternity and family planning services safe?

Good



There were systems in place to ensure that women and their babies were treated in a safe, well-equipped environment by suitable numbers of qualified staff. Consultant cover on the labour ward met national recommendations and over 95% of women consistently received one-to-one care during established labour. There was a shortage of junior doctor cover overnight on the labour ward, but due to midwife competencies, we found no evidence that this created a risk or had a negative impact on patient safety. Any adverse changes to a mother or baby's condition were escalated appropriately and staff reported they could always get a medical review day or night.

Risks to the service had been identified and were monitored regularly. There was a process for reporting incidents and any areas for learning were shared with staff. While patient areas were clean and tidy, other areas on the labour and postnatal ward were cluttered and some emergency medication was not stored securely. This was a trust-wide issue and senior management were aware of it but no action had been taken to address this.

Incidents

- There had been no maternal deaths and no never events in the year preceding our inspection. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Analysis of data from our intelligent monitoring which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations before our inspection showed that there were a lower number of perinatal deaths than expected.
- Between January 2013 and March 2013 there had been more incidents of puerperal sepsis reported than expected. CQC asked the trust to investigate and it was found that some patient notes had been incorrectly coded, which had led to misreporting.
- There was an electronic incident reporting system in place, which staff told us was easy to complete.

However, the community midwives told us they could not access the system unless they were using a trust computer. Therefore, if they were working from a GP practice or out in the community, this could lead to a delay in them reporting an incident.

- Incidents were reviewed and investigated, where necessary. Feedback from incidents was disseminated to staff on an individual basis or as a group. For example, the department held "weekly wash" meetings where incidents from the previous week were discussed to share any learning. We were told the incidents were anonymised to encourage an open and supportive culture. Staff told us they were encouraged to report incidents and felt confident doing so.
- There were a variety of forums and groups in place to discuss particular topics. For example, there was a multidisciplinary stillbirth study group and a perinatal mortality review group where individual cases were examined to determine if there were any areas for learning or improvement.
- Staff at all levels were able to provide examples of where lessons had been learned following incidents. For example, the documentation for postnatal examinations had been reviewed to ensure there was a standardised approach, and that it was recorded when such examinations had been refused by a patient.

Cleanliness, infection control and hygiene

- During our inspection we observed the environment at Queen's Hospital to be visibly clean. However, despite notices informing staff and visitors to wash their hands, we observed a lack of hand gel on the entrance to each ward and staff did not carry hand gel with them.

Environment and equipment

- The environment in the maternity service was secure. All areas were accessed by entry phone and/or swipe cards. Staff were aware of emergency procedures and practice drills were randomly undertaken to test staff reactions.
- Some areas at Queen's Hospital were cluttered and staff told us that storage was a problem, particularly on the labour and postnatal wards. This led to the inappropriate storage of some items and a potential infection control risk. For example, there were printers located in the treatment room on the labour ward and the sluice contained mops for cleaning clinical areas.
- There was sufficient equipment in each area visited to ensure that patient safety was maintained. For example, there was a Resuscitaire® in each of the seven delivery

Maternity and family planning

rooms on the labour ward as well as two in the obstetric theatres, plus a spare. Staff told us they had a sufficient number of cardiotocography (CTG) monitors, which are used to monitor the foetal heartbeat during labour.

- Resuscitation equipment was checked daily in the areas we visited and a record was kept of these checks. However, not all emergency medication was secure. The adult resuscitation trolleys did not have lockable drawers and so items, including adrenalin, were accessible to unauthorised persons. We were told that this was a trust-wide issue and senior management were aware but no action had been taken to address this issue.
- Units were suitably equipped to provide effective care. Staff had received training on the equipment available and this was reviewed and updated routinely.

Medicines

- There were appropriate arrangements in place for the safe storage of medications in clinical areas. These were stored in lockable rooms that could only be accessed via a swipe card. Medication fridge temperatures were checked daily and controlled drug checks were completed appropriately.

Records

- There was a maternity dashboard in place which monitored performance against safety-related targets on a monthly basis. This included indicators such as staffing levels, admissions to the neonatal unit, stillbirths and admissions of mothers to intensive care.
- The dashboard was discussed at monthly divisional risk meetings and any variation in performance was investigated.

Safeguarding

- There were systems in place to identify and protect people in vulnerable circumstances from abuse.
- Staff received safeguarding training in line with the trust's mandatory training. All doctors, midwives and care assistants working in the maternity department received level 3 child protection training.
- While there were no formal safeguarding supervision arrangements within the trust, we saw evidence that managers within the maternity service monitored the status of alerts raised by staff and provided support where necessary.

- Staff we spoke with were able to describe the process for reporting any concerns to both social services and the lead midwife for safeguarding.

Mandatory training

- All staff were required to complete the trust's mandatory training. As of February 2014, 96% of midwives and 91% of the obstetric consultants had completed their mandatory training. However, only 59% of junior doctors had completed this training. During our inspection we were not provided with evidence to demonstrate what action was being taken to address this issue.

Management of deteriorating patients

- There were systems in place to respond to medical emergencies. Specific observation charts were used to quickly identify women or new-born babies who were becoming unwell so that their condition could be escalated appropriately.
- These charts included the nationally recognised modified obstetric early warning score as well as the new-born observation track and trigger chart, developed by a midwife working at the trust, with input from the paediatric team.
- Staff reported a good working relationship with the neonatal team and found them responsive should they have a concern about a new-born baby. We were told the neonatal team visited the postnatal ward daily to determine if there were any potential admissions.

Midwifery staffing

- Ward rounds were conducted by ward managers and matrons on at least a weekly basis. These focused on the quality of care being provided and involved talking to staff, patients and reviewing documentation.
- The maternity dashboard showed that the midwife-to-birth ratio was 1:31 (one midwife to 31 mothers), which was higher than nationally recommended ratio of 1:28.
- Over 95% of women received one-to-one care during established labour and midwives told us they were never asked to care for more than one woman during this time.
- Unexpected midwife absences were filled using in-house staff, working additional hours. The maternity department did not use agency staff. If there were any

Maternity and family planning

unfilled shifts, all staff were alerted via a text message system to alert as many possible replacement staff at one time. Staff were very positive about the efficiency of this system.

Medical staffing

- Effective handovers took place between staff at the beginning of each shift to ensure continuity and safety of care. Each patient was discussed so that staff were aware of their current status and plan of care.
- Consultant ward rounds took place daily and were attended by a midwife so that any changes to the plan of care, such as medication or diagnostic tests, were noted. Medical staff clearly documented care plans for consultant-led women on the labour and postnatal ward.
- Consultants were available on the labour ward 60 hours a week, including weekends, as recommended by the Royal College of Obstetricians and Gynaecologists. They were also on call at night.
- During the day there was a dedicated consultant anaesthetist for the labour ward.
- There was appropriate cover from junior and middle grade doctors during the day. At night there was one registrar on the labour ward with a consultant on call.
- The doctors we spoke with told us the consultants would always come in if needed and they felt able to call them for advice.
- There were no junior doctors on the labour ward between midnight and 7am. This had been put on the service's risk register as this meant it could not meet nationally recommended guidelines as set out in Towards Safer Childbirth.

Are maternity and family planning services effective?

Good



Care was based on nationally recommended guidelines and performance had been sustained over time. However, there were some indicators where improvements could be made, including the caesarean rates and transfers of women from the midwifery-led unit. Targets set by the service had not been reviewed or changed in a two-year period. Women had antenatal assessments to develop a plan of care that reflected their wishes and clinical need.

The proportion of 'normal' births was better than the national average and some initiatives had been recently implemented to reduce the number of elective caesarean sections. However, it was too early to evaluate their impact. Care was multidisciplinary and involved other teams within the hospital as well as external organisations, such as GPs and social services.

Mothers received care from staff who were appropriately trained and appraised. Training and supervision was ongoing and included unannounced practise drills to test staff. Midwives rotated throughout the department daily to assist in keeping their skills up to date. There was sufficient equipment to provide effective care and staff were trained in how to use it.

Evidence-based care and treatment

- Patients' needs were assessed and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.
- Care and treatment was based on nationally recommended guidance, including those produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists. These were applied to patients based on their clinical need.
- All clinical guidelines and protocols were available to staff via the trust's intranet. We noted that a few of these guidelines were due, or had passed the date, for review.
- Senior staff were aware and a log was kept of all guidelines and who was responsible for reviewing them. We were told that guidelines where national changes had been made were prioritised for updating.

Pain relief

- Antenatal assessments were carried out; incorporating any health or social risks to the mother or unborn child, and a plan of care was developed. Where necessary, this assessment triggered a referral to the most appropriate person. For example, if a woman had cardiac condition, they may be referred to a consultant anaesthetist to determine what pain relief could or could not be provided during labour.

Patient outcomes

- Up-to-date performance information was accessible via the maternity dashboard. Delivery of care achieved positive outcomes for patients, which were in line with the expected norms and performance had been sustained over time.

Maternity and family planning

- Analysis of data from our intelligent monitoring information before our inspection showed that the number of births that were classified as a 'normal' delivery were similar to that of the national average of 60.7%. However, senior managers in the service told us these figures included women who had had any intervention, including an epidural, whereas the national figure did not. Therefore, the actual number of 'normal' births was around 70%, which was better than the national average.
- Data provided by the trust showed that, between May 2013 and January 2014, the service's caesarean section rate ranged from 18.4% and 30.5%. The trust's target was 25%.
- The service's emergency caesarean rate was 15.7% slightly worse than the national average at 14.7% and the elective caesarean rate was 8.9 %, which was better than the England average of 10.7%.
- The maternity dashboard reported the number of elective caesareans had remained static. We were told that clinics for vaginal birth after caesarean had been recently implemented as one way to improve this figure, but it was too early to evaluate the impact. This was the only initiative staff referred to when asked what was being done to reduce the caesarean section rate.
- In 2013, 58 women were transferred from the standalone birthing unit at the Samuel Johnson Community Hospital in Lichfield to the labour ward at Queen's hospital, a distance of 10 miles, in the second stage of labour. The service sets its target as having no more than four transfers in each month.
- The service was one of the only maternity services nationally to use the enhanced recovery programme for women following a caesarean section, if it was clinically appropriate for them. The aim of the programme was to speed up the recovery process, so that women could be discharged the day following post-elective caesarean section if it was safe to do so.
- An audit of the programme had found there had been a reduction in the length of stay. However, staff we spoke with told us they also considered a woman's emotional wellbeing before discharge, and if they needed more support, for example, with breastfeeding, this would be taken into account.
- The service had achieved level 2 of the UNICEF UK Baby Friendly Initiative which aims to encourage breastfeeding among new mothers.
- The maternity dashboard showed that, between April 2013 and February 2014, the proportion of women breastfeeding within 48 hours was over 70%.
- The service participated in national clinical audits to benchmark its performance. For example, the service persistently achieved over 90% for the proportion of women who accessed maternity services before 12 weeks and six days of their pregnancy, as recommended by NICE. Each year the service was audited by West Midlands Local Supervising Authority, are responsible for ensuring that statutory supervision of midwives is carried out to an acceptable standard. No concerns were raised by the 2012/13 report in relation to the trust's maternity services.
- The service also carried out local audits on a variety of topics. For example, an evaluation of the anaesthetic clinic found that not enough of the women identified as 'high risk' were being referred. Pregnancy is called high risk if the mother and/or baby have an increased risk of a health problem. Women identified as having a high risk pregnancy fall into four categories existing medical condition, age, life style and conditions in pregnancy. The findings of the audit resulted in additional training for staff and the clinic numbers have now increased, leading to improved care planning for women with increased clinical risks in pregnancy.
- As part of the ongoing supervision of midwives, supervisors of midwives audited 100 sets of patient notes per month, randomly selected to ensure that records were accurate and reflected best practice.

Competent staff

- The General Medical Council's 2013 National Training Survey found that the trust's performance was worse than expected in five of the 12 areas for obstetrics and gynaecology, including induction, experience and local teaching.
- Senior managers and the clinical lead described the challenges faced by the trust due to the low number of trainees provided by the deanery and long-term sickness within the consultant team.
- Recent changes that had been made in response, and the junior doctors we spoke with told us training and support had markedly improved recently. They now had three hours of protected learning time each week. Also, 100% of junior doctors and 94% of consultants had been appraised.

Maternity and family planning

- Midwives and care assistants reported they had good development opportunities, including support to complete degree courses.
- The appraisal rate for midwives at Queen's Hospital was 94%.
- All midwives had a named supervisor of midwives to meet statutory obligations and all reported that they had had their annual review.
- Weekly multidisciplinary training was provided on CTG monitors, and midwives were required to complete annual skills and drills training which covered common scenarios. The service also carried out unannounced scenarios randomly to test staff reactions.

Multidisciplinary working

- Systems within the maternity service supported multidisciplinary working within the trust and with external organisations.
- All staff we spoke with described a positive working environment where different staff groups worked as a team. There were a variety of multidisciplinary groups and forums that met on a regular basis to discuss incidents, individual cases and to share learning.
- Care and treatment was multidisciplinary, ensuring that people were cared for by the most appropriate person at the right time.
- There were specialist midwife roles for bereavement, breastfeeding, governance and safeguarding who acted as a source of support for staff and who shared learning.
- Staff worked closely with external organisations and there was effective communication, information sharing and decision making.
- Referrals were made to social services, health visitors or other hospitals where there were individual concerns. For example, if foetal abnormalities were detected, women were referred to Birmingham City Hospital for confirmation.
- The management team also engaged with other health and social care partners, including the clinical commissioning group and Healthwatch in order to inform strategic decisions.
- There was a commercial company working within the unit at Queen's Hospital, providing free samples to women and photographs of their new baby for a fee. While staff acknowledged that the company representatives respected women's choices and privacy, some felt it was inappropriate for them to be on the unit endorsing products and approaching women during a

time when they may feel vulnerable. Women we spoke with who had been approached by the company told us they did not feel pressurised into purchasing their services.

Seven-day services

- There was appropriate cover from junior and middle grade doctors during the day. At night there was one registrar on the labour ward with a consultant on call. The doctors we spoke with told us the consultants would always come in if needed and they felt able to call them for advice.
- Staff told us that, as midwives were able to suture and cannulate, there had been minimal impact on the quality of care women received. During our inspection we found no evidence that the lack of junior doctor cover at night caused additional risk or resulted in a negative impact.

Are maternity and family planning services caring?

Good



Women and their families were treated with compassion, dignity and respect. Women and their partners we spoke with felt the care they had received had been excellent. They felt informed, involved and able to ask questions when they were unsure. Staff demonstrated that providing a positive experience for people who used the service was their main priority and felt disappointed if they let someone down.

There was good emotional support provided for women and their partners when needed with a dedicated bereavement room and specialist bereavement midwife.

Compassionate care

- The 2013 CQC Survey of Women's Experiences of Maternity Care reported that the trust performed better than other trusts in questions around staff during labour and care in hospital after the birth. These indicated that women did not feel they were left alone by staff at a time when it worried them, and felt they were spoken to in a way they could understand.

Maternity and family planning

- Staff treated patients with dignity and respect. We observed staff talking to patients in a kind and supportive manner. Staff knocked on doors or announced their presence before entering a curtained area.
- We spoke with 12 women and their partners. All the women we spoke with were positive about the way they had been treated. They felt their pain had been managed and they could ask for assistance, if needed.
- One woman described how a care assistant had supported her to have a shower and how much better this had made her feel. Overall, the women and their families could not speak more highly of the staff that had cared for them. Some of the women had had difficult births, but praised the midwives for supporting them through it.

Patient understanding and involvement

- Women and those close to them were treated as 'partners' in their care. We spoke with five women and their partners in the antenatal clinic who told us they had sufficient time at their appointments with the doctors and the midwives to discuss any aspect of their care.
- Women we spoke with were positive about the time and information they got from their community midwife.
- Antenatal appointments at Queen's Hospital were conducted by a consultant and a care assistant. Women were then seen by an 'exit midwife' to ensure their follow-up appointment had been booked and to check they understood the plan of care.
- Women who had given birth were positive about the way they and their partners had been involved throughout the process. They told us the midwives and doctors explained what was happening at each stage. One person told us that their birth plan had been fully respected by staff.
- There was a virtual tour of the maternity unit on the trust's website and we were told that people could also have a tour of the labour ward, if requested.
- There was a low prevalence of Mothers from ethnic minority groups within the local population; however the service had systems in place to meet cultural and religious needs if required.

Emotional support

- There were systems in place to provide psychological support, including counselling and the opportunity to talk with a bereavement midwife. Memory boxes were supplied, which included a print of the baby's hand and foot.
- Women who had undergone a termination of pregnancy for medical reasons were supported by the bereavement team. They could choose whether to be cared for on the labour ward or the gynaecology ward. Staff told us they encouraged women to attend the labour ward and use the bereavement room's facilities to help them cope with the loss of their baby.
- Staff demonstrated that emotionally supporting women, their partners and giving them a good experience was a priority. Recognising the challenges faced by midwives in providing adequate support post a caesarean; the service had assigned a dedicated care assistant to the elective caesarean team. They stayed with the woman throughout the procedure and during recovery to provide emotional support. The service had received repeatedly positive feedback from women in relation to this staff role.

Are maternity and family planning services responsive?

Good



Maternity services were responsive to the needs of mothers who used the service. Managers engaged with relevant stakeholders to ensure that the service's development strategy was reflective of this. There was a good flow through the service and women did not have difficulty accessing the service when they needed to.

Women were assessed to ensure that their needs were met. If women wished to deliver their baby at the midwifery led unit, staff ensured it was safe for them to do so. Women received continuity of care and there were a variety of initiatives in place to support women once they had been discharged. Women were encouraged to give feedback on their experience and we saw that this was listened to by staff.

Maternity and family planning

Service planning and delivery to meet the needs of local people

- Maternity services at the trust had not had to close in the two years preceding our inspection for any reason. However, there was a contingency plan in place should the unit begin to reach capacity.
- The trust worked with commissioners of services, local authorities, GPs, relevant groups and people who used the service to understand the needs of the local population and to promote the maternity services.
- Feedback from such engagement was used to inform the service's strategy for development.
- Staff demonstrated an understanding of the demographic profile of women accessing the service. They were able to describe woman from vulnerable circumstances and how they planned services to meet their needs. For example, community midwives carried a portfolio of around 100 women, but in areas of high deprivation, or where there were safeguarding concerns; portfolios were adjusted so that midwives could give women appropriate support.

Access and flow

- There was a good flow of women through the maternity pathway and we found no evidence of delayed discharges.
- Women were able to access maternity services at the trust when they needed it. There was a clear booking process in place and over 90% of women received an initial antenatal appointment within 12 weeks and six days of their pregnancy. If people required a referral to another clinician or part of the service, such as the maternal foetal assessment unit, this was arranged.
- Maternity services had not had to close to admissions in the two years preceding our inspections, but they had had to accept labouring women from other trusts nearby. Women were able to contact the unit 24 hours a day and there was maternity triage for women in the early stages of labour.
- The service did not have facilities for a co-located midwife-led birthing unit which is uncommon. Many maternity units have developed this area of service to fully offer choice of place of birth to mothers.
- Most women reported they had received continuity of care. One woman told us she had had to chase test

results, while another told us she had seen a different midwife at each antenatal appointment. However, neither woman felt this had impacted negatively on their overall care.

- Community midwives were assigned to specific GPs in the area, which meant they could provide continuity to care to women on their portfolios.
- Women and their babies were only discharged when they were well enough and had the right support in place.
- Before women were discharged, staff checked they knew when their community midwife would be visiting. They were also given information on how to contact the service if they had any concerns.
- We were told that discharges were processed by midwives at the bedside so that women felt involved in the process.
- All women were given a “red book,” also known as the child health record, which provided information on the health of their baby and the immunisations they would be expected to have.
- Care assistants and midwives supported women with breastfeeding. At Queen's Hospital there was a protected hour each day outside of ward rounds and visiting hours to provide individual, undistracted support.

Meeting people's individual needs

- Women's choice was respected, depending on clinical need and individual preference. Women were able to plan to have their babies at the midwife led unit or at Queen's hospital. If complications arose during labour at the midwife lead unit, there was an escalation procedure in place to transfer them rapidly to the labour ward at Queen's Hospital.
- There was also a home birth service available, which was provided by the community midwife team. However, uptake of this service was low.
- There was one dedicated room for bereaved families where they could spend the night if they wished. This was separated from the rest of the labour ward and decorated to feel like “home” rather than a clinical space. The service had managed to raise money to refurbish the area to include a kitchenette so it felt more homely if people wanted to spend longer periods there.
- Written information was readily available throughout the unit. Some information was available in other languages and there was a trust-wide translation service

Maternity and family planning

Learning from complaints and concerns

- There was information displayed throughout both sites on how women and their partners could give feedback on the service they had received and how they could make a complaint.
- The women we spoke with told us they had no reason to make a complaint.
- The service received a low number of complaints. However, all comments and complaints were listened to in order to improve the quality of care. A folder of all complaints was kept on each ward so that any issues or learning could be shared across the maternity pathway.
- Complaints were discussed at monthly team meetings or with individual staff members where necessary. They were also a standard agenda item at the labour ward forum and monthly risk meetings.
- Complaints were made available to all staff as a way of sharing information and learning. Where appropriate, action plans were put in place and monitored by senior management.
- The service actively engaged with women and encouraged them to share their experiences. All women were offered a debrief session following their discharge to discuss their birthing experience to give them an opportunity to seek clarification or to understand why certain things happened. This service was not just used by people that wished to make a complaint.
- The service also engaged with external stakeholders to seek their feedback. For example, a project had been undertaken with the local Healthwatch following some negative comments about the discharge process. As a result, discharges now took place at the bedside and midwives had been trained in carrying out baby checks to prevent delays rather than waiting for a paediatrician.

Are maternity and family planning services well-led?

Good



The leadership, management and governance of maternity services ensured staff worked in an environment where the focus was on providing high quality care to women. There was an open reporting culture and staff were positive

about the feedback and learning that was provided from incidents. Staff were engaged and involved in making changes that directly impacted on patient experience for the better.

There was a clear governance structure for the service which ensured that risks were identified and monitored on a regular basis. Performance was monitored and reported upwards to senior managers within the trust.

Vision and strategy for this service

- Staff within the service shared the trust's vision. Their priority was to provide safe, effective care and to give people a good experience. They felt very disappointed if they let people down.
- There was a strategy in place to develop maternity services and this was focused on encouraging "normality" in birth. There was a clear action plan which was organised against different domains, including leadership, quality, patient experience and sustainability.

Governance, risk management and quality measurement

- Senior staff were aware of the risks that may impact on the safety or effectiveness on the service and these were logged on the trust's risk register and monitored at monthly risk meetings.
- There were clear governance arrangements. The governance structure ensured there was clear reporting from the ward to board.
- Performance reports were submitted to divisional boards monthly and to the Trust Board every six months. These included information on staffing, incidents, complaints and quality of care. These reports were informed using the maternity performance dashboard and ward assurance reports which measured quality.
- There was a specialist midwife for governance whose role included conducting audits, root cause analysis investigations following incidents and monitoring any identified risks.
- Senior staff were aware of the risks to the service and were able to describe what was on the trust's risk register in relation to maternity. They were also able to describe what action had been taken to mitigate the risks.

Maternity and family planning

Leadership of service

- Staff were very positive about the service's senior management and the trust's senior management, particularly the chief executive and the director of nursing.
- Staff felt able to raise issues with senior staff and described the team as supportive. All staff were aware of the matron's monthly "open clinic" where staff could drop in.
- All midwives had a named supervisor who conducted an annual review. The supervisors also monitored performance on an ongoing basis.
- The maternity dashboard, as of February 2014, showed the ratio of supervisors to midwives was 1:15, as recommended by the local supervisory authority. However, following recent recruitment, we were informed that this ratio was now 1:12.

Culture within the service

- There was a culture of collective responsibility within the maternity services at the trust. All staff felt they had a role to play in providing quality care to people.
- Staff at the midwife focus group described the culture of the service as "open". They felt able to report concerns and if learning or improvements were required this was managed in a supportive way.
- All staff we spoke with demonstrated pride in what they did and told us they felt privileged to work as part of the maternity team.
- Staff had participated in the 2013 NHS Staff Survey, but it was not possible to break this down to service area. The trust performed in the top 20% of trusts nationally for the number of staff who had received an appraisal in the last 12 months.
- Areas where the trust performed worse than expected included job satisfaction and percentage of staff reporting good communication between senior management and staff. These negative results did not reflect what we found during our inspection of maternity services.

Public and staff engagement







- Women's experience of care was used to drive improvements in the service. Feedback was collected through a variety of ways.

- There was a patient representative on the monthly labour ward forum, the service engaged with the local Healthwatch and people were encouraged to leave comments or complaints via the NHS Friends and Family Test or comments cards. Changes had been made to the discharge process following feedback from patients.
- Women were offered the opportunity to discuss their experience of labour – good or bad – at debrief sessions.
- There were a variety of forums and groups that staff could attend. Staff told us they felt they had a voice and were actively involved in making improvements to the service. For example, the implementation of a dedicated care assistant for elective caesareans was a result of staff feedback.
- The chief executive and director of nursing had recently begun to conduct "board to ward" visits. Staff described these as informal and not intimidating and an opportunity for staff to say what was needed. For example, staff on the postnatal ward said they would like to provide a buffet breakfast for women. This request had been ongoing for a sometime and now the chief executive became involved to help implement this. Staff were unsure what the barrier had been previously.

Innovation, improvement and sustainability

- The service strived to improve and the experience of people who used the service was the focus of any changes made. Staff at all levels told us what they enjoyed about working for the service was the fact they were encouraged to explore good practice and to be innovative.
- The newborn observation track and trigger chart had been developed by a midwife working at the trust, with input from the paediatric team. This neonatal observation chart had been nominated for a national award by the Royal College of Midwives.
- The service was one of the only maternity services nationally to use the enhanced recovery programme for women following a caesarean section, if it was clinically appropriate for them. The aim of the programme was to speed up the recovery process, so that women could be discharged the day following post-elective caesarean section if it was safe to do so.

Services for children and young people

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

Information about the service

Children's services are provided at Queen's Hospital which has two children's wards. Ward one for acute admissions. Ward two for elective surgery, day cases and young people. The children's outpatient clinic was adjacent to the wards. However children with fractures, orthopaedic needs or with conditions affecting the ear, nose and throat were seen in specialist clinics in the main out patients departments.

The unit is part of the Midlands Central New-born Network. This trust provided neonatal care at level 1. Level 1 care is for those babies requiring continuous monitoring of their breathing or heart rate, additional oxygen, tube feeding and phototherapy (neonatal jaundice). The unit had facilities to care for a baby requiring intensive care for a short period of time until they were transferred to a specialist unit. There were facilities to accommodate parents overnight.

We spoke with five patients and eight relatives and 18 staff including consultants, doctors, nurses domestic and support staff. We observed care and looked at care records of the six post- operative or acute patients and we reviewed other documentation including performance information provided by the trust. We received comments from our listening event and from people who contacted us to tell us about their experiences.

Summary of findings

We found that staff were caring and compassionate and responded to children's needs. Staff in children's services considered they worked in a supportive team. The number of inpatients was relatively low and children did not have complex conditions.

We had multiple concerns regarding children's safety which were not seen as a priority. Not all staff had not completed the appropriate level of safeguarding training, some staff were delivering care to children without having an appropriate level of knowledge of Paediatric Life Support (PLS) and there was inconsistent response to Paediatric Early Warning Scores (PEWS). There was no dedicated room with suitable equipment in which to provide high dependency care on the children's wards if needed. It was common practice to transfer children from theatre to the ward without oxygen and suction. There was no system for sharing information about children known to social services who missed outpatient appointments and not all treatment guidelines were systematically updated in line with national guidelines.

Staffing levels in the neonatal unit were below standards recommended by the British Association of Perinatal Medicine (BAPM) and the Central Neonatal Network of which the unit was part.

Services for children and young people

The nursing and medical staff did not operate as a unified team, setting out a vision and giving leadership to staff. The children's department did not share in the trust's wider vision of improving quality.

Are services for children and young people safe?

Inadequate



The identification of risk was not a high priority. We observed multiple areas where safety issues needed to be addressed. Not all relevant staff were trained in safeguarding or in paediatric or neonatal life support. It was not current practice to carry portable suction or equipment when transferring children from the operating theatre to the ward.

The trust did not have facilities and appropriately skilled staff for children who may need high dependency care. There was no dedicated room on the children's ward with suitable equipment to provide high dependency care for children should they deteriorate while they await transfer. Although most equipment was in date, one oxygen cylinder on the neonatal unit was out of date.

Other safety issues on both wards were that the drawers in the resuscitation trolleys were not properly labelled and the paediatric life support guidelines were not visible on one of these. There was not always an appropriate response documented to raised PEWS scores of children on the ward.

There was no system for sharing information about children known to social services who missed outpatient appointments. Treatment guidelines were not systematically updated in line with national guidance.

An external review of the neonatal unit by BLISS in July 2013 had noted areas for improvement, for example that staffing did not meet the requirements of the British Association of Perinatal Medicine (BAPM) or of the Central New born Network which was potentially a risk to babies in the unit.

Incidents

- The trust had reported two SIs from the paediatric and neonatal department for 2013, and two for 2014. There had been one neonatal death in the unit in the year preceding our inspection, this was an unexpected death.

Services for children and young people

- There had been no Never Events; never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- We noted that the BLISS report of July 2013 (BLISS is an organisation concerned with the care of premature and sick babies) found that not all staff in the neonatal unit were confident in neo natal resuscitation. We saw from the action plan that the Band 6 nursing staff were "buddying up" with a band 5 nurses to train them, and all staff were expected to complete Basic Paediatric Life Support. This action was not completed at the time of our inspection
- Incidents and risks were investigated and reviewed. Feedback was given to staff individually or as a group. However, staff could not provide examples of changes that had been made that demonstrated lessons had been learned.

Cleanliness, infection control and hygiene

- Hand washing facilities were limited to one basin per bay and one hand gel to two rooms.
- There was insufficient storage in the neonatal unit and in the children's wards. Cluttered areas make it difficult to clean. There was insufficient space to store cleaned equipment in closed rooms or cupboards. This was a potential infection control risk especially as corridors were used for storage.
- There had been no cases of MRSA or Clostridium Difficile (C. difficile), or norovirus on the children's wards in the past year.
- We saw staff using personal protective equipment. However, we observed two different senior nurses failing to wash their hands after patient contact.
- There were single rooms which could be used for a child needing isolation.

Environment and equipment

- Wards were secure. All areas were accessed by entry phone and/or swipe cards.
- The layout of the neonatal unit with four different nurseries resulted in more staff being required to supervise the 14 cots in the four small nurseries.
- The nursery for those babies in the neonatal unit requiring a higher level of care was designed to accommodate three cots. We were told there were

occasions when five cots would be in this space which resulted in it being very cramped and which led to staff experiencing difficulties delivering care, and potentially impact on the safety of babies.

- The majority of the equipment we looked at had been serviced within the last year; however one oxygen cylinder in the neonatal unit was 16 months out of date.
- The children's clinic and the triage area attached to the ward were bright and airy with a selection of toys for different ages and a games console. There were also secure play spaces, and books in the adult outpatient clinics that children attended.
- Resuscitation equipment was checked daily and a record was kept of these checks. However, not all drawers on either trolley were labelled with content and on one trolley the advanced paediatric life support guidelines were not very visible.
- One resuscitation trolley on the ward was kept in a room behind the nurses' station which could only be accessed by a swipe card this would limit access in an emergency. There was a second resuscitation trolley in the treatment/triage room which was not very close to the ward.
- At the time of our inspection, there was no dedicated room for the stabilisation of children requiring a high level of care prior to transfer to another hospital.
- Since our visit the trust stated that they now have a designated 'Stabilisation and Treatment Room' on ward one which they stated is fully equipped to receive acutely unwell children, whilst they are stabilised and await transfer if necessary to the tertiary centre.
- Cleaning schedules were prominently displayed, but not all cleaners were completing checklists to show what had been cleaned. Green tape was used to show clinically clean equipment.

Medicines

- There were appropriate arrangements for the safe storage of medicines in secure areas.
- Fridge temperatures were checked and recorded.
- The correct procedures were used for checking and recording the use of controlled drugs.

Records

- Children were risk assessed on admission and there was sufficient information recorded in their notes.
- Care plans were updated regularly; we noted that pain scores were not always recorded.
- Observation charts were fully completed.

Services for children and young people

Consent

- Parental consent was recorded on all the children's notes we reviewed.
- Older children told us they were involved in discussions and gave their own consent, supported by their parent.

Safeguarding

- Most staff we spoke with could describe the referral process for alleged or suspected child abuse and knew the names of the lead professionals.
- Not all relevant staff across the trust were trained to Level 3 in Child Protection. The trust mainly offered Level 3 training over three years. Senior members of the paediatric team confirmed that they do not consider staff to have achieved Level 3 until they have completed all three sessions. This means it takes a considerable period of time to achieve the required level of competence to ensure the safeguarding of children.
- The trust have since advised us that training has been arranged for all new staff who are not trained to level 3 and have requested a review of this training. This action had not been completed at the time of our inspection.
- We saw evidence of safeguarding referrals made by the trust. However there was no standard policy for sharing information in a timely manner about children known to social services who failed to attend children's clinic appointments. Doctors told us that they would follow up missed appointments but could not evidence that information was shared with social services. Following our inspection the trusts have stated that a database is being implemented to ensure information sharing takes place.
- The named doctor for safeguarding held quarterly 'lessons learned' sessions for junior doctors. Although all staff were welcome we were told that nurses rarely had time to attend.
- A paediatrician was the named doctor for safeguarding. 80% of the staff in the neonatal unit knew this, and all staff on the children's wards.
- The statutory role of the named nurse for safeguarding was temporarily shared between the safeguarding midwife and the matron. All NHS trusts must have a named nurse who will provide advice and expertise for fellow professionals and promote good practice on safeguarding. There was a risk that a job share could not discharge this leadership role effectively with possible

risks to children in need. We were told that a named nurse had been appointed, and would take up post shortly. We noted it was unusual that the named doctor had not been on the interview panel.

- In February 2014 there had been an increase in safeguarding training however this remained below 90%. We saw documentation stating that a third of staff failed to attend safeguarding training. 97% of senior medical staff had completed training at level 3 but only 23% of junior doctors on the children's wards had completed level 3 training.

Management of deteriorating patients

- The Paediatric Early Warning System (PEWS) was used to identify children whose condition was deteriorating to ensure appropriate timely escalation. We observed that in two out of three cases during our inspection there was no written evidence in children's nursing notes that concerns had been escalated in response to raised PEWS scores. Despite training and updates the system was not fully embedded. This issue had been identified in audits in autumn 2013 however remained an issue in May 2014.
- Staff did not proactively identify risks. We observed that it was not current practice to carry portable suction or equipment when collecting children from the operating theatre, this equipment would be required in an emergency situation. This was a particular risk to children after ear nose and throat surgery who were particularly vulnerable to post-operative bleeding and consequent airway compromise if they were to deteriorate during transfer.
- Not all staff that were providing care to children were trained in paediatric life support, 72% of staff in the Women's and Children's Division had training in intermediate life support but only 56% of staff in the surgical division and 33% in the minor injuries department at Samuel Johnson. Some staff in the paediatric department could not tell us the correct ventilation to compression ratio when resuscitating a child.
- Training data showed not all staff in the trust had up to date training in Paediatric Basic Life Support (PBLs) which was mandatory. In surgery and paediatric A&E both areas where staff would have significant contact with children, the level of training in PBLs was under

Services for children and young people

60%. A locum doctor told us that he had been called to A&E the previous day to assist with a peri-arrest as there was no full time paediatric nurse or doctor cover in A&E department.

- None of the junior medical staff in paediatrics had Advanced Paediatric Life Support (APLS) training and only half these doctors had paediatric intermediate life support training; We would expect that these doctors might need to lead a team in an emergency. Three senior medical staff in paediatrics did not have advanced training. Only 36% of nurses had APLS training
- The hospital policy was only to offer Paediatric Intermediate Life Support (PILS) training to those for whom it was absolutely necessary, on grounds of cost. We were told that PILS training was often cancelled.
- An audit of staff's knowledge of PILS in the paediatric department identified gaps in knowledge, particularly in relation to drugs to use. There was no action plan to address findings.
- Intubated babies were transferred from the delivery room to the neonatal unit on a resuscitaire with a neonatal life support box. The units were adjacent and therefore transfer took only a few minutes so this was considered safe by the staff on the neo natal unit.
- New-born babies needing complex care such as ventilation for more than 24 hours or surgery were transferred to other hospitals within the Central Newborn Network (CNN). Staff told us that a number of babies were transferred each year but did not provide us with actual figures.
- Since our inspection the trust has advised us that it will review the provision of paediatric services across the organisation, by the end of May 2014.

Nursing staffing

- There were adequate numbers of suitably skilled staff on the children's wards, although staff told that it was sometimes difficult to release staff for training or to attend meetings outside the unit.
- Staffing in the neonatal unit, despite being staffed to establishment did not currently meet the requirements of the British Association of Perinatal Medicine (BAPM) of one neonatal nurse or nursery nurse for each nursery. There were four nurseries in this neonatal unit, and the number of cots in each varied according to the babies' dependencies. The staffing shortfall was on the current women's and children's risk register. It had also been noted by the CNN review.

- Unexpected staff absences were filled using bank paediatric-trained staff where possible.
- If a child needed one to one care, additional staff could be requested and we were told that staff were regularly found.
- There were monthly ward meetings to discuss paediatric cases, review staffing levels and disseminate information to staff.

Medical staffing

- Staff handovers between the night team and the day team took place in the morning and a consultant was present.
- In the evening a consultant took handover by telephone. Each patient was discussed and there was also a written handover sheet to ensure continuity and safety of care. A lunchtime handover covered patients admitted in the afternoon.
- The neonatal team visited the maternity unit daily to identifying if there were any potential admissions. The unit took babies over 29 weeks and would ventilate babies for 24 hours before if necessary transferring them to a specialist unit for on-going care.
- There was appropriate cover from junior and middle grade doctors on the children's wards day and night. The doctors we spoke with told us they felt able to call the on call consultant for advice and that they would come in if needed.
- There were two locum doctors at the time of our visit. We spoke to one locum paediatrician who said he had a good induction to the service and was able to access the IT systems.

Are services for children and young people effective?

Good



The services for children and young people and the neonatal unit used evidence based guidance from national organisations in providing care. Guidelines for all common conditions were up to date, although we found some other guidelines had not been recently updated. Care was multidisciplinary and involved other teams within the trust as well as GPs and social services.

Services for children and young people

In the neonatal unit there was sufficient equipment to provide effective care and staff were trained on how to use it.

Although children were asked about pain and pain appeared to have been responded to appropriately, documentation on pain scores and pain reviews were not always recorded in children's notes.

Evidence-based care and treatment

- Children and young people's needs were assessed and care and treatment was delivered in line with nationally recommended guidance and evidence based practice. Such as paediatric antibiotics, childhood meningitis and neonatal sepsis.
- The guidelines for the most common childhood illnesses were found to be up to date. Some other guidelines had passed the trust's planned review dates, for example that on burns and scalds was dated 2009 with an internal review date of May 2012. NICE paediatric guidelines on burns and scalds were updated in June 2012 so the trust guidelines did not take account of this update.
- Hospital protocols were based on National Institute for Health and Care Excellence (NICE) guidelines and staff knew where to find policies and local guidelines on the intranet and in hard copy.
- The hospital carried out local audits on various topics including pain in children and infection screening of children for surgery.

Pain relief

- Five children told us they were asked about pain, and said they had felt better after they had been given analgesics.
- Not all children's records recorded a pain score or a review post-analgesia. We saw from trust documents that this had been a recurrent concern since at least November 2013.

Nutrition and hydration

- The NHS Friends and Family test for March 2014 noted that 7% of children said they didn't like the food. Other choices were offered where this was the case and most were satisfied with that.

Patient outcomes

- The service took part in national clinical audits to benchmark its performance, for example, the national paediatric audits on diabetes, epilepsy, asthma,

pneumonia and neonatal audit programme. The asthma audit showed that care at Queen's Hospital was comparable with care nationally and that there was less unnecessary intervention and better discharge planning than previously.

- Changes as a result of local audits included the introduction of the rapid access clinic for GPs to refer children who require an urgent opinion from a paediatrician but not necessarily a hospital admission.

Competent staff

- All staff on the children's wards and neonatal unit had an appropriate neonatal or paediatric qualification.
- Junior doctors reported good training in paediatrics with protected learning time and cover when they were on-call as far as possible.
- We saw a nursing appraisal tracker to identify when appraisals were due and nurses we spoke with confirmed they had had appraisals.
- Staff had received training on the equipment and staff took part in monthly simulations of incidents. We were told that there would be a simulation held on the new resuscitation trolleys that were to arrive the day after our inspection.
- The trust had set an internal target of 30% of medical staff to have completed revalidation and the recommendations from these to be submitted by 31 March 2014. In the women and children's division, 88% of doctors had undergone revalidation.

Multidisciplinary working

- We saw evidence of multidisciplinary meetings taking place, for example discussions with pharmacists and therapists to improve outcomes for children both on wards and in outpatients.
- Staff worked with external organisations as required. For example potentially suspicious fractures were reviewed via telemedicine in Nottingham University Hospital on the same day as the injury as well as being reviewed internally at Queen's Hospital.
- Specialist leads for child protection and bereavement provided advice and support as appropriate, and social workers were involved as necessary. There were two plays specialists, who mainly focused on younger children.
- The July 2013 BLISS audit of the neonatal unit identified that communications with the community team could be improved. It also rated as red the fact that the hospital had no neonatal outreach service and had no

Services for children and young people

funding for such a service. They referred babies with specific problems to the community paediatric nursing team, the health visitor or community midwife for support.

- Referrals were made to other hospitals where necessary. All neonates under 29 weeks and complex cases were referred within the central newborn network.
- Complex paediatric cases and all under-fives were referred to other hospitals, particularly Birmingham Children's Hospital and Nottingham University Hospital. These hospitals offered support, coordination and retrieval if a sick child needed to be transferred

Seven day service

- There was a 24 hour consultant led service with consultants on site nine and a half hours per day during weekdays and at weekends five hours per day. Outside this time consultants were on call from home for advice over the telephone and available to be on site within 15 minutes if required.
- The Child and Adolescent Mental Health Service (CAMHS) provided seven day cover between 9:00 and 17:00. There were plans and funding in place for 24 hour cover, either in person or via the telephone. At the time of our inspection this 24 hour service had not yet been commenced.

Are services for children and young people caring?

Good



Babies, children and young people and their families were treated with compassion, dignity and respect in a child friendly environment. Parents and relatives spoke highly of the care in the children's wards. They felt informed, involved and able to ask questions when they were unsure.

There was emotional support provided for families when needed. In the neonatal unit there was a specialist bereavement midwife who also covered babies dying after a period in hospital, including babies who had been transferred to other hospitals for intensive neonatal care. There was also a dedicated bereavement room.

Compassionate care

- Staff treated patients in a kind and reassuring manner. Children reported that the nurses were friendly and responded quickly to their buzzers.
- Relatives felt staff kept them informed and were positive about the care and treatment children and young people received.
- Waiting times in children's outpatients departments were generally not long, and parents and carers were kept informed about waiting times if there was a delay.

Patient understanding and involvement

- All the young people we spoke to said nurses offered choices and explained what they were doing.
- We noted that one in five children and young people in the Friends and Family survey March 2013 thought they did not have enough privacy.
- One 15 year old patient commented that the doctors talked among themselves and to their parent although they did check their understanding and invited their questions.
- Parents reported that they had time to ask questions of doctors. Most were given some written information about conditions and diagnostic tests. We did not see information on the children's wards in languages other than English.
- The NHS Friends and Families survey results were consistently over 80% positive. In March 2013 100% of parents considered the service good or mainly good. The area for improvement was to ensure that parents had a better understanding of doctors' explanations.
- In the neonatal unit there was information for parents in several languages. The bereavement service was also able to meet the cultural and religious preferences of parents, for example Muslim families.
- Parents we spoke with in outpatients, the neonatal unit and the paediatric wards were very satisfied with their experience.
- Wards were expected to achieve a score of 95% on a set of quality measures to meet ward assurance standards. The wards in children's services were achieving this target. Parent experiences of the ward were noted as being higher than 95%, the experiences reported by children and young people were slightly lower. This may be explained by children and young people being less accepting of staying in hospital, as well as there being fewer returns from young people.

Services for children and young people

Emotional support

- One of the ward sisters ran a monthly support group, away from the hospital, for parents whose babies had been in special care. She told us this was well attended but we were not provided with any data about the numbers of parents who attended this group.

Are services for children and young people responsive?

Good



Children and young people's services generally met their needs and those of their families; the trust was seeking ways to make the patient experience better. Outpatient clinics were offered on several different trust sites to minimise travelling time for families.

Parents of children needing diagnostic appointments and surgery said they had not had to wait long for care and treatment. The availability of rapid access clinics for GP referrals and triage on the children's ward was reported to have reduced hospital admissions. Those admitted as inpatients became the responsibility of the consultant on duty that week, unless the child was known to another consultant.

Parents told us they had the information they needed about their children's conditions and about treatment options. Whether their child was an inpatient or attending outpatients most parents and carers had not had concerns but knew how to give feedback if they wanted to. There were effective arrangements for transition from children's to adult services for young people, this process started when the young person reached the age of around 14 years.

Service planning and delivery to meet the needs of local people

- The trust was seeking ways to improve the experience of children and young people, and sought feedback in a variety of ways. Children and young people put comments on a 'comment tree' as well as answering NHS Friends and Family test questions. There were 38 comments in April 2014. The hospital had invited students from Burton College to visit the children's wards to help improve insight into the service and suggest improvements.

- GPs were able to seek advice from paediatricians by telephone, and if necessary children could attend the ward for triage in the paediatric assessment unit, or be referred to the rapid access clinic. We were told that these services were frequently used by local GPs.
- The staff on the children's wards and in outpatients understood that the timing of transition between child and adult services varied from person to person and showed a flexible approach to this, particularly for those young people with disabilities.
- We were told that the transition to adult services was started when the young person was around 14 years old. This allowed the young person and their parents/guardians to acclimatise to the change in consultant, clinic or ward, and managing any long term chronic conditions.
- Paediatric ward rounds took place daily including weekends. Visits from the orthopaedic surgeons took place outside main ward rounds at irregular times which meant that it was harder for parents to plan to be present to speak with these doctors.
- We noted that there were a number of staff approaching retirement and others going on maternity leave. Staff on the wards seemed unclear about succession planning or induction plans for new staff covering these posts.

Access and flow

- Outpatient appointments were slightly below planning targets.
- Parents reported their child had received continuity of care on the children's wards. Although some had seen different doctors, each knew the child's history and parents did not think this had a negative impact on their child's care. Admissions to the ward were under the consultant on duty that week, unless the child was already known to another consultant.
- Parents we spoke with were involved in the plans for their child's discharge and felt informed about how to look after their child at home.
- The neonatal unit had no outreach team in the community; staff gave parents information about their baby's care and development plan. While a baby was in the unit, nurses showed parents the importance of touch, and how to hold and talk to the baby to give reassurance they also taught parents paediatric life support. Parents could continue to attend a monthly support group outside the hospital run by a nurse from the unit.

Services for children and young people

- Staff told us most children were discharged within one to two days. We were not provided with figures on the average length of stay.
- Parents were given information on discharge, this ranged from an outpatient appointment referral to community nursing referral if required.
- Families told us and the clinic staff confirmed that children did not have to wait long periods for outpatient appointments.

Meeting people's individual needs

- Care and treatment records were personalised and those we looked at included information about children's likes and dislikes, toileting needs and risks.
- In the neonatal unit parents were involved in decision making and parents' preferences were noted in nursing notes and handover sheets.
- All parents with babies in the neonatal unit were seen by a senior clinician within 24 hours.
- There were two rooms where parents of babies on the neonatal unit could stay, as well as a quiet room and kitchen.
- There was plenty to entertain young children on the wards and in outpatient clinics. The general children's clinic beside the children's ward was well equipped to receive children. Outpatients clinics that required special equipment such as ophthalmology or the fracture clinic were also family friendly and had play spaces. The triage area shared toys with the children's ward and play specialists were available.
- The ward ran a Sunday club where young people due for surgery could visit the ward and find out about their treatment, including the anaesthetic and what to expect after discharge. Families were also given a leaflet about the ward.
- Parents were able to stay overnight on the children's wards. There was also a room where parents could sit without their children.
- There were translation services, including sign language if required.
- Staff were able to work with children with physical and learning disabilities. We saw a comment from one young person saying how well the ward had accommodated her needs.
- The Child and Adolescent Mental Health Service (CAMHS) provided seven day cover between 9:00 and

17:00. There were plans and funding in place for 24 hour cover, either in person or via the telephone. At the time of our inspection this 24 hour service had not yet been commenced.

- The paediatric outpatient department at Queen's Hospital was located next to the children wards. However, children were required to attend the adult outpatient area for some clinics such as the fracture/plaster clinic, radiology and ENT.
- There were children's play areas and books available for children visiting the areas for clinics or with their parents who were attending adult services.
- Children with diabetes attending outpatients clinics had access to paediatric diabetic clinical nurse specialist, a paediatric dietician and paediatric psychologist for diabetes.
- Parents of children coming to clinics for diagnostic tests were sent written information about the tests. They were also given written information about chronic conditions. Parents said they had been given time to talk to staff about how to support their child during illness.
- On the neonatal unit there was a dedicated room for bereaved families where people could spend the night if they wished. This was shared with the maternity unit.
- Psychological support and counselling was offered. Memory boxes that included photographs, foot and handprints, and clothing worn by the baby were created according to the parent's wishes. If parents did not want this immediately then the hospital kept these with the baby's notes in case they were requested later.

Learning from complaints and concerns

- There was information displayed at outpatient clinics in all three hospitals on how to provide feedback on the service they had received and how they could make a complaint.
- There was a comments board in the ward. We saw staff had responded to the feedback for example purchasing spare remote controls for the televisions, and letting parents know how to connect to Wi-Fi. Most of the 38 comments were positive; one mentioned a child's perception of a long delay to see their consultant.
- All women taking their babies home from the neonatal unit were asked about their experiences to help improve the service. These interviews indicated that parents felt

Services for children and young people

well informed. As the BLISS audit had highlighted the need for more information, leaflets for parents were being updated including signposting other sources of support.

Are services for children and young people well-led?

Requires improvement



Services for children and young people were part of the women and children's group, which had recently become part of the Surgery Division. The clinical director for Women and Children, to whom the paediatric matron reported, was one of four clinical directors reporting to the Associate Director of Surgery Division.

We did not see a specific vision for services for children and young people, and although staff were clearly committed to providing good care, many did not seem aware of the trust's objectives for the current year relating to the quality strategy.

The key safety issues that we raised on our inspection included: paediatric transfers from theatres, a designated high dependency room and safeguarding training were issues that the department had not been aware of until we raised them, although they responded promptly to our concerns.

There was insufficient communication between the medical and nursing staff. Changes seemed slow to embed: paediatric early warning scores were not being properly used; pain scores were not always recorded.

There was no clear ownership of the risks on the risk register and little sense of pace about making improvements. For example two external reviews of the neonatal unit had raised concern about staffing levels but there had been no change almost nine months after the review. Staffing of the neonatal unit had been on the Women's and Children's risk register since September 2013 but no action had been taken to ensure compliance with national standards.

Vision and strategy for this service

- Children's services were rarely mentioned in board level papers and staff told us that they did not feel integrated into the wider trust. There was no clear vision or strategy for children's services.
- The neonatal unit took part in the UNICEF UK Baby Friendly Initiative to support breastfeeding and strengthen mother, baby and family relationships.

Responses and action in response to internal and external audits were slow, for example not all the recommendations from the BLISS audit in July 2013 had been delivered nine months later.

Governance, risk management and quality measurement

- Under the governance structure, the children's services were part of the women's and children's group, and within the surgery division. However, staff we spoke with in the children's service did not seem to understand the rationale for the management change.
- Staff showed limited understanding of some of the risks within the service. Senior staff were aware of the risks on the children's risk register, but front line staff were unaware of these.
- There was not a regular programme of audit for children's services.

Leadership of service

- There was a lead consultant for paediatrics, and a matron on the nursing side. However, we did not see evidence that the medical and nursing staff worked as a unified team, or were aware of each other's ways of working. For example a consultant was not aware that nurses brought children back from theatre without oxygen and suction. Conversely, nurses were not aware of any action doctors might take when children missed appointments.
- The children's services did not have a strong influence on other areas of the trust which delivered care to children and young people. For example, the paediatric service had requested a paediatric life support officer for the hospital however no action had been taken. The trust did not recognise the importance of ensuring staff with paediatric life support training were required across the trust.

Services for children and young people

- Nursing staff in the paediatric and neonatal wards, and outpatients considered their teams to be supportive and communication to be effective. The matron led the units and everyone we spoke to was aware of her leadership and visibility
- There were monthly team meetings of nurses in addition to daily handovers.

Culture within the service

- We had limited evidence that staff in general were striving for improvement or innovation although they were proud of offering good care.
- Nurses said the culture was open and there was no blame attached to reporting incidents.
- Junior doctors said that consultants were approachable and supportive.

Public and staff engagement







- Children's experience of care was reported on the comments tree on display at the ward entrance. NHS Friends and Family Test responses were also displayed prominently on wards. Children were slightly less happy than their parents. The ward was engaging with college students to identify ways of improving children and young people's experience of being in hospital.

- Nurses said complaints would be discussed at monthly team meetings but there were few formal complaints. We saw evidence of changes in response to feedback, for example advertising the availability of Wi-Fi to parents on the ward.
- Staff felt engaged with their ward and enjoyed their work but seemed not to identify closely with the rest of the trust.

Innovation, improvement and sustainability

- A newborn observation track and trigger chart had been developed by a midwife working at the trust with input from the paediatric team. This neonatal observation chart had been nominated for a national award by the Royal College of Midwives.
- A paediatric pilot of on-call consultants to advise GPs between 09.00 and 17.00 had received positive feedback from GPs and the trust was considering rolling out this service as a way of reducing admissions. However, at the time of our inspection a final decision had not been made.

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 is delivered in most wards in the trust. The end of life care team is made up of the Macmillan palliative care team, the Macmillan oncology acute team, allied healthcare professionals, the chaplaincy team, an oncology psychologist and medical cover from another provider outside of the trust.

We spoke with 30 members of staff, including doctors, nurses, the chaplain and 15 patients and relatives using the services. We looked at care records and other documents, including meeting minutes and audit results staff used when delivering care. We received comments from our listening event about their experiences of end of life care.

The end of life team were available Monday to Friday only. Staff requiring the end of life team input out of hours accessed a telephone support service which was delivered by another provider. Arrangements for absence of the nurse team such as annual leave; these were covered internally within each nurse team.

Although the nurse teams have the cancer charity name, Macmillan, in their titles, they would support people who did not have malignancies who required end of life support. However, the referral process it was left to staff to identify who to contact within the nurse teams.

The trust's end of life provision was not clearly defined and is fragmented. Basic information such as the number of inpatients who are receiving end of life care as inpatients is available but staff do not routinely use it effectively.

Patients receiving end of life care could be admitted and discharged without seeing a member of the end of life team resulted in some patients not receiving appropriate support. The referral criteria was not understood by staff on the wards as there was no clear definition regarding who was to be called when a patient was at the end of their life.

Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) paperwork was not fully completed and this led to confusion and raised safety concerns for patients. There was no guidance for staff to follow on the action staff should take if mental capacity assessments found an individual lacked capacity. The trust's resuscitation policy did not have parity with the DNA CPR form used and led to further confusion.

End of life care

Summary of findings

The trust's end of life provision was not clearly defined and is fragmented. Basic information such as the number of inpatients who are receiving end of life care as inpatients is available but staff do not routinely use it effectively.

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Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) paperwork was not fully completed and this led to confusion and raised safety concerns for patients. There was no guidance for staff to follow on the action staff should take if mental capacity assessments found an individual lacked capacity. The trust's resuscitation policy did not have parity with the DNA CPR form used and led to further confusion.

Are end of life care services safe?

Requires Improvement



The trust was not always able to support patients and family on an end of life pathway. The criteria for referral was not uniformly understood and allowed some patients to not have any interactions with the end of life care team. Previous audits had identified that 28% of end of life patients had input from the end of life care team (May 2013). However, when referrals were made to either the palliative care team or the Macmillan team, the response rates were timely and the interactions were supportive and effective.

The trust's current resuscitation policy, which is scheduled for review in August 2014, was not up to date. It referred to DNA CPR paperwork that was no longer in use within the trust. The use and completion of the DNA CPR paperwork and staff understanding of mental capacity was not adequate, and this was confirmed by the staff we spoke with. Staff stated that they did not fully understand their responsibilities under the Mental Capacity Act 2005 or how it related to DNA CPR.

Incidents

- The bereavement office collected feedback regarding their service, and this was generally positive.
- The resuscitation team in the last quarter of 2013 undertook an audit of DNA CPR paperwork. The intermediate findings were that there was a marked improvement in completion of these forms as opposed to the previous forms. The results were due to be presented in March 2014 but the meeting was postponed. During our inspection we were not provided with the results of this audit.
- There was a second audit of end of life care which was presented to the board May 2013. It identified that end of life care training should be part of the mandatory or essential training for staff as both medical and nursing staff were requesting it.

Cleanliness, infection control and hygiene

- Side wards were used appropriately, but when they were not available, staff used curtains to afford more privacy to patients whose condition had deteriorated.

End of life care

We observed that, when a side room became available, a patient on an end of life care plan was moved to side ward; this offered more privacy for the person and family.

Environment and equipment

- The trust does not have a dedicated ward for end of life patients; they were treated by an appropriate consultant for their medical condition at the time of admission.

Medicines

- Daily or every-second-day pharmacy support was available on most wards we visited. One ward told us they received pharmacy support weekly, but they felt this was adequate.
- Arrangements were in place for patients whose condition could deteriorate. These included medications being prescribed in advance, syringe drivers being available so that patients' waiting time and discomfort was minimised.

Records

- The trust had a resuscitation policy in place, which did not reflect the current practice or the DNA CPR paperwork currently in use.
- Patients receiving end of life care who had been identified as not for resuscitation had paperwork visible in their notes so that staff were aware of what actions to take. However, DNA CPR forms were not always filled in to clearly demonstrate how decisions had been arrived at. Both nursing and medical notes lacked detail of discussions with patients and families.
- We looked at 25 DNA CPR forms, 19 of which had been incorrectly completed, ranging from flowcharts not being completed correctly, and people identified as having capacity not having the decision discussed with them. The most serious inaccuracies were the lack of consultant signatures were not signed for more than 72 hours after the decision was taken. This led to confusion amongst staff when we asked them to tell us if they would act on the forms missing signatures. Some said they would and others said they would not act on them.
- During our inspection we found one patient's records indicated that they had made an advanced decision, but staff were unable to find the advanced decision paperwork.

- Most wards had no processes for the review of DNA CPR paperwork or any agreement about when a review of the DNA CPR decision should be taken. Both medical and nursing staff gave us conflicting information, thinking that the other team would take that decision.
- One senior member of nursing staff told us the paperwork had no place to record a review date which meant they had no guidance of when it should take place. This could result in decisions remaining in place which could have been revoked.
- We saw one patient with an incorrectly completed DNA CPR form, some staff on the ward thought it was invalid and would not resuscitate, some staff thought it was valid and would resuscitate. We raised our concerns which resulted in the DNA CPR being revoked for that person.
- The trust board had made the decision to use their own DNA CPR forms which were not recognised outside of the trust. In the event that a patient needed to be moved, the nationally recognised DNA CPR transport form was to be used.
- Senior staff were unable to tell us what happened to patients who are admitted with a different DNA CPR form. We were therefore unclear if a new form would be completed or if the patient would be resuscitated, despite previously agreeing to DNA CPR with another trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The use of mental capacity assessments for patients was not fully undertaken in line with the trust's resuscitation policy.
- The resuscitation policy made reference to a specific consent form to be used in the event of a patient being identified as lacking capacity. We asked a number of staff if they used this specific consent form, and they could not recall using it or ever having seen it when we asked about the form.
- Where some patients had been identified as lacking capacity on their DNA CPR forms, we were told that no formal capacity assessment had been undertaken. Most documented that family had been involved with the decision, but not in every case. The resuscitation policy and the advice on the back of the form makes reference to mental capacity assessments, but we saw none had been done for patients identified as lacking capacity.

End of life care

- Both medical and nursing staff were not clear whose responsibility it was to undertake the assessments.
- When patients had been identified as lacking capacity to make DNA CPR decisions, no formal review was undertaken. Therefore if this lack of capacity was temporary, the patient was not given the opportunity to discuss the decision and make staff aware of their views.

Safeguarding

- We were told by senior staff within the trust that safeguarding training was currently being undertaken and dissemination of information was to commence. We received no indication from senior staff of how many staff were to have received this training and when by. We did see that, among nursing and allied healthcare staff, the mandatory training completion rate was 90% for February 2014. Medical staff achieved 72%.

Mandatory training

- End of life training is not part of the trust's mandatory training programme. Following a review of the service in May 2013 it was recommended that this training should be included in the mandatory training programme. However, one year later this recommendation had not been delivered.
- Both medical staff and nursing staff did have some limited opportunity to receive specific end of life training. When time was available in the timetable of the mandatory training days, training was delivered, but this was not always possible. The trust had no target or expectation for numbers of staff to have received this training.

Management of deteriorating patients

- Deteriorating patients were seen by the palliative care team or the Macmillan team. We observed that, when contacted for advice and support, the teams responded appropriately.
- Patients were followed up by nursing and medical staff of the end of life teams. This was to check that the patient responded as intended to the implemented change in treatment.
- Ward staff could not identify who they would contact in the event of requiring support to deliver end of life care.
- Staff called individual members within the team, but could not give clear reasons why they contacted that

particular member of staff. At the time of the inspection there were no clear protocols for referral. However, when we returned for the unannounced inspection the trust had drawn up a referral pathway document

- A member of the palliative care team told us that, on receiving a referral, the correct clinical nurse specialist was identified for their experience, and knowledge of the patient, this ensured the patient's individual needs and wishes were met.

Nursing staffing

- All wards had individual arrangements for staff handover, producing different types of documents identifying patients who were for resuscitation or not, which staff felt provided them with sufficient information to deliver care that met people's needs. However, as patients were frequently moved between wards, there was a risk that their needs or wishes may not be met.
- On two wards we visited we found the information DNA CPR handover paperwork information was incorrect, as it identified patients for resuscitation or not for resuscitation who had invalid or incomplete paperwork.
- The end of life team consisted of palliative care team and Macmillan team, allied healthcare professional, complementary medicine, psychologist and medical support from another provider.
- The Macmillan palliative care team consisted of two nurses with another joining the team in June 2014. The Macmillan acute oncology team was fully staffed with two clinical nurse specialist staff.
- Both the palliative care team and Macmillan acute oncology team covered each other when staff were absent for such things as annual leave and sickness. Both teams covered Monday to Friday day-time hours, but were planning from June 2014 to extend to cover to include Saturdays.
- The clinical nurse specialists held post-qualification degree level courses and had experience with their areas prior to their current positions.
- The team was managed by a lead nurse manager who had been in post for approximately two months.

Medical staffing

- Medical support was procured from two other providers. The majority was from St Giles Hospice and a smaller amount of consultant cover was purchased from Royal Derby Hospital. This was the equivalent of two-and-a-half days a week on-site consultant cover.

End of life care

When patients had been referred to the Macmillan palliative care team or the Macmillan acute oncology team, the specialist nurses would seek input from the consultants for these patients when they were on site.

- Senior staff told us that this level of cover was sufficient. However, the hospital had not undertaken any evaluation to determine if this level of cover was adequate or achieving outcomes.
- Following our inspection, the trust informed us that they would be recruiting a consultant for end of life care, to improve the service further. This action had not been completed and therefore we were unable to confirm if this post had been successfully recruited to.

Are end of life care services effective?

Requires Improvement



Patients who were referred to the end of life service received appropriate care and treatment from the team but not all patients requiring this service were referred. We saw that multidisciplinary team working was available. The input from physiotherapy and occupational therapy was most evident.

The pilot phase of the 'amber care bundle' was underway and was being used on three wards. At the time of the inspection, there was no lead for this pilot. We found that some staff were unaware and or uncertain of how it was to be used. The trust was aware that staff lacked knowledge about how to use the amber bundle and were due to commence training for staff to improve competence in undertaking mental capacity assessments and end of life training.

Evidence-based care and treatment

- The trust was currently trialling on three wards a nationally recognised care pathway called the amber care bundle, which identifies patients who may not recover but were considered as pre-terminal.
- Senior staff and ward staff told us that there was some confusion with its use. We found some staff were confident in its use and were able to describe to us its use and benefits.
- One member of a medical team on one of the wards that was piloting the amber care bundle was not aware of it or its use at all.

- Other patients not being treated on the pilot wards who were identified as requiring end of life care were started on end of life care plans, which identified the individual's specific nursing care needs.
- The trust maintained records of the average percentage of patients who die in hospital who are admitted and assigned with palliative care coding. The result showed that it was below the England average on the Keogh Dashboard 2014.
- Audits of the effectiveness of the end of life provision were not undertaken routinely. We did see limited audits of end of life care produced for commissioners to detail impact of the provision the last of which was produced and presented in May 2013.
- The resuscitation team undertook reviews of the DNA CPR paperwork to identify if this was being used correctly. The last review following a change in the paper work found that there had been improvements in the completion of DNA CPR paperwork. However, during our inspection, we found that not all DNA CPR paperwork was completed correctly conflicting with the findings of the audit.
- Staff told us that part of the end of life care was pain control and if they could not achieve this for the patient this is one reason they would refer to the palliative care team.
- In response to the Cancer Patient Experience Survey, which asked patients whether staff did all they could to reduce their pain, the trust scored higher than the England average for this question.

Patient outcomes

- Patients identified as requiring end of life care were started on an end of life care plan. The palliative care team had produced guidance for ward staff. This took the form of a folder which we saw in the ward settings and included anticipatory prescribing.
- Staff we spoke to were aware of this guidance on the ward.
- When staff contacted a member of the end of life team, they responded by giving telephone advice which was followed up by the specialist nurse the same day (Monday to Friday in hours), and the nurse and consultant from the palliative care team would visit the patient the next day. Telephone support was available out of hours via St Giles Hospice.

End of life care

- Referrals were usually responded to within 24 hours, except weekends, when out-of-hours cover was provided via a telephone service.
- An audit presented to the trust in May 2013 found that 28% of patients receiving end of life care within the trust had contact with the end of life team.
- Within the surgical wards DNA CPR orders were in place for those patients assessed as needing them. We witnessed patients were also put on an amber care pathway for end of life care. The amber care bundle supported a patient with end of life care in acute hospitals. The four DNA CPR forms we looked at in surgery were appropriately signed and documentation of discussions with the families was written in the medical notes.
- To support patients who had any communication needs, the trust had developed the 'This is Me' document to help staff when providing direct care. Families were encouraged to complete the document, which was placed at the end of the bed for staff to better understand the person they were caring for.
- The trust participated in the National Care of the Dying Audit and achieved three out of the seven organisational key performance indicators.

Competent staff

- We were told by a board member that the palliative care team had undertaken training with appropriate staff in end of life care.
- Both nursing and medical staff we spoke with stated that they would benefit from training to care effectively for people receiving end of life care.
- An audit presented to the board in May 2013 (6.14.4 EOL Re-audit 2013) recommended that end of life care should be mandatory or essential training, however, this had not been actioned at the time of the inspection.
- Two of the staff within the palliative care team had completed the palliative specialist nurse training.
- The oncology nurse team were appropriately trained for their role, having a post-graduate qualification and appropriate experience prior to the uptake of their posts.
- Despite being told that mandatory training was at 92%, many medical and nursing staff we spoke with were not confident in undertaking mental capacity assessments and felt they needed more training to understand their responsibility.

- We were told by senior staff within the trust that safeguarding training was currently being undertaken and dissemination of information was to commence.

Multidisciplinary working

- We saw that multidisciplinary team working was undertaken in the trust.
- Patients receiving end of life care were offered complementary medicine which included aromatherapy, reflexology, acupuncture and homeopathy in the community, but not when they were in the hospital as this was only available in the community.
- The end of life team had access to spiritual support from the chaplaincy service. This included support for people of all religions and beliefs 24 hours a day, seven days a week.
- Multidisciplinary team working took place, and we observed patients being discussed with the palliative care nurse, a consultant and an occupational therapist.
- The lead nurse manager of the service chaired a weekly formal meeting between the clinical nurse specialists and allied healthcare professionals involved with patients receiving end of life care.
- On admission patients identified as requiring end of life care who also had a malignancy had this need documented on the electronic care plan. This information was used to generate a report of the number of inpatients with malignancies on an end of life pathway and was sent to the Macmillan acute oncology team. However, when we spoke with senior staff and management they were unable to tell us how many people were currently in the hospital on an end of life pathway. Therefore it was not possible to confirm how many patients in the trust were receiving end of life care.

Seven-day services

- Mortuary staff worked Monday to Friday, but were available on call if needed, for example, where an unexpected death had occurred and families needed to view their relatives.
- The chaplaincy service offered an on-call service and was available seven days a week.
- Medical consultant cover and specialist nurse support was available out of hours via a telephone support from St Giles Hospice.
- The trust plans to offer Monday to Saturday end of life clinical nurse specialist service from June 2014.

End of life care

Are end of life care services caring?

Good



Patients received care and treatment that met their needs. Patients and families were happy with the level of care they received and were afforded a good level of dignity and compassion from all the professionals. However, not all patients were able to die in their preferred place.

Compassionate care

- We observed staff interactions with patients and their families were compassionate and appropriate at all times.
- Patients and families we spoke to told us they were happy with the level of care they or their family members received.
- We observed a person being taken to the morgue and the conduct of the porter staff was respectful.

Patient understanding and involvement

- Patients were able to make decisions about their care. Patients had the opportunity to actively identify preferred places of dying. An audit presented to the board on end of life care 2013 showed that, from a sample of 20 people who had identified a preferred place of dying, 6% had died in their preferred place. This was the latest information available at the time of the inspection.
- Staff we spoke with were able to describe conversations they had had with patients about their wishes. The trust ensured that people who needed support to express their views used a tool called "This is me". These were forms completed by people who knew the person and were able to identify what was important to them.
- Families were involved in identifying their relative's likes and dislikes and personality traits, along with life history and people who were important to the patient.

Emotional support

- The end of life care team supported people emotionally. The team had received training to enable them to support patients and families.
- Ward-based nursing staff described how they supported patients and families after medical staff had told patients their condition was now terminal. This took place after the medical staff had departed, allowing them to ask further questions.

- The cancer care team had regular meetings where staff were given the opportunity to discuss a patient's care that was worrying to them.
- Counselling services were available to patients from the clinical nurse specialists. We were told that an oncology psychologist was available once a week, but their focus was patients diagnosed with a malignancy.

Are end of life care services responsive?

Requires Improvement



The trust does not always meet the needs of people at the end of their life. People on an end of life care plan may have not been able to access additional support as they had not been referred. The trust did not take a proactive approach to developing end of life services.

The mortuary and bereavement office communicated effectively with families and funeral directors to ensure religious customs were honoured and respected. Reduced car parking fees were available to families of patients, who were dying, but this was not publicised, and many families were unaware that this support was available to them.

Service planning and delivery to meet the needs of local people

- At the time of our inspection, the trust was not able to tell us how many people in the hospital were receiving end of life care. The lack of this information does not allow the team to manage their workload and the development of the service.
- The morgue viewing room was restful and allowed family's privacy. We noted that, if the deceased was considered to be infectious, families could still view the body from behind a glass screen.
- Patients were able to make decisions about their care. Patients had the opportunity to actively identify preferred places of dying. An audit presented to the board on end of life care 2013 showed that, from a sample of 20 people who had identified a preferred place of dying, only 6% had died in their preferred place. This was the latest information available at the time of the inspection. However, this equates to 1.2 people which is not possible and calls into question the quality of this data that the trust has relied upon.

End of life care

Access and flow

- During the inspection we did not see any patients on an end of life pathway whose religious beliefs meant that, in the event of their death, they needed to be buried/cremated as soon as possible.
- However, while reviewing the records in the mortuary, we saw that families had been able to arrange to remove their family member in accordance with their religious customs and beliefs. In one record we saw evidence that this had been achieved where the person was in the mortuary for only five minutes.
- During the listening event, we were made aware that staff did not actively seek local Imam support when Muslim patients were admitted. The hospital chaplain usually tried to inform the Imam if he was aware of any Muslim patients in the hospital.
- We saw that families were not restricted to the stated visiting times, being offered open visiting times to support them and the patient on an end of life pathway.
- Reduced cost car parking vouchers were available for families who needed to be with their family member for extended periods due to receiving terminal care. Not all staff on the wards were aware that such a service was available to families.
- Staff confirmed that translation services were available for people. This was both in person and via a three-way telephone service.
- At the time of our inspection, no one in the hospital required translation service.
- The trust employed discharge facilitators who liaised with the multidisciplinary team to ensure all the support the patient required was in place prior to their discharge.
- The trust had recognised that further improvements to discharge planning were required. The end of life action plan dated September 2013 included an action that patients were to be discharged within four and 24 hours when appropriate. However, we did not see evidence that this occurred in practice. The Keogh mock review in January 2014 also found that discharges were delayed within the trust.

Meeting people's individual needs

- There was a lack of consistent approach from both the ward-based medical and nursing staff about when to contact a member of the end of life team. All agreed they would seek further support if the patient was not responding to pain medication..

- Mortuary arrangements were in place such as fridges, trolleys and a protocol for bariatric patients. We saw that a cot was available for families to view infants who had died.
- We saw when staff identified patients requiring the input of a member of the end of life team this was responded to in a timely manner.
- Most referrals to the end of life team were responded to within 24 hours. However, if patients were not referred to the team, the patient could be at risk of not receiving all of the additional support the end of life team were able to offer.
- The report presented to the board in May 2013 showed only 14 out of 50 patients who were eligible to see the end of life care team actually did.
- Ward staff told us that regular reviews with a member of the end of life team took place, usually daily once a patient had been referred to the end of life team.
- Pharmacy reviewed medication daily or every other day for patients receiving end of life care to ensure medications were still appropriate.
- The trust had a Macmillan cancer care resource centre at Queen's Hospital. A facilitator was based there and described the ways they could support patients emotionally and practically. They gave the example of a patient's family that wanted advice regarding home improvements to support the person when they got home.
- This service was only available to patients diagnosed with a malignancy. The trust did not have an end of life facilitator for patients who did not have a malignancy.
- Over the past two years the trust had identified that the access for families to morgue viewing room was in need of refurbishment. However, no improvements had been made to date.
- We were not provided with information to demonstrate that patients could be discharged within 24 hours if necessary.

Learning from complaints and concerns

- Complaints relating to end of life were not identified specifically. When a complaint or compliment was received and mentioned a member of staff from this team, the information was shared with them from the Patient Advice and Liaison Service or the complaints department.

End of life care

Are end of life care services well-led?

Inadequate



At the time of our inspection a clear vision or strategy for the service was not evident. There was no effective leadership of the service and no clear lines of accountability and assurance that end of life care was being adequately delivered. The trust has been aware that the end of life steering group has lacked leadership for the last 12 months, no action has been taken.

Audit and feedback information was limited and where actions had been identified they had not been addressed in a timely manner.

Vision and strategy for this service

- At the time of our inspection a clear vision or strategy for the service was not evident.
- Senior staff and board members we spoke with told us they felt they had more to do to strengthen the service.
- We noted in board minute papers (Mortality Assurance Review Group, March 2014) that the end of life steering group was a concern to the trust as it lacked senior representation. This issue had previously been identified and presented to the board in May 2013 (End of life re-audit 2013) but to date had not been addressed.
- We observed staff wearing the 'Ask me' badges, to encourage patients and families to ask questions, and staff we spoke with reported that this was a positive initiative.
- The end of life staff were committed to the service and patient care.
- Following our inspection, an end of life action plan detailing the changes required to improve patient experience and care was developed, which included timescales for making improvements.
- Also after our announced inspection, the trust told us they had appointed an interim medical lead for end of life care with immediate effect.

Governance, risk management and quality measurement

- There was no evidence of the quality measures that were in place for the end of life team.
- The care of people was devolved to the treating physician within the trust.

- Risk management was not effective and we observed numerous incorrect DNA CPR forms.
- Staff's lack of confidence in undertaking mental capacity assessments, resulted in patients not being fully safeguarded.
- Measuring quality was not effective due to the lack of feedback arrangements available for end of life care. This included the end of life teams not knowing the number of patients in the trust receiving end of life care.
- The trust had recognised the risk to patients and that the service required more staff to fully deliver on patients' needs. They had recruited but the new staff had not started at the time of the inspection.

Leadership of service

- The leadership for the end of life service was unclear and it was not possible to identify who was operationally responsible for the service other than the director of nursing was the strategic lead.
- The end of life team comprised the palliative care team and Macmillan oncology team, plus allied healthcare professionals, complementary medicine practitioners, psychologists and part-time consultant cover from another provider.

Culture within the service

- While the end of life team were committed to improving patient experiences at the end of their life, they faced numerous challenges when delivering the service. These included a lack of structures in place.
- Since our inspection we were informed that several improvements had been made, including the appointment of a medical lead for the end of life steering group and the completion of an action plan which was to be presented at the next meeting. However, as these changes occurred following our inspection we were unable to assess the impact they were having on patients' experience.


Public and staff engagement

- There was no evidence of feedback from families of patients receiving end of life care.
- The trust had taken part in some national surveys of patient experience, including a bereavement survey. The results the trust provided to us during our inspection were from the bereavement survey completed in 2011. This report showed that most results were within the normal parameters.

End of life care

- We did note one result which continued to remain unresolved by the trust. This related to people dying in their preferred place. The trust's last audit of end of life provision in 2013 showed that, from a sample of 20 people, only 6% had died in their preferred place.
- During our inspection we saw that the Macmillan part of the service had prepared a feedback questionnaire which was due to be sent out shortly.

Outpatients

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

Information about the service

The Burton Hospitals NHS Foundation Trust provided outpatient services to 358,607 patients in the year April 2012 to March 2013. Clinics were held at Queen's Hospital Burton Upon Trent, Samuel Johnson Community Hospital in Lichfield and Sir Robert Peel Community Hospital in Tamworth. The departments were staffed by reception staff, doctors, nursing staff, clinical support workers, and student nurses who attended outpatients on placement as part of their training. The clinics at the community hospitals in Lichfield and Tamworth were attended by doctors from Queen's Hospital or other providers, such as the Heart of England NHS Foundation Trust and Midland Eye Care. Specialist nurses also held clinics.

We inspected the outpatient services provided by Burton Hospitals NHS Foundation Trust at Queen's Hospital. We spoke with 36 patients and two parents of a patient using the service. We spoke with eight senior staff, which included nursing managers, consultants and the outpatients department business manager, as well as 29 other staff, including nurses, assistant nurses, technicians and administrative staff. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Equipment was maintained and regularly checked, and the areas were visibly clean and uncluttered. Staff had completed mandatory training and had opportunities to access further appropriate training. There was evidence of multidisciplinary meetings and shared learning with other departments and organisations.

Most patients had access to outpatient services within the national guidelines. We found that there were significant waiting times for patients attending appointments in some clinics. The organisation reviewed care and treatment through local clinical audits and monthly performance dashboards by division. All the staff we spoke with felt supported by their immediate manager. We saw evidence of the middle management working well to improve links between senior and lower grade staff. However, it was evident that the executive board had not reached all the staff within the trust.

Outpatients

Are outpatients services safe?

Good



There was a clear process for reporting incidents and any learning was shared with staff. We found the outpatient areas we visited visibly clean, tidy and uncluttered. Patient records were transferred to clinics in an appropriate manner. However an issue was raised that some records were not securely stored while waiting to be transferred back to the records office.

Incidents

- There was a clear process for reporting incidents and any learning was shared with staff.
- The trust's risk management policy states that all staff are personally required to make the management of risk part of their daily duties. Staff were encouraged and felt confident about reporting incidents to their manager and using the electronic reporting system.
- The patients we spoke with told us the clinical staff were aware of their medical history and would check whether there had been any changes since their last visit if they were a regular visitor to the department. We heard administrative staff check patients' identity and contact details when they arrived for their appointment.
- In the last 12 months, there were no Never Events. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- The senior sister reviewed all the reported incidents relating to the department. Incidents relating to staff supporting the clinics or environmental issues were investigated by the outpatient services. Incidents that related to a clinician were escalated within the division they worked in, for example, medicine, surgery or orthopaedic.
- The outcome, learning and any changes in policies or procedure relating to incidents was communicated back to staff through monthly meetings or on an individual basis.
- Staff were able to provide examples of where lessons had been learned following incidents. For example, an escalation process had been introduced for patients who required admitting to the hospital from any of the trust's outpatient departments. This followed an incident where a patient's condition deteriorated while

attending an outpatient appointment. An ambulance was called as the patient required a trained medical crew to transfer them to the hospital. On arrival the ambulance was turned away from the outpatients department as it had closed and staff were unaware of the situation. Although there was no risk to the patient on this occasion, staff realised they did not have a procedure in place in the event of a patient requiring admission from the outpatients department. The escalation procedure included the process to follow for clinically stable and unstable patients.

Cleanliness, infection control and hygiene

- The outpatient clinics we visited were visibly clean, tidy and uncluttered.
- Staff complied with the trust's policies for hand hygiene and wearing personal protective equipment.
- Hand gel was readily available for staff and visitors to use in all the departments we visited.
- We observed that all staff followed the 'bare below the elbow' best practice guidance.
- Cleaning was provided by the in-house housekeeping team. Cleaners were visible and we observed them clearing general and clinical waste areas. Nursing staff were responsible for cleaning clinical areas. We checked a sample of cleaning audits and schedules and saw they were completed regularly.

Environment and equipment

- Equipment, including resuscitation equipment, was checked daily in the areas we visited and a record was kept of these checks and audits.
- The equipment we looked at had stickers to demonstrate they had been portable appliance tested and these tests were up to date.
- The resuscitation trolleys were kept in unlocked rooms for ease of access in an emergency. They were covered but did not have lockable drawers which meant items could be accessible to unauthorised people. We were told that this was a trust-wide issue and senior management were aware of the situation but no action had been taken to address the issue.
- The radiology department had identified a risk of attaching radiology reports to the wrong patients records due to an incompatibility between the radiology IT and the hospital's IT system for storing patient records. They had clear processes in place to prevent an incident from happening.

Outpatients

- A new radiology IT system had been identified and was going through the tendering process at the time of our inspection. This new system will be compatible with the patient records system and prevent recording a patient's diagnosis against the wrong patient.
- We were told by staff there was sufficient equipment and facilities. Staff told us that broken equipment was replaced. If any equipment was broken, the department was able to use equipment in the private outpatients department located at Queen's Hospital until a repair or replacement was arranged.
- The ophthalmology clinic at Queen's Hospital was bright and easily accessible. However, the ophthalmology clinic at Sir Robert Peel Community Hospital was not easy to navigate for people with impaired vision, and there was very little signposting. We were told there were no plans to address this issue.

Medicines

- Patients reported that the clinical staff and pharmacy discussed any medication changes and treatment with them, and they understood any side effects they might experience. They knew who to contact if they had any concerns. Nursing staff told us they would answer any queries patients had after their consultation.
- There were appropriate arrangements in place for the safe storage of medications in the pharmacy area and where medicines were stored in the outpatients department. These were stored in lockable rooms that could only be accessed by appropriate staff.
- Medication fridge temperatures were checked daily and controlled drug checks were completed appropriately.

Records

- Staff described the processes they would follow if patients' paper case notes were unavailable. This did not present a significant risk to the patient as records were kept in an electronic format that clinicians accessed, unless a consultant wished to compare x-rays older than five years old or medical photographs older than two years which were not stored on the IT system.
- The hospital was in the process of rolling out the scanning of letters from patients' GPs and consultants from other hospitals. At present only letters relating to gynaecology or paediatrics were scanned in.
- The patients we spoke with told us the clinical staff were aware of their medical history and would check whether

there had been any changes since their last visit if they were a regular visitor to the department. We heard administrative staff check patients' identity and contact details when they arrived for their appointment.

- There was safe transfer of patient medical records from the medical records office to clinics. Patient records were kept behind the reception desk in open trolleys and transferred to the clinic receptions by hand once the patient had booked in at the main reception. Nursing staff took patient notes into clinic rooms between appointments.
- Patient notes at reception desk B were not stored securely. Although they were behind the reception desk, they were visible to patients and could be accessed by unauthorised people without being seen by the reception staff.
- Volunteers who worked at the hospital helped to transfer patient notes to clinics. All volunteers had the relevant checks to ensure they were of good character and had to sign a confidentiality agreement.
- We saw that when patient records were carried a short distance, they were always carried face down so names were not seen. If notes were taken any distance, they were put in a sealed bag or envelope to ensure personal information was not shared inappropriately.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All senior staff had completed training in the Mental Capacity Act 2005 and its associated deprivation of liberty safeguards.
- We saw information on staff noticeboards on how to respond to people with learning difficulties, such as difficulties with reading, writing or expressing themselves. Staff told us that most people who attended the department with any mental health issues or learning difficulties came with a relative or carer. However, they said if they had any concerns, they would speak to their manager immediately.

Safeguarding

- There were systems in place to identify and protect vulnerable people from abuse. These included how to recognise different signs of abuse and who to escalate any concerns to at the trust and local authority. All outpatient department staff, including clinical and administrative staff, had received training in safeguarding, in line with the trust's mandatory training.

Outpatients

- Staff we spoke with were able to describe the process for reporting any concerns.

Mandatory training

- Staff were required to complete a range of mandatory training. At the time of our inspection, all the nursing staff who were currently working in the outpatients department had completed their mandatory training.
- All the staff working in the department (apart from those on long-term leave or sickness) had completed their mandatory training.
- The senior sister showed us the IT system used to monitor staff training on a weekly basis. The senior sister was able to give appropriate reasons why some staff were in breach of their required training. This included long-term sickness or annual leave. They were due to complete their training when they returned to work.

Management of deteriorating patients

- There was a procedure in place for patients whose condition might deteriorate during their visit to the outpatients department. This included how to transfer stable and unstable patients to the main hospital for admission. Stable patients could be transferred with the aid of a porter and nursing staff, as opposed to unstable patients who would require an ambulance with a trained medical crew.
- Staff we spoke with were aware of the procedure they should follow.

Staffing

- Clinics were supported by reception staff, doctors, nursing staff, clinical support workers, and student nurses who attended outpatients on placement as part of their training.
- Staffing levels varied on a daily basis according to the clinics running, and rotas could be adjusted quickly to ensure extra clinics could take place if necessary.
- Some clinics were run by specialist nursing staff.
- Unexpected staff absent was covered by the senior sister moving staff from another clinic to ensure that the clinic was covered by a member of the nursing staff with the required skills.
- The department used long-term regular bank staff to cover permanent staff absence. Many of the bank staff were experienced, retired permanent staff who wished to continue working at the hospital.

- In some departments, such as ophthalmology and radiology, it had been identified that staffing levels were insufficient. Posts were in the process of being advertised and recruited to. However, the radiology department were finding it difficult to recruit experienced staff, especially sonographers, but this was also identified as a national problem.

Major incident awareness and training

- All staff we spoke with were aware of the evacuation procedure and their roles and responsibilities. However, there had been no mock evacuation drill in the outpatients department.
- We were told the fire safety officer regularly held lectures to refresh staff knowledge and they visited the department to ask staff what they would do in different scenarios.
- Staff could explain the procedure they would follow in the event that the IT system should fail and they could not access a patient's electronic records or the appointment booking system.

Are outpatients services effective?

Not sufficient evidence to rate

The organisation reviewed care and treatment through local clinical audits and monthly performance dashboards by division. There was a rolling programme of surveys used to assess the quality of patients' experience in the department. These were conducted on a monthly basis across different outpatient and diagnostic service departments at each of the trust's hospitals. The department visited other hospitals to research alternative systems to increase the effectiveness of the service.

Staff followed national guidelines where appropriate, along with the trust's policies and procedures, and guidelines relating to their profession. The outpatient service measured some elements of their effectiveness by using data from accredited agencies. People received care from suitably qualified staff who were appropriately trained, regularly supervised and appraised. The environment was spacious and light and suitable for wheelchairs. Patients were able to obtain copies of letters sent to their GP. However, we found that the onus was on the patient to know they were entitled to them and ask for the letter.

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Evidence-based care and treatment

- Nursing staff followed trust's policies and procedures. Specialist nursing staff were expected to follow the National Institute for Health and Care Excellence (NICE) guidance relating to their speciality, such as cardiovascular disease, diabetes or cancer.
- The Royal College of Nursing and the Royal Marsden Hospital national guidelines were followed for clinical nursing procedures. Staff could access clinical guidelines, policies and procedures through the trust's intranet system.
- The Queen's Hospital endoscopy unit was JAG accredited, and so was audited in line with JAG requirements for pain control, staff competencies and training, comfort scores and sedation. The audit results for 2013 were generally positive, with a negative finding about the waiting list causing a backlog of patients.
- The lead clinician chaired an endoscopy multidisciplinary team user group. They had discussed the need to improve continuity of care and treatment plans. They aimed to improve patient outcomes, for example, after biopsy, when new symptoms are reported or when completing a course of treatment.

Patient outcomes

- There was a rolling programme of surveys to assess patients' experience of using the outpatients department. These took place for a month at a time in different outpatient and diagnostic service departments at Burton, Samuel Johnson and Sir Robert Peel Hospitals. The first question on the survey incorporated the NHS Friends and Family Test.
- We saw examples of patient care and treatment plans at the ophthalmology clinic. These included pathways for people with chronic long-term conditions such as diabetes, glaucoma and age-related macular degeneration.
- The Burton Hospital NHS foundation Trust's research team visited outpatient rheumatology and dermatology clinics to share understanding of the conditions with staff and patients.
- The outpatients department had visited other hospitals to look at systems they used to ease and safeguard the patient's care pathway. For example, the radiology department had visited other hospitals while exploring options for a new radiology IT system.
- Several other departments within the trust used CHKS, a provider of healthcare and healthcare improvement

services, to measure their performance against other hospitals and trusts. Senior staff told us they were joining the NHS Benchmarking Network initiative which typically runs projects to fill the gaps in existing national data coverage. Senior departmental staff said that they hoped that an outpatients department benchmarking project could be initiated through this scheme which they could use to assess the effectiveness of the care, treatment and support they provided.

Competent staff

- All outpatients' department nursing staff had an annual appraisal and a six-monthly review.
- All staff reported that they had good opportunities to further their development through attending courses and seminars appropriate to their role. One staff member gave us an example of having attended a course in cryotherapy so they could assist the consultants by cleaning the instruments. Another member of nursing staff was attending a specialist training day on ambulatory care in gynaecological services with a consultant so they could investigate how to develop the services in the outpatients department.
- Gaps in knowledge regarding any new guidance were explored in divisional governance meetings and were disseminated by the senior sister at the departmental meetings. Records showed that these meetings covered topics including training, policies and procedures and updates from the senior nurses meeting.

Multidisciplinary working

- The outpatient departments shared experiences and learning with other hospitals. For example, the maxillofacial and ophthalmology departments were sharing their practices with Royal Derby Hospital.
- The staff focus group informed us that letters sent from outpatients to patients' GPs or other services related to the patient's care should be sent out within five days. However, only 60-70% of letters were sent within this timescale as it was dependent on the junior doctors having time to write them. Therefore, some patients' treatment or changes in treatment could be delayed due to letters being sent late.
- Monthly multidisciplinary meetings took place at which teams shared their experience, concerns and learning.

Are outpatients services caring?

Outpatients

Good



Patients and their families and friends were treated with compassion, dignity and respect. All the patients and their relatives said the care they received from the staff “could not be any better.” Patients told us they always had enough time with the clinician and felt involved in their care. They understood explanations and had the opportunity to ask questions.

Staff told us their main priority was the care and welfare of people using the outpatient services and wanted to ensure they had a positive experience while visiting the department.

Compassionate care

- All the patients we spoke with talked highly of the care and attitude of the outpatient staff. Patients described them as “warm”, “caring” “compassionate”, “patient” and “kind”. One person said “the staff could do nothing to improve on the quality of their care, we are lucky to have such dedicated well-trained staff.”
- We observed staff being considerate to patients’ needs such as turning the air conditioning down when they noticed someone was cold, and apologising to patients when clinics were running late or cancelled. Staff acknowledged patients in a friendly manner and spent time talking to people who were regular attendees.
- Patients reported being seen in privacy with doors closed. There were signs asking people to step back from the reception desk areas to allow people privacy while talking with reception staff.
- During our inspection, the oncology department had a two-hour delay. We saw a volunteer offering patients refreshments while they waited to help ease the waiting time.

Patient understanding and involvement

- A hospital survey to identify if patients wished to have a copy of hospital letters found that the majority of patients stated that they did not want a copy. However, they found that most oncology outpatients wanted the information. In response to this feedback it was decided that all oncology and paediatric outpatients were provided with a copy of the letters sent to their GP.

- One parent told us they had a child with disabilities which meant it was difficult for them to communicate. The parent described how the staff directed the conversation to their child while speaking to them about the care and treatment for their child.

Emotional support

- Patients told us they felt confident that they could contact the clinic if they had any concerns following their consultation.
- Staff told us that patients quite often forgot what the consultant had spoken to them about during the appointment. They said they would try and answer any queries, but have on occasions asked the consultant if the patient could have another few minutes with them to clarify any questions or answer any concerns.

Are outpatients services responsive?

Requires improvement



Most patients had access to the outpatient services within the national guidelines. However, staff identified the main area for concern was the demand for clinics and the complexity of some patients’ health outstripping the capacity of the service. There were long waiting times for people attending their appointment in some clinics and the service was reviewing ways to increase capacity and reduce the waiting times where possible.

Staff aimed to deal with any complaints or concerns at the time of them happening, to prevent the need for a formal complaint. The service took account of patients’ comments and complaints and discussed any learning from them with department teams.

Service planning and delivery to meet the needs of local people

- At the time of our inspection, the patient access team told there were 20 patients breaching the 18-week deadline for first appointment: 10 of these were for the rheumatology department; three for the ear, nose and throat (ENT) clinic; three for dermatology; and one each for general medicine, gynaecology and oral surgery.
- Burton Hospitals NHS Foundation Trust’s rate for patients not attending appointments averaged between 5% and 10% compared to the national average of 8% from November 2012 to October 2013.

Outpatients

- All the staff we spoke with identified the major challenge for the future as being the demand for the service outstripping the department's capacity. Staff were concerned that the potential increase would mean patients wait longer for their first appointment from referral.
- The hospital was exploring running more nurse-led clinics to increase capacity and ease the burden on consultants. There were some satellite clinics available in the community such as ENT.
- The ophthalmology department told us during our inspection that they had 176 patients who were breaching the 18 weeks. However, this information did not correlate with the information provided by the patient access team who stated 20 patients were breaching and did not provide information that any of these were ophthalmology patients. We were told that ophthalmology also had 582 patients waiting for surgery. On the day of our inspection there were no breaches for patients requiring their first appointment within two weeks of referral pathways.
- Many of the patients we spoke with at the hospital and at the listening event told us about long waiting times in the outpatients department, especially in oncology, ophthalmology, ENT and the blood test clinic.
- Staff told us that appointments could run behind due to patients' needs becoming more complex because of multiple, long-term conditions meaning they needed more time than their appointment allowed.
- On the day of our inspection the oncology clinic was running two hours late and we were told it could run up to three hours behind. The department had identified the capacity issues and how much extra time each clinic required to shorten the waiting time. The plan had a short-term solution and a medium-to-long-term solution to increase capacity.
- Staff told us if the waiting time was considerable they could, on occasions, suggest to patients that they could wait in another part of the hospital, such as a coffee shop, or go home if convenient. Staff took people's mobile numbers to ensure they could call them when they were close to being seen. However, this was not always possible as some consultants changed the order they saw their patients, especially if a patient needed tests or x-rays before the consultation.
- The outpatients department had identified an increased demand for gynaecology clinics. As a temporary measure, there was an increase in clinics; however, it was the staff's view that this would not be sustainable over time.
- The department was reconfiguring one hysteroscopy clinic to a gynaecology urgent cancer referral clinic where patients with post-menopausal bleed could have all the tests they required during one visit. This clinic expected to increase their appointments by 10 to 20 per month.
- There was a chaperone policy and patients could request a member of staff of the same gender if they were being examined by someone of the opposite gender. Clinical staff could also request a chaperone if they felt they could be at risk of abuse or accusations of harming the patient.

Access and flow

- Up-to-date performance data was accessible via the outpatients department's performance report. The data showed that the department was consistently achieving the over the expected target for non- admitted patients receiving an appointment within 18 weeks of referral, or within two weeks for cancer or breast care referrals.
- On the day of our inspection, the ENT clinic had been cancelled three days prior. This was reported to be unusual and due to a correspondence error between the consultant's secretary and the patient access department. All the patients had been called immediately to inform them that their appointment was cancelled and letters were sent by first class post. However, one patient had not received the message and had arrived for the clinic.
- The sample of clinic appointments we looked at showed that there were very few occasions of two patients being booked for the same appointment slots. We were told that this only occurred if the consultant had to see an additional urgent case patient. Wherever possible, these appointments were at the end of the clinic schedule to avoid other patients being delayed.
- Information provided by the trust showed that the referral to treatment times and waiting times for diagnostic test were all similar to other trusts.
- We saw that the outpatients department had considered the flow of a patient's visit across the

Outpatients

different elements of the department. For example, patients visiting cardiology for chest checks on the first floor had to visit a different clinic area on the ground floor for their tests.

- The department recognised that it was difficult for some patients to travel between floors repeatedly. Therefore, they changed the order the patients attended the different clinic areas to reduce travelling between the floors as much as possible.
- Patients attending the rheumatology clinic in the treatment centre received prescriptions that could be used at high street pharmacies, so that patients who were potentially in pain did not have to take a long walk to the pharmacy in the main hospital.
- The business team had visited other hospitals when considering a system for patients to use to book themselves in when they arrived for their appointment. However, it was found that it did not ease queues at the reception desk, as some patients such as elderly and poor-sighted patients, found it difficult to use. Patients had also fed back to staff that they liked to have face-to-face contact.
- There were some nurse-led clinics, such as endoscopy, micro-suction and plastic surgery dressings, which alleviated some of the pressure on consultants. However, we found in ophthalmology that there was scope for enhanced nurse practitioner roles to run some clinics, but this had not been fully explored at the time of our inspection.
- Most of the patients we spoke with knew who they were seeing prior to their appointment. However, in a limited number of cases, patients were not told of a change of consultant until they walked into the consultation room.
- In the breast clinic nursing staff attended pre-operative meetings so they were aware of the patient's care pathway and any concerns they might have. This helped the staff know how to care for the patient on an individual basis.
- There were procedures in place for the management of cancellation of clinics. These included consultants submitting their availability for clinics no later than six weeks prior to the clinic being scheduled. Cancelling and re-scheduling clinics after this time were due to extenuating circumstances.

Meeting people's individual needs

- Patients' needs were assessed and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.
- All the people we spoke with told us they had consistency of care. One person told us they visited a number of different clinics for different health issues and each consultant was aware of their care and treatment plan.
- There was a transition process for children moving from paediatric to the adult outpatients department. The transition was taken slowly and started when a child was around 14 years old. This allowed the child and parents/guardians to acclimatise to the change in consultant, clinic and managing any long-term chronic conditions.
- The ophthalmology clinic's written information was provided in large print if requested. Patients were sent details of their appointments by letter and, although this was a normal way for appointments to be sent, there had been no consideration that the person may not be able to read it or that they may have to rely on someone to read it for them.
- Patients could be offered appointments with consultants of the same gender. We were told of an occasion when an Asian female patient arrived for her appointment and did not want to be examined by the male consultant. The clinic was able to immediately arrange a female consultant from the division to see the patient instead.
- Patients told us they found it easy to cancel or re-arrange their appointments. One patient told us they were able to book side-by-side appointments for two family members so that they could attend the hospital at the same time which cut down on the number of journeys the family had to make.
- Some clinics were flexible in their appointment system and opening times, for example, the genito-urinary medicine clinic offered a walk-in service as well as appointments, and were open two days a week up to 20.00.
- The radiology department operated an on-call system so that CT scanning was available out-of-hours.
- A new system of 'payment for parking' had been introduced and caused many people immense anguish and upset, especially when visiting for extended lengths of time.

Outpatients

- Staff told us they could offer people who may wish to pray a private room. There was also a multi-faith chapel available for people to use. Vulnerable patients, such as people living with dementia, people with disabilities or learning difficulties, children who had attention deficit hyperactive disorder or prisoners from the local prison were given priority, where possible and if appropriate.
- In response to patients reporting that they did not know if a clinic was running to time or not, clinics had introduced whiteboard to display the waiting times for each clinic and clinician. We were told by staff that they informed patients verbally of any delays too.
- Patients are entitled to a copy of letters the hospital sent to their GP. They were made aware of this through notices displayed in waiting areas that they could request a copy. Patients we spoke with had not seen the notices and did not know they were entitled to a copy of letters.
- The majority of the patients spoke highly of the information they received relating to their care and that they had received information about what to expect at their appointment, including how long it may take, the name of the consultant they were seeing and contact details. People told us they were fully aware of tests, results and follow-up procedures for appointments.
- The hospital had a chaplaincy service and there were volunteers available to help people to find their way around the hospital.
- There were a number of support groups available through the hospital, such as Macmillan cancer care and glaucoma support groups.

Learning from complaints and concerns

- Staff we spoke with were unable to confirm how many complaints had been received that related to the department. If the complaint related to a specific consultant, it was sent to their division to be reviewed. However, we did see that the senior sister responded to complaints that related to the department and kept records of these. Any complaints and learning was discussed at the department's staff meetings.
- Patients we spoke with felt that all their needs were catered for at Queen's hospital. Most of them spoke of positive experiences and felt they were fortunate to have the hospital in their local area. We found the main outpatients department in Queen's Hospital was clearly signposted. Patients' letters informed them of which of

the two main reception desks they must book in at. Staff at these desks directed patients to their clinic.

Volunteers were available to escort patients to the correct clinic if necessary.

- We saw posters and leaflets displayed about Health watch and the Patient Advice and Liaison Service in most waiting areas. However, most of the patients we spoke with were unaware of the services offered or how to make a complaint.
- The hospital had a campaign called 'Ask me' which was designed to improve communication between nursing staff and people visiting the hospital, but the patients we spoke with were unaware of the campaign. However, all the people we spoke with felt confident that if they needed to make a complaint it would be addressed appropriately.
- We were told by all the staff and patients that their main concern related to the car park issues. As a result of these complaints, the department could arrange for patients delayed by an hour or more from their appointment time to pay for a maximum of one hour for parking, or if the clinic was cancelled, for the parking to be free. However, we found that not all staff and patients were aware of this arrangement as we overheard one member of reception staff suggesting the patient contacted the Patient Advice and Liaison Service to arrange a refund for parking as their appointment had been cancelled.
- Patients who attended our listening event also reported issues with parking at the hospital. Issues included shortages of parking spaces, the lack of paying machines, the height of the paying machines as people in wheelchairs found it hard to use.
- The booking staff were responsible for raising any issues relating to booking appointments – such as urgent 'must see' patients being booked in the middle of clinics, causing double appointments and delays to other patients. Staff gave us examples of how they had altered running orders to ease the patient flow.
- If patients were not happy with any aspect of their care, they were encouraged to complain to staff at the time as detailed in the 'Your Rights' information leaflet.
- Written complaints were directed to the complaints department at the hospital to investigate and responded to in line with the trust's policy and procedure.

Outpatients

Are outpatients services well-led?

Good



Some staff in the outpatient services thought the board members were visible and approachable, while other staff said they would not recognise them and their clinic had never been visited by a board member. We also found that, in some areas, staff were unaware of the trust's vision and strategy. However, all the staff spoke highly of their immediate manager.

There was a strong caring ethos in the outpatients department. Staff felt confident in reporting anything that could affect the safety and welfare of patients. There was a clear governance structure to ensure that risks, complaints and poor practice were reported upwards to senior managers within the trust. Outcomes were reported back down through the management levels to staff in the department.

Vision and strategy for this service

- The outpatients staff we spoke with at Queen's Hospital identified with the vision and mission of the trust. They told us their priority was to ensure that patients received safe and effective care and to provide patients with the best experience possible.
- There were forums staff could attend to hear and discuss the trust's vision and future plans. We found that the senior staff felt included in the vision and were able to have discussions relating to the strategy during senior staff meetings. Meeting minutes showed that the senior sister disseminated any information from these meetings to staff during the outpatient department meetings.

Governance, risk management and quality measurement

- Governance meetings involving the senior management from each division at the hospital took place where they discussed complaints and the actions taken. The outcomes from these meetings were passed down through the division at departmental meetings.
- There was a system that facilitated reporting from the department to the board. Staff were aware of their responsibility to report any issues or concerns to their manager, who would then escalate this as appropriate.

- Staff in the diabetic services told us they "don't have enough time to prepare management information due to work load". The staff told us the senior management team were keen for risk management actions and quality measures to be passed down to staff.
- Senior staff were aware of any risks that may impact on the safety or effectiveness of the service, such as insufficient clinic appointments, equipment or IT issues and achieving the target for outpatient department letters to be sent out within five working days. These were logged on the trust's risk register and monitored at monthly risk meetings.
- The department's risk register included the impact for booking in processes at the reception following the implementation of the new IT system. We were told that there were processes in place to mirror the old IT version while the transition took place.
- The outpatient division meeting minutes showed that performance reports included complaints, incidents, environmental issues and anything related to staffing. Other outpatient clinics had monthly meetings within their division – for example, the radiology department held a monthly discrepancy meeting to discuss cases and share learning.
- Some clinics participated in external audits specific to their field, such as the Royal College of Ophthalmologists. Other departments, for example the records office, produced internal audits to evaluate internal performance such as the number of, and reasons for, paper records not reaching clinics on time (for those patients who had both paper and electronic records).
- The outpatients department risk register identified issues that could impact on patients' care and welfare. These included clinics breaching the 18-week referral to appointment deadlines, and the number of appointment slots available.

Leadership of service

- Staff told us they thought the trust's managers did not take people's frustration and comments about parking seriously and some staff took the brunt of patients' anger about it.
- All staff at all levels spoke highly of their immediate manager. They told us they would feel comfortable speaking with them about any concerns or issues. Staff gave us examples of concerns they had raised with their manager and the support they were given.

Outpatients

- The senior sister had an 'open door' policy and staff felt they could approach them at any time. We observed positive support from the senior sister and matron for an experienced junior member of staff who had encountered a difficulty during their work day.
- The senior managers told us they were expected to have a clear diary every morning so they were visible to patients and staff in the department.
- All the staff we spoke with felt confident that they could raise any difficulties, concerns or development needs with their managers.
- Records showed the outpatients department senior staff hosted a meeting every month and reported outcomes to departmental staff.
- Staff told us they aimed to deal with a patient's complaint at the time to try and prevent escalation. Complaints were a standard item to be considered at the patient experience group meeting and as part of the monthly review of the risk register (if appropriate). Any learning and actions planned were also discussed at the monthly departmental meetings.

Culture within the service

- There was a strong caring ethos across all the outpatient departments we visited. All the staff felt they had a role in contributing to the patients' experience. One member of staff said "I care for the patients in a way I would want myself or loved ones cared for."
- Staff told us they were encouraged to report any issues which impacted on patient safety or care, which included concerns about the way another member of staff performed. Staff felt empowered to challenge staff behaviour and attitudes towards patients and their colleagues, for example, poor practice, such as not following infection control best practice, or clinical procedures not being adhered to.
- The business manager described how there had been a change in the organisation's focus from being 'finance led' to one of being 'quality and safety led'. They told us the nursing, operations and finance teams work together to find the best solutions for patients. They said that the attitude was no longer "we can't afford it" but "that's expensive, but how can we make it work".
- The hospital ran a scheme called the 'Going the Extra Mile (GEM) Awards'. The scheme encouraged patients to nominate staff who had done something outstanding. Staff nominated in the month would be awarded a

certificate marking their achievement. We saw some posters relating to this scheme in the department. However, most of the patients we spoke with were unaware of it.

Public engagement

- Patient appointment booking teams were involved in the divisional meetings to discuss the booking rules for clinics. This assisted in them understanding the patients' care pathway, the order appointments should be booked in and the required length of time, and if it was appropriate to offer a 'one stop' appointment to have all the tests they required during one visit.
- There was a rolling programme of monthly patients' experience surveys in different outpatient and diagnostic service departments at Burton, Samuel Johnson and Sir Robert Peel hospitals. The surveys included questions as about issues such as waiting times, how staff treated patients and whether patients had enough time to ask questions and were given answers in a way they could understand.
- The results of the outpatient surveys were reported to the department they related to, the hospital's quality and safety group and the patient experience group. These groups were involved in ensuring the patients' experiences were monitored and actions identified when there were shortfalls in quality care or safety. We saw that one of the main issues related to the car park at Queen's hospital. Minutes of the patient experience group showed this concern was being reviewed. However, the patients we spoke with were unaware that this issue was being addressed by the hospital.
- We saw some departments such as the genito-urinary medicine department had run a separate patient survey to assess the quality of care their patients received. They also asked patients what genito-urinary medicine services they wanted so they could assess whether the types and availability of clinics offered was appropriate.

Staff engagement

- During one of the staff focus group we were told, "the pathology and x-ray staff morale was 'rock bottom' due to changes in working practices and losing their accreditation." This was confirmed by staff we spoke with in the radiology department. However, they had high hopes for positive changes under the new management structure and with a new radiology system which was expected to be up and running by October 2014.

Outpatients

- There were a variety of forums and groups that staff could attend. We saw that staff were given trust/hospital messages about topics such as forums, groups and updates through computer screen-savers. Therefore, staff were constantly informed of any developments and opportunities to be involved in anything related to the hospital.
- The outpatient nursing staff attended a monthly meeting to discuss anything related to the department. This was not a compulsory meeting; however, each member of staff was given a copy of the meeting's minutes.
- The administrative/reception staff, managed by the administration team at the trust, told us they had not had a monthly staff meeting for a number of months. They said they valued these meetings as it gave them an opportunity to raise any issues and suggest new approaches. We noted that the last monthly meetings took place in June 2013.

Innovation, improvement and sustainability

- The breast clinic ran a bra-fitting initiative for women to overcome pain and discomfort after a mastectomy and

this was being adopted by other breast care clinics across the country. The success of the initiative had not been formally audited at the time of our inspection, but the patient feedback was very positive.

- The staff's main concern was that the demand for services would outweigh the capacity of the department and, as a result, they were continually looking at ways to adapt the way the service was run to increase the capacity without reducing the quality of care. However, they were aware that change could take time due to the consultation processes they were required to go through.
- Evidence provided by the trust demonstrated that the trust were aware of outpatient capacity issues and the impact of capacity on cancer waiting times. The issue had been discussed at the board meeting and possible solutions suggested. The outpatient performance dashboard showed that the referral to treatment time target was not met. However, at the time of our inspection the potential solutions to address this issue had not been implemented

Outstanding practice and areas for improvement

Outstanding practice

- The maternity services were recognised in May 2014 as providing excellent care by an independent provider of healthcare intelligence and quality improvement.
- The service was one of the only maternity services nationally to use the enhanced recovery programme for women following a caesarean section, if it was clinically appropriate for them. The aim of the programme was to speed up the recovery process, so that women could be discharged the day after a post-elective caesarean section if it was safe to do so.
- There was a seven-day therapy service available from 7am to 7pm, with a focus on patient care within medical services.
- A tool developed by a nurse and a pharmacy colleague that assessed the impact of certain medicines in contributing to the risk of falls had been shortlisted for a national award. This tool was used on wards and had significantly reduced the number of falls.
- The orthopaedic team had introduced an enhanced recovery pathway for hip and knee replacements that had reduced the length of stay. National data demonstrated that their hip and knee revision rates were significantly lower than other trusts.
- The bereavement office participated in the doctors' training programme, delivering joint training with coroners on a range of issues, including completion of death certificates. This significantly reduced the number of death certificates completed incorrectly.

Areas for improvement

Action the hospital MUST take to improve

- Complete the 16 outstanding actions from the Keogh review that had not been delivered and were overdue in April 2014.
- Ensure that all relevant staff in the trust are trained in paediatric life support and staff in the neonatal unit are confident in neonatal resuscitation.
- Review the arrangements and facilities for the stabilisation of high dependency children on the paediatric ward.
- Review the arrangements for junior doctors cover on the labour ward between midnight and 7am, to ensure it meets nationally recommended guidelines as set out in Towards Safer Childbirth.
- Review which staff require training to Level 3 in child protection and provide this training.
- Review staffing in the neonatal unit and ensure it meets the requirements of the British Association of Perinatal Medicine of one nurse per nursery.
- Review the resuscitation committee and consider whether the current frequency of meetings is sufficient to mitigate the risks.
- Ensure that all resuscitation trolleys are easily accessible in an emergency and that all oxygen cylinders are in date and fit for use.
- Ensure that the trust's resuscitation policy reflects current best practice.
- Review the Do Not Attempt Resuscitation (DNA CPR) paperwork currently in use and take action on the findings to ensure this is fit for purpose and staff are trained in the completion of this paperwork.
- Review the pathway of care for patients at the end of their life and ensure that all nurses know who to contact and when.
- Review bed capacity to reduce the number of medical outliers and minimise the number of times patients are moved during their stay in hospital.
- Take action to ensure that the care for people living with dementia is embedded in all division across the trust.
- Take action on the findings of the WHO surgical safety checklist audit and strengthen the assurance process.
- Review the training provided to staff in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards as not all staff had appropriate knowledge of these areas to ensure that patients' best interests were protected.

Outstanding practice and areas for improvement

Action the hospital **SHOULD** take to improve

- Consider reviewing the maternity targets, such as the numbers of women having either elective or emergency caesareans and the maternity dashboard, as the current targets are not stretching.
- Consider developing and using a tool to monitor quality of paediatric services.
- Review and amend the hospital's safeguarding policy so that it is in line with best practice set out in Working together to safeguard children (March 2013).
- Take action to mitigate or resolve risks identified on department's risk registers in a timely manner.
- Review capacity in outpatients to minimise the long waiting times for patients when attending outpatient appointments.