Worcestershire Acute Hospitals NHS Trust

Kidderminster Hospital and Treatment Centre

Quality Report

Kidderminster Hospital and Treatment Centre
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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
Minor injuries unit	Requires improvement
Medical care	Good
Surgery	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Worcestershire Acute Hospitals NHS Trust (WAHNHST) was established on 1 April 2000 to cover all acute services in Worcestershire with approximately 900 beds. It provides a wide range of services to a population of around 570,000 people in Worcestershire as well as caring for patients from surrounding counties and further afield.

The Trust includes four hospital sites, Worcestershire Royal Hospital (WRH), Alexandra Hospital in Redditch (AHR) Kidderminster Treatment Centre (KTC) and one day ward and a theatre at Evesham Community Hospital, which is run by Worcestershire Health and Care NHS Trust

We carried out this inspection between 14th and 17th July 2015 as part of our comprehensive inspection programme.

Overall, we rated Kidderminster Hospital and Treatment Centre as requiring improvement, with 4 of the 5 key questions we always ask being judged as requiring improvement.

Four of the six core services (maternity and gynaecology, urgent and emergency care, children's and young people, and outpatients and diagnostics) were rated as requiring improvement. Surgical and medical services were rated as good overall.

We have judged the service 'good' for caring. We found that services were provided by dedicated, caring staff. Patients were treated with kindness, dignity and respect and were provided the appropriate emotional support. However, improvements were needed to ensure services were safe, effective, responsive and well-led

Our key findings were as follows:

- There were inconsistent thresholds of reporting of incidents by staff. Where incidents had been reported, investigation and dissemination of lessons learnt was insufficiently robust.
- Mandatory training compliance rates were consistently below the trust target of 95%
- Rates for methicillin resistant staphylococcus aureus (MRSA) and Clostridium Difficile for the trust were within acceptable range nationally. All surgical patients were screened for MRSA during their pre-assessment appointment.
- All areas we visited were visibly clean and personal protective equipment was available as well as hand washing facilities and hand gel. We observed staff followed appropriate practices and were bare below the elbow whilst in clinical areas
- Appropriate food and drink were available to all patients on the ward. Choices were available which provided variety and multiple faith foods were available on request.
- Vulnerable patients or patients who required more intensive care had assessments completed to identify their needs. Malnutrition universal screening tool (MUST) scores were calculated, which meant that patients who required additional support or special diets were identified and supported.
- In the minor injuries unit (MIU) there had been ten incidents since October 2014 where staff had been physically or 'non-physically' assaulted (such as patient being verbally aggressive towards staff). We were not assured that lessons were learnt from the incidents and risks had not been highlighted on the risk register before our inspection.
- In Radiology concerns were raised that the replacement of ageing and unreliable equipment had not been effectively managed which had resulted in patient-related

incidents occurring including the loss of diagnostic images such as plain x-rays.

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

Importantly, the trust must:

- Improve incident reporting processes to ensure all incidents are reported and investigated and that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly.
- Ensure mandatory training compliance meets the trust target of 95%

Summary of findings

In addition the trust should:

- Review the security of confidential patient records to ensure they are safe from removal or the sight of unauthorised people.
- Develop a policy on restraint and / or supportive holding and staff should receive training to ensure they understand how to apply the policy.
- Approve the audit plan for children and young people and ensure audits are completed in line with the plan with regular updates on audits outstanding with revised completion dates.
- Review and update the dashboard for children and young people to include all pertinent information.
- Develop a suitable business plan for children and young people which identifies the needs of patients and adequately plans services for the year ahead. This should identify areas for improvement or expansion and ensure that patient demand can be met safely with the resources available.
- Ensure that complaints are responded to within agreed timeframes and summary data should be explicit as to which location the complaint relates to. Improve governance arrangements to ensure meeting minutes accurately reflect discussions held and /or that discussion takes place in accordance with the terms of the committee and that actions agreed are followed up at subsequent meetings.
- Use the risk register should as a tool to identify and monitor emerging and existing risks, ensuring it contains sufficient detail.
- Ensure all medicines storage areas have systems for measuring and recording temperatures
- Ensure all risks are risk assessed and are on the risk register with mitigated actions taken, this includes sufficient security measures are in place on the Kidderminster site to protect staff, patients and visitors.
- Ensure investigations of incidents have clear learning points and actions to prevent similar incident occurring, particularly in relation to staff assault.
- Install a panic button within the treatment area of the MIU.
- Ensure all MIU staff have personal attack alarms.
- Ensure the issue regarding the toilet in the MIU waiting area and the risk of drug users using the area for illegal activities is risk assessed and mitigating actions taken.
- Ensure morbidity and mortality meeting minutes clearly document discussions.
- Ensure that an alarm is fitted in the waiting room for paediatric patients to alert help if required.
- Ensure staff are aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people and the actions required if a patient presents with associated symptoms.
- Ensure information about patients care and treatment and their outcomes is routinely collected, measured and used to improve care, treatment and patient outcomes.
- Ensure all staff received annual appraisals.
- Ensure that there are enough wheelchairs to meet patient need.
- Ensure patients receive an initial assessment within 15 minutes.
- Ensure all senior staff are visible enough for staff to recognise them and feel supported.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Minor injuries unit	Requires improvement	
Medical care	Good	Staff were aware of how to report incidents and feedback was usually provided on incidents reported. We saw that learning had happened from incidents. Risk registers were in place and reviewed regularly. Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved. Medicines were generally stored and administered safely; however, room temperatures in medicine storage areas were not always maintained. Effective infection control precautions were in place. Equipment was well maintained. Staffing reflected patients' needs at the time of the inspection. Nursing staff were aware of what to do if they had a safeguarding concern and how to escalate patient concerns out of hours. Most staff were up to date with mandatory training. Care was generally provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Multidisciplinary team working was good. Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measurement of patient outcomes. Local audits were being undertaken. Most staff said they were supported effectively, but there were limited opportunities for regular formal supervisions with managers. We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Staff understood the concept of Deprivation of Liberty Safeguards (DoLS). People were supported, treated with dignity and respect, and were involved as partners in their care. Overall, medical services at the hospital were

Summary of findings

caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. Patients told us that the staff were caring, kind and respected their wishes.
We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary, and full of praise for the staff looking after them.
The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams. Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases.
People's needs were consistently met through the way services were organised and delivered.
Services met the needs of patients in a timely way. The trust was meeting the 62 day referral to treatment times for cancer.
Generally, patients' care and treatment was planned and delivered to reflect their individual needs. Information was available for patients regarding how to make a complaint and complaints procedures were effective.
The arrangements for governance and performance management operated effectively at the local level. The local leadership, governance and culture promoted the delivery of high quality person-centred care. There was evidence of effective communication within staff teams.
The visibility and relationship with the management board was less clear for junior staff, not all of whom had been made aware of the trust's vision and strategy. Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust.
Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in changes and improvements to the service such as the closure of Cookley ward. All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders and the executive team were not visible

Summary of findings

Surgery	**Good**		Processes were in place to keep people safe. Staff numbers and skill mix were maintained, infection prevention and control measures were effective. People were protected from abuse. Procedures were based on recognised pathways of care. People received treatment in a timely manner. Staff were friendly, kind and supportive. The services met the needs of the local community Whilst the range of treatments available to patients was limited, this was appropriate and in line with national guidance, dictated by the facilities available. Good local leadership had introduced innovative communications systems to keep staff informed of clinical alerts and local issues. Theatres did not work at their full capacity, meaning people had to wait longer to be treated Referral to treatment time performance was below both the national standard and the England average for admitted patients between April 2013 to February 2015 in every service except ophthalmology.
Maternity and gynaecology	**Requires improvement**		Incidents were reported, but not investigated in a timely manner. There was evidence that lessons had been learnt. There was a risk register in place, although this was not updated regularly. There was a shortage of medical staff and clinics were often curtailed at short notice. Staff spent time to ensure women understood their care and any further procedures that were necessary. Women were able to access maternity and gynaecology services locally. The department was clean and equipped, medicines were stored appropriately. There were reliable systems in place for the management and disposal of waste.
Services for children and young people	**Requires improvement**		Incidents were not always reported and investigated promptly and lessons were not always learned. Some important policies had not been developed, for example there was no policy on the use of restraint. Compliance with completion of mandatory training did not meet the trust's target.

Summary of findings

Audits were not always undertaken in line with agreed plans and learning not implemented or evidenced.
There were no detailed service plans for the year ahead outlining the direction of the service, including improvements required.
Governance arrangements were not effective and failed to demonstrate that areas of concern were sufficiently discussed or that agreed actions were carried forward or implemented.
Patients were generally very satisfied with the level of care they received with few complaints made about their care and treatment.

Outpatients and diagnostic imaging

Requires improvement

The premises were visibly clean; regular audits took place to ensure that housekeeping staff were undertaking cleaning duties in line with trust standards. Routine hand hygiene audits took place and staff were well versed in the requirements of both local and national infection prevention and control standards.
Whilst staff were aware of their roles and responsibilities with regards to reporting patient safety incidents, the frequency with which incidents were reported in outpatients was extremely low; where incidents had been reported, the dissemination of lessons learnt was insufficiently robust. However staff working in radiology were positive around incident reporting and there was evidence that lessons were learnt and changes to practice were made.
The process for keeping patients informed when clinics overran was good with information being made available in written formats but also we observed nursing staff verbally updating patients where clinics overran. There was however no formal process for the on-going monitoring of clinics to ensure that the outpatient department operated at optimal capacity. The trust was failing to meet a range of benchmarked standards with regards to the time with which patients could expect to access care as well as the time with which imaging reports were produced.
Leadership within the outpatient's team was visible however the management of risk was insufficiently robust and further improvements were necessary.
Within radiology, governance arrangements existed

Summary of findings

which ensured that risks which had the likelihood to impact on the clinical effectiveness of the service were discussed, business cases and strategies developed and monitoring of on-going concerns existed with oversight from the clinical and operational leadership team.
However, concerns were raised that the replacement of ageing and unreliable equipment had not been effectively managed which had resulted in patient-related incidents occurring including the loss of diagnostic images such as plain x-rays.

Kidderminster Hospital and Treatment Centre

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Kidderminster Hospital and Treatment Centre

Kidderminster Hospital houses the Kidderminster Treatment Centre which offers clinical facilities and patient accommodation for a wide range of day case, short stay and inpatient procedures. The nurse-led minor injuries service is open 24 hours a day and treats more than 24,000 patients every year. Other facilities at the Kidderminster site include a full range of outpatient clinics, including outpatient cancer treatment in the Millbrook Suite, MRI and CT scanners and a renal dialysis unit.

Our inspection team

Our inspection team was led by:

Chair: Liz Childs, Non-Executive Director, Devon Partnership NHS Trust.

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: Experts by Experience, Specialist Advisors including; Medical Director, Head of Patient Experience, Human Resources Lead, Clinical Governance Lead, Adult Safeguarding Nurse Specialist, Children's Safeguarding Lead, Emergency Department Doctor and Nurses, Medical Consultant and Nurse, Emergency Care Technician, Consultant Surgeons, Surgical Nurses, Critical Care Nurse, Critical Care Consultant, Consultant Obstetrician, Midwife, Paediatric Nurse, Palliative Care Consultant and Nurse Consultant, Radiographer, Consultant Cardiologist, Head of Outpatients, Junior Doctor, Student Nurse, Pharmacist.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust and asked other organisations to share what they knew about the hospitals. These included the Trust Development Authority, Clinical Commissioning Groups, NHS England,

Detailed findings

Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges, local MP's, 'Save the Alex' campaign group and the local Healthwatch.

We held listening events in both Worcestershire and Redditch in the two weeks before the inspection where people shared their views and experiences of services provided by Worcestershire Acute Hospitals NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of Worcestershire Royal Hospital, Alexandra Hospital Redditch, Kidderminster Hospital and Treatment Centre and Burlingham ward and theatre, Evesham Community Hospital between 14 and17 July, 2015

We held focus groups with a range of staff in both the Worcestershire Royal Hospital and the Alexandra Hospital Redditch, including nurses, junior doctors, consultants, health care assistants, midwives, allied health professionals and clerical staff. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Worcestershire Acute Hospitals NHS Trust.

Our ratings for this hospital

Our ratings for this hospital are:

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

Minor injuries unit

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

Information about the service

The minor injuries unit (MIU) at Kidderminster Hospital and Treatment Centre (KTC) provides a 24 hour, seven-day a week service. It saw 25,893 patients between July 2014 and June 2015. Of those, 6,231 were between 0 and 16 years old. The percentage of patients attending the unit had increased by 23% since 2012.

The unit is staffed by emergency nurse practitioners and provides a range of treatments for patients with minor injuries. Patients with a wide range of minor injuries including cuts, grazes, wounds, sprains, strains, minor burns and broken bones can be treated at the MIU.

Patients present to the department by walking into the reception area and booking in.

The unit consists of five treatment rooms and a triage room.

We spoke with five members of nursing staff, three patients and one relative. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's MIU performance data.

Urgent and emergency services provided by this trust were located on three hospital sites, the others being Worcestershire Royal Hospital and Alexandra Hospital. Services at the other sites are reported on in separate reports. However, services on all hospital sites were run by one urgent and emergency services management team. As such they were regarded within and reported upon by the trust as one service, with some staff working at all sites. For this reason it is inevitable there is some duplication contained in the three reports.

Minor injuries unit

Summary of findings

Overall we rated this service as requires improvement. It was rated requires improvement for safety and well-led, and good for effectiveness, caring and responsiveness.

Staff told us that they were encouraged to complete incident reports via the electronic reporting system. Most staff told us that they had feedback from the reports.

However we found risks were not always appropriately identified, monitored and actioned by the unit or added to the risk register. We were not assured that the senior management team had sufficient control or oversight of the security risk within the unit. There had been ten incidents since October 2014 where staff had been physically or 'non-physically' assaulted (such as patient being verbally aggressive towards staff). We were not assured that lessons were learnt from the incidents and risks had not been highlighted on the risk register however after we highlighted this concern, the risk was added to the risk register on 15th July 2015.

Care and treatment was delivered in line with current evidence based guidance and best practice. There was a lack of audits to measure performance. This meant that it was difficult to measure and improve clinical performance and patient outcomes.

The unit had consistently achieved the target of 95% of patients being seen within four hours since July 2014, averaging 100%. However, the average time from arrival to initial assessment between 6 April 2014 and 28 June 2015 was 26 minutes.

MIU staff were enthusiastic and passionate about their service and enjoyed working within the unit. However, at all levels some staff felt that they were the poor relation of the other two hospitals within the trust. Management meetings and mandatory training sessions were often held at Worcestershire Royal Hospital, which meant that staff could not always attend due to staff cover arrangements.

There were enough nurses on shift to meet patients need, with adult and paediatric experience. There were no staff vacancies.

Compliance with mandatory training was overall 86%. This did not meet the trust target of 95%. Staff had completed competencies to carry out their roles effectively and in line with best practice. Processes were in place to identify and manage adults and children at risk of abuse (including domestic violence).

Staff adhered to the trust's infection control policy. Equipment, including resuscitation equipment, was clean and in working order. The hospital had appropriate systems in place regarding the safe handling and administration of medicines.

Escalation plans were in place for patients who needed higher dependency facilities and a trust-wide escalation policy which set out a range of triggers that would enable the trust to mitigate risks associated with capacity and overcrowding.

We saw patients were treated with compassion and respect. All of the patients we spoke with told us they were happy with the care provided by staff. Staff gained consent and explained the treatment and care they were delivering to patients in a way patients could understand.

There were examples of where the MIU were trying to meet patient needs, for instance, translation services, a children's waiting room and playhouse, information leaflets on a variety of minor injuries and flash cards in different languages. However, there were not enough wheelchairs to meet patient need.

Minor injuries unit

Are minor injuries unit services safe?

Requires improvement

Overall we rated this service as requires improvement for safety

The average time from arrival to initial assessment time between 6 April 2014 and 28 June 2015 was 26 minutes.

Staff told us that they were encouraged to complete incident reports via the electronic reporting system. Most staff told us that they had feedback from the reports.

There had been ten incidents since October 2014 where staff had been physically or 'non-physically' (such as patient being verbally aggressive towards staff) assaulted. We were not assured that lessons learnt from the incidents would prevent similar incidents from occurring.. There was no reference to this on the risk register however after we highlighted this concern, the risk was added to the risk register on 15th July 2015.

Treatment room doors were left open when treating patients to prevent staff becoming isolated. This practice put patient confidentiality at risk and had not been risk assessed until we requested this information.

Compliance with mandatory training was overall 86%. This did not meet the trust target of 95%. Processes were in place to identify and manage adults and children at risk of abuse (including domestic violence).

Staff could describe the major incidents policy and what they would do if a major incident occurred. Staff reported receiving Ebola training but were not aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people.

Staff adhered to the trust's infection control policy. Resuscitation equipment was checked and fit for purpose. Equipment was clean and in working order. The hospital had appropriate systems in place regarding the safe handling and administration of medicines.

Escalation plans were in place for patients who needed higher dependency facilities and a trust-wide escalation policy which set out a range of triggers that would enable the trust to mitigate risks associated with capacity and overcrowding.

There were enough nurses on shift to meet patients need, with adult and paediatric experience. There were no staff vacancies.

Incidents

- Staff told us that they were encouraged to complete incident reports via the electronic reporting system. Most staff told us that they had feedback from the reports.
- There have been no "never events" reported in ED between January 2014 and December 2014. A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented.
- There had been three incidents between 3 June and 15 July 2015 where staff had been physically assaulted. One had resulted in moderate harm and the other two in minor harm. There was lack of evidence of effective learning from these incidents and actions having been implemented to prevent similar incidents from occurring. For example one of the lessons learnt for two of the incidents was to contact the police earlier, despite one of the patients being brought in to the department by the police.
- There had been seven incidents of 'non-physical assault' on staff between 8 October 2014 and 12 June 2015, such as patients being verbally aggressive towards staff. Again the lessons learnt from these incidents did not outline actions that would prevent similar incidents from occurring.
- Staff told us that actions had been implemented in order to improve staff security Secure swipe access had been installed to gain entrance into the unit and a panic button on the reception desk was fitted linked to switchboard. However, there was no panic button within the treatment area where the incident occurred. It was recommended for all staff to wear personal attack alarms. However, not all staff had been provided with an alarm and staff told us that because there were so few staff a night in the unit, the likelihood of someone hearing and being able to respond to the alarm was reduced.

Minor injuries unit

- Offsite security was provided by an external company. However, there was no service level agreement in place and as a result the company had no formal commitment to the trust other than to respond in a way that they saw fit given the circumstances of any situation. We were informed that this service level agreement was being negotiated. We requested a risk assessment for the provision of offsite security. The trust were unable to provide this. As a result the trust had raised an incident report that identified the risk of offsite security and that this needed to be assessed. It was noted on the report that the security response times were slow, and that it can take up to an hour for the response team to be on site.
- Staff told us that they now contacted the police if they needed increased security.
- All senior staff initially thought that the lack of security was highlighted on the risk register but it was not. After we highlighted this concern the risk was added to the risk register on 15th July 2015.
- Staff left treatment room doors open when treating patients because when the door was closed the rooms were almost soundproof. If difficulties arose in the room when reviewing patients, staff could not be heard calling for help, equally if staff outside required assistance they could not be heard. Staff told us that this was as a result of an incident where staff could not be alerted because treatment room doors were closed. We asked the trust for details of this incident. They believed it was from an incident in 2007 but could not provide a risk assessment or action plan that confirmed the reason treatment room doors within the MIU were left open when treating patients.
- Although staff felt safer in the unit performing this practice, it put patient confidentiality at risk. A department risk assessment was completed earlier this year, but the issue relating to the doors was not included. After we requested a risk assessment, the trust did complete one. The trust assured us that the risk will now be incorporated into the wider department risk assessment, and will be added to the risk register. The fire risk officer has been informed and highlighted the door must be closed in the event of a fire in the department.
- Patient safety incidents were discussed at the emergency medicine cross county meeting, including serious incidents, NHS England new guidance and safeguarding issues.
- The morbidity and mortality meeting formed part of the (emergency department (ED) cross county and senior department meetings. However, we could not find within the minutes from the January, February and April 2015 meetings where morbidity and mortality had been discussed.
- Staff told us that they had received informal unit training regarding the new duty of candour regulations (where people who use services are told when they are affected by something that goes wrong, given an apology and informed of any actions taken as a result). Staff were familiar with the concepts of openness and transparency. There was a 'Being Open & Candid Following a Patient Safety Incident or Complaint Policy' in place.

Cleanliness, infection control and hygiene

- Staff had access to personal protective equipment such as gloves and aprons. We observed staff adhering to the trust's 'bare below the elbow' policy, applying gloves and aprons as required, and washing their hands and using hand sanitising gel following their time spent with patients.
- The MIU was visibly clean. There were adequate hand-washing facilities and soap dispensers, hand hygiene foam and paper towels for staff and patients to use.
- There was a playhouse for children in the waiting area that was steam cleaned weekly and wiped daily.
- Staff told us that the triage room could be used in urgent cases where infected patients needed to be isolated and barrier-nursed to prevent the spread of infection.

Environment and equipment

- Staff told us that the toilets in the MIU reception area had the lights changed from blue to white that week. The blue lights were originally implemented to prevent visitors injecting illegal drugs which had become an issue at the hospital. The staff were concerned that drug users would return to the hospital now the toilet lights had changed.
- The trust later told us that the light was changed from blue to white following a patient complaint. This had not been discussed with staff and there was no risk assessment to support the change.

- The unit provided a waiting room for paediatric patients in a room opposite the reception. The room was difficult to see inside from the reception area. There was no alarm to alert help if required.
- We inspected the resuscitation trolley and saw that it was centrally located, clean, and the defibrillator had been serviced. Daily checks were documented.
- There was a standard paediatric resuscitation equipment checklist to remind staff what equipment to check.
- Equipment including beds, hoists and wheelchairs, was clean and in working order. Items were labelled with the last service date, and some equipment had decontamination status labels that identified when equipment was cleaned.
- We found equipment was serviced and where required had received a portable appliance test (PAT).
- The unit had recently received low rise beds funded by the League of Friends.

Medicines

- The hospital had appropriate systems in place regarding the safe handling and administration of medicines.
- We found prescription medicines were appropriately stored in locked facilities. All medicine we looked at was in date.
- Records showed fridge temperature checks had been completed daily.
- All medication on the resuscitation trolley as in date and there was a separate paediatric drug box.
- There was piped oxygen in the triage room.
- There was no pharmacist permanently on site. Medication orders were faxed to the Alexandra Hospital on weekday mornings and delivered the same day. Two nurses were responsible for ordering medication; they rotated stock to prevent wastage.

Records

- The hospital had systems in place to keep records stored confidentially. All patient records we saw were behind the nursing station and out of reach of patients or visitors.
- We looked at four patient paper records and found that all required information had been documented fully in legible handwriting. Medical notes and care plans were up to date, including the time a patient arrived in the unit and when they received their initial assessment. Initial observations were recorded, including past medical history, injury description, blood pressure and pain score.
- Once a patient had completed their treatment, paper records were scanned onto the 'patient first' system and the hard copy confidentially destroyed.

Safeguarding

- Processes were in place to identify and manage adults and children at risk of abuse (including domestic violence). Nursing staff were aware of what to do if they had a safeguarding concern. There was a safeguarding team and staff knew how to contact the team when they required support.
- Children were checked against the child protection, missing children and unborn registers. If there were any concerns about the safeguarding of a child, these were escalated to the sister.
- During our inspection, we saw staff appropriately deal with a child who they had safeguarding concerns about, escalating concerns in a timely manner to the local authority.
- Safeguarding training for children (level one) was over 90%. Thirty per cent (7) of staff had completed children's level two safeguarding training and 13% (3) had completed children's level three training.
- Eight-two per cent of nursing staff had received adult safeguarding training level one. None of the staff had received higher level safeguarding training. This did not meet trust target of 95% compliance.

Mandatory training

- Mandatory training covered information governance, fire, mental health, resuscitation, hand hygiene and infection control. Compliance with mandatory training was overall 86%. This did not meet the trust target of 95%.
- Only 74% of nursing staff had information governance training, 78% fire training and 78% infection control training.
- All staff including administrative personnel had received conflict resolution training which did include an element of breakaway training. However, not all staff felt they had sufficient skills to protect themselves from patients or visitors to the unit that may become aggressive and violent.

Minor injuries unit

Assessing and responding to patient risk

- Guidance issued by the Royal College of Emergency Medicine's (CEMs) (triage position statement dated April 2011) stated that a rapid assessment should be made to identify or rule out life-/limb-threatening conditions to ensure patient safety. This should be a face-to-face encounter within 15 minutes of arrival or registration, and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life-threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- The average time from arrival to initial assessment time between 6 April 2014 and 28 June 2015 was 26 minutes. This meant that the unit was not always meeting the 15 minute target. During our inspection the waiting time for initial assessment was ten minutes. The waiting time was displayed on the reception desk.
- The unit had a triage room but in the past there had been no dedicate nurse leading triage. A temporary six month band 5 triage staff nurse business case was accepted during our inspection. This meant that there would be a post in place in the day to triage patients.
- There was no dedicated resuscitation room; staff told us that the triage room would become the resuscitation room in an emergency.
- Patients who needed emergency treatment were transferred to Worcestershire Royal or Alexandra Hospital. Staff told us that they had a good working relationship with the EDs to escalate patients who needed higher dependency facilitates, in emergencies patients would be transferred by ambulance.
- Staff were able to describe how they would treat a deteriorating paediatric patient. They knew where paediatric equipment and medication was within the unit. There was guidance to aid the nurses to provide a safe accessible service for paediatric patients who presented to the MIU, with minor or major illness. The guidelines were based on a five-tier system produced by the Manchester Triage Group (2006, the guidance from the national Advanced Life Support Group 'APLS' manual (2011) and the Resuscitation Council UK, Guidelines for Resuscitation (2010). The main aim of the staff was to maintain patients' airway, breathing and circulation until safe transfer to an appropriate unit could be arranged.
- In the August 2014 head injury and record keeping audit, all patients were assessed to establish whether the patient is at risk for clinically important brain and/or cervical spine injuries.
- Staff told us that if there was a cardiac arrest on site that they tended to be the response team. This meant this could leave the unit short staffed.
- The MIU completed an audit of 50 clinical cases associated with a need to risk manage anti-tetanus status seen between January and March 2015. The results showed that no tetanus status or risk assessment of the anti-tetanus status was recorded in 23 out of 50 patients (46%). This put patients at risk. We saw that the findings had been highlighted to Emergency nurse practitioners (ENPs) via the monthly departmental letter, which clearly stated the risks associated, and a re-audit was planned.
- There was a trust-wide escalation policy which set out a range of triggers that would enable the trust to mitigate risks associated with capacity and overcrowding. This included the EDs monitoring ambulance arrivals and identifying patients who could be taken to an alternative centre such as the MIU.
- There was a hospital and trust-wide standardised approach for detection of the deteriorating patient. The Patient At-Risk Scoring (PARS) tool was based upon the Royal College of Physicians National Early Warning Score tool designed to standardise the assessment of acute-illness severity in the NHS. If a patient triggered a high risk score from one of a combination of indicators, a number of appropriate routes would be followed by staff.

Nursing staffing

- The nurse in charge had a red badge to enable people to identify them easier.
- During our inspection there were the number of nurses on shift met the planned establishment. The staffing of the MIU at KTC was reviewed as part of a review of all nurse staffing conducted twice per year. This review included consideration of activity levels and service provision. In the latest review, the MIU recruited an additional 1 whole time equivalent (WTE) registered nurse and 1.5 WTE healthcare assistants. The MIU team were planning a review of similar units in the region to benchmark staffing levels.

Minor injuries unit

- In March 2015 there was an overall 0.14 whole time equivalent vacancy rate. By June 2015 recruitment had been undertaken and there were no vacancies within the unit.
- Between July 2014 and March 2015 the average qualified nurse agency cover was 1%.
- There was a paediatric trained nurse within the unit, with experience of working within a children's ED, who disseminated teaching to other staff.
- At night there were two registered staff on duty. Although staff felt generally this met patient demand, they also felt they were left venerable in terms of their own security.
- The MIU reception desk was the first reception located within the KTC. There were two part-time reception staff manning the desk but they did not provide daily reception cover. MIU staff identified problems at weekends with KTC patients and visitors asking for assistance. This meant MIU nursing staff had to leave their task, including treating patients, to answer queries at the reception desk. MIU completed an audit over 43 weekends between 8 November 2014 and 2 May 2015. It showed that 1452 non MIU patients and visitors requested support from the MIU reception. The MIU manager was going to use this as evidence to support the case that the service required a receptionist each day.

Medical staffing

- There was an ED consultant two days each week on shift, specialising in soft tissue reviews. Apart from this there were no doctors on duty at the MIU as it was a nurse-led service.
- An ophthalmologist was on call every data for advice.

Major incident awareness and training

- Staff could describe the major incidents policy and what they would do if a major incident occurred.
- Staff reported receiving Ebola training. There was an equipment kit with information required in such crisis
- Staff were not aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people. There was no information in the unit about this. This was not in line with the Public Health England 2013 'Infection Control Advice: Possible or Confirmed MERS-CoV' guidance, as staff were not aware of what actions to take if a possible or confirmed case presents.
- Ebola patient management and effect on the rest of the ED was categorised as a very low risk on the risk register. MERS did not feature of the risk register.

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

Good

Overall we rated this service as good for effectiveness

Care and treatment was delivered in line with current evidence based guidance and best practice. Some clinical audits were completed to ensure MIU was treating patients according to NICE guidance and appropriate actions taken, although there was no formal clinical audit plan.

The unit was meeting the standard that requires the percentage of patients re-attending (unplanned) within seven days to be less than 5%. Information about patients care and treatment and their outcomes was not routinely collected and measured which meant the service could not use information to improve patient outcomes.

Staff, teams and services mostly worked well together to deliver effective care and treatment. Staff had completed competencies to carry out their roles effectively and in line with best practice. Staff told us that they received regular one to ones and annual appraisals. Data showed that 78% of staff had received an appraisal in the last 12 months. This did not meet the trust target of 100%.

Staff obtained and documented verbal consent before carrying out interventions. Pain relief was effectively managed. Pain charts were in several languages to help staff communicate with patients who did not speak English.

Evidence-based care and treatment

- Staff told us guidelines were based on local need and practice, and on national best practice guidance from the National Institute for Health and Care Excellence (NICE).

Minor injuries unit

- We saw evidence that the latest best practice guidance was shared in the unit newsletter. For example, there was an article on the NHS campaign 'Hello my name is…' which described why and how this could be implemented in the unit.
- There was no formal clinical audit or research plan for the MIU, although some clinical audits were completed.
- The trusts transport guideline from the MIU to a hospital with an ED was last reviewed in May 2008 and required a further review in May 2013 but we did not see evidence that this had been completed.

Pain relief

- Nurses asked patients if they were in pain, identified the location of the pain and delivered pain relief medication where necessary.
- There were pain charts in several languages to help staff communicate with patients who did not speak English.
- We heard nurses explain treatment and pain medications to patients in preparation for discharge.
- None of the patients we spoke with reported being in pain.

Patient outcomes

- Information about patients care and treatment and their outcomes was not routinely collected and measured. There were few local audits that had been completed regarding patient outcomes. This meant the service could not use information to improve care, treatment and patient outcomes.
- In August 2014 MIU completed a head injury and record keeping audit. The aim was to ensure that MIU was treating patients according to NICE guidance CG176 (Head injury: Triage, assessment, investigation and early management of head injury in children, young people and adults) published January 2014.
- Ninety-eight sets of notes were audited. Over 95% of them had all the correct demographics recorded with the exception of ethnicity (80%) and next of kin (93%). The head injury results showed that 73% of patients were assessed and 61% of patients had their first set of neurotically observations performed within 15 minutes of arrival. It was concluded that the lack of a triage nurse had resulted in the department failing to triage patients within 15 minutes. An action plan had been developed as a result of the audit and as a temporary six month band 5 triage staff nurse business case was accepted during our inspection.
- The unit was meeting the standard that requires the percentage of patients re-attending (unplanned) within seven days to be less than 5%. Performance between June 2014 and June 2015 ranged averaged 4.8%.

Competent staff

- ENPs could prescribe and administer drugs including intravenous antibiotics and fluids. Nurses were able to read electrocardiograms, provide plaster casts and review x-ray film.
- There were two to three yearly nursing competencies in place for staff, such as taking a clinical history and interpreting x-rays. Management were working with community services to provide clinical competencies, such as soft tissue injury.
- All staff were trained to plaster.
- Staff told us they were able to access funding and time to attend training courses. The manager created an annual training plan for the unit and asked staff what training they would like to undertake to develop their skills.
- Staff told us that they received regular one to ones and annual appraisals. Data dated the 31 August 2015 showed that 78% of nursing staff had received an appraisal in the last 12 months. Ninety per cent of administration staff had also received an appraisal. This did not meet the trust target of 100%.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment.
- Nurse reported a good working relationship with each other. There was supportive collaborative working.
- There was no substance misuse or mental health service at the hospital. But staff could refer to the services at the Worcestershire Royal or Alexandra Hospital.

Seven-day services

- The unit was open 24 hours a day every day of the year.
- Radiology was available seven days a week, 24 hours a day.

Access to information

- Staff could access further clinical guidelines and pathways on the trust intranet.
- A discharge summary was sent to GPs when patients were discharged from the department.

Minor injuries unit

- Patient information was available to all relevant staff in the form of the 'patient first' system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff obtained verbal consent before carrying out interventions. We noted that consent to treatment was noted in the patients' records that we looked at.
- There had been no formal mental health audit as the trust reported that the numbers of detentions were so low and that the lead safeguarding adult nurse was involved in all detentions to check the documents.
- The hospital did not provide a section 136 suite for those patients requiring a place of safety under the Mental Health Act.
- The trust had been liaising with the CCG to expand the mental health provisions within urgent care. There had been a meeting between the urgent care division and the Worcestershire Health and Care Trust to discuss how they could work together to provide a better service to patients.
- Staff we spoke with knew how to make an application under Deprivation of Liberty Safeguards (DoLS).

Are minor injuries unit services caring?

Good

Overall we rated this service good for caring.

We saw patients were treated with compassion and respect. All of the patients we spoke with told us they were happy with the care provided by staff.

Staff explained the treatment and care they were delivering to patients in a way patients could understand.

The trust used the Friends and Family Test response rates in June 2015 were better than the England average and 95% of respondents said they would recommend the service to friends and family, which was better than the England average of 88%.

Staff wellbeing was promoted on in the unit newsletter and they knew how to access emotion support if needed.

Patients' privacy and dignity could be compromised if the treatment room doors were left open. However, the patient we spoke with all felt this was acceptable.

Compassionate care

- Patients were treated with compassion, dignity and respect.
- We saw staff speak with patients in a respectful way, engaging and laughing with patients.
- All patients and carers we spoke with told us that they were happy with the care they received. Patients told us "staff are very friendly".
- Patients felt that their privacy and dignity was respected by staff and did not mind the treatment room doors being left open. There were curtains in some of the rooms to protect patient privacy even when the door was open.
- The trust used the Friends and Family Test to capture patient feedback. Response rates in June 2015 were better than the England average, 19% compared to 15%. Ninety-five per cent of respondents said they would recommend the service to friends and family, which was better than the England average of 88%.

Understanding and involvement of patients and those close to them

- Staff explained the treatment and care they were delivering to patients in a way patients could understand. Staff asked patients if they had any questions or concerns at the end of the treatment.
- In the August 2014 head injury and record keeping audit all patients or carers were given an information leaflet on head injury.

Emotional support

- Staff told us that they provided emotional peer support for one another and that they could access occupational health services provided by the trust if they needed additional support.
- Staff wellbeing was promoted on in the unit newsletter.

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

Good

Overall we rated this service as good for responsiveness

Minor injuries unit

The unit had consistently achieved the target of 95% of patients being seen within four hours since July 2014, averaging 100%. Examples and learning of complaints and compliments were shared with staff.

Staff told us how they adapted their approach to people living with dementia and some had attended dementia training. Staff could describe how they adapted their approach to comfort the children with learning disabilities. There was a box of toys staff could use to support children.

Staff told us that they always could access X-ray services in a timely manner.

There were examples of where the ED were trying to meet patient needs, for instance, access to translation services, a children's waiting room and playhouse, information leaflets on a variety of minor injuries and flash cards in different languages. However, there were not enough wheelchairs to meet patient need.

Service planning and delivery to meet the needs of local people

- The trust engaged in regional patient flow centre meetings to establish bed capacity and also identify patients who needed to be admitted but could avoid ED and potentially attend the MIU. The trust had redesigned bed meetings to fall 15 minutes after the patient flow centre meeting. Staff said that this had helped to plan patient flow in the urgent and emergency services and across the trust.

Meeting people's individual needs

- Staff told us how they adapted their approach to people living with dementia and some had attended dementia training. They said that they had created signs for the toilet to help patients identify where to go. However, they reported that at the last senior management walk about a divisional staff member had told the staff to remove the signs as they were not laminated. Staff said that the way this had been conducted was disheartening and they although they had ideas about how the unit could be more dementia friendly were worried that these would be dismissed.
- There was a local school for children with learning disabilities. Staff could describe how they adapted their approach to comfort the children. There was a box of toys staff could use to support children.
- There was a waiting room separate to the main are for children to stay. There was a playhouse for children in the waiting area. Staff told us that where appropriate they could do minor assessments within the playhouse to help children feel at ease.
- A translations service was available for non-English speakers.
- MIU had flash cards, a dictionary and information about how to register with a GP in Polish to cater for the Polish population.
- There were information leaflets on a variety of minor injuries, such as head injury, provided information for patients on how to manage pain symptoms following discharge from the unit.
- We saw one patient go to X-ray on crutches. Staff told us that there were no more wheelchairs available and that this was a regular problem.
- The unit could be accessed by wheelchair users; it was all on one level with wide doors.
- There was a telephone for patients to call local taxis free.
- There was no alcohol and drug liaison service available at the site.
- At weekends there were no canteen facilities available and staff, patients and visitors had to rely on vending machines if they wanted to purchase food or drinks.

Access and flow

- The emergency access four hour target of 95% of patients being seen within four hours had been consistently achieved since July 2014, averaging 100%.
- Media campaigns encouraged the public to think about attending the MIU for injuries that could be treated at the unit rather than attending the ED.
- Patients who had had a new fracture were seen by a consultant at the next available appointment. However, staff were concerned that when a consultant was not available patients had to attend clinic at Worcestershire Royal Hospital.
- Staff told us that they always could access X-ray services in a timely manner.

Learning from complaints and concerns

- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display.

Minor injuries unit

- Staff explained that they would always try to resolve informal complaints on the unit. Formal complaints were directed to PALS who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully.
- Examples of complaints and compliments were displayed in the staff room and within the department newsletter. Lessons learnt and actions taken as a result of the complaint were also displayed.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Are minor injuries unit services well-led?

Requires improvement

Overall we rated this service as requires improvement for well-led

Staff we spoke with were aware of and committed to deliver the trust's visions, values and objectives. The manager told us that there was no succession plan for the unit.

Risks were not always appropriately identified, monitored and actioned by the unit or added to the risk register. We were not assured that the senior management team had sufficient control or oversight of the security risk within the unit. This risk was not on the risk register and we were not assured enough timely mitigating actions were being taken however after we highlighted this concern, the risk was added to the risk register on 15th July 2015.

There were a lack of audits to measure performance. This meant that it was difficult to measure and improve clinical performance and patient outcomes.

MIU staff were enthusiastic and passionate about their service and enjoyed working within the unit. However, at all levels some staff felt that they were the poor relative of the other two hospitals within the trust. Management meetings and mandatory training sessions were often held at Worcestershire Royal Hospital, which meant that staff could not always attend due to staff cover arrangements.

Staff felt that the sister and matron were visible and approachable on the unit but did not see staff at divisional level regularly enough as the unit was not priority.

There was a monthly newsletter created by a staff member that included clinical and service updates, training days and staff social events.

Vision and strategy for this service

- Staff we spoke with were aware of and committed to deliver the trust's visions, values and objectives.
- The manager told us that there was no succession plan for the next band 7 post, despite encouraging band 6 staff to consider their development.
- The urgent care transformation leads told us that the urgent care redesign plan was in place with some actions due to be complete by the end of September 2015. They told us that the aim was to have 16 to 18 ED consultants, to integrate an urgent care network to establish a countywide service, with common ways of working, focusing on admission avoidance, triage and streamlined patient pathways. A three month programme was in place to train staff across each hospital site to understand current patient pathways and how they could be improved to facilitate appropriate discharge. Urgent care will continue to sit within the medical division but with its own structure to manage its own finances and governance. They were in the process of integrating and RAG rating each sites urgent care plan into one, to establish one stable system with common objectives.

Governance, risk management and quality measurement

- Management meetings and mandatory training sessions were often held at Worcestershire Royal Hospital. Staff told us that this meant getting cover as staff would be unavailable for an hours. The manager told us that they 'cherry picked' the meetings that they attended as to attend meetings it meant ensuring staff cover was in place. This created an element of disengagement from the MIU with the rest of the trust.
- The emergency medicine directorate risk register fed into the corporate register. Staff were aware of the risk register and how to raise a risk to be included. Yet senior staff did not know exactly what was on the register, for example they were not aware that the security risk was not on the register.
- Risks were not always appropriately identified, monitored and actioned by the unit or added to the risk

register. Risks such as the possibility of patient confidential and dignity being breached due to the treatment room doors being left open was not highlighted.
- We were not assured that the senior management team had sufficient control or oversight of the security risk within the unit. This risk should have been on the risk register and all actions to mitigate the risk taken however this risk was added to the risk register on 15th July 2015 after we highlighted this concern.
- A draft risk assessment was written for the MIU security issues after we raised the concerns. This was approved and assigned to the MIU, and became part of the emergency medicine directorate risk register.
- There were a lack of audits to measure performance. This meant that it was difficult to measure and improve clinical performance and patient outcomes.
- Patients did not always receive an initial assessment within 15 minutes to meet the target. Although assessment times were monitored, effective governance and performance management was not yet established to make significant improvements in the quality measures.
- Quality measures were shared on the staff notice board, such as Friends and Family.

Leadership of service

- Most staff spoke positively about the new chief executive officer and felt the trust was moving in the right direction.
- Staff felt that the sister and matron were visible and approachable on the unit. It was clear that the sister was part of the team. However, they felt at they did not see staff at divisional level regularly enough as the unit was not priority.
- Senior nurses told us that they supported one another. They said that the divisional nurse was not visible at the unit but that they could contact them via phone.
- The band 7 nurse aimed to have two management days per month however, this was usually reduced to one day as they were often needed to help staff the clinical area.
- There was a lack of shared learning across the trust. For example, the flash cards in that the unit had developed had not been shared with the other urgent services within the trust.
- Matrons told us that they had attended the matron's development course, which included training in root course analysis, complaint management and media training.
- Senior staff had a divisional away day to help team build.

Culture within the service

- All managers told us that they were proud of their teams and recognised that staff worked hard within their roles.
- Staff reported that they were happy working in the MIU, one staff member described the team as a 'family'.
- Each staff member had a responsibility for part of the running of the service, for example, one staff member was responsible for the monthly newsletters, and another for ensuring there was sufficient patient information. This gave staff ownership of their unit. One staff member said that they felt "empowered" on the unit.
- MIU staff were enthusiastic and passionate about their service and enjoyed working within the unit. However, at all levels some staff felt that they were the poor relative of the other two hospitals within the trust. They felt the focus of the executive team was at Worcestershire Royal and the Alexandra Hospitals. Senior staff acknowledged that there was room for improvement with the engagement and presence on the Kidderminster site.
- Between July 2014 and March 2015 the average qualified nurse sickness rate was 1%.

Public engagement

- Divisional staff told us that they were looking at setting up patient focus groups to gain feedback about urgent and emergency services within the trust.
- There was a new display board in the entrance to MIU, with 'You said we did' spaces to display patient feedback. However, this was not completed when we inspected the unit.
- There was information about the services on the provider's website.

Staff engagement

- There was a monthly newsletter created by a staff member. All staff were emailed a copy and there was also a hard copy in the staff room. The newsletter included clinical and service updates, training days and staff social events.

Minor injuries unit

- Staff told us that they were encouraged to raise concerns and they felt they could do this openly with their peers and managers.

Innovation, improvement and sustainability

- We did not see any evidence of the innovation during our inspection.

Medical care (including older people's care)

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

Information about the service

At Kidderminster Hospital and Treatment Centre we inspected the Millbrook Suite and the renal dialysis unit. Cookley ward, for the rehabilitation of patients, had closed prior to the week of the inspection.

We spoke with over 10 members of staff including: nurses, doctors, therapists, and housekeepers. We spoke with 12 patients. We observed interactions between patients and staff, considered the environment and looked at six care records. We also reviewed the trust's medical performance data.

Summary of findings

Overall, we rated the service as good for all five key questions (safe, effective, caring, responsive and well led).

Staff were aware of how to report incidents and feedback was usually provided on incidents reported. We saw that learning had happened from incidents. Risk registers were in place and reviewed regularly. Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.

Medicines were generally stored and administered safely; however, room temperatures in medicine storage areas were not always maintained. Effective infection control precautions were in place. Equipment was well maintained.

Staffing reflected patients' needs at the time of the inspection. Nursing staff were aware of what to do if they had a safeguarding concern and how to escalate patient concerns out of hours. Most staff were up to date with mandatory training.

Care was generally provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in. Multidisciplinary team working was good. Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. There was some measurement of patient outcomes. Local audits were being undertaken.

Medical care (including older people's care)

Most staff said they were supported effectively, but there were limited opportunities for regular formal supervision with managers.

We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Staff understood the concept of Deprivation of Liberty Safeguards (DoLS).

People were supported, treated with dignity and respect, and were involved as partners in their care. Overall, medical services at the hospital were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances. Patients told us that the staff were caring, kind and respected their wishes.

We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary, and full of praise for the staff looking after them.

The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams. Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases.

People's needs were consistently met through the way services were organised and delivered.

Services met the needs of patients in a timely way. The trust was meeting the 62 day referral to treatment times for cancer.

Generally, patients' care and treatment was planned and delivered to reflect their individual needs. Information was available for patients regarding how to make a complaint and complaints procedures were effective.

The arrangements for governance and performance management operated effectively at the local level. The local leadership, governance and culture promoted the delivery of high quality person-centred care. There was evidence of effective communication within staff teams.

The visibility and relationship with the management board was less clear for junior staff, not all of whom had been made aware of the trust's vision and strategy. Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in changes and improvements to the service such as the closure of Cookley ward. All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders and the executive team were not visible.

Medical care (including older people's care)

Are medical care services safe?

Good

Overall we rated this service as good for safety.

Staff were aware of how to report incidents and feedback was usually provided on incidents reported. We saw that learning had happened from incidents. Risk registers were in place and reviewed regularly.

Senior staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.

Medicines were generally stored and administered safely; however, room temperatures in medicine storage areas were not always maintained.

Effective infection control precautions were in place.

Staffing reflected patients' needs at the time of the inspection.

Nursing staff were aware of what to do if they had a safeguarding concern and how to escalate patient concerns out of hours.

Most staff were up to date with mandatory training.

Incidents

- Staff told us that they were encouraged to complete incident reports on the trust's electronic reporting system. Staff told us that they had feedback from the reports.
- In the renal dialysis unit, we saw that monthly multidisciplinary quality assurance meetings were held and that incidents were reviewed and systems were in place to cascade learning to wider staff teams as required. Staff confirmed they received copies of meeting minutes on a regular basis.
- There had been a serious incident in April 2015 regarding a deteriorating patient and we saw that appropriate action had been taken in the renal dialysis unit to ensure this had been investigated and that a series of actions, including an additional patient pathway flowchart and checklists had been implemented. This showed that lessons had been learned and actions taken to minimise the risk of further incidents of a similar nature occurring.
- The renal dialysis unit and Millbrook suite had risk registers and we saw evidence that all risks on the register were reviewed regularly and actions required were discussed and recorded at monthly unit meetings.
- Trust wide, there had been 13 incidents reports between October 2014 and January 2015. Eight of these were different types of patient falls. They were all categorised a no harm or low harm. One category three pressure ulcer was reported in Octobers 2014. We saw evidence of how falls and skin risk assessments had been reviewed and updated to ensure these risks were minimised.
- Staff we spoke with were aware of the Duty of Candour legislation and able to describe the responsibilities involved.

Safety Thermometer

- The service had a Quality and Outcome Metrics Dashboard that collated service wide data. It showed that the number of falls resulting in serious harm had fallen to eight in the year to the end of March 2015 which was a reduction from 33 in the previous year (April 2013 to March 2014).
- This service dashboard also showed a rise in grade 2, 3 and 4 newly acquired pressure ulcers (which were classified as avoidable) in the year to the end of March 2015 to 61 from a total of 23 in the previous year.
- The medical care service had achieved the trust target of 95% for the completion of VTE assessments in the year ending March 2015.
- There were some safety-related goals at trust and service level against which the wards could demonstrate continuous improvement called the "matrons' audit". These goals showed performance regarding falls, pressure ulcer prevention, complaints and patient feedback and related to overall staffing levels on individual wards and was sent to matrons via email. Ward managers said this "matrons' audit" did have an overall summary for each ward.
- Senior staff told us that summary information from the monthly audit was usually shared with staff regularly via team meetings and we saw this was recorded in team meeting minutes.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean and wards had cleaning schedules in place.

- Equipment had green "I am clean" stickers on them so staff would know which equipment was safe to use.
- Staff had access to personal protective equipment such as gloves and aprons.
- We observed staff adhering to the trust's 'bare below the elbow' policy, applying gloves and aprons as required, and washing their hands and using hand sanitising gel following their time spent with patients.
- We checked cleaning schedule records and found that they had been completed in accordance with trust policy.

Environment and equipment

- The Millbrook suite provided an appropriate and comfortable environment that met the needs of patients receiving treatment in this area.
- We inspected the resuscitation trolley in the Millbrook suite. It was visibly clean and the defibrillator had been serviced in line with trust policy. We found that staff had documented daily equipment testing for the resuscitation trolley to ensure equipment was fit for use.

Medicines

- Clinical areas had appropriate facilities for the safe storage of medicines. We checked fridge temperatures in the Millbrook suite and found that a daily record of checks had been maintained. However, ambient room temperatures were not been recorded. We raised this with senior staff, who took action to arrange for this to be implemented.
- We looked at three patients' drug records and found that they were up to date and had been completed in accordance with trust policy.
- The hospital did not have an on-site pharmacy and were reliant on support from the Alexandra hospital. Pharmacists visited three times a week.
- If patients were allergic to any medicines this was recorded on their prescription chart. Medicine incidents were recorded onto a dedicated electronic recording system. We found that overall medicines and IV fluids were stored securely in locked cupboards.

Records

- All healthcare professionals used the medical notes to record patient care. Medical notes were up to date. Notes and patient information was kept stored confidentially.
- We looked at three sets of patients' records in the renal dialysis unit and found that they were up to date and maintained in accordance with trust procedures. Skin care and falls risk assessments had been completed and reviewed in accordance with trust policies.

Safeguarding

- Nursing staff were aware of what to do if they had a safeguarding concern and were able to tell us what constituted such a concern. There was a safeguarding team and staff knew how to contact the team when they required support.
- Staff informed us that they had completed safeguarding training, and were able to tell us of the signs for recognising abuse, how to raise an alert and that the trust had a whistleblowing policy in place.
- We checked nursing staff safeguarding records for both services and found that all the permanent nurses on the ward had received safeguarding adults' training.

Mandatory training

- Staff told us that mandatory training generally met their needs.
- Team leaders had access to an electronic system for recording and monitoring staff training records and said they were able to plan ahead in terms of staff requiring training.
- We looked at the training records for the renal dialysis unit and found that over 80% of staff had had mandatory training in seven out of eight core training units with 76% staff having had fire safety training. We saw that plans were in place to book future training sessions.

Assessing and responding to patient risk

- Patient care plans and clinical risk assessments were up to date. These included assessments for pressure ulcers, nutrition and National Early Warning Score (NEWS) where required.
- Senior nurses told us that at weekends, nurses contact the out of hours the on call registrar if a patient was poorly. Nursing and medical staff told us that if they were concerned weekend transfers into the trusts other hospitals would be arranged.

Nursing staffing

Medical care (including older people's care)

- The units had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment on the days of our inspection. Staff rotas demonstrated that where there were reduced staffing levels, plans were in place to address the risk to care delivery.
- All areas were reporting planned and actual staffing levels using the trust's safe staffing protocols and the daily shift cover of nurses and health care assistants was on display in each area we visited.
- The Millbrook suite had three oncology trained band 7 qualified nurses. There were usually three or four health care assistants on duty daily.
- The renal dialysis unit was nurse led providing care and treatment for up to 20 patients at any time and had a qualified nurse to patient ratio of 1:4. The unit also had two healthcare assistants in the morning and one in the afternoons.
- Nurse practitioner support was also available when needed on site.

Medical staffing

- The Millbrook suite had consultant cover daily with support from a registrar and a junior doctor. The trust had a transfer policy governing the urgent transfer of patients to the other two hospitals in event of deterioration.

Major incident awareness and training

- The trust had appropriate plans in place to respond to emergencies and major incidents including staffing escalation plans. Plans were practiced and reviewed on a regular basis. Staff at all levels were not fully aware of these plans.
- All the senior nurses we spoke with were aware of the trust's major incident plan and business continuity plans to ensure minimal disruption to essential services. The major incident plan was available on the trust's internal computer system and accessible for all staff. Not all junior staff were aware of major incident planning and protocols and had not received any major incident training.
- Staff we spoke with were aware of the trust's fire safety policy and their individual responsibilities. Ward sisters told us of fire drill discussions with staff on an ad hoc basis. Most staff had had mandatory fire safety training for the year and we saw plans were in place to ensure staff needing this training would be booked onto a training session. For example, in the renal dialysis unit, 76% of staff had had the mandatory fire safety training against the trust target of 95%.

Are medical care services effective?

Good

Overall we rated this service as good for effectiveness.

Care was generally provided in line with national best practice guidelines and the trust participated in all of the national clinical audits they were eligible to take part in.

Most staff said they were supported effectively, but there were limited opportunities for regular formal supervisions with managers.

Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain.

There was some measurement of patient outcomes. Local audits were being undertaken.

Multidisciplinary team working was good.

We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Staff understood the concept of Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- A paper at the trust's board meeting on 24 June 2015 showed that overall the service's policies were 67% compliant with the National Institute for Health and Care Excellence (NICE) guidance. 24% of polices were partially complaint and 10% of polices were not complaint with NICE guidance. An action plan was in place to address this.
- New treatment pathways were being developed to be an interactive, on-line document on the trust's intranet. Each pathway would have the relevant links to NICE Guidance. So clicking on each box takes the user to the next step and/or relevant national or local guidance or policy. Treatment pathways were available on the trust's

intranet and were in place for acute kidney injury, managing sepsis, however, some polices were not yet in place, for example, for the management of community acquired pneumonia.
- Assessments for patients were generally comprehensive and did cover all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. People's care and treatment was generally being planned and delivered in line with evidence based guidelines. However, nursing care plans were not generally person centred.
- We found trust policies and guidelines available on the intranet, such as medicines management. Staff were aware of how to access these.
- Local audits were carried out in the clinical areas, including infection control, environmental and sepsis monitoring. Senior staff received outcomes of audits on a monthly basis and discussed with staff team in regular team meetings.

Pain relief

- We saw nurses asked patients if they were in pain, identify the location of the pain and deliver pain relief medication where necessary. None of the patients we spoke with told us that they were in pain.
- Patients indicated that they received pain relief medication when they required it. Staff used an assessment tool to determine if people were in pain. For people who were not able to communicate, staff told us the assessment of pain depended on the experience of nurse using the tool.
- Records examined showed that patient's pain relief was reviewed regularly and appropriate pain relief was given as prescribed when required.

Nutrition and hydration

- Across all services we saw patients were screened for malnutrition and the risk of malnutrition on admission to hospital using a recognised assessment tool.
- Generally, care plans were in place to minimise risks from poor dietary intake as appropriate.
- We saw evidence that care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment.
- Areas had protected meal times and patients generally had a choice where to eat their meals.
- Wards had appropriate systems in place to ensure that patients' food and fluid intake was recorded when required.
- Dieticians provided support mainly through telephone or other remote communication. Staff completed nutrition assessments and they told us that dietetic support on the wards could be arranged if required.
- Patients with special dietary requirements or who required assistance with eating were highlighted in plans.
- We looked at two patients' records where Malnutrition Universal Screening Tool (MUST) risk assessment had been recorded correctly.

Patient outcomes

- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether the number of in-hospital deaths is higher or lower than would be expected. The trust's HSMR for the 12 month period July 2013 to June 2014 was significantly higher than expected, with a value of 109. Previous publications of this indicator have shown a steady rise in mortality since 2013.
- The trust had implemented a series of actions to address this concern including the introduction of regular mortality review meetings to identify any actions to improve overall patient care and treatment.
- Relative risk of readmission was lower than the England average for both elective and non-elective care at Trust level. Elective gastroenterology at Worcestershire Royal Hospital and non-elective cardiology at Alexandra Hospital had higher than average rates of readmission.
- At Kidderminster, the Relative risk of readmission was higher than the England average for the rehabilitation service (elective and non-elective) and clinical haematology.

Competent staff

- Generally, we found there were effective induction programmes, not just focused on mandatory training, for all staff, including students. The learning needs of staff were identified but training was not always put in place to have a positive impact on patient outcomes.
- Most staff said they had had annual appraisals with a discussion about their learning and development

needs, whilst others said they had one booked for the near future. We checked records and found all nurses on the renal dialysis unit had had an appraisal in the current year.
- The trust did not have clear mechanisms in place to ensure appropriate levels of formal supervision of all staff. Staff at all levels said there was no structured approach for regular operational and clinical supervision.
- The majority of staff said informal support from their managers was effective and provided when they needed it. Senior staff said they received excellent informal support from their line managers.
- Staff said there where were limited opportunities for professional development.
- Most staff said they had had annual appraisals with a discussion about their learning and development needs, whilst others said they had one booked for the near future.
- Dementia training was provided for staff via online learning. Dementia link nurses had had specific training to undertake this role.

Multidisciplinary working

- A multi-disciplinary team (MDT) approach was evident across all areas. We observed effective MDT working in the areas we inspected. The Millbrook suite worked closely with local McMillan nurses and a local hospice so that care and treatment was co-ordinated for patients.
- Across all of the wards within inpatient services communication between the MDT team was integral to the patient's pathway.
- Nurses said that relationships with doctors and other professionals were inclusive and positive and facilitated effective MDT working.
- Staff were aware of which clinician had overall responsibility for each patient's care.

Seven-day services

- Senior staff said the service was looking at ways to fully adopt a seven day a week working practice for doctors. Newly admitted patients were seen by the on call consultant at weekends as required, but there were not generally full ward rounds at the weekends.
- Staff said there was a lack of speech and language therapists over the weekend.
- The renal dialysis unit was open on Saturdays but not Sundays.
- The Millbrook suite was not open at the weekends.
- Diagnostic services were available over the weekend and out of hours.

Access to information

- Staff could access further clinical guidelines and pathways on the trust intranet.
- Generally, nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.
- Information from community services and GPs was sufficient and provided in a timely way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent.
- Ward offices had posters on display giving staff guidance on mental capacity assessments and DoLS.

Are medical care services caring?

Good

Overall we rated this service as good for caring.

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

Overall, medical services at the hospital were caring. Patients received compassionate care and their privacy and dignity were maintained in most circumstances.

Patients told us that the staff were caring, kind and respected their wishes.

We saw that staff interactions with people were generally person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary, and full of praise for the staff looking after them.

The data from the hospital's patients' satisfaction survey Friends and Family Test (FFT) was cascaded to staff teams.

Medical care (including older people's care)

Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases.

Compassionate care

- People who used the service and those close to them were generally treated with respect, including when receiving personal care.
- Most people who used the service felt supported and well-cared. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with people using the service and those close to them. Staff spent time talking to people, or those close to them. Patients generally valued their relationships with staff and experienced effective interactions with them.
- Staff generally respected people's individual preferences, habits, culture, faith and background. People felt that their privacy was respected and they were treated with courtesy when receiving care.
- We observed a number of staff and patient interactions whilst visiting the renal unit and found the staff approach to patients was extremely respectful, compassionate and caring. All patients had drinks and call bells to hand. The atmosphere hour was relaxed and calm.
- Confidentiality was generally respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication.
- We spoke with 12 patients. Patients were positive about their experience within the inpatient services. We observed staff spoke in a kind and considerate manner with patients.
- The majority of patients were positive about the care they received on the wards.
- A patient told us on the renal dialysis; "The treatment I have received is second to none".
- Staff were proud of the positive feedback they received from patients.
- All wards had a performance noticeboard on display with showed the most recent Friends and Family Test (FFT) scores.

Understanding and involvement of patients and those close to them

- Staff generally involved people who used the services as partners in their own care and in making decisions, with support where needed.
- Most patients who used the service felt involved in planning their care, making choices and informed decisions about their care and treatment.
- Staff generally communicated in a way that people could understand and was appropriate and respectful.
- Verbal and written information that enabled people who use the service to understand their care was available to meet people's communication needs.
- We found medical staff generally took time to explain to patients and relatives the effects or progress of their medical condition which meant that people understood why changes of arrangements were required. Patients said doctors explained their treatment options for them.

Emotional support

- Most patients we spoke with were very positive about the support they had been offered by the multidisciplinary team. Support was provided to families members when required.
- We saw some evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care.
- Visiting times could be flexible to allow for relatives of elderly patients to maintain family contact.
- Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessments tools for anxiety, depression and well-being were available for staff to use when required.

Are medical care services responsive?

Good

Overall we rated this service as good for responsiveness.

People's needs were consistently met through the way services were organised and delivered.

Services met the needs of patients in a timely way.

The trust was meeting the 62 day referral to treatment times for cancer.

Generally, patients' care and treatment was planned and delivered to reflect their individual needs.

Information was available for patients regarding how to make a complaint and complaints procedures were effective.

Service planning and delivery to meet the needs of local people

- The Millbrook suite was open 9am to 5pm Mondays to Fridays and provided seating for up to 10 patients and one bed space.
- The renal dialysis unit was open from 8am to 5pm on Mondays to Saturdays and could provide dialysis treatment for up to 20 patients. It accommodated some patients from other local hospital trusts.
- The trust generally planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible, in line with their preferences, and wherever possible provided accommodation that was gender specific, and ensuring the environment and facilities were appropriate and required levels of equipment were available promptly.
- We observed an integrated approach to care delivery across all the services involving nursing staff, therapists, medical staff and pharmacy and a commitment to facilitating a timely, safe and person-centred discharge for the patient.
- The hospital had a Chronic Obstructive Pulmonary Disease (COPD) outreach team, an asthma service across all hospitals and the trust was also planning to expand the sleep service for patients with ongoing respiratory health conditions.

Access and flow

- The Millbrook suite did not have a waiting list of patients waiting to commence treatment. Staff said that there had been a 30% increase in number of patients being referred to the suite since January 2015 but that the suite was managing this increase in demand appropriately.
- The average length of dialysis treatment for patients was four hours.
- People were able to access the right care at the right time. There was a planned approach to managing the capacity in the Millbrook unit and renal dialysis unit.
- Bed management "Hub" meetings were held three times a day in another trust hospital to discuss and prioritise bed capacity and patient flow issues. Matrons and senior managers also had a daily meeting at 9am to discuss bed pressures and overall the daily situation report for the hospital, including staffing pressures. Bed managers liaised with the Patient Flow Centre (PFC), which was a county council led team designed to facilitate timely and appropriate discharges back to the community.
- Senior managers said that the trust initiative "Breaking the Cycle" to focus on patient flow had been recently introduced and that all wards were working towards having a "board round" at 8am to identify patients ready for discharge.
- The PFC started in October 2014 and was responsible for managing admission and discharge to community beds (provided by another organisation), including those at Kidderminster hospital. Admissions were only possible on Mondays to Fridays and staff said usually there was a high threshold of criteria for admission. These 20 beds were managed with oversight from a local general practitioner (GP) service which provided medical cover during weekdays but not at weekends.
- The trust had consistently met the Referral to Treatment time 18 week target for admitted patients at Trust level.
- The trust did not meet three of the cancer standards in July 2015. Performance on the two week wait 'all cancer' indicator declined from 87% in June 2015 to 83% in July 2015 against the 93% target. The trust did not achieve the 85% target of patients seen within the two week standard for symptomatic breast cancer referrals in July 2015 as performance was 83%. 31 day performance for first treatment had improved to meet the target of 96% in July 2015.
- The Department of Health has recently reiterated the pre-eminence of the 62 day cancer standard from urgent referral to treatment. For the trust, 62 day performance for first treatment for GP referrals had improved by 4.4%% to 79.8% in July 2015 and remained below the 85% national target.
- Average length of stay at trust level was higher than the England average for elective care and slightly below the England average for non-elective care.
- For the period January to December 2014, the average length of stay for Kidderminster Hospital was 12 days, which was higher than the England average of 4.5 days for elective treatment. It was significantly higher than

the England average for non-elective treatment at 20.4 days compared to 6.8 days. This was reflective of the rehabilitation function of the majority of the inpatient beds.

Meeting people's individual needs

- People who used the service were asked about their spiritual, ethnic and cultural needs and their health goals, as well as their medical and nursing needs.
- Generally, their care and treatment was planned and delivered to reflect these needs. The needs and wishes of people with a learning disability or of people who lacked capacity were understood and taken into account, although some staff said they needed more training in this area.
- The hospital provided dementia link nurses on most wards to help support effective care for people living with a dementia. The hospital used the "About Me" documentation books that, when completed by patients and their families gave person centred information to staff to facilitate more effective care.
- Staff generally showed awareness of the care needs of people with a learning disability and how to detail and necessary reasonable adjustments for these patients in care plan records.
- Across all areas we observed a commitment to providing services to patients who did not have English as their first language, though we did not always see information on display concerning interpreting services.
- Staff told us they knew how to access interpreting services and how to use them to support patients who needed to make decisions about changes to their care pathway.
- In the care records we reviewed the patients' religious needs were assessed on admission. Staff told us patient care would be tailored according to their needs.
- A multi faith room was available to patients to use.
- Patient information leaflets were available describing treatment options and staff told us they were given to patients on arrival.
- Some wards had quiet areas for discussion with patients and relatives. Wards had access to a chapel and multi faith room on site.
- We saw cultural information files available, with details of religions and their naming conventions, beliefs, rites and rituals and end of life beliefs. Staff said they have had training and support in this area.
- In most wards patients had minimal stimulation or activities provided beyond access to a television or radio.

Learning from complaints and concerns

- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display on most wards. Complaints procedures and ways to give feedback were in place.
- Staff explained that they would always try to resolve informal complaints first. Formal complaints were directed to PALS who initiated an acknowledgment. The complaint was then passed to the relevant person in the unit to respond fully.
- Patients generally knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care.
- People were supported to use the system and to use their preferred communication method. This included enabling people to use an advocate where they needed to. People were informed about the right to complain further and how to do so, including providing information about relevant external second stage complaints procedures.
- The trust reviewed and acted on information about the quality of care that it receives from patients, their relatives and those close to them and the public.
- Not all wards were able to show consistently the difference this had made to how care was delivered however, we saw that the stroke had had listened and responded to patients' comments by now providing more information regarding stroke and stroke discharge packs were now made available to patients and their relatives.
- Staff received feedback or information from complaints or what had been done to address the concern.
- We saw many examples of compliment letters and thank you cards displayed in ward areas.
- Patient feedback was generally very positive about the staff and service.
- Staff said complaints and incidents were regularly discussed at team meetings so the wards were not always able to show how lessons had been learning and shared from complaints. Patient satisfaction surveys were carried out in all areas.

Medical care (including older people's care)

- Staff said senior nurses investigated complaints and the outcomes were usually discussed with staff. Areas had performance boards on display so visitors and patients could see how their comments were being acted upon.
- Neither service had had a complaint in the month prior to the inspection, but we saw both had received many compliments.

Are medical care services well-led?

Good

Overall we rated this service as good for being well led.

The arrangements for governance and performance management operated effectively at the local level.

The local leadership, governance and culture promoted the delivery of high quality person-centred care and was good at the local level.

There was evidence of effective communication within staff teams.

The visibility and relationship with the management board was less clear for junior staff, not all of whom had been made aware of the trust's vision and strategy.

Not all staff felt able to contribute to the ongoing development of their service. Not all junior staff were fully aware of the vision and strategy of the trust.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in changes and improvements to the service such as the closure of Cookley ward.

All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders and the executive team were not visible.

Vision and strategy for this service.

- Some staff were aware of the trust's vision and values, whereas others could not describe what these were.
- There was no service specific written strategy for the medical care service as the service was liaising with local commissioners regarding the trust's bed capacity and longer term planning based on local need.

Governance, risk management and quality measurement

- Staff across all wards demonstrated awareness of local governance arrangements. They detailed the local actions taken to monitor patient safety and risk. This included incident reporting, contributing to the divisional risk register and undertaking audits.
- Teams had their own risk registers in place. Team managers were aware of how to escalate risks to the divisional risk register. Senior staff were aware of the divisional governance structure and how action plans addressing risks were devised and implemented at ward level.
- Teams had display boards showing performance and patient safety information, including actual and planned staffing levels and showed how the units had listened and responded to feedback from patients and their relatives.

Leadership of service

- Managers told us that they were proud of their teams and recognised that staff worked hard within their roles.
- Local teams generally had clearly defined tasks, membership, roles, objectives and communication processes.
- Staff at Kidderminster said senior managers and the executive team rarely visited and were not visible to staff teams. Half of the staff at Kidderminster hospital did not know the director of nursing.
- Some staff told us that they did not know the structure of the organisation.
- Staff said the reasons for the closure of Cookley ward recently had not been communicated very effectively by senior managers and that it had not been planned effectively.
- Almost all staff felt able to raise problems and concerns without fear of being penalised, bullied or harassed.

Culture within the service

- Most staff reported that they were happy working at the trust and felt very well supported by their local managers.
- Staff morale had been affected by the closure of Cookley ward and subsequent redistribution of staff to other teams in the hospital.
- Staff told us that recruitment and retention was a problem within the trust. Some staff believed that nurses had left the trust due to increased work pressures.

Medical care (including older people's care)

- Across all wards staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Staff were aware of the trust's values.
- Some staff felt listened to and involved in changes within the trust; many staff spoke of involvement in staff meetings, and receiving newsletters.
- Senior managers said they were well supported and effective communication with the executive team.

Public engagement

- The trust and all staff recognised the importance of the views of patients and the public. A range of feedback was sought from patients using surveys and feedback and comments cards.
- Information on patient experience was reported and reviewed alongside other performance data but not all staff felt patient feedback was used to make informed decisions about the service.
- Most staff were able to tell us how learning from incidents or complaints was shared.
- Patients were asked for their views about the care they received. Views were displayed on a performance board in patient areas.
- Most staff said the main way that patients' views were gathered about services was via the services' questionnaires.
- Millbrook suite had received approximately £2000 in charitable donations. Plans were being devised to invest this on complimentary therapies to offer to patients receiving chemotherapy four days per week.

Staff engagement

- There was effective ward leadership and support but not all staff felt their views were being heard at more senior levels beyond the local level. Staff generally did not feel actively involved in making decisions about the wider service. Some staff said there was a culture of "silo working" and that best practice was not effectively shared across the trust.
- Some staff who had worked on Cookley ward said they not consulted about the ward closure and expressed concerns about the rapid redeployment process to work in other areas.
- We saw information displayed on the wards advising staff of the whistleblowing procedure.
- Staff generally felt communication at local level was very good but that at senior levels, it was "top down" and didn't always feel their views were listened to at senior levels in the service.

Innovation, improvement and sustainability

- All the ward sisters talked of involving staff in service developments and shared learning from incidents.
- Some staff felt they were not engaged in key decisions made about their service.
- A dedicated helpline was available for haematology and cancer treatment patients.

Surgery

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

Information about the service

Worcestershire Acute Hospitals NHS Trust surgical services were located on four hospital sites. The Royal Worcestershire Hospital, the Alexandra Hospital, Kidderminster Hospital and Treatment Centre and Evesham Community Hospital.

Each hospital was visited as part of the inspection process and each is reported upon separately. However; services on all four hospital sites were run by one management team. As such they were regarded within and reported upon by the trust as one service, with some of the staff working at all sites. For this reason it is inevitable there is some duplication contained in the four reports.

The trust had five clinical divisions, the services we inspected under the CQC heading of Surgery actually sat within two different divisions. Surgery division governed surgical practice and wards whilst theatres sat within the Theatres Ambulatory Critical Care and Outpatients (TACO) division. The structure was further split into regions; Worcestershire Royal Hospital and Evesham Community Hospital theatres were managed by one team headed by a matron and Alexandra Hospital, Redditch and Kidderminster Hospital by another team led by their matron.

Kidderminster Hospital had 5 theatres and 3 treatment rooms including ophthalmology based in the Treatment Centre. The surgical ward had 12 individual rooms for patients. The unit was staffed to care for 12 patients but with additional staffing the unit had capacity to increase to 18 patients if ever this were required.

National statistics showed that there had 15,200 procedures completed between January and December 2014.

95% of surgical procedures completed on site were day case patients the remaining 5% being elective inpatients. No emergency surgery takes place on site.

The main specialities covered at Kidderminster Hospital were Ophthalmology 37%, Trauma & Orthopaedic 16%, and General Surgery 15%, the remaining 32% shared between other disciplines.

Surgery

Summary of findings

Overall we rated this service as good. It was rated requires improvement for responsiveness and good for safety, effectiveness, caring and well-led

Processes were in place to keep people safe. Staff numbers and skill mix were maintained, infection prevention and control measures were effective. People were protected from abuse.

Procedures were based on recognised pathways of care. People received treatment in a timely manner.

Staff were friendly, kind and supportive.

The services met the needs of the local community Whilst the range of treatments available to patients was limited, this was appropriate and in line with national guidance, dictated by the facilities available.

Good local leadership had introduced innovative communications systems to keep staff informed of clinical alerts and local issues.

Theatres did not work at their full capacity, meaning people had to wait longer to be treated

Referral to treatment time performance was below both the national standard and the England average for admitted patients between April 2013 to February 2015 in every service except ophthalmology.

Are surgery services safe?

Good

Overall we rated this service as good for safety.

Incidents were recorded and analysed, learning was shared both within local teams and the wider trust.

We saw that reliable systems, processes and practices were in place to keep people safe and safeguarded from abuse.

Recognised tools were used to assess and monitor risk to patient's health.

Potential risks to services were identified, escalated and monitored. Risks were reduced or mitigated where possible.

However we did observe an example of poor practice which meant there was the potential opportunity for patient medication to be tampered with.

Incidents

- The trust had reported two surgical never events during the previous twelve months. One never event had occurred at Kidderminster Hospital; this related to wrong site surgery where laser treatment had been applied to the wrong leg of a patient. Analysis of the cause revealed that the World Health Organisation (WHO) safety checklist had not been followed correctly. As a result the trust instigated 'Stop before proceeding' and confirmation of the surgical site, into the process for all theatres trust wide. Compliance with the WHO checklist was audited through the bluesphere computer system.
- The second never event had occurred in Critical Care at Worcestershire and involved a misplaced naso-gastric tube. Staff at Kidderminster Hospital were aware of the incidents which showed that the trust had effective methods to disseminate learning.
- Kidderminster Hospital surgical division had reported four serious incidents on site. We saw that the incidents had been investigated and learning had been disseminated to teams to prevent further occurrences. We were able to view the root cause analysis documents provided by the trust and we saw evidence of how one incident had been discussed in the team meeting minutes.

- The trust had an electronic incident reporting system. Staff were familiar with the system and were able to describe incidents they had reported.
- Learning from incidents was shared at team meetings and through a site specific communications board. We saw copies of the team meetings and the latest minutes formed part of the rolling information on the communications board. Staff explained they were able to 'get up to speed' if they had not been able to attend the team meeting by reviewing the information on the communications board. The information on the board was updated by the matron who had introduced the system.
- Mortality and Morbidity meetings took place monthly but tended to held at Worcestershire Royal or Alexandra Hospitals.
- Staff understood the concept of duty of candour. Staff told us that they always tried to open with patients and apologised if they did not meet patient's expectations. More serious issues were reported on the incident recording system and dealt with by senior managers. Policies were in place which outlined the process to be followed including updating and apologising to patients, investigating, and feeding back the results.

Safety thermometer

- During the twelve months May 2014 to April 2015, there had been no hospital acquired pressure ulcers, although a number of patients had attended with ulcers and these had been referred to the tissue viability link nurse when required
- During the same period there had been no catheter induced urinary tract infections, and only one fall. We were told the fall was an ambulant patient who was walking with staff, they lost their footing and staff were able to support them and lower them to the ground which meant no actual harm occurred.
- We saw that some patient information was displayed on the ward. The usual safety thermometer information; hospital acquired pressure ulcers, Venus thromboembolisms (VTE) and catheter related urinary tract infections (UTI's) were not displayed. This was because the short length of stay which patients experienced meant these issues did not occur.

Cleanliness, infection control and hygiene

- Theatres and the surgical wards were clean and tidy.
- Theatre cases were planned such that procedures which might result in closure of the theatre for cleaning were completed at the end of lists. An example of this was a patient who was known to have an infection. The patient was moved to the end of the list which prevented the risk of cross contamination and meant that deep cleaning of the theatre did not have to be done until the list had been completed.
- All day case patients were screened for MRSA during their pre-assessment appointment. We saw evidence of this within patient records. Patients we spoke with also confirmed that staff had explained the screening process to them during their pre assessment.
- We saw that ward staff used appropriate personal protective equipment, aprons and gloves when providing care.
- Theatre staff followed recognised scrub techniques.
- We saw that one patient on the surgical ward was being barrier nursed. This consisted of being nursed in a side room with additional notices to remind staff and visitors that additional protection was required prior to entering or leaving the room.
- Healthcare workers on the ward had been given responsibility for different areas of the ward including cleanliness and sorting of storage areas. They explained how this had given them more responsibility and encouraged them to compete on a friendly basis to keep their area better than their colleagues.
- Cleaning schedules identified which areas had been cleaned and any issues identified during the process. Hand Hygiene audits demonstrated that ward staff complied with the trust infection control policy.

Environment and equipment

- We observed that equipment throughout the four sites was standardised which meant that staff would be familiar with equipment if called to work at other locations within the trust.
- Resuscitation trolleys were available, were properly stocked and regularly checked. Logs were kept of when checks had been completed.

Medicines

- We saw that medication in one theatre had been drawn up for a patient and left in the anaesthetics room. The anaesthetist had taken medication for the patient currently in theatre, through to the operating room. This meant that medication was left unattended and there

was potential for contamination or tampering. We spoke with the anaesthetist who told us they were confident that no medication errors could occur because although they had prepared medication for more than one patient, each patient's medication had been placed in separate containers. The relevant containers were taken into theatre with the patient and each drug was checked individually prior to administration. However; we were not reassured that the medication left in the anaesthetics room counter could not be tampered with whilst the anaesthetist was in theatre.

- We checked the general storage of medication and found that drugs were secure and properly accounted for. We checked a random sample of medicines and found that all were within their expiration date.
- Temperature sensitive medicines were stored in refrigerators and temperature checks were completed and recorded.
- Pharmacy support was available and regular pharmacy checks were completed and recorded.

Records

- We checked two sets of patient notes whilst on the ward, we saw that they contained appropriate information which would enable staff to provide appropriate care and keep the patient safe. Risk assessments had been completed which highlighted areas of concern for the individual concerned.
- Pre-operative assessments had been completed which showed that the patients were fit for the procedures planned.
- We saw copies of audits and other documentation relating to training of staff, infection control and the general running of the ward and theatres. We saw that information was clear. Training matrix identified when staff had completed training and when it was next due. We saw how the ward sister made notes to prompt her to complete records or tasks.

Safeguarding

- The trust had a safeguarding lead. Staff at Kidderminster Hospital had all received safeguarding training and understood how to recognise the various forms of abuse.
- We were shown the training matrix which showed that 100% of staff had completed both adult and children's level 2 safeguarding training.

Mandatory training

- Mandatory training in the trust was separated into nine subjects. These were Fire training, Information Governance, Personal Development Review training, Manual Handling, Safe Child, Safe Adult, Resuscitation training, Hand hygiene and Infection Control training. We saw that 90% of theatre staff had completed all mandatory training,
- Adult and Paediatric life support training was provided as a one day joint course with half day refresher courses. 98% of theatre staff had completed adult and paediatric intensive life support training. 100% of ward staff had completed mandatory training.
- 85% of theatre staff and 100% of ward nursing staff had received an appraisal in the last twelve months, against the trust target of 100%, with the remainder planned.
- Ward staff had received adult life support training; they were not trained in paediatric life support as any young people were accompanied by paediatric nurses who had received the appropriate training.

Assessing and responding to patient risk

- The majority of surgical procedures at Kidderminster Hospital were day case surgery and patients were relatively fit and healthy. Some procedures involved planned hospital stays for recuperation or observation. Patients who remained on the ward were seen following their surgery by a member of the surgical team, most often the consultant surgeon. Regular monitoring of patients was conducted by nursing staff and any patient who was not improving as expected or was deteriorating was escalated to the consultant if available or the hospital medical team.
- We were told that consultants were very approachable and would ask to be informed if there were issues with their patients.
- We observed appropriate use of the five steps to safer surgery. We attended the morning briefing where the theatre list was discussed including issues for individual patients such as allergies or medical conditions. We observed the 'sign in', 'time out', 'sign out' and debrief sessions.
- If patients deteriorated, staff followed the trust 'Guideline for the transfer of patients from Ward 1 at Kidderminster to other hospitals' policy. This stated that

staff call an ambulance and the Resident Medical Officer (RMO), who is onsite 24hours a day, seven days a week should be called to stabilise the patient until the ambulance crew arrived.
- The trust reported that there was only one incident recorded in the past year when an ambulance needed to be called to KHTC, when a patient deteriorated after surgery. It was assessed that no harm was sustained.

Nursing staffing

- Staffing levels in theatres and on the surgical ward followed national guidance. Both theatres and the ward had the option to use bank and agency staff to supplement staff numbers where required.
- Theatres at Kidderminster Hospital had not used agency staff for over ten years. They had covered vacancies within the department or by using bank staff employed by the trust.
- Patient needs were assessed on the ward and if additional care were required bank staff or agency staff were used. Agency staff were used on the ward, predominantly covering weekend shifts. The induction process was described to us, and would be sufficient to enable unfamiliar staff to understand the ward and hospital policies. Agency staff were all employed from the same company and tended to be from a small group of staff who worked regularly on the ward.
- The handover process at Kidderminster Hospital was described by staff and followed procedures we had observed at other sites within the trust
- Levels of nursing and healthcare staff numbers consistently met the planned staffing levels on the ward.
- Senior nursing staff ensured that the skill mix on the ward met patient needs. We were told how rota systems had changed recently which had enabled more flexibility for staff to request particular shifts and helped ensure skill mix could be maintained.
- Theatre staff had been trained in different techniques which enabled them to provide cover for absences. All staff were trained in two of the three disciplines; either scrub and recovery roles, or recovery and anaesthesia roles, some had completed all three.
- Theatres had increased their staff numbers to meet an increase in workload with two additional band five nurses, one bad three health care assistant (HCA) and one band two HCA, recruited in the last two months.

Surgical staffing

- Surgical teams worked across the trust providing specialities to patients at the four hospital locations.
- The Surgical team consisted of 227 staff. 46% Consultants, 10% middle grade doctors 29% Registrars and 16% junior doctors. The trust had a higher proportion of consultants and slightly higher number of junior doctors than the England average skill mix with proportionally less registrar and middle career doctors.
- Consultant cover was available between 8am and 6pm with out of hours covered by on call rota system.
- After 5pm there was no dedicated surgical doctor presence. If a doctor was required staff called the Resident Medical Officer (RMO).

Major incident awareness and training

- The trust had major incident/business continuity plans which identified roles for individual personnel.
- Protocols were in place for deferring elective activity to prioritise unscheduled emergency procedures. Whilst Kidderminster Hospital would not be used for emergency surgery, the availability of surgeons would effectively mean the cancelation of lists.
- Copies of procedures and protocols were stored in the ward sister's office. Staff were aware that they could access the ward copies; they also understood how to access information on the trust intranet. We observed staff using the intranet to access guidance.

Are surgery services effective?

Good

Overall we rated this service as good for effectiveness

People's needs were assessed and care and treatment delivered in line with national guidance and recognised good practice.

Local audits and engagement with national audits enables managers to monitor performance and identify areas for improvement.

Staff were skilled and knowledgeable, and had access to information to enable them to provide effective care.

Consent was sought prior to any procedures being carried out. Processes were in place to support patients who did not have mental capacity to consent to treatment.

Evidence-based care and treatment

Surgery

- Enhanced recovery pathways were followed in line with the clinical needs of the patients. Enhanced recovery involves including the patient in shared decision making and planning support throughout the process including after discharge. All surgical patients received a follow-up phone call within 24hrs of discharge.
- The Divisional Medical Director of Theatres, Ambulatory, Critical Care and Outpatients (TACO) was not available during the inspection but wrote to us describing how anaesthetists had contributed to a number of enhanced recovery programmes. These included laparoscopic colorectal surgery, reconstructive breast surgery and hip replacement surgery.
- Trust policies, procedures advice and guidance were all available electronically to staff at Kidderminster Hospital.
- Local audits were completed in both ward and theatre areas. These included equipment audits, hand hygiene audits records audits. General results of audits were shared with teams during meetings and handovers. We were advised that issues identified involving individual staff would result in advice being given and training or support being provided if required. We were not given examples of where this had been required. A register was kept of the reviews and outcomes.
- We saw audit outcomes for waste and linen services which showed 100% compliance with trust policy and procedure. Cleanliness audits showed 95% compliance.

Pain relief

- The trust had a consultant led pain relief service. Four consultants specialised in chronic pain, and both consultant anaesthetists and surgeons worked across all sites of the trust.
- The trust also had three county wide pain nurses.
- Pre-operative pain assessment clinics were completed for more complex conditions.
- Patients told us that staff had been very proactive in respect of their pain relief. They described how staff always asked if they were in pain or discomfort and provided prescribed analgesic when they requested it. No audit of the pain service had been completed

Equipment

- Theatre equipment had been standardised at all sites across the county including at Kidderminster Hospital. This meant that nursing staff and doctors who moved between sites were familiar with equipment available to them.
- The trust had developed additional airway systems for their anaesthetics trolleys with colour coded sections to assist connection which speeded use and prevented errors, Trolleys also had dedicated automatic flow meters used for patients undergoing spinal or nasal procedures.
- Resuscitation trolleys were identical to those at other sites across the trust. They were checked regularly and a register kept of the checks.

Nutrition and hydration

- Appropriate food and drink were available to patients on the ward. Choices were available which provided variety.
- Additional drinks were available between meals and water or juice were left with patients at their bedside.
- Vulnerable patients or patients who required more in intense care had assessments completed to identify their needs. Malnutrition universal screening tool (MUST) scores were calculated, which meant that patients who required additional support or special diets were identified and supported.
- Referrals could be made to dieticians if required.

Patient outcomes

- The surgical ward at Kidderminster Hospital was made up of individual side rooms. There was one bay area which could accommodate four patients but due to its position the area was never used. The ward was staffed to care for 12 patients, but had capacity to go to 18.
- Ward staff at Kidderminster Hospital explained that they had very few medical outliers that is medical patients occupying surgical beds. However, when we visited the ward we saw that four medical patients had been accommodated. Staff explained that immediately prior to our inspection a ward in another part of the hospital had been closed. The four patients had been transferred to the ward as an interim measure. Staff who had previously worked on the closed ward had also transferred with the patients which meant that there was little or no impact on surgical patients. Adequate capacity remained on the ward to deal with all planned surgical patients.

- Patient reported outcome measures (PROM's) use a set of health and wellbeing questions to enable patients to assess their own personal level of health and their quality of life. The information is collated by the Health and Social Care Information Centre (hscic). Data is recorded prior to operations and then repeated after 3 or 6 months dependant on the procedure.
- Four surgical procedures are subject to PROM's data submission; hip replacement, knee replacement, groin hernia and varicose vein procedures. Kidderminster Hospital undertook all these procedures; however PROM's data was not available for varicose vein surgery. We asked the trust why they did not engage with the varicose vein PROMs data. They advised that they did provide data. However, the system employed by the hscic was designed to protect the identity of patients. This meant that low patient numbers would not be used in order to protect patient identity.
- Trust wide data was submitted to the Health and Social Care Information Centre who publish the results and provide comparison with other hospital trusts.
- PROM's results were presented under EuroQol trademarks as EQ-5D and EQ-VAS. EQ-5D is based on descriptive information relating to five areas; mobility, self-care, usual activities, pain or discomfort and anxiety or depression. EQ-VAS is a visual analogue score. Patients mark on a chart their current health status, zero being the worst possible state and 100 being the best possible.
- EQ-5D data for the trust showed that the majority of groin hernia patients had experienced overall improvement in the five areas measured, however the number of improved patients was slightly below the England average. EQ-VAS levels were in line with England average.
- The trust engaged with national audit programmes, however not all audits involved procedures completed at Kidderminster Hospital. Results did suggest that surgical procedures in the trust were effective. In the National Hip Fracture Audit 2014, which assessed ten performance targets; the trust scored above the England average in seven of the ten targets. 2014 Bowel Cancer and Lung Cancer audits showed similar positive overall performance.
- The trust had enrolled in the Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation scheme (ACSA). The RCoA had yet to conduct a peer review of the Trust. Accreditation onto the scheme provides a structured process for improving services, Peer review and support, an assessment of performance against other hospitals and sharing of best practice to improve services.
- Kidderminster Hospital's surgical procedures were mainly undertaken on a day-case basis. 95% of cases were day case surgery and the remaining 5% were elective cases. No emergency surgery was undertaken at Kidderminster.
- Patients at Kidderminster Hospital enjoyed shorter length of stay following operations than national averages. Length of stay was also shorter than at its sister hospitals at Worcestershire Royal and Alexandra, Redditch.
- Breast surgery patients stayed on average 1.2 days with the England average being 1.6 days. Trauma and orthopaedic patients had an average stay of 2.2 days and general surgery averaged 1.1 days while the England average for both disciplines was 3.1 days.
- Readmission rates for Kidderminster Hospital were very low. The rates are a guide to successful outcomes for patients. The lower the readmission rate the better the outcome. The analysis of data provides a ratio of observed to expected emergency readmissions, multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Kidderminster Hospital's readmission rate for general surgery was 64, ophthalmology was 57 and urology was 47. Overall readmission rate was 57.

Competent staff

- Nursing staff and doctors we spoke with were knowledgeable and understood how to support patients they cared for.
- All nursing staff and health care assistants on the surgical ward had received appraisals within the last twelve months. The ward manager explained how additional senior nursing staff had been trained to complete appraisals; each had a dedicated number of staff to review. We saw records which showed that 100% of nursing surgical division nursing staff at Kidderminster had current appraisals. Of the 9 administration staff at Kidderminster 7 had received

appraisals this equated to 78% compliance. Of 7 healthcare scientists 5 had current appraisals amounting to 71% and additional clinical services staff had achieved 100% appraisal compliance.
- Doctors in the surgical division at Kidderminster had 100% appraisal compliance. They told us they were supported to revalidate their registration with the General Medical Council (GMC). Junior doctors told us they found consultants approachable and supportive.

Multidisciplinary working

- We saw evidence of multidisciplinary working in patient records. Staff described the system for referral to therapies. We were told that physiotherapy and occupational therapists visited the ward each day. The ward manager described how OT and Physio therapists update the patient lists which were printed and discussed during nurse handovers.
- MDT meetings took place at which individual cases were discussed which ensured staff had a holistic approach to care.

Seven-day services

- Ward services were provided on a 24/7 basis.
- Theatres operated on week days between 8am and 5pm although lists often went beyond this time.
- Consultant presence at Kidderminster Hospital ended when lists had been completed. Although ward staff said that most consultants asked to be contacted if there were any issues with their patients.
- Out of hours cover was provided by the Resident Medical Officer for the hospital.
- Out of hours pharmacy support was available on a call out basis.

Access to information

- Staff had access to patient information both through the electronic systems and also to written records. Staff we spoke with confirmed that they had access to information and guidance to enable them to fulfil their role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients confirmed that they had consented to the procedures they were about to undergo. They described how consent had been given during outpatient appointments and during the admissions process.
- Staff we spoke with had a good knowledge of the mental capacity act. They understood how to support patients and their carers or family when they attended appointments. There was clear guidance available for staff to follow if a patient did not have capacity to make important decisions about their health care. Documentation was available in the department which enabled staff to follow the guidance and ensured correct procedures would be followed.
- We did not encounter any patients during our inspection that did not have capacity. Staff described how capacity issues occasionally arose in relation to elderly patients with dementia or other memory problems, and with people with a learning disability.

Are surgery services caring?

Good

Overall we rated this service as good for caring.

People were seen to be treated with respect and kindness. Patients and their relatives or carers appeared happy in the presence of staff.

Patients described how they and their partners or carers had been fully involved in discussions with doctors and nurses about their condition and options for treatment.

Staff described how patients were supported if they had to be given bad news.

Compassionate care

- We observed interactions between staff and patients in theatres, on the ward and in the pre assessment unit. Staff were polite and friendly towards patients. We saw that staff were professional and caring.
- Personal conversations took place in private locations. People were called by name from waiting areas and they were asked to confirm some personal information when first attending reception areas, however most conversations took place away from public areas.
- Patient's privacy and dignity were maintained when personal care was given or when any procedure or treatment was undertaken.
- We saw that patients in theatre were treated with respect even when unconscious.

- Patients we spoke with all confirmed that staff had been polite and friendly. This had included encounters with receptionists, nursing staff, doctors and staff such as porters and housekeepers.
- All patients were contacted by telephone within 24hours of their discharge. This had not only enabled additional advice to be given if required; but staff told us the system had been extremely popular with patients.
- We were able to speak to a healthcare worker on the ward had been nominated for a national award of Healthcare Worker of the Year. They described how they enjoyed working with and supporting patients and how they understood that patients could be very anxious; being away from home and cared for by people they didn't know. They described trying to see the ward from the patient's perspective and that helped understand how they felt and therefore how to reassure and support them. They also told us that they felt the other staff on the ward worked equally hard.

Understanding and involvement of patients and those close to them

- Patients told us that they had been able to discuss their care and treatment with their consultant and with junior doctors. They said they had been able question different options and they had been given information which they could understand. Some patients described how they had been provided leaflets describing their procedure so they understood what to expect.
- Patients told us that their relative or carer had been able to attend meetings and consultation's and had been able to take a full part, asking and answering questions.

Emotional support

- All patients were assessed when they attended clinics and when they were admitted prior to their operation. The assessments included the patient's anxiety. Staff said that in most instances patients with anxiety could be reassured by spending a little extra time explaining exactly what they should expect. If patients were unable to control their anxiety doctors were able to prescribe medication.
- There were processes in place to enable staff to give patients or relatives bad news.
- A chaplaincy service was available for patients, relatives and carers.

Are surgery services responsive?

Requires improvement

Overall we rated this service as requires improvement for responsiveness.

Referral to treatment time performance was below both the national standard and the England average between April 2013 to February 2015

Theatres did not work at their full capacity, meaning people had to wait longer to be treated.

Processes were in place which ensured vulnerable people were supported.

There were processes in place to support and respond to people who wished to complain.

Service planning and delivery to meet the needs of local people

- Patients admitted for surgical procedures at Kidderminster Hospital have to be relatively fit and well.
- Patients need a body mass index (BMI) under 40, and an ASA score no higher than ASA2. ASA scores range from 1 to 6. ASA1 is a normal healthy patient; health and wellbeing reduce as the ASA number increases. ASA scores are assessed by anaesthetists following the American Society of Anaesthesiologists (ASA) physical status classification system.
- Procedures were completed primarily to meet the needs of the local population; however, some patients had elected to have their surgery at Kidderminster Hospital as an alternative to longer waiting periods elsewhere in the Worcestershire Acute Hospitals NHS Trust.

Access and flow

- The theatres and ward at Kidderminster Hospital were not used to full capacity. From January to June 2015, theatres operated at an average of 66% of optimum capacity for main theatres and 71% for ophthalmology. However during the week of our inspection only 63% of the theatres capacity was utilised. Although the trust said that spaces on the operating lists at Kidderminster were offered to patients from its sister hospitals in order

for them to be treated earlier, it was clear that there were not effective systems in place to ensure that operating lists were full. This means that patients were waiting longer for their operations than was necessary.
- 4.2% of all operations from April to June 2015 were cancelled
- Theatre activity at Kidderminster Hospital was administered from the Royal Worcestershire Hospital; the referral to treatment time for patients attending Kidderminster was not separately reported by the trust Referral to treatment time performance was below both the national standard and the England average for admitted patients between April 2013 to February 2015 in every service except ophthalmology. The standard is that 90% of admitted patients should start consultant led treatment within 18 weeks of referral. Some specialities such as ear nose and throat were as low as 69%, and trauma and orthopaedics scored 76%.
- Bed occupancy was consistently below the national guidance of 85%. Review of incidents nationally had identified that significantly more untoward incidents occur when bed occupancy exceeds 85%.
- We observed different aspects of the admissions process. Identification processes were followed, consent to treatment and understanding of the procedure were discussed with patients.
- Discharge from the ward was nurse led within the guidance agreed with consultants. Patients who used the service were generally well and were able to care for themselves or be cared for with assistance from family. Discharge letters were provided for GP's explaining the procedure the patient had undergone. GP on call services were available to the ward through a service level agreement.
- Fractured Neck of Femur patients who were seen at Kidderminster Hospital were recorded as part of the Alexander Hospital data. This showed that of the ten areas assessed eight were better than the England average, these included; pre-operative assessment by a geriatrician, non- health medication assessments completed and falls assessments completed. Of the two areas where the hospital performed less well, one was overall length of stay which was almost identical to the England average of 19 days at 19.4 days. The worst area of performance was in relation to the number of patients who underwent operations on the day of admission or day following admission where the hospital achieved 66% against an average of 74%.
- The surgical ward at Kidderminster Hospital had sufficient capacity to deal with all surgical admissions. The ward was staffed to manage 12 beds but up to 18 patients could be accommodated if required.

Meeting people's individual needs

- Paediatric lists were all scheduled for Wednesdays. This enabled specialist staff to plan such that paediatric anaesthetists, consultants and specialist nurses were all available to provide support to patients and parents.
- Care plans reflected the needs of individual patients.
- Patients with complex needs were discussed at MDT meetings before hand and where required carers were allowed to remain with the patient if the procedure involved local anaesthetics, and they were able to remain with patients until sedated when general anaesthesia was required. Carers and relatives were encouraged to help care for the people they supported whilst they were on the ward.
- Translation services were available by telephone. Face to face interpreter services could be arranged by appointment if required.
- Staff understood how to support people with a learning disability and carers were encouraged to be involved.
- Ward staff had received dementia awareness training.

Learning from complaints and concerns

- The trust had a complaints policy and clear procedures for staff to follow if patients or visitors wished to raise issues.
- The trust website provided guidance on how to resolve problems or concerns. A separate area refers people to the trust's patient advice and liaison service (PALS) and to external support.
- We saw evidence on the surgical ward notice board of how the ward staff had responded to issues raised. A 'you said – we did' notice identified that patients and visitors had outlined that signage in the pre-assessment unit was confusing; as a result new clearer signs had been erected.
- Kidderminster Hospital ward and theatre staff described how they tried to support people in a way that meant they didn't have cause to complain. If people were not happy with the service, staff attempted to provide solutions or explanations there and then which they

said prevented issues escalating to the level of complaints. There was no formal recording of these encounters which meant that it was not possible to monitor trends and respond to them.
- There had been one formal complaint on the ward in several years. This was an ongoing complaint and the ward manager was in communication with the complainant.

Are surgery services well-led?

Good

Overall we rated this service as good for well-led

Governance processes ensured that staff understood their role and responsibilities. Regular audits ensured that quality and risk were monitored and assessed.

Staff described the culture of the trust as open and honest; they felt supported by their managers and were happy to work at the trust.

Staff engagement was primarily through email and intranet systems.

Local managers had introduced innovative communication systems.

Vision and strategy for this service

- Staff we spoke with were familiar with trusts mission statement and were aware of the trust values relating to Patients, Respect, Improvement and innovation, dependability and empowerment (PRIDE).

Governance, risk management and quality measurement

- Trust policies, procedures and guidance were available to staff through printed copies and through the intranet.
- Systems were in place to enable managers to monitor audit and assess the quality of service provided.
- Regular meetings took place between staff groups with clear escalation and feedback where required. . We saw copies of the team meetings and the latest minutes formed part of the rolling information on the communications board.
- The Surgical and TACO divisional risk registers both contained issues relating to Kidderminster hospital. We also saw that an identified risk to staff during procedures with anaesthetised patients had been identified in October 2011, whereby staff who supported limbs of anaesthetised patients whilst procedures were carried out could potentially be injured by the patient. This was classified as low risk, however remained on the risk register and had not been resolved.

Leadership of service

- Local on-site leadership was good within theatres and on the surgical ward.
- Staff we spoke with at Kidderminster Hospital told us that the management team had improved the working environment over the last twelve months. Additional staff had been recruited. Communication within the teams and across the trust had improved, particularly in respect of the communications boards which were displayed in theatres at both sites.
- Staff told us that senior managers were visible and occasional executive level managers visited.
- Managers understood their role within the organisation, supported their staff and escalated issues where required.
- Staff told us they felt supported. Ward and theatres staff confirmed that senior staff regularly performed clinical tasks which enabled them to learn and provided supervisors with the opportunity to review the practice of staff.
- Senior managers were focused on reducing risk. Matrons in the division from Kidderminster and Redditch hospitals met regularly, however we were told that trust wide meetings involving matrons at Worcestershire Royal and Evesham Hospitals did not take place. Telephone conferences had been trialled but with limited success. Options for video link systems were being explored.

Culture within the service

- Staff we spoke with described the culture within the trust as open and supportive. Interactions between staff of different disciplines and at all levels were respectful and professional.
- Staff told us they were happy working at Kidderminster Hospital.

Public engagement

- Information about services at Kidderminster Hospital was available to the public on the trust website.

Surgery

- The Kidderminster Hospital League of Friends charity group ran a coffee shop and charity shops to raise funds for the hospital.
- Trust Board meetings were held in public and the venues rotated round the three main hospital sites. Therefore Kidderminster Hospital hosted the meeting every third month. Minutes of the meetings were also published on the trust website.

Staff engagement

- Staff engagement was primarily through team meetings, training events and email and intranet services. Training was provided trust wide which enabled staff from the different hospitals to meet and network.
- All staff based at or visiting Kidderminster Hospital had access to the trust computer systems, and could access their email accounts and intranet information.

Innovation, improvement and sustainability

- Kidderminster Hospital theatres were not used to their optimum capacity. On average the theatres were one third under used. This appeared at odds with the trust decision to use a mobile theatre to supplement theatre space at the Alexandra Hospital Redditch. We were told that a mobile theatre had been sited at the Alexandra Hospital to increase capacity at that site.
- The communications board within Kidderminster Redditch Hospital theatres was innovative and provided staff with up to date information including medical alerts and local information.
- The matron had also introduced advanced medical device training for all theatre staff which had increased skills and flexibility within teams.
- Staff allocation boards had been ordered for theatres at Kidderminster Hospital and Redditch, staff described how these would assist with planning.
- The trust had developed additional airway systems for their anaesthetics trolleys with colour coded sections to assist connection which made them easier to use and prevented errors, Trolleys also had dedicated automatic flow meters used for patients undergoing spinal or nasal procedures.

Maternity and gynaecology

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

Information about the service

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

Kidderminster Hospital and Treatment Centre Hospital and Treatment Centre forms part of Worcestershire Acute Hospitals NHS Trust. The hospital provided outpatient clinics for maternity and gynaecology services and routine minor day case gynaecological operations. It does not provide emergency services. There is no labour suite of facilities to give birth at this site.

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

Summary of findings

Overall we rated this service as requires improvement. It was rated requires improvement for responsiveness and well-led, and good for safety and caring. Since the majority of activity was provided as outpatient services, we did not rate the service for effectiveness

Incidents were reported. There was evidence that lessons had been learnt. There was a risk register in place, although this was not updated regularly.

There was a shortage of medical staff and clinics were often curtailed at short notice.

Staff spent time to ensure women understood their care and any further procedures that were necessary.

Women were able to access outpatient maternity and gynaecology services locally. The department was clean and equipped, medicines were stored appropriately. There were reliable systems in place for the management and disposal of waste.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Overall we rated this service as good for safety

Staff reported incidents electronically according to the maternity trigger lists. Locally lessons were learnt from incidents and actions taken to improve services. There had been no serious incidents reported for this site.

Appropriate standards of hygiene and cleanliness were maintained. Medicines were stored and managed correctly. Risks to patients using the service were appropriately assessed and managed.

Risk assessments were performed appropriately prior to procedures.

Compliance for mandatory training was poor. There were different compliance targets for trust wide and midwifery specific mandatory training, and these targets were often not met.

Incidents

- Data concerning incident reporting was collated trust wide. Staff who spoke with us at Kidderminster Hospital and Treatment Centre demonstrated their awareness and use of the electronic incident reporting system, according to the maternity trigger lists. The senior midwife for antenatal clinic reviewed and disseminated information from relevant incidents. Staff were able to highlight systems and processes that had changed as a result of incidents they reported. Examples of these were improved patient communication of results, and a double checking system implemented for administration of anti D immunoglobulin.
- There were no never events reported across the sites between May 2014 and April 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There were also no serious incidents at KHTC reported to the NHS strategic executive information system (STEIS) by maternity services at during that time
- The management team and staff were aware of the Duty of Candour Regulation which came into law in November 2014 for all NHS bodies. This requires NHS Trusts to be open and honest with patients when things go wrong. Midwives and nurses were not able to explain what this was. Medical staff we spoke with had a good understanding of the process.

Cleanliness, infection control and hygiene

- There were arrangements in place for managing waste to keep people safe
- Monthly infection prevention and control audits demonstrated good compliance at Kidderminster Hospital and Treatment Centre hospital. The standard of cleanliness was good in all clinical areas. The most updated internal statistics showed overall cleanliness was rated between 86% and 90% August 2014 to October 2014.
- The hospital's bare below the elbow' policy for best hygiene practice was adhered to.
- We observed staff to be following best practice with infection control and prevention principles in relation to management of waste, including sharp items, and contaminated waste.

Environment and equipment

- Equipment was appropriately tested and readily available.
- Resuscitation equipment was readily available in clinical areas; it was cleaned and there was evidence it was checked daily.
- Within the antenatal day assessment unit two cardiotocograph (CTG) monitors used for monitoring the fetal heart were available, cleaned and checked daily.
- Forty eight percent of staff attended equipment training

Medicines

- Basic stocks of medications were available for use in the clinics and day assessment area. These were stored appropriately in a locked cupboard within the locked clinical rooms.
- Community midwives stored emergency drugs in on call bags. These were stored in accordance with manufacturer's recommendations.

Records

- In line with the remainder of the trust the clinics were using 'easy notes' electronic document management system. This digitises previous case notes into an online system, meaning that the clinic ran an essentially paperless record system
- Staff did express that the use of easy notes could slow clinics down if notes were required at short notice, although they appreciated that care was enhanced by having electronic access to all the woman's health records.

Safeguarding

- Clinic staff were aware of the trust's safeguarding policy and how to report any concerns. Antenatal clinic staff also liaised with the community safeguarding team.
- Staff told us that they used a pink folder in the woman's medical records to alert staff to any safeguarding issues.
- The service did not have a female genital mutilation (FGM) guideline for staff to use if a case was identified. It has been mandatory to report identified cases to the Department of Health since September 2014.
- The safeguarding children's training was provided by the Lead Nurse Safeguarding Children. In June 2015 89% of nursing and midwifery staff at KHTC were up-to-date with child safeguarding training, against a trust target of 95% .The senior team were aware that this was not compliant they told us it was difficult to release staff for training due to staffing shortages.
- 96% of nursing and midwifery staff were compliant in adult safeguarding training, meeting a trust target of 95%

Mandatory training

- The maternity training policy identified that the Divisional Director of Nursing and Midwifery was responsible for developing the annual training plan. However the practice development nurse and the senior team were reviewing the training plan at the time of our inspection
- The maternity training needs analysis document provided by the trust indicated a compliance target for all maternity specific training of 75%. This was queried after the inspection, and has subsequently been raised to 90% for the service, however this remains below the compliance target of 95% for all trust wide mandatory training
- Training attendance was not meeting the required targets. We were told by the senior team this was because it was difficult to release staff. In March 2015 this was reviewed and the decision made by the senior team was for staff to attend training every two years instead of annually. This was not in accordance with the trust policy.
- In July 2015, the trust reported that 79% of midwives had attended midwifery specific mandatory training which was provided over three days. Subjects included: maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, caring for high risk women, manual handling, epidural update, suturing update, perinatal mental health updates, normal birth, infant feeding and bereavement
- Online CTG training compliance was reported in July 2015. Hospital midwives were 90% compliant, with community midwives demonstrating 81%.
- In June 2015, the trust reported that nursing and midwifery staff at KHTC had achieved the trust wide compliance targets (95%) for mandatory training in hand hygiene (100%), however they were not compliant in health and safety (89%) information governance (44%), fire training (89%), moving and handling (30%), resuscitation (70%), and infection control (89%)
- Community Midwives in June 2015 had not achieved the trust compliance standard of 95% for health and safety (68%) information governance (58%), Fire training (68%), moving and handling (28%), resuscitation (88%) and infection control (70%)

Assessing and responding to patient risk

- The antenatal day assessment unit had a strict inclusion policy to risk assess which women were appropriate to attend. This was necessary in view of the remote nature and the potential lack of obstetric medical staff on site. Women who presented with complex high risk symptoms would be referred to the labour ward at WRH or AH where there was immediate medical support available.
- If a second opinion was required for a CTG either a community midwife was asked to review it or the woman was referred for a review at AH maternity unit.
- Gynaecology patients were risk assessed in accordance with the trust policy for minor procedures to establish whether treatment at Kidderminster Hospital and Treatment Centre was appropriate and safe.

Midwifery, Nursing and Medical Staffing

Maternity and gynaecology

- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, was one whole time equivalent (WTE) midwife to 28 births. The maternity service had a ratio of one WTE midwife to 30 births which was meeting the local and commissioned target, and more recent RCM guidance (2010) of 1:29.5. Although the unit's midwifery staffing was below that of recommended national minimum standards, National Quality Board guidance 'How to ensure the right people, with the right skills, are in the right place at the right time' A guide to nursing, midwifery and care staffing capacity and capability – November 2013 was used to monitor staffing and a six monthly 'Safer Staffing' paper was presented to the board in line with this guidance'.
- In the antenatal and gynaecology clinics, the planned and actual staffing levels were displayed at the entrance to the clinic areas. A white board was in place which showed the staff on duty and the clinics in progress.
- Community midwives reported that all pregnant women had a named midwife with a staff to patient ratio of 1:130 for full time staff. This is worse than the national recommendation of 1:100.

Major incident awareness and training

- Staff were aware of the major incident policy, which covered items such as actions when there were staffing shortages and massive external emergencies.

Are maternity and gynaecology services effective?

Not sufficient evidence to rate

As the majority of this service was provided as outpatients, we did not rate it for effectiveness

Women's needs were assessed and their care and treatment planned and delivered following local and national guidance for best practice.

Staff worked together to meet women's needs.

Consent to care and treatment was obtained in line with legislation and guidance.

Evidence-based care and treatment

- Care, guidelines and policies were based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth guidelines.
- We reviewed guidelines and policies, eight maternity and three relating to gynaecology day case procedures, all were based on NICE or RCOG guidelines. They were in date; version controlled and showed a record of changes so that staff would know if there had been any new updates.
- Staff had access to the policies and guidelines via the trust's intranet.
- The service performed audit in line with the service clinical audit programme which was agreed for 2015 - 2016. The clinical audit programme was led by the audit consultant.

Pain relief.

- Pain relief was safely prescribed and administered to gynaecology day patients.

Nutrition and Hydration

- Refreshments were provided after surgery to gynaecology patients having day surgery prior to being discharged home.

Patient outcomes

- The number of women booked before 12 weeks and six days of their pregnancy was 88% across the trust, against a target of 90%.
- National antenatal key performance indicators were not reported for screening in pregnancy, as an electronic system to report captured data was not in place, although there were plans to procure one.
- The service performed the same as other trusts in all areas in the CQC Survey of Women's Experiences of Maternity Services 2013.

Competent staff

- Junior and preceptor midwives did not work at Kidderminster Hospital and Treatment Centre treatment centre.
- In June 2015 75% of nursing and midwifery staff at KHTC were reported to have had an appraisal in the previous months against a Trust target of 100%.

Multidisciplinary working

- Community and hospital midwives worked closely within the department sharing facilities. Two trained community midwives performed all early ultrasound scanning for patients at Kidderminster Hospital and Treatment Centre in the antenatal clinic.
- Midwives and nurses reported good working relationships between the multidisciplinary teams.

Access to information

- In line with the remainder of the trust the clinics were using 'easy notes' electronic document management system.
- Staff told us that care was enhanced by having electronic access to all the woman's health records.

Seven-day services

- Antenatal and scanning services were available on weekdays only 08:30 to 17:00.
- Postnatal clinics were available at weekends.
- Gynaecology surgery was performed three of four days a week, between the hours of 08.00 and 18.00 from Monday to Saturday.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Verbal consent was sort prior to any procedures.
- Written consent for surgery was gained in the pre-assessment clinic prior to the woman attending for day surgery.

Are maternity and gynaecology services caring?

Good

Overall this service was rated as good for caring

Staff demonstrated a very caring approach treating women with kindness, dignity and respect. A compassionate approach was used, always having the women's best interests at the centre of the care provided.

Information was provided in ways that could be understood and women felt involved in making informed decisions about their care.

Staff took into account the individual needs of women and their partners and ensured appropriate support was provided to them.

Compassionate care

- Family and Friends Test (FFT) results were consistently better than average 95.5% for birth, postnatal ward and postnatal community care between March 2014 and February 2015. 97-100% of respondents said that they would recommend the antenatal service to friends and family if they needed similar care or treatment. The national average was 95.5%.
- We saw staff giving patients time to talk and discuss their fears within the fetal medicine clinic.
- Maternity support workers worked within the same consultant clinics each week to build supportive relationships with patients.

All staff that we spoke to expressed a passion for working at Kidderminster Hospital and Treatment Centre and felt privileged to be able to care for patients there.

Emotional support

- People using the maternity services could access clinical nurse specialists, for example, screening coordinator, two infant feeding coordinators, a diabetic link midwife, three specialist safeguarding midwifes supporting substance misuse. There were also midwives supporting pregnant teenagers and women who were suffering domestic violence.
- Counselling and advice for women who had difficult decisions to make about their pregnancies was available.
- The Supervisors of Midwives offered care following birth to women who needed to talk through their experiences. One of the specialist community midwives offered further support and care to teenagers during their pregnancies. They arranged buddies for young woman for support and continuity of care. Midwife visits were increased to ensure emotional support was sufficient.

Maternity and gynaecology

Are maternity and gynaecology services responsive?

Requires improvement

Overall we rated this service as requires improvement for responsiveness

Clinics were often cancelled at short notice due to medical staff shortages.

The early pregnancy unit was temporarily closed at the time of inspection.

Many of the services were designed to meet the needs of the local population. Clinical and waiting areas were spacious and comfortable.

Service planning and delivery to meet the needs of local people

- Women were given a choice about where to give birth depending on their clinical need. The community midwives offered an on-call service to support mothers who planned to have a home birth.
- Community midwives told us they carried out Transcutaneous Bilirubinometer testing, a non-invasive test on the surface of the baby's skin, to establish if it was suffering from neonatal jaundice. If necessary they were able to follow this up with blood tests, taken in the family's home or in a postnatal clinic, to determine blood bilirubin levels as a further indication. This had the potential to prevent unnecessary readmissions. Antenatal education and breastfeeding groups in the community were available for women to access. The dates and times were advertised on the trust website.

Access and flow

- The early pregnancy unit had been closed temporarily at the time of inspection due to the number of staff on maternity leave. Women who needed this service had to travel to the Alexandra Hospital, Redditch which was 17 miles away.
- On the day of our visit part of the gynaecology clinic had been cancelled, reducing available appointments from twenty to ten due to lack of medical staff availability. The women concerned had only been given twenty four hours' notice of the change. We saw during our inspection that patients waiting to be seen in the gynaecology being delayed due to medical staff shortages.

Meeting people's individual needs

- Staff in the clinic had implemented a redesign programme via a 'transformation team' to improve patient flow and staff roles. Restocked trolleys were locked for clinic rooms' giving staff greater assurance that equipment would be available and easy to access when required.
- Maternity support workers were utilised for non-clinical roles, for example stocking rooms, taking basic observations, releasing midwives to provide midwifery care.
- The Consultant referral pathway had been revised to accommodate midwife led diabetic clinics, in order to give them the opportunity to experience less medicalised care. The women were reviewed by a consultant at twelve weeks and thirty five weeks. This was planned to improve the woman's education and the planning of care.
- Staff used an interpreting service for women whose first language was not English.
- The maternity leaflets on the trust intranet covered topics that were not in the maternity hand held records kept by the women. This ensured staff could refer to them when discussing care with women. All leaflets had a number for women to call to request a version in their spoken language.
- Midwives and nurses knew how to access support from the safeguarding adult nurse for women with a learning disability and told us about using communication passports for women with a learning disability.
- A patient experience midwife offered appointments at Alexandra or Worcestershire hospital, for women and partners to discuss their care during their pregnancy and birth, to allay any fears that they may have.
- The fetal maternal medicines unit on site offered specialist care to women requiring further investigations. The doctors, supported by specially trained midwives, offered special tests

Learning from complaints and concerns

- Information on how to make a complaint was available in the clinic areas.

Maternity and gynaecology

- Complaints were discussed at clinical governance meetings and disseminated to staff at team meetings. The trust performance dashboard identified that when a complaint was made, in 20% of cases, the service did not respond to their complaints within 25 days.

Are maternity and gynaecology services well-led?

Requires improvement

Overall we rated this service as requires improvement for be well-led

Staff did not know there was a strategy for the service; however staff were able to tell us about the trust wide strategy.

There was a culture of teamwork and supportive management locally. However, staff worked as a small unit and did not have contact from the wider trust

The staff were not able identify avenues of support or escalation beyond that provided by their matron.

There were identified management roles in the maternity services, and at site and ward level, staff felt supported by the matron and ward sisters.

Vision and strategy for this service

- The strategic vision for the maternity service was based on the national document, 'Maternity Matters.' (DoH 2007) the Divisional Director of Nursing and Midwifery (DDNM) told us that this was outdated and the strategy needed an update. We reviewed the strategy it was lengthy, complicated and lacked clarity. The strategy was not displayed for staff to see and staff we spoke to did not know that there was a maternity strategy. The service did not have a clear vision and a set of values.
- Staff in clinic were aware of the trust value of PRIDE and we saw care to be patient centred and treating patients with dignity and respect.

Governance, risk management and quality measurement

- A governance framework was in place for maternity and gynaecology services. In addition, the same governance team managed neonatal and paediatric governance. Meetings consisted of gynaecology governance meetings, maternity governance meetings perinatal meetings and paediatric improvement meetings. Exception reports from these meetings were escalated to the women and children's divisional governance meeting. Chaired by the Divisional Medical Director and attended by the senior team. The meetings were not held on the KHTC site; however we were told that staff were welcome to attend.
- The governance team told us that they were always at meetings and lacked time to focus on other aspects of their role. They told us they found it difficult to meet deadlines because of this. They told us it was a concern to them that they were unable to investigate incidents in a timely manner.
- The Deputy Head of Midwifery had the added responsibility of being the governance lead for maternity, gynaecology, paediatrics and neonatal services across the whole trust. The fact that this role had a very large remit and was not therefore almost impossible for one person to undertake this role effectively had been escalated to divisional level. Recently a team of two band seven governance posts had been recruited into and an administrative post had been funded to support the deputy HOM/governance lead.

Leadership of service

- The leadership of the service lacked vision and clarity for the future of services. The DDNM told us that this was because their role was too large and could not be achieved by one person. This was compounded since the role of the head of midwifery recently had taken over to encompass paediatrics and neonates.
- Nursing, midwifery and support staff told us senior managers of the trust board were not visible in the departments and were not well known to the teams. Staff spoke highly of their matrons; they were visible and performed daily walks of the areas. Staff told us that the DDNM was not as visible and supportive since their role had changed from being the Head of Midwifery to the Divisional Director of Nursing and Midwifery.
- The service had a trust board performance dashboard, a maternity outcome indicator table and local risk registers, none of them were displayed for staff to see. We asked several staff about the dashboard and they were unaware of its function.

- Staff at Kidderminster Hospital and Treatment Centre felt very supported locally by their site managers and the maternity matron, but expressed that their contact with the Head of Midwifery was minimal.
- The three staff we spoke to were only able to name one of the senior management team.

Culture within the service

- Staff expressed they were encouraged to report incidents. They described feeling very supported locally with their day to day work at Kidderminster Hospital and Treatment Centre.
- Staff in antenatal clinic, day assessment unit and theatres were all proud of the services they offered to women in the area.

Public engagement

- We reviewed three meeting minutes of maternity service liaison committee meetings which were well attended. This is a forum for maternity service users, providers and commissioners of maternity services to group together to design services that meet the needs of local women, parents and their families.

Services for children and young people

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

Information about the service

Services for Children and young people at Kidderminster Hospital include outpatient and day surgery facilities for babies and children up to the age of 17. Day surgery is for children over the age of two and at least 15kg in weight.

Outpatient clinics are held four days per week. There are two clinics which have two consultation rooms and a treatment room which is used for some nurse led procedures.

A dedicated day each week is assigned for paediatric day surgery and can cater for a total of 24 children. There are four theatres dedicated to paediatrics which are used for community dental surgery, ear nose and throat, head and neck, ophthalmology as well as general surgery.

Day surgery has staggered admission times into the waiting rooms. There were six bedded day case bays for patients in recovery with 14 spaces available, although on average the trust work to six patients at any one time.

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

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

Services for children and young people

Summary of findings

Overall this service was rated as requires improvement. It was rated as requires improvement for safety, effective and well-led, however we rated the service as good for caring and responsiveness

Incidents were not always reported and investigated promptly and lessons were not always learned.

Some important policies had not been developed, for example there was no policy on the use of restraint.

Compliance with completion of mandatory training did not meet the trust's target.

Audits were not always undertaken in line with agreed plans and learning not implemented or evidenced.

There were no detailed service plans for the year ahead outlining the direction of the service, including improvements required.

Governance arrangements were not effective and failed to demonstrate that areas of concern were sufficiently discussed or that agreed actions were carried forward or implemented.

Patients were generally very satisfied with the level of care they received with few complaints made about their care and treatment.

Are services for children and young people safe?

Requires improvement

Overall we rated this service as requires improvement for safety

There was a delay in investigating incidents reported, with a lack of learning taking place The trust had developed an incident reporting policy which was available to staff on the trust intranet. Review of the policy confirmed it outlined the reporting process and responsibilities, however, there was no guidance regarding categorisation of incidents, with exception of serious incidents. This meant staff who reported incidents had no clear structure or guidance to clearly assess the category of an incident. There was a lack of information regarding the consistency of sharing details of the incident with the patient.

Nursing and paediatric medical staff who worked at Kidderminster were permanent members of staff who worked at one of the trust's other locations, either the Alexandra Hospital or the Worcester Royal Hospital and therefore their training records were incorporated within the data supplied for both of these locations

The only training data provided to us specifically for Kidderminster related to a small number of administrative and support worker roles. Completion of training for these staff was below the trust's target of 95%. Most of the mandatory training, including safeguarding training, had not been completed by either member of staff.

Staffing arrangements were not sufficient and this had been identified as a risk by the trust, this was because there were not enough nursing staff to provide support for the consultant clinics.

Physical security arrangements were adequate but policies on abduction and on restraint and supportive holding had not been developed.

The environment was observed to be visibility clean and staff used appropriate personal protective equipment and followed trust guidance.

There were no processes in place for staff to undertake checks on the child protection register for children who attended appointments or attended for day surgery.

Services for children and young people

There was good use of assessment tools to detect deterioration in paediatric patients.

Incidents

- Thorough and robust reviews or investigations were not always carried out. Relevant staff were not always involved in the review or investigation. There were a total of 11 incidents reported within the children and young people's services between the period January to May 2015, with no incidents categorised as serious.

It was noted, however, that a small number of serious incidents which related to paediatric patients had been reported by other departments. These had not been reported by paediatrics or directly linked to paediatrics or their reporting tool.

- The trust used an electronic incident reporting tool to report incidents. The staff we spoke with were confident in the use of the electronic system and told us that they always reported incidents where it was appropriate to do so. We noted that recording of the majority of incidents had been completed by nursing staff, few incidents had been reported by medical staff. We were told that the trust were aware of this and support from the newly expanded governance team was being provided to medical staff to improve reporting. We noted for example that staffing levels did not always meet minimum requirements but staffing shortages were rarely reported as an incident.
- Not all incidents required a formal investigation and most were updated with informal investigation details. We found that there were significant delays in completed informal investigations of incidents. From our analysis, we found that of the 11 incidents, six had been informally investigated and closed. Three of these incidents had been investigated on a timely basis, with the remaining three having taken in excess of 85 days. We noted that none of the incidents we reviewed were complex. For the remaining five incidents, investigations had not been recorded as having commenced. Some incidents dated back to January 2015. This meant incidents were not being investigated in a timely manner.
- The trust had developed an incident reporting policy which was available to staff on the trust intranet. Review of the policy confirmed it outlined the reporting process and responsibilities, however, there was no guidance regarding categorisation of incidents, with exception of serious incidents. This meant staff who reported incidents had no clear structure or guidance to clearly assess the categorisation of an incident.
- We selected a sample of incidents for further review and requested additional data. In the incident above relating to the patient who had undergone a surgical procedure despite the x-ray not being available, this should have required a formal investigation but an investigation had not taken place either formally or informally.
- Review of the incidents demonstrated that information was communicated with the patients and their parents in some instances but this had not been recorded for each of the incidents reported which meant that the trust may not have consistently followed guidance in relation to duty of candour.
- We identified through review of meeting minutes that a serious incident had occurred in May 2014. It had taken 11 months for the investigation report to be completed and a further three months for the report to be presented at the Paediatric Quality Improvement Meeting. The investigation report identified weaknesses in the processes for making referrals to other hospitals and recommended that lessons learned were shared with the Ophthalmology department. We were provided with a statement from the trust that the processes for making referrals to other hospitals would be audited later in the year. The staff we spoke with were unaware of the incident or any changes required as a result. The incident related to the death of a child, the investigation concluded that the clinical outcome for the patient would not have been different, however, the report failed to consider that had the family known of the likely outcome at an earlier stage, they may have chosen to spend their time differently with the child.
- We spoke with staff about learning from incidents. Staff told us that learning was shared via a risk bulletin which was produced monthly but most of the staff we spoke with were unable to provide examples of incidents that they had read about. None of the staff we spoke with were aware that there had been any serious incidents which related to paediatric patients.
- Paediatric mortality and morbidity meetings were held at the Worcester Royal Hospital. There were no cases discussed which related to patients treated at Kidderminster during 2015.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and the staff we spoke with told us they were satisfied with the level of cleanliness and had no concerns.
- Personal protective equipment was available as well as hand washing facilities and hand gel.
- We observed staff followed appropriate practices and were bare below the elbow whilst in clinical areas.
- Training records provided to us were expressed as percentages for staff who worked at the whole trust, broken down into separate locations, Alexandra Hospital, Worcester Royal Hospital and Kidderminster Hospital. Nursing and Medical staff who worked at the Kidderminster were included in the data for the Alexandra Hospital and Worcester Royal Hospital, and not separated according to those who also worked at Kidderminster. Therefore the only data provided specifically for Kidderminster Hospital included two members of staff. From a review of training data, we noted that none of the staff who worked only at Kidderminster Hospital had completed hand hygiene or infection control training. Training data for staff at the other trust locations reported a low level of compliance in completing training.
- Equipment we reviewed was visibly clean and we saw that labels were used which were dated to show when equipment had been cleaned.
- We saw that clinical, domestic waste and sharps bins, on the ward, were used and stored appropriately.
- We requested audits on infection control, but were not provided with any for Kidderminster Hospital.

Environment and equipment

- We saw that the resuscitation trolley was checked daily and records maintained.
- The theatre was fully equipped with anaesthetic trolleys in each room and monitors were appropriately configured.

Medicines

- We observed that medication was stored in an appropriately locked room and controlled drugs were stored in line with requirements. Administration of medication was recorded on the patient's prescription chart.
- We saw that checks on fridge temperatures were made daily.

Records

- Patient records were stored securely.
- We reviewed a sample of records and saw that they had been completed with detailed information. Surgical checklists had been completed and early warning tools used appropriately.

Safeguarding

- There was a safeguarding children policy and safeguarding adults policy in place which were in date.
- We saw that neither of the two members of staff who worked only at Kidderminster Hospital had completed safeguarding training.
- There were no processes in place for staff to undertake checks on the child protection register for children who attended appointments or attended for day surgery.

Mandatory training

- There were 10 mandatory training modules which each member of staff was required to complete in line with agreed frequency, this included; equality and diversity including bullying and harassment, health and safety, information governance, fire, moving and handling, safeguarding adults, safeguarding children, resuscitation, hand hygiene and infection control.
- Data provided for Kidderminster included two members of staff,
- The trust had a target of 95% compliance which had been achieved for equality and diversity. 50% of staff working at Kidderminster had completed moving and handling training, none of the other training modules had been completed by staff who worked directly at Kidderminster.
- The trust did not have an abduction policy in place. We were informed that they were in the process of reviewing their safeguarding children's policy and the revision would include guidance relating to abduction.
- The trust did not have a policy on restraint or supportive holding. We were informed that staff could make reference to guidelines published by the Royal College of Nursing (RCN) on restraining/holding and could access these directly from the RCN website.

Assessing and responding to patient risk

- A paediatric early warning (PEWS) tool was used to monitor and manage deteriorating patients on the children's day ward, a separate tool was used according to the child's age and we saw examples of these having been completed with scores accurately calculated.

Services for children and young people

- A trust audit on the use of PEWS was last undertaken in 2012 and rescheduled to be re-audited in 2017. It was agreed by the trust that this should be increased in frequency.

Nursing staffing

- Nursing staff who worked at Kidderminster Hospital in the outpatient department and day surgery were sourced from both the Alexandra Hospital and the Worcester Royal Hospital and were all registered children's nurses.
- Outpatient clinics were open four days per week. A staffing needs assessment for paediatric outpatients had been undertaken which identified there was a need for one nurse per day. However we were told that staffing needs were not always met and that one day per week there was no nurse available. This meant that the consultant clinic was supported by a healthcare assistant only which placed more pressure on medical staff to undertake additional clinical duties usually provided by the nurse.
- Day surgery was undertaken one day per week for paediatrics. Nursing cover was arranged using four nurses sourced from the trust's other locations, two from the Alexandra Hospital and two from the Royal Worcester Hospital.
- We were not provided with data for Kidderminster Hospital to confirm the number of shifts that had been filled.
- There were no reported incidents of short staffing and the staff we spoke with did not raise any concerns with us.

Medical staffing

- Outpatient clinics were held at Kidderminster four days per week and were staffed by a mixture of consultants and middle grade doctors from a range of specialties. A consultant paediatrician was on site in clinic on Wednesdays to offer support to the children's day surgery facility.
- Day case procedures were carried out at Kidderminster Hospital. Wednesday was a dedicated day for paediatric patients and we saw that the department was staffed appropriately on the day of our inspection.

Major incident awareness and training

- The trust had a major incident plan reviewed in January 2015. The policy had been approved by the Emergency Preparedness, Resilience and Responsive Committee reporting to the trust board. The plan carried action cards which gave written instructions for key staff who would be involved in the organisation and management of a major incident.

Are services for children and young people effective?

Requires improvement 

Overall we rated this service as requires improvement for effectiveness

A clinical audit plan had been developed for 2014/15 and 2015/16, but a proportion of audits had not been completed and there was little evidence to demonstrate that actions identified to improve services had been completed. The Audit plan was for all three locations.

The department used a dashboard to monitor performance, although not all fields were populated and some criteria relevant to the performance of the service had not been included. There was little evidence that performance was reviewed and discussed in governance meetings.

Emergency readmission rates within two days of discharge were higher than the England averages, especially for non-elective gynaecology (ages one to 17).

In 2014/15 the paediatric clinical audit plan included epilepsy and diabetes as national audit topics. The epilepsy audit was completed and full compliance was observed. The diabetes audit was not completed and reported that a decision had been made not to undertake this audit because an action plan was still in progress from the previous audit.

Guidelines and policies had been developed in line with national guidance and we saw evidence that these had been followed.

Pain relief was managed effectively and distraction techniques used for younger children.

Appraisal arrangements were in place. Data was requested in relation to the number of staff who had received an

appraisal, however, this was not provided for Kidderminster Hospital. There was a process in place to ensure medical and nursing professionals had a valid registration for their profession.

Evidence-based care and treatment

- We saw that the trust had a range of guidelines to ensure for paediatric patients were treated in line with best practice. Reference had been made to the National Institute of Clinical Excellence (NICE) as appropriate. From the sample of records we reviewed, we saw that completion of notes was in line with local and national policy. Although we noted that there was no overarching policy for highly dependency patients.
- We were provided with copies of the joint paediatric and neonatal clinical audit plans for 2014/15 and 2015/16. The audit plan was devised based on audits required nationally as well as to assess compliance with NICE with regards to paediatrics. In addition local priorities and issues identified through complaints and incidents were included in the audit plans.
- The audit plan for 2014/15 listed 14 audits which were planned for the year, of which six had been completed. The 2015/16 plan listed 15 audits for the year, one had been completed. Both audit plans comprised only of national audits and compliance with NICE guidance. There had been no local priorities or issues listed for audit purposes. Therefore there was an overall lack of involvement in completing audits or drawing from incidents or other issues to inform the audit process.
- We requested copies of the two most recent audits and action plans along with minutes of the meetings where they had been presented. We were provided with copies of four audits and accompanying action plans. We noted that two of the audits, one in relation to peanut allergy and another for meningitis were not scheduled on the clinical audit plans.

Pain relief

- There were pain assessment tools for staff to help determine pain scores for babies and young children and pain assessment charts used for completion of children of all ages. Children were able to indicate their level of pain.

Nutrition and hydration

- Food and fluid charts were introduced as necessary, monitored appropriately and used effectively.
- Drinks, snacks and an appropriate choice of food were available for children and young people who had undergone a surgical procedure. Multiple faith foods were available on request.

Patient outcomes

- A dashboard was used by the department to monitor performance. The dashboard reported on data relating to the number of serious incidents, infection control, risk management, as well as elements of patient experience, for example the number of complaints each month as well as activity data for readmissions. The dashboard did not consider other data relevant to paediatrics, for example, performance against referral to treatment targets.
- Emergency readmission rates within two days of discharge were higher than the England averages, especially for non-elective gynaecology (ages one to 17).
- In 2014/15 the paediatric clinical audit plan included epilepsy and diabetes as national audit topics. The epilepsy audit was completed and full compliance was observed. The diabetes audit was not completed and reported that a decision had been made not to undertake this audit because an action plan was still in progress from the previous audit.

Competent staff

- Staff completed an annual appraisal as part of their Personal Development Review. We requested data on appraisal rates but were not provided with this for staff who worked at Kidderminster Hospital.
- There was a process in place to ensure all medical and nursing professionals had their registration status checked, we confirmed through review that all staff listed as employed and registered had a valid registration.

Access to information

- On discharge, all patient notes were scanned onto the system, hard copy notes were sent for destruction and notes subsequently accessed using the electronic patient record tool. There were no recently reported incidents of staff not having patient notes available as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Services for children and young people

- Staff obtained consent from patients and or their parents appropriately in relation to care and treatment. Staff were able to explain how consent was sought and how they involved both the child and the person with parental responsibility in obtaining consent where appropriate. The staff we spoke with were aware of relevant national guidance around obtaining consent from young people under the age of 18.
- We noted that verbal and / or written consent was obtained for both medical and / or surgical interventions, with signatures obtained to confirm consent.
- Consent forms for surgical procedures included an explanation of any risks to the child from receiving treatment. However we were told by one member of staff that the consent forms were scanned onto the electronic patient record and that not all nurses had been trained to use this and therefore consent was not always verified prior to patients being taken to surgery.

Are services for children and young people caring?

Good

Overall we rated this service as good for caring

All of the patients and relatives we spoke with told us that they were satisfied with the care they received and felt that staff listened to them and were compassionate; and this was supported by our observations.

Comment cards completed by patients and parents demonstrated positive feedback

The staff we spoke with demonstrated an appropriate understanding of the needs of children and young people and made sure that that they and their families were involved in decisions about their care.

Compassionate care

- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after.
- We observed staff supporting and treating patients in a kind and caring manner.
- The 'Friends and Family' test is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across all NHS Trusts, although has only recently started being used within paediatrics. However, feedback from Friends and Family data was not yet available.
- Comment cards were available for patients and parents to provide feedback. We reviewed a number of comment cards and found feedback was positive. Staff also received cards and emails from patients and their families thanking them for the care they received.
- The trust performed about the same as other trusts for most of the indicators related to caring in the National Children's Inpatient Survey 2014 and better than average for children receiving care and attention when needed, as well as feeling listened to.
- Distraction techniques were used to distract children from painful procedures and anaesthetic cream was used when taking blood from children.

Understanding and involvement of patients and those close to them

- All the patients and relatives we spoke with on the ward and in the outpatients department told us that staff had communicated well with them and that they were satisfied with explanations provided about the treatment and care whilst in hospital.

Emotional support

- Children received support from nursing staff or a play therapist before being taken for surgery.
- Children and young people were supported and enabled to discuss their concerns about having surgery.
- Patients and their families could access support as required from the chaplaincy service which provided support across the hospital.

Are services for children and young people responsive?

Good

Overall we rated this service as good for responsiveness.

Access to the service and flow through it, worked well.

One day each week was dedicated for paediatric patients who required surgery; this included support from a play therapist.

Services for children and young people

There were a small number of complaints received about the service and these were mostly responded to in a timely manner.

Arrangements were in place to accommodate the needs of patients.

Service planning and delivery to meet the needs of local people

- West Midlands Clinical Senate had undertaken a review of the health economy in Worcestershire which had identified a need to reconfigure health services. A service model had been developed which was planned to be presented to the Independent Clinical Review Panel in November 2015. Consideration will be given to any proposals prior to public consultation. The reconfiguration proposal included a case for change for children and young people's services.
- There were arrangements for transitioning paediatric patients to adult services before they reached adulthood. Specific care plans had been developed for some of the specialist services, with a generic plan used for others. We reviewed a sample of these and saw that communication was good with the receiving departments and that care plans helped facilitate this process.
- There are four theatres dedicated to paediatrics which are used for community dental surgery, ear nose and throat, head and neck, ophthalmology as well as general surgery.
- Day surgery has staggered admission times into the waiting rooms. There were six bedded day case bays for patients in recovery with 14 spaces available, although on average the trust work to six patients at any one time.

Access and flow

- Paediatric patients attended outpatient appointments and day surgery as necessary. We were told that the patient flow worked well and there were no concerns about managing the outpatient or surgical lists.
- Paediatric outpatient clinics ran four days per with the surgical team dedicating one day each week specifically for paediatric patients.

Meeting people's individual needs

- Translation services were available either by using a telephone translation service. Face to face interpreter services could be arranged during office hours if required. We were told there was limited demand for translation services.
- A play therapist worked half a day per week during the pre-admission clinic.
- The paediatric department had a number of nurse specialists, which included nurse specialists for respiratory, epilepsy and allergies.

Learning from complaints and concerns

- A small number of complaints were received about the children and young people's service.
- We were provided with a detailed summary of complaints for 2014/15 up to and inclusive of March 2015. Three complaints had been received about paediatric outpatients although it was unclear which hospital location the complaints related to. We saw that one of the complaints had taken three months to be resolved.
- We saw that complaints and lessons learned from them were shared in the monthly risk bulletin.

Are services for children and young people well-led?

Requires improvement 

Overall we rated this service as requires improvement to be well-led.

The business plan provided included generic objectives; these were not specific to paediatric services, nor did they specify the areas in need of improvement.

A committee structure was in place, but, minutes for the governance meetings we saw, lacked detail and did not function as intended because there was a lack of learning from incidents and audits. In addition, the purpose of information presented was not always clear and decisions made were not always acted on.

The performance dashboard had not been fully populated and lacked relevant information to ensure performance of the department was being adequately monitored.

Services for children and young people

We were told that local leadership worked well and staff reported that they felt well supported by the managers who were approachable. It was apparent through observing interactions as well as discussion with staff that there were excellent working relationships between all staff groups.

Patients and staff were given the opportunity to provide feedback about the service. It was not clear how feedback from staff was acted on.

Vision and strategy for this service

- The values for the directorate were Patients, Respect, Improve, Dependable, and Empower (PRIDE). Some of the staff we spoke with, but not all, were able to tell us what the values were.
- The values were underpinned by a strategic vision to deliver safe high quality care, realise staff potential and ensure financial viability. These were all linked to six key objectives and a delivery plan for the year.
- We were told that the paediatric department had not developed a departmental business plan. However, we were provided with a business plan for the Women and Children division which incorporated paediatrics. The plan consisted of a one page summary of goals, six objectives, business themes and delivery statements for 2015/16. The summary provided was generic and there were no specific details for children and young people's services.

Governance, risk management and quality measurement

- There was a Paediatric Quality Improvement Meeting (QIM) held monthly which reported in to the Women and Children Monthly Governance (WCGM) meeting. Meetings were trust wide and not specifically for Kidderminster.
- The QIM met a few days in advance of the WCG, although we did not see evidence that the QIM minutes were presented to the WCG or that discussion / actions agreed were taken to the WCG. The June 2015 WCG was not quorate because there were no medical representatives; this was noted in the minutes.
- Review of the WCG minutes for June and April 2015 confirmed that there were standing agenda items and that these were largely in accordance with its terms of reference, although we noted that not all governance issues were included or discussed in accordance with its the terms. For example, the terms of reference required training and competencies of staff to be monitored and discussed, but there was no evidence of this recorded in the minutes we reviewed.
- The minutes reported that only 10% of actions for incident investigations had been implemented and there was no distinction defining whether this related to paediatrics, or obstetrics and gynaecology, or both. Minutes lacked discussion around incident detail and focussed on the timeliness of investigations.
- We saw that the risk register was discussed at the April 2015 meeting, a comment was made regarding new risks and those which were outstanding, but there was no further discussion recorded or action agreed to address these.
- Complaints were discussed at the June meeting and it was reported that there was 100% compliance with closing complaints during the month of May 2015. There were some historic outstanding complaints but it was unclear whether these related to paediatrics or obstetrics and gynaecology. The May meeting reported complaints were not always responded to within timescales but there was no detail of the types of complaints being received or what timescales were and by how long they had been exceeded.
- Review of the QIM minutes for April, May and June 2015 all included standing agenda items in accordance with its terms. There was evidence of good discussion around some governance issues, but not all.
- The clinical audit plan for 2015/16 was presented at the May meeting. Minutes recorded that clinicians should not undertake audits not included on the plan until the audit plan has been completed. Although we noted that the June 2015 minutes recorded discussion around the Peanut Challenge audit which had not been included on the clinical audit plan for 2015/16 or the previous year.
- There was no evidence that the clinical audit plan had been approved or that individual audit actions had been discussed or followed up in the above or previous sets of minutes., The one exception was recorded in the January 2015 minutes which recorded that, 'A few audits that have not been finished in the initial plan but should be finished by the end of March 2015'. There was no evidence of confirmation that all audits had been completed in subsequent minutes and the copy of the plan we were provided with indicated a number of audits had not been completed.

- Very few complaints were received for the paediatric service, but those received were discussed at the QIM.
- There had been no serious incidents reported and there was no evidence of discussion of less serious incidents although we saw that that the monthly governance report for May and June had been presented, but reports lacked detail. A brief summary of potential serious incidents were provided as well as statistics on the number of incidents and complaints reporting during the period. The report did not include information around categories of incidents, trends or themes.
- Discussion recorded in the May and June minutes focussed on the overall number and closure of the incidents, rather than identifying themes or trends. There was no discussion recorded around themes or trends.
- The risk register had been discussed at the May 2015 meeting; the emphasis was on reviewing overdue risks prior to the CQC visit. The April minutes also commented that some risks were overdue and needed to be updated prior to the CQC visit. There was no discussion recorded regarding what these risks were or action required. We saw some improvement reflected in the June minutes although limited detail had been recorded. For example, a new risk around paediatric staffing had been recorded, but the minutes did not record where the staffing shortages were or how this impacted on the service.
- There was a standing agenda item on 'Standards' this was to ensure staff were aware of new national and local standards as well as to ensure compliance with standards as applicable. For example, the May 2015 minutes recorded that 'Facing the Future' a set of standards developed by the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of General Practitioners (RCGP) and the Royal College of Nursing (RCN) which aimed to ensure there was always high-quality diagnosis and care. Attendees were informed this was available on the internet and it was agreed that this would be discussed at the next meeting, but there was no evidence in the June minutes that this had been discussed.
- A dashboard was used by the department to monitor performance. The dashboard reported on data relating to the number of serious incidents, infection control, risk management, as well as elements of patient experience, for example the number of complaints each month as well as activity data for readmissions. The dashboard did not consider other data relevant to paediatrics, for example, performance against referral to treatment targets. We did not see evidence of discussion of the dashboard at the QIM of WGM, although it was listed as an agenda item at both meetings.
- There were eleven risks recorded on the paediatric risk register (including neonatal unit), six of which were directly or indirectly attributed to staffing levels both medical and nursing. Each risk had been scored according to its likelihood and impact, with mitigating controls documented if they were in place. It was difficult to identify which risks related to which location, however, we noted that one risk which related to outpatient clinics had been recorded which related to inadequate staffing, a business case had been prepared in May 2015 to address this. The risk register did not adequately describe which location this related to.

Leadership of service

- Local leadership worked well, the clinical management for medical and nursing was well established and the staff we spoke with reported that they had good relationships with their immediate manager and that they would feel comfortable expressing their views to more senior management if they needed to.

Culture within the service

- The staff we spoke with in paediatrics told us that the hospital was a wonderful place to work and that they felt supported by their peers and managers. We observed positive interaction between all staff groups. Nursing staff and support workers told us that they felt comfortable in raising serious issues directly with consultants if they needed to and always felt listened to.

Public and staff engagement

- Patients were given the opportunity to provide feedback using comment cards and more recently via the friends and family test. The comments we reviewed were largely positive and we saw examples of action taken, if appropriate when negative comments were received.
- An annual staff survey took place each year to gauge staff perception on a range of matters; we requested a copy of the action plan for paediatrics. However, the action plan provided was trust wide and therefore we were unable to link this directly to the satisfaction of staff working within paediatrics and neonates.

Services for children and young people

- We were told that staff were able to raise issues as part of their annual appraisal.
- The staff we spoke with told us that they felt confident in raising concerns with managers.

Outpatients and diagnostic imaging

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

Information about the service

Kidderminster Hospital offers a range of outpatient clinics across varying specialities including cardiology, dermatology, gastroenterology, general medicine (including specialist clinics for stroke, osteoporosis, falls and Parkinson's disease), geriatric medicine, trauma and orthopaedics, infectious diseases, vascular surgery, general surgery, respiratory medicine, pain management, gynaecology, colposcopy, sleep and chest specialities.

During 2014/2015, the hospital facilitated 112,030 outpatient appointments, of which 42,312 were new appointments and 69,718 were follow up's. Additionally, during 2014/2015 the hospital conducted 75,359 radiology procedures including CT scans, MRI's, obstetric ultrasounds, general ultrasounds, plain x-rays, mammographies and fluoroscopies.

During our inspection we spoke with 6 patients and/or their relatives, 17 members of staff including consultants, junior doctors, nurses, radiographers, radiologists, booking staff, secretaries and housekeeping staff.

We observed care and treatment and carried out visual checks on a range of clinical environments and equipment as well as considering information from external stakeholders and supporting information provided to us by the trust in the lead up to, during and after the inspection.

Summary of findings

Overall we rated this service as requires improvement. It was rated inadequate for well-led, requires improvement for safety and responsiveness and good for caring. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging

The premises were visibly clean; regular audits took place to ensure that housekeeping staff were undertaking cleaning duties in line with trust standards. Routine hand hygiene audits took place and staff were well versed in the requirements of both local and national infection prevention and control standards.

Whilst staff were aware of their roles and responsibilities with regards to reporting patient safety incidents, the frequency with which incidents were reported in outpatients was extremely low; where incidents had been reported, the dissemination of lessons learnt was insufficiently robust. Staff working in radiology however were positive around incident reporting and there was evidence that lessons were learnt and changes to practice were made.

The process for keeping patients informed when clinics overran was good with information being made available in written formats but also we observed nursing staff verbally updating patients where clinics overran. There was however no formal process for the on-going monitoring of clinics to ensure that the outpatient department operated at optimal capacity.

Outpatients and diagnostic imaging

The trust was failing to meet a range of benchmarked standards with regards to the time with which patients could expect to access care as well as the time with which imaging reports were produced.

Leadership within the outpatient's team was visible however the management of risk was insufficiently robust and further improvements were necessary. Within radiology, governance arrangements existed which ensured that risks which had the likelihood to impact on the clinical effectiveness of the service were discussed, business cases and strategies developed and monitoring of on-going concerns existed with oversight from the clinical and operational leadership team. However, concerns were raised that the replacement of ageing and unreliable equipment had not been effectively managed which had resulted in patient-related incidents occurring including the loss of diagnostic images such as plain x-rays.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall we rated this service as requires improvement for safety

The threshold at which staff reported incidents within the outpatient department was high; whilst staff were aware of their responsibilities with regards to reporting incidents, unless they considered action would be taken to prevent similar incidents in the future, they would not formally report patient safety concerns. Where incidents were reported within the outpatient setting, there was limited evidence that lessons were disseminated amongst the nursing team. Within radiology and endoscopy, staff were fully aware of their requirement to report and to learn from patient safety incidents; there were processes for ensuring that lessons were learnt and that these were shared amongst the team and across the three acute locations. There were however some discrepancies with regards to the data we were provided and the division's dashboard in respect of the number of IR (ME) R incidents that were reported by the service.

Staff had received basic training in safeguarding vulnerable adults and children; the uptake of more advanced training with regards to safeguarding vulnerable children was below the trust standard for a range of healthcare professionals.Staffing levels and the deployment of appropriately skilled staff varied depending on the clinical setting. Within outpatients, nursing levels were considered to be satisfactory however there was a reliance on care support staff to support some clinics. Additionally, staff reported difficulties in ensuring that diagnostic images were reported by a qualified practitioner within a timely manner due to a shortage of consultant radiologists.The service was placed under additional pressuredue to a shortage of radiographers; this meant thatconsultantradiographers who were employed by the service and used to report on imageswere also beingused to support the radiographer rotas.Staff raised concerns that ageing radiology equipment had led to some electronic diagnostic images being lost; a significant system failure event had resulted in the plain film x-ray service being halted for a period of 48 hours prior to the inspection whilst

a remedial temporary fix was instigated; staff had raised the ageing radiology equipment as a risk in 2014 and there was limited evidence that remedial action was being taken to address the risk in a timely fashion.

Incidents

- We reviewed all incidents which were reported within the ophthalmology department,outpatient department, and radiology departments. The number of incidents reported within the outpatient department was exceptionally low; there had beentenincidents reported between the ophthalmology (7 incidents) and outpatients (3 incidents) between December 2014 and March 2015. 4 incidents were reported as minor harm, 5 incidents resulted in no harm and the remaining incidents reported as ungraded.
- The nursing lead for the service reported that their view was that staff would not routinely report common issues, especially if there was a view that the issue would remain unresolved. We spoke with three nurses who supported the outpatient clinics; they each said that they would not report issues such as clinic overruns as they did not perceive them to be "Patient safety issues" and there was limited action that could be taken to resolve the matter. Staff reported that clinic overruns, which were known to occur frequently but never formally monitored, would not be reported as an incident even when patients became frustrated with the delays.
- The radiology department reported 23 incidents between 1st December 2014 and 31 March 2015.
- There was a discrepancy between the data provided on thequality dashboard for clinical support services whichreported that no reportable radiation incidents had occurred between March 2014 - March 2015; CQC however, had been notified by the trust of ten incidents during that time which related specifically to radiation incidents as per the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Three of the ten incidents had occurred at Kidderminster Hospital. Radiology staff were able to describe the most recent incident which involved a patient not being appropriately identified prior to receiving a dose of radiation for a diagnostic procedure. We found that changes had been made to practicewhich included ward based nursing staff completing a patient identifier slip prior to the patient leaving the ward. We observed radiology staff checking the details of the slip with the patient and also against their name band to ensure the right patient had been transferred to the department.
- Within the outpatient department,whilst staff were able to describe the process for incident reporting, we considered the threshold for incident reporting to be high.Staff reported that incidents would be reported if patients or staff were injured as a result of an accident such as a slip, trip or fall, or where staff members hadexperienced aggressive or violent behaviour. However, staff reported that they would not routinely report clinic'swhich had over-run by asignificant amount of time.
- The approach to learning from incidents was varied, depending on the grade and health profession of staff that we spoke with. Radiologists for example,were able to describe the process for incident reporting and provided examples of where changes had been made to practice in response to incidents. Staff working in the outpatient department told us that learning from incidents was fed back by disseminated via local meetings which were facilitated by the matron; we reviewed minutes of these meetings and found that the minutes were insufficiently detailed and so staff not present at the meetings would not be fully appraised of learning outcomes from incidents.

Cleanliness, infection control and hygiene

- Audits which measured performance and compliance against the trust policies for "Clean your Hands" and "Bare below theelbows" withinthe Ophthalmology department demonstrated that staff consistently attained 100% compliance between April 2014 and March 2015.
- We observed staff in the OPD and radiology departments washing their hands in accordance with the guidance published in theFive Moments for Hand Hygiene published by the World Health Organisation (WHO 2014). The radiology department attained an annual average score of 97% compliance with the clean your hands audit although it was noted that there was no audit data entered for November 2014, December 2014 nor February 2015.
- Staff working in the radiology department were able to describe the process for managing patients who had or who were suspected of having a communicable disease. This included ensuring that patients were isolated from

other patients when attending the radiology department, as well as ensuring that equipment and the environment was effectively decontaminated on completion of the procedure. Staff advised that patients who were receiving inpatient care, who required MR or CT imaging were placed at the end of planned lists so that the imaging suite could be decontaminated without there being a significant impact on the timings of the imaging timetable.

- We observed staff using alcohol based hand rubs between patient contacts within the outpatient department. Staff used personal protective equipment; this included staff responsible for carrying out decontamination procedures within the endoscopy unit; staff used aprons, gloves and face masks as per the localtrust policy.
- The infection prevention and control performance monitoring audit demonstrated that for endoscopy, staff consistently complied with the bare below the elbow policy between May 2014 and February 2015.
- Routine water sampling was conducted within the endoscopy unit to ensure that the water supply was not contaminated. Further, regular protein quality checks and random checks of endoscopes were carried out to ensure they were being effectively decontaminated.
- There were processes and procedures in place for tracking each endoscope which had been used; decontamination records were filed in the relevant patient notes to ensure that equipment could be traced including details of the staff members who were responsible for operating and decontaminating them.

Environment and equipment

- There were radiation warning signs and lights outside any areas that were used for diagnostic imaging. Lead aprons were available for staff; these were routinely checked and screened for damage.
- In diagnostic imaging, quality assurance checks were in place for equipment
- Electrical safety checks had been carried out on mobile electrical equipment and labels were attached which recorded the date of the last check.
- The MR suite was restricted to authorised personnel only. Access to waiting areas within MR was controlled by the MR staff. Safety checks were carried out for each person who required access to the MR suite, including checks for members of staff.
- The local IR (ME) R rules had been updated on 10th July 2015 and were available within the radiology department.
- Staff raised concerns that there had been persistent reliability issues with the plain film imaging devices in radiology. Staff spoke anecdotally about incidents whereby patients had attended for plain film investigations which had been loaded onto the database however due to ageing equipment, images had subsequently disappeared meaning that patients had to re-attend for repeat radiology investigations; this meant patients were being exposed to additional doses of radiation. We found that shortly prior to our inspection, the computer equipment supporting the plain film imaging equipment had failed resulting in the service having to close for a period of 48 hours whilst a remedial temporary fix was instigated. At the time of the inspection, the remedial temporary fix had remained in place and the provider was undertaking a procurement process to obtain replacement equipment. The loss of radiology image retrieval and viewing had been logged on the divisional risk register on 10 February 2014 as had a radiology capital equipment replacement programme risk which had been reported on the risk register since 23 December 2014. Senior staff working in radiology reported that there concerns had been escalated to the executive team however considered that their concerns had not been sufficiently acknowledged. Six incidents had been reported between 01 December 2014 and 31 March 2015 whereby equipment failures had resulted in patients requiring repeat images which resulted in patients receiving additional doses of radiation.

Medicines

- Medicines were stored in locked cupboards or refrigerators. Nursing staff held the keys to the cupboards so as to prevent unauthorised personnel from accessing the medication supply.
- Fridges used to store medications were checked by staff in line with trust policies and procedures.
- Some nursing staff working within the ophthalmology service were responsible for administering medication in line with a local patient group direction (PGD). The senior sister responsible for the clinical area reviewed the competency of nursing staff on an annual basis to ensure staff met the requirements of the PGD.

- Staff working within the endoscopy unit reported that due to a lack of pre-assessment clinics, patients attending for colonoscopies could expect to receive prescribed medication (bowel preparation) via the post; this was listed as a risk on the departments risk register; whilst staff recognised this as an area of risk, there was limited action being taken to resolve the issue.

Records

- Staff reported, and we found that notes were generally readily available for clinic appointments as the hospital utilised an electronic patient record system. One incident had been reported whereby operation notes had been scanned into the incorrect section of the patient notes; two consultants that we spoke with said that whilst they had access to medical notes for clinics, they sometimes spent additional time during clinic appointments searching through the electronic file to locate operation notes.
- There was a process in place for ensuring that when the electronic patient record system was unavailable, clinical staff could access a back-up system, as well as using a range of alternative databases in order to review discharge summaries, clinical letters, pathology and radiology investigation reports andendoscopy reports.

Safeguarding

- Staff were able to describe the processes and procedures that were in place for escalating safeguarding concerns of both adults and children.
- 99% of staff (nursing, unregistered health care support workers, administration and clerical, allied health professionals, scientific therapeutic and technical support staff and medical and dental staff assigned within outpatients, radiology, microbiology or pathology)had received training in safeguarding vulnerable adults including learning disability awareness.
- 95% of staff (nursing, unregistered health care support workers, administration and clerical, allied health professionals, scientific therapeutic and technical support staff and medical and dental staff assigned within outpatients, radiology, microbiology or pathology)had received training in safeguarding in safeguarding children level 1, 63% in level 2 safeguarding children and 38% in level 3 safeguarding children.

Mandatory training

- 63% of staff(nursing, unregistered health care support workers, administration and clerical, allied health professionals, scientific therapeutic and technical support staff and medical and dental staff assigned within outpatients, radiology, microbiology or pathology)had completed their mandatory training in health and safety major incident awareness, accident reportingand minor incident investigation; the trust standard for completion of this training was 80%.
- 96% of staff had completed introductorytraining in information governance and record keeping and 66% had completed a refresher course; the trust standard for completion of this training was 95%.
- 87% of staff had completed mandatory training in manual handling; the trust standard for completion of this training was 95%.
- Staff reported that mandatory training was provided in a range of formats including e-learning and face-to-face sessions.

Assessing and responding to patient risk

- 45% of nursing, medical or unregistered health supportstaff assigned to outpatients orradiology had completed paediatric basic life support;the trust standard for completion of this training was 95%.
- 34% of nursing, medical or unregistered health support staff assigned to outpatients or radiology had completed adult basic life support training.
- Emergency resuscitation equipment was available throughout the outpatients and radiology departments; this equipment was checked frequently to ensure that all items were present and correct.
- Staff reported that they could seek assistance from the hospital wide patient at risk team by dialling 2222 should an emergency situation arise.
- In radiology, inpatients who required diagnostic tests and who were acutely unwell, were either managed on their ward by way of a portable x-ray or were transferred to the radiology department with a nurse escort. Any patients who presented with an infection risk were discussed on a case-by-case basis and provision was made for the patient to attend the radiology department at a time which was clinically assessed

dependent on the condition of the patient and at a time when arrangements could be made for any examination room to be cleaned so as to reduce the risk of infection to other patients.

Nursing, allied health care professionals and otherstaffing

- One matron was assigned to oversee the management of the entire outpatient's service across all of the registered locations. On each hospital site the matron was supported by a team of sisters/charge nurses, junior sisters and staff nurses. Clinical support workers were also utilised to support the outpatients departments
- The average staff turnover rate for all health care professionals and support staff assigned to outpatients, radiology, pathology, histopathology and microbiology was 11% during 2014/2015; this was a marginal increase when compared to the turnover rate for the previous year which was reported as 9.9% during 2013/2014.
- Nursing staff working in the outpatients department considered there were sufficient numbers of staff to support the clinics. The outpatient service had a budgeted establishment of 13.15 WTE nursing staff; at the time of the inspection 13.12 WTE staff were in post. Specialities such as diabetes, ear nose and throat and dermatology supplied their own clinical nurse specialists to support clinics.
- The vacancy rate amongst health care assistantswas high with an actual establishment of 11.99WTE against a budgeted establishment of 20.61 WTE.
- Radiography staff reported significant concerns with vacant radiographer posts.Data provided by the trust demonstrated that the budgeted radiographer establishment was 61.01 WTE; the number of people in postwas 50.03 WTE. Radiography staff reported that the service was working under significant pressure as the workforce was attempting to sustain a 24 hour, seven day service to patients. The trust were utilising temporary staff, both bank and agency, as a means of sustaining the service. The management team within radiology reported that despite numerous recruitment campaigns, there continued to be a shortage of competent radiographers to join the service and so would continue to use short to medium term agency staff as a means of mitigating any risks associated with staffing shortages.

Medical staffing

- The clinical lead reported that the service had a budgeted establishment of 26 whole time equivalent radiologists whose job plan involved them working across the three main sites and that there were 7 WTE vacancies. Data provided by the trust prior to the inspection demonstrated that the radiology service was budgeted for 17.28 WTE consultants; the actual establishment at the time of the inspection was 22.23 WTE consultants and 4 WTE "Other grade" medical staff. There was no reference to staff shortages being recorded on the radiology risk register. We reviewed the performance indicator dashboard for the radiology department which reported that the year to date staff turnover rate for clinical staff within radiology was 10.9% and that the actual versus budgeted establishment was 21 WTE consultants and 29 WTE equivalent consultants respectively; it was therefore not possible to corroborate the actual versus budgeted establishment due to conflicting data from various sources. The trust provided further information post-inspection which indicated that as of July 2015, the budgeted number of Consultant Radiologists was 29.25 WTE; a total of 21.73 WTE were in post therefore indicating avacancy factor of 7.52 WTE. Individual medical and surgical specialities were responsible for arranging clinical support for their clinics. Due to the nature of how services were configured, medical and surgical staff were required to work across a range of sites in order to facilitate outpatient clinics; whilst some medical staff raised concerns that this had led to increase travelling times, the majority of clinical staff were accepting of this configuration as they believed in delivering services to the local population which was convenient to patients.

Major incident awareness and training

- There was mixed understanding amongst nursing and medical staff with regards to their roles and responsibilities during a major incident.
- Staff were able to signpost us to the trust wide policy which was located on the trust intranet.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

Within the outpatient setting, there was a general lack of monitoring with regards to nursing quality outcomes. Within radiology, staff were undertaking a range of audits although these had not been concluded at the time of the inspection and so it was too early to determine what action would be taken in response to the audit outcomes to ensure that practice was reviewed. Staff from a range of specialities accessed a range of best practice guidance and evidence to help in the delivery of care. Whilst pathology, microbiology and haematology services were accredited with national quality assurance schemes, the radiology department were not, at the time of the inspection, accredited with the Imaging Services Accreditation Scheme. Staff undertook initial corporate induction on commencement of their employment with the trust. The uptake of annual appraisals varied between the various specialities; whilst staff spoke positively about the appraisal process, staff working within radiology reported that there were not always sufficient opportunities to further develop their skills in the various imaging modalities.

Evidence-based care and treatment

- Some specialities including cardiology, breast screening and trauma (fracture clinics) offered one stop, rapid accessclinics which enabled patients to be seen by a clinician or nurse specialist as well as undergoing any physical or diagnostic examination on the same day and then seen again by a consultant on that day to determine whether any further clinical intervention was necessary.
- We observed posters around the department sign-posting patients who think they may be pregnant to let a member of staff know. All women of child bearing age having examination of the abdominal or pelvic areas are checked for their last menstrual period. We were told that if a patient was pregnant but radiological examination was clinically indicated, then the examination would take place with lead protection being used to protect the foetus. Radiological investigations on women who were pregnant required discussion between senior Radiologist and/or the referring clinician to consider the risks versus benefits.
- The clinical teams within ophthalmology, cardiology, dermatology and the respiratory clinic were all seen to have access to, and utilised a range of guidance from the National Institute of Health and Care Excellence, Royal Colleges and other national best practice sources.
- Protocols were in place for radiology examinations such as cervical spine and orthopaedic x-rays.
- The radiology department participated in two national audits namely the National Audit of radiology alert systems and the BSCI forCardiac Angiography audit. Whilst data from the first audit had been submitted, the results were not yet available at the time of the inspection. The department had yet to start submitting data for the Cardiac Angiography audit.

Pain relief

- Where patients underwent out-patient based procedures such as was common within the ophthalmology clinic, patients were offered pain relief; we spoke with four patients who each reported that they had considered that staff had managed their pain well. There was however, no formal process in place for staff to assess whether they effectively managed people's pain so it was not possible to fully assess this line of enquiry.

Patient outcomes

- Radiology services were not accredited with the Imaging Services Accreditation Scheme (ISAS).
- There was a general lack of local initiatives within the outpatient department to monitor and report on patient outcomes. The nursing lead for the service reported that individual clinical specialities were responsible for assessing and measuring clinical effectiveness and outcomes.
- The trusts follow-up to new ratio wasconsistently below the England average.
- The lead nurse reported that the hospital did not monitor the number of patients who waited longer than 30 minutes from time of arrival to being seen at their appointment time. Further, the trust was not monitoring

the number of patients who were seen without medical records as it was reported that clinical staff could access all medical records via an electronic patient record system.

Competent staff

- There were arrangements in place for temporary staff to be inducted to clinical areas such as within the radiography department. We reviewed completed documentation to this effect.
- All new substantive staff were required to attend mandatory induction on commencement of employment; 99% of staff had completed corporate induction.
- Staff working in the outpatients department reported that they undertook annual appraisals and those they considered the process to be useful when considering their professional development needs.
- Some staff in radiology however considered that whilst they undertook appraisals, there were not always sufficient opportunities to develop their professional needs within the department and that this was attributed to the continued shortage of competent radiographers to support the service; staff reported that there was a lack of flexibility within rosters to enable them to rotate to gain experience in other imaging modalities such as CT or MR. Two staff that we spoke with reported that they had since acceptedjobs inother organisations which offered them the ability to rotate through the various imaging modalities.
- Data provided by the trust demonstrated that 90% of non-medical staff had undertaken an appraisal within the clinical support division; this was below the trust standard of 100%.
- 80.6% of non-medical staff employed within the "TACO" division which encompassed outpatients had undertaken an appraisal year to date; this was below the trust standard of 100%.

Multidisciplinary working

- Radiologists attended a range of multi-disciplinary meetings to provide clinical support to treating physicians and surgical teams.
- All staff that we spoke with told us that medical and surgical teams worked well with the outpatients teams.
- Some clinics such as the one-stop breast clinic were jointly facilitated by breast specialists and clinical nurse specialists.
- We noted that the multi-disciplinary working within the diabetes team and the ophthalmology team asespecially strong; Doctors and nurses offered joint clinics as well as separate nurse and consultant clinics in which different issues were discussedwith patients.

Seven-day services

- Outpatient services were not available seven days per week. There was however provision for additional clinics to be provided on Saturdays to assist with outpatient backlogs.

Access to information

- There was a process in place for ensuring that when the electronic patient record system was unavailable, clinical staff could access a back-up system, as well as using a range of alternative databases in order to review discharge summaries, clinical letters, pathology and radiology investigation reports andendoscopy reports.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Patients who attended for cataract surgery were sent information to their home address prior to them attending for surgery. This information provided patients with an overview of their intended procedure, as well as detailing the risks, benefits and any alternative treatments available to them, so as to allow them to make an informed decision.
- Staff that we spoke with demonstrated an understanding of the Mental Capacity Act and how it was applied within the outpatient setting.

Are outpatient and diagnostic imaging services caring?

Good

Overall we rated this service as good for caring

Feedback from people who used the service and those who were close to them were positive about the way staff had treated them. Patients considered that they had been treated with dignity, respect and kindness during their interactions with staff and relationships with staff were positive. People were involved and encouraged to be

partners in their care and in making decisions and were provided with the necessary support to enable them to make decisions. Staff were observed to communicate with and provided information to patients in a way that they could understand.

Compassionate care

- Patients we spoke with in radiology and outpatients praised the staff for the level of compassionate care they provided.
- Patients were provided with the option of being accompanied byfriends or relatives during consultations.
- We observed a good rapport between patients, reception and nursing staff. We observed volunteer staff directing patients to the various outpatient and radiology departments within the hospital.
- We observed staff stopping to speak with and greet patients they knew; it was apparent that patients who attended clinics frequently had built professional relationships with the nursing and medical staff.
- In radiology, we observed radiographers speaking with patients who appeared anxious when attending for MR scans; patients were offered reassurance and staff were observed to frequently communicate with patients during scans so as to keep them informed of the intended duration of the scan as well as to enquire about their well-being.
- We observed staff knocking on doors before entering clinic rooms.
- During April, May and June 2015, the number of patients who would recommend the outpatients department to friends or family was 90%, 93% and 91% respectively; the England average for the same period was 92%.

Patient understanding and involvement

- The radiology department was notoperating any formal patient satisfaction or feedback survey so it was not possible to determine, from a wider cohort of patients, whether the general consensus of patients were fully supported or involved in their care.
- Patients we spoke with felt wellinformed about their care and treatment. Patients understood when they would need to attend the hospital for repeat investigations or when to expect a repeat outpatient appointment. Where some patients had presented with complex conditions, they told us that nursing staff were available to explain in further detail and in a manner which they could understand, any amendments to their treatment or care
- .Patients informed us, and we saw that information leaflets were available for a host of different conditions and treatments which were available for different specialities. These information leaflets were located around the various departments and were written in plain English.

Emotional support

- Patients told us that they considered their privacy and dignity had been maintained throughout their consultation in outpatients.
- We observed staff using curtains when patients were on beds in the main radiology department so as to protect people's dignity.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Overall we rated this service as requires improvement for responsiveness

The hospitals performance with regard to ensuring that patients had access to the right care and treatment, in line with national standards was consistently poor. Performance against a range of national benchmarks including the two week wait referral for cancer was poor and performance was noted to be on a downward trajectory.

Radiology services were required to outsource unreported images to ensure that referring clinicians received timely results in order to plan care and treatment for patients.

Service planning and delivery to meet the needs of local people

- Staff working in the outpatients department informed us that the majority of referrals into the department were received in paper format and that whilst some patients could choose to utilise the "Choose and book" system to book appointments which were convenient to them, this was not widely used across the county.

Outpatients and diagnostic imaging

- A range of rapid access clinics were available which meant patients could be referred for urgent care.
- The outpatients departments were well sign posted and easy to find; volunteers were also available to direct patients to the relevant outpatient or radiology department

Access and flow

- There were 133,942 appointments scheduled in 2014 (January to December). 8% of patients did not attend (DNA) for their appointments; this was marginally worse than the England average of 7%. We spoke with the nursing lead for the department to determine what action was being taken to resolve the DNA rate and were advised that there currently was no formal initiative to address the issue.
- The percentage of patients seen by a specialist within 2 weeks following an urgent referral by their GP for all cancers was worse than the England average and it was noted that performance in this standard had significantly worsened during quarter 2 and 3 of 2014/ 2015. For April, May and June 2015, the trust's performance fell below the national standard of 93% with performance reported as 91.5%, 90.3% and 86.8% respectively.
- The percentage of patients waiting less than 31 days from diagnosis of cancer to first definitive treatment was worse than the England averageduring 2013/2014 althoughit was noted that whilst still worse than the England average, improvements had been made in this standard, with an increase in the number of patients waiting less than 31 days.
- The percentage of patients waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was worse than the England average during Q2 and Q3 of 2014/2015. For April, May and June 2015, the trust's performance fell below the national standard of 85% (May excepted) with performance reported as 80.9%, 85.3% and 75.5% respectively.
- The average year to date referral to treatment time for non-admitted patients was 97.3% between May 2014 and May 2015; this was better than the England average.
- The trust reported that in 2014, they had significant concerns regarding the data quality of some 94,000 patients who were flagging as open care pathways; the trust requested support from the Intensive Support Teamin order to seek assurance in relation to the trust's referral to treatment programme. The trust was undertaking further work to improve the robustness of their validity programme to ensure that all patients were appropriately tracked across their treatment pathway.1 patient was reported as breaching the 52 week referral to treatment time; this had been reported as a serious incident and had been investigated to determine whether the patient had come to any harm as a result of the delay in receiving an appointment.
- As of June 2015, 1,266 patients had been waiting between 18 and 25 weeks for an appointment, 899 had been waiting between 26 and 51 weeks; 37 patients had been waiting for more than 52 weeks although it was noted that the information provided by the trust included patients who were awaiting follow-up appointments. Where patients were waiting more than 18 weeks, these patients were referred to the relevant clinician for review and to determine any relevant action which should be taken. Additionally, a report submitted to the trustin July 2015 confirmed that there had been 305 patientslisted as "Urgent" who had waited for more than 18 weeks for an initial appointment; 46 patients on the inpatient waiting listhad been identified as requiring further investigation to determine whether they had come to any harm as a result of their delay in receiving care or treatment. Eachof the 46 case notes werereviewed and action taken to ensure they had or were scheduled to receive the necessary care or treatment.
- Outpatient booking efficiencyranged from 89.6%to 92.6% between May 2014 and May 2015; the booking efficiency rate was consistently rated as amber on the performance dashboard for outpatients which meant that the department was not being used to its full operating potential.
- Monthly clinic cancellation rates ranged from between 6% in January2015 to as high as 13.3% in August 2014. The average clinical cancellation rate over a thirteen month period (May 2014 - May 2015) was 8.6%; there were 7,586 clinics cancelled during 2014/2015 withconsultant annual leave being given as the main reason for cancellations
- The trust monitored the number of patients who were waiting longer than 6 weeks for a diagnostic procedure. Between May 2014 and May 2015 193 patients had waited for more than 6 weeks for a CT scan, 50 had waited for more than 6 weeks for an MRI and 406 patients had waited for more than 6 weeks for a general ultrasound. It is important to note that the service had

experienced a significant backlog in the number of patients awaiting a general ultrasound (154 in May 2014 and 181 in June 2014); this backlog had since been cleared with only 4 patients reported as waiting for longer than 6 weeks for a general ultrasound in May 2015.

- Prior to the inspection we had received information of concern relating to the number of images or diagnostic tests which had been carried out but had not been reported. A total of 514 plain x-rays which had been carried out between February and May 2015 had not been reported. Additionally, 30 patients who had undergone an angiogram were still awaiting reports. In order to resolve the backlog, the trust had outsourced reports to an external agencyin order that reports could be generated and results passed to the referring clinician for action.
- The radiology service reported that whilst the majority of patients referred for diagnostics were seen within 6 weeks, there was a significant delay in patients awaiting CT cardiac scans; we noted at the time of the inspection that patients were being offered appointments in October 2015 which was outside the 6 week target.
- Radiology staff reported that whilst they were able to meet the demands of the service in order that waiting lists were kept to a minimum, it was considered by staff that the equipment and department was operating at "Full capacity" and so there was limited capacity when considering the future needs of the population.
- Prior to our inspection we had received information of concern relating to the number of patients who had experienced delays in receiving appointments within the ophthalmology service. We found that the ophthalmology service was, in the main,meeting the 18 week referral to treatment time. Patients were seen in the cataract clinic at around 9 weeks from initial referral. Where additional pressure was placed on the service as a result of increases in referrals for example, additional clinics could be held so as to effectively manage the waiting lists. As of June 2015, a total of 2,137 patients were on the ophthalmology waiting list with the majority waiting (2,110) waiting less than thirteen weeks and27 waiting between 14 and 17 weeks. There were nopatients reported as waiting more than 18 weeks. 3 patients had been reported ashaving their clinic appointment cancelledon more than one occasion during 2014/2015.
- Both patients and staff complained that clinics would often over run for a range of reasons. Four patients that we spoke with on the first day of inspection reported that their clinic appointment was running between 45 minutes and 65 minutes late; patients were accepting of the fact that delays occurred however they reported being frustrated with the lack of announcements and information associated with the delays.

Meeting people's individual needs

- Patients reported that they were kept informed by the nursing staff if clinics were running with delays; boards were available which were also updated regularly if clinics were over-running. There was however no formal process in place for the management team to regularly review clinic over-runs so it was not possible to determine the actual extent or severity to which clinics would over-run.
- Staff working in the MR and CT scanning suite reported that they could support patients living with dementia or those with patients with profound learning disabilities to ensure that scans could be conducted in a safe and effective way. Where patients could not be scanned due to high levels of anxiety, referrals were made for the patients to be seen at the Worcestershire of Royal Alexander hospital so that consideration could be given to those patients to undergo their scan under sedation or general anaesthetic.
- Patients reported that parking on the Kidderminster site was accessible.
- Staff working in the MR suite operated Monday to Friday from 08:00 to 20:00 in order that they could keep the backlog of referrals to a minimum. Staff reported that further consideration was being given to extending the operating hours of the service to include a Saturday service however this remained in the planning stage.

Learning from complaints and concerns

- Information was accessible on the trust website and also throughout the hospital which provided details of how patients could raise complaints about the care they had received. Staff informed us that patients could be directed to the Patient Advocacy and Liaison Service (PALS) should they wish to raise a complaint although immediate resolution was often the preferred method for dealing with complaints.

Outpatients and diagnostic imaging

- The matron for outpatients informed us that the service received very few formalcomplaints on an annual basis and that face-to-face mediation was the preferred method for addressing any concerns that was raised. When we spoke with the matron regarding the complaints we had received regarding the long waits in some clinics, there was little evidence that action was being taken to address the issue; the service had not introduced any clinic monitoring to determine how efficient clinics were running, nor had there been any drive to introduce notice boards or other visual displays which could be used to keep patients informed of delays.
- A total of 18 complaints were received for the Clinical Support Division which included radiology, pharmacy and pathology during 2014/2015, of which100% were responded to within 25 days.

Are outpatient and diagnostic imaging services well-led?

Inadequate

Overall we rated this service as inadequate for well-led

Whilst wider governance arrangements were in place which involved members of the senior divisional teams within Radiology and Outpatients, local governance arrangements were not as sufficiently robust so as to ensure that all staff were engaged with and robustly participated in measuring the quality outcomes of services provided.

Improvements were required with regards to how risks were recorded and managed as there were was a lack of continued oversight and effective management of risks which were on the relevant risk registers.

Whilst staff working in the outpatient department felt supported by their managers, those working in radiology reported that the management team were not visible and that they lacked direction or robust sustained leadership. The relevant divisions for outpatients and radiology had developed strategic vision and objectives which were aligned to the trust's wider view. Whilst there was oversight of the strategic vision within radiology this was not the case within outpatients.

Vision and strategy for this service

- The majority of staff that we spoke with in both outpatients and radiology could not describe a vision or strategy for either service.
- Both the clinical support directorate and TACO division had produced "Strategic triangles" which were aligned to delivering the organisations value of PRIDE (Patients, Respect, Improve, Dependable and Empower). Whilst staff were able to describe the trust wide values of PRIDE, almost every staff member we spoke with were unable to describe the strategic triangles nor were they able to describe any local vision for the outpatients department for the future.
- It was unclear from our discussions with the nursing lead for the outpatient department whether any demand and capacity assessments had been conducted. This was despite clinic capacity and usage being listed as an objective on the TACO strategic triangle.
- Within radiology, a range of key priorities had been identified within the strategic triangle and these were supported by business cases. However, an unstable leadership team within the radiology department had meant that it was unclear who was responsible for each of the key priorities; further, it was difficult to determine whether progress had been made on a range of areas including demand and capacity assessments, recruitment and retention initiatives and report turnaround times.

Governance, risk management and quality measurement

- The clinical and nursing team within the ophthalmology department held bi-monthly during which time outcomes from local nursing and clinical audits were reviewed in order that changes to practice could be made. Incidents were also reviewed and discussed and lessons learnt disseminated to the nursing and medical team. We noted that the incidents discussed were more likely attributed to inpatient areas than incidents that occurred within the ophthalmology department; this demonstrated that the ophthalmology service was considering how changes could be made to practice even when incidents happened outside the scope of their department.
- Staff in the outpatients department described meetings that they had had with the matron or sister during which time they discussed matters such as annual leave,

reporting faulty equipment and the completion of nursing documentation. There was no discussion of incidents which had occurred within the department or discussions of any risks within the department

- .Wider clinical governance meetings were held within the TACO division whereby discussions took place which described progress against the development of governance frameworks as well as receiving feedback from the individual clinical areas within the TACO division including theatres, critical care, anaesthetics and outpatients. Whilst verbal assurance was received that risks on the directorate register were being managed, it was not clear how individuals assigned to manage individual risks were being held to account. For example, it was noted that the risk associated with the dispatch of prescribed medication via post was being managed locally by the matron and divisional manager. Whilst a process had been introduced in which two nurses were responsible for checking and dispatching the medication, as well as logging the dispatch of medication in a register, there was no formal plan in place to resolve the lack of pre-assessment services at Kidderminster Hospital. Further, it was noted that issues such as the under-reporting of incidentsin outpatients, which had been acknowledged by the local team as an issue, were not on the risk register.
- Within radiology, governance processes existed whereby matters associated with the radiology risk register were discussed, incidents werereviewed, and clinical guidelines were discussed and assigned to individuals for updating, waiting list lengths reviewed, reports received from the chief radiographer and financial performance considered. However, it was noted that issues such as the shortage of radiographers were not reported on the divisional risk register despite this being identified as one of the most significant risks by the clinical lead and local managers within the department. Whilst staff were working to address the recruitment issue, there was no robust action plan in place to address the matter.
- Both the Clinical Support Division and the TACO division utilised performance dashboards as a means of measuring the overall effectiveness of the departments to which they applied. There was little in the way of quality outcome measures for the outpatient department, with only RTT, waiting list backlogs and outpatient booking efficiencies being reported.The remaining components of the dashboard referred to staffing establishment, completion of training and financial performance.

Leadershipand culture of the service

- Leadership within the outpatients department was by way of a matron; there was no specific clinical oversight of the department. The matron was responsible for overseeing the provision of outpatient services trust wide andwas supported by an operational manager. The matron described the outpatient service as a support service and as such, clinical oversight was not required as individual speciality clinicians were provided by the wider directorates in which matters such as clinical effectiveness and patient outcomes was monitored.
- Nursing staffreported that they generally felt supported by their manager within outpatients and the endoscopy unit. However, some senior nursing staff told us that they would have benefited from additional support from the matron, especially in regards to matters such as governance and risk management.
- Within radiology, the service was managed by a clinical lead, radiology manager and operations manager all of whom were based on other sites. Radiographers reported feeling undervalued by the organisation as a whole; three radiographers that we spoke with told us that they considered the leadership to not be visible and that they lacked any clear management with issues associatedwith rotas, training and development and annual leave consistently being raised as the main themes linked to the lack of visible management. Further, staff reported the lack of effective recruitment and a lack of engagement from their managers to ensure staff were retained were also compounding the issues associated with resourcing the imaging service.

Public and staff engagement

- Following our discussion with the nurse leadership team responsible for outpatients, it was apparent that there was a general lack of public or staff engagement with regards to how the outpatient department was led. Nursing staff reported that the department had recently introduced the national friends and family test as a means of determining whether patients would

recommend the outpatients department to others, however there was no other formal process in place to seek the views and opinions of patients to assist with the development of the service.

- Staff working in the outpatient department told us that whilst they were engaged in making decisions which impacted on local matters which were in keeping with the day-to-day management of the department, they did not feel fully engaged in the wider context in determining how the department was run or how services were provided to the wider population.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Improve incident reporting processes to ensure all incidents are reported and investigated and that actions agreed correlate to the concerns identified, are acted on and lessons learned are shared accordingly.
- Ensure mandatory training compliance meets the trust target of 95%

Action the hospital SHOULD take to improve

- Review the security of confidential patient records to ensure they are safe from removal or the sight of unauthorised people.
- Develop a policy on restraint and / or supportive holding and staff should receive training to ensure they understand how to apply the policy.
- Approve the audit plan for children and young people and ensure audits are completed in line with the plan with regular updates on audits outstanding with revised completion dates
- Review and update the dashboard for children and young people to include all pertinent information.
- Develop a suitable business plan for children and young people which identifies the needs of patients and adequately plans services for the year ahead. This should identify areas for improvement or expansion and ensure that patient demand can be met safely with the resources available.
- Ensure that complaints are responded to within agreed timeframes and summary data should be explicit as to which location the complaint relates to. Improve governance arrangements to ensure meeting minutes accurately reflect discussions held and /or that discussion takes place in accordance with the terms of the committee and that actions agreed are followed up at subsequent meetings.
- Use the risk register should as a tool to identify and monitor emerging and existing risks, ensuring it contains sufficient detail.
- Ensure all medicines storage areas have systems for measuring and recording temperatures
- Ensure all risks are risk assessed and are on the risk register with mitigated actions taken, this includes sufficient security measures are in place on the Kidderminster site to protect staff, patients and visitors
- Ensure investigations of incidents have clear learning points and actions to prevent similar incident occurring, particularly in relation to staff assault.
- Install a panic button within the treatment area of the MIU.
- Ensure all MIU staff have personal attack alarms.
- Ensure the issue regarding the toilet in the MIU waiting area and the risk of drug users using the area for illegal activities is risk assessed and mitigating actions taken.
- Ensure morbidity and mortality meeting minutes clearly document discussions.
- Ensure that an alarm is fitted in the waiting room for paediatric patients to alert help if required.
- Ensure staff are aware of Middle East Respiratory Syndrome (MERS), a viral respiratory infection caused by the MERS-coronavirus that can cause a rapid onset of severe respiratory disease in people and the actions required if a patient presents with associated symptoms.
- Ensure information about patients care and treatment and their outcomes is routinely collected, measured and used to improve care, treatment and patient outcomes.
- Ensure all staff received annual appraisals.
- Ensure that there are enough wheelchairs to meet patient need.
- Ensure patients receive an initial assessment within 15 minutes.
- Ensure all senior staff are visible enough for staff to recognise them and feel supported.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (2)(b) 2008 (Regulated Activities) Regulations 2014** **Systems or processes must be established and operated effectively to ensure compliance with assessing, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity, maintaining and keeping secure appropriate records and evaluating and improve their practice in respect of the processing of the information.** **The trust did not have effective systems in place to show how staff at all levels understood safety and quality information and how this was being used to implement learning from incidents**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18, (1) (2) (a) (b) 2008 HSCA 2008 (Regulated Activities) Regulations 2014** **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed and receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.** **The trust had not ensured all staff were supported by effective appraisal and completion of mandatory training.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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