Care Quality Commission

Worcestershire Acute Hospitals NHS Trust

Worcestershire Royal Hospital

Quality Report

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

Ratings

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

Worcestershire Royal Hospital is the newest and largest of the three sites. It was built under the private finance Initiative (PFI) and opened in 2002. It has 500 beds and serves a local population of more than 550,000, and provides specialist services for the whole of Worcestershire including stroke services and cardiac stenting. It has nine operating theatre including four laminar theatres, a level 2 neonatal unit and a cardiac catheterization laboratory

We carried out this inspection between14th and 17th July 2015 as part of our comprehensive inspection programme, and undertook unannounced inspections at Worcestershire Royal Hospital on 26th and 27th July 2015

Overall, we rated Worcestershire Royal Hospital as inadequate, with 2 of the 5 key questions we always ask being inadequate (safe and well-led)

Two of the 8 core services (Maternity and gynaecology, and children's and young peoples services) were rated as inadequate, and four required improvement (Surgery, urgent and emergency care, children's and young peoples services and outpatients and diagnostics). Critical care and end of life care 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. We judged that maternity and gynaecology services were outstanding for caring. However, improvements were needed to ensure services were safe, effective, responsive and well-led.

Our Key findings were as follows:

- Staff we spoke to were friendly and welcoming.
- Staff were caring, compassionate and kind.
- Patients did not always receive timely care and treatment. The Emergency Department was consistently failing to meet the national treatment standards. Actions taken to improve access and flow through the ED and the hospital had reduced the time patients waited for initial assessment. Although they still did not meet RCEM guidance, waiting times had reduced since our unannounced inspection in March 2015.
- Mandatory training compliance was consistently below the trusts target of 95% across all areas.
- All clinical areas were seen to be tidy and visibly clean.
- Staff followed the trusts infection control policy. Staff were 'bare below the elbow', used sanitising hand gel between patients and used personal protect equipment.
- Rates for methicillin resistant staphylococcus aureus (MRSA) and Clostridium Difficile for the trust were within acceptable range nationally.
- There were challenges in recruiting doctors to the hospital. Surgical services, medical care, children's and young people's services and maternity and gynaecology especially had high vacancies for middle grade doctors and relied heavily on locum staff. There were not enough consultants in the Emergency Department to meet College of Emergency Medicine's (CEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in all EDs for 16 hours a day, 7 days a week as a minimum.

Summary of findings

- Nursing and allied professional staffing was good in critical care. However, midwifery staffing did not meet national recommendations, minimum staffing levels were not always met in children's and young people's services, and the outpatients and radiography department had significant vacancies for health care assistants and radiographer's.
- There was good feedback from patients about the availability and quality of food and drinks across the hospital. Multiple faith foods were available on request, and choice was supported particularly for children's and young people, and patients at the end of life.
- The hospital promoted breastfeeding and was awarded the UNICEF full accreditation in July 2015. Statistics for breastfeeding initiation were consistently better than the trusts own targets.
- The Malnutrition Universal Scoring Tool (MUST) was used to assess and record patient's nutrition and hydration status. This was well used in critical care and medical services. However this was not consistently completed for surgical patients where there had been poor nutritional management of some patients, and this was reported as a contributing factor to the development of Grade 3 pressure ulcers.
- Governance systems were not always effective; incidents were not always reported or investigated in a timely way. Lessons learnt from incidents were not always shared.

We saw several areas of outstanding practice including:

- There was an exceptional patient observation chart used within the critical care unit. This chart was regularly reviewed and updated with any new developments or patient safety, care quality and outcome measures. The detail within the chart meant few if any crucial measures or indicators were not recorded, regularly reviewed, and deterioration or improvements acted upon.
- The critical care unit had shown an outstanding example of responsiveness with obtaining and using noise monitoring devices. Patients need peace and quiet for their recovery in critical care, and this had been recognised by the provision of devices that reminded staff when noise levels were increasing to disruptive levels.
- The pharmacy department operate an innovative seven day clinical service in the ED. This had shown a reduction in some direct admissions to hospital, patient's treatment had been optimised, patients had been counselled about their medicines to prevent readmission and a significant amount of patients (25%) benefitted from an intervention from the clinical pharmacist to prevent a future admission. The pharmacist told us that they often lectured at healthcare events and had other pharmacists visit the service to share the good practice. The service was planning to roll this practice out to other parts of the trust.
- We observed outstanding care in the early morning whilst visiting Avon 4 ward and found the staff approach to patients was extremely respectful, compassionate and caring. The atmosphere on the ward at this early hour was relaxed and calm with appropriate low levels of lighting, and staff spoke with each other in low tones to ensure patients were not disturbed whilst asleep.
- In Maternity and gynaecology services, overwhelmingly we received feedback that staff were excellent and compassionate. Women reported being treated with respect and dignity and having their privacy respected at all times. Outstanding practice was noted with staff having thought about the caring needs of women and devising innovative solutions to support them. This was demonstrated by staff facilitating a teenage buddying system and developing bereavement care pathway for women who suffer pregnancy losses at any gestation. The patient experience midwife was available to support women who were anxious or fearful about pregnancy and childbirth. We observed staff demonstrating a strong, visible person centred culture throughout the service.

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

Importantly, the trust **must**:

Summary of findings

- Improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards; reduce the unacceptable number of discharges at night; reduce the risks of this situation not enabling patients to be admitted when they needed to be or discharged too early in their care; reduce occupancy to recommended levels; and improve outcomes for patients.
- Ensure all staff meet the trust wide mandatory training target of 95% compliance
- Review the HDUs to bring their data collection and provision of care and treatment up to all Faculty of Intensive Care Medicine Core Standards.
- Ensure there is a timely and appropriate response from the medical teams to the CCU requests for support, follow-up and patient discharge.
- Risk assessments must be completed and used effectively to prevent avoidable harm such as the development of pressure ulcers.
- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the service including the provision of daily ward rounds.
- Ensure that patient records are accurate, complete and fit for purpose, and ensure they are safe from removal or the sight of unauthorised people.
- Ensure patients nutrition and hydration status is fully assessed recorded and acted upon in a timely manner.
- Evaluate and improve their practice in response to the results from the hip fracture audit for 2014.
- Ensure patients receive appropriate training and information about self-medication such as self-administration of heparin prior to discharge home.
- Ensure that staff providing care or treatment to patients receive appropriate support, and training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- Take steps to ensure that all staff are included in lessons learnt from incidents and near misses, including lessons learned from mortality reviews, with effective ward based risk registers and safety dashboards being in place and understood by all staff.
- Ensure that suitably qualified staff in accordance with the agreed numbers set by the trust and taking into account national policy are employed to cover each shift.
- Review the environment within outpatients to ensure that the seating is fit for purpose
- Review the existing arrangements with regards to the management of referrals in to the organisation in order that the backlog of patients on an 18 week pathway are seen in accordance with national standards.
- Develop a robust system to ensure children and young people who present with mental health needs are suitably risk assessed when admitted to the department to ensure care and support provided meets their needs.
- Ensure all medicines are prescribed and stored in accordance with trust procedures.
- Ensure there are effective systems in place for the ongoing management of outlying patients.
- Ensure that the risk matrix in MAU is completed to the frequency required by the trust policy.
- Review consultant cover in the ED in line with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum
- Ensure there are the appropriate number of qualified paediatric staff in the ED to meet national guidelines.
- Respond to complaints within agreed timeframes and summary data and meeting minutes should be explicit as to which location the complaint relates to and where performance times need to be improved.

In addition the trust should:

- Ensure that staff in critical care are supported with training and guidance to investigate and report upon serious incidents.
- Ensure that adherence to the Duty of Candour regulation should be recorded in incident reports in line with requirements.

Summary of findings

- Record mortality and morbidity reviews in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust.
- Ensure trolleys for resuscitation equipment in critical care are secured in such a way to highlight to staff if they had been opened, used or tampered with between daily checks.
- Review and risk-assess the provision of the critical care Outreach team service which was not being provided for 24 hours a day.
- Review the cover and continuity of presence from specialist registrar doctors in the CCU to ensure this meets recommended safe levels at all times.
- Review the provision of care for CCU patients as this currently does not meet the National Institute for Health and Care Excellence (NICE) guidance 83 in relation to some parts of patient rehabilitation, including discharge advice and guidance and follow-up clinics.
- Review the role of the clinical nurse educator in the CCU to ensure adequate time and resources are given to this essential post in line with best practice and FICM Core Standards.
- Ensure patient notes in CCU have clear records of assessments and best interest decisions for patients who lack the mental capacity to make their own decisions.
- Revisit the use of patient diaries in order to use them more creatively to the benefit of patients and their loved ones.
- Review CCU access to a Regional Home Ventilation and weaning service in line with the Faculty of Intensive Care Medicine Core Standards.
- Ensure leaflets and information they provide contain the most up-to-date information for people to contact services. Information about getting leaflets in other formats should be included in all printed literature.
- Review the use of care plans in Critical Care for patients living with a dementia in line with national guidance and best practice.
- Ensure critical care strategies and future plans are part of the overarching vision of the division in which it sat.
- Ensure that the critical care team are represented in all clinical governance meetings.
- Ensure high-level risks on the local risk register in the CCU are incorporated into the corporate risk register and have board oversight.
- Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology service.
- Ensure staff at ward level have access to information and agreed outcomes from governance meetings to continually improve their practice.
- Evaluate the effectiveness of the Patient Flow service to ensure it meets patient needs and improves access and flow of services.
- Review the management of medical outliers and devise a trust wide policy to improve their management.
- Develop an action plan to improve NNAP compliance.
- Ensure staff are aware of the trust's strategy and vision for the future.
- Improve the visibility of all senior staff in all of the areas of the maternity and gynaecology service.
- Ensure all staff in the maternity and gynaecology service understand their role and responsibilities regarding the Deprivation of Liberty Safeguards.
- Ensure cardiotocogragh (CTG) documentation is clear, in order to be assured that staff are following current local and national guidance.
- Review the system in the triage area on the delivery suite to develop a pathway to prioritise women attending by clinical need.
- Ensure that women are assessed in the emergency department before being transferred to the gynaecology ward.
- Ensure that antenatal screening KPI data can be reported.
- Develop a policy on restraint and / or supportive holding and provide training for staff to ensure they understand how to apply the policy.
- Consider developing/ adopting an early warning tool for neonates.

Summary of findings

- Ensure that staffing records relating to medical staff accurately record who has worked each shift and that sickness absence is accurately recorded in order to monitor the shortfalls in shift and take necessary action to fill shifts to the required number.
- Approve the audit plan for children and young people and ensure audits completed in line with the plan with regular updates on audits outstanding with revised completion dates.
- Ensure that pain assessments for children are consistently completed.
- Review the dashboard for children and young people and update it to include all pertinent information.
- Develop a 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.
- Make available a communication tool for children who are unable to explain their needs and may require assistance from picture books for example.
- 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.
- Implement a risk register for end of life care services in order to ensure that risk is adequately assessed and monitored.
- Resolve the issues relating to the faulty refrigerated storage units and inadequate water system in the mortuary.
- Develop an end of life strategy with well–defined objectives that are aligned to the 'five priorities for care of the dying person' as recommended by the Leadership Alliance (2014).
- Routinely audit the numbers of patients who achieve their preferred place of dying.

- Ensure all patients can reach their call bell, to facilitate alerting staff for help if needed.
- Ensure the ED door for entrance of patients brought in by ambulance is used appropriately.
- Ensure the child protection register is stored safely and securely to prevent theft, damage or misuse.
- Ensure that there is a systematic screening to identify patients with alcohol misuse to facilitate all patients who attend the ED for alcohol consumption receiving a brief intervention and signposting.
- Ensure all nursing and medical vacancies are recruited to.
- Ensure all appropriate patients have a drink within their reach.
- Continue to liaise with other organisations to improve the mental health service provisions.
- Ensure patients receive care and treatment in a timely way to enable the trust to consistently meet key national performance standards for E.Ds.
- Continue to engage with local organisations to improve patient flow to ensure that patient waiting for hospital beds in ED can be transferred in a timely manner to prevent breaches.
- Reduce the speciality referral time to less than 60 minutes to meet the trust target.
- Ensure that the whiteboard behind the reception in ED that displayed the waiting time is regularly updated to keep patients informed.
- Ensure delays in ambulance handover times are reduced to meet the trust target of 80% of patients admitted via an ambulance having handovers carried out within 15 minutes and 95% of patient handovers being carried out within 30 minutes of arrival by ambulance.
- Ensure the vision of the ED is understood by all staff.
- Ensure effective governance and performance management of ED to make significant improvements in the quality measures.
- Ensure audit action plans are always in place and provide assurance, evidence or progress updates to show how improvements had been achieved.
- Ensure all senior staff are visible enough for staff to recognise them and feel supported.
- Ensure the changes to manage overcrowding and patient safety in ED are sustainable.

Summary of findings

- Review the audit process relating to the management of FP10 prescription pads to ensure that there is a robust audit trail for all pads used within the organisation.
- Ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.
- Ensure all temporary staff have an effective ward induction.
- Ensure that any chemicals are stored appropriately, and 'out of bounds' areas are appropriately secured.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Patients did not always receive timely care and treatment. The ED was consistently failing to meet the national treatment standards. Patients arriving by ambulance waited too long to be handed over to ED staff. The trust failed to meet its aim of speciality referral time being less than 60 minutes between December 2014 and June 2015.Overcrowding in the ED was an on-going risk. 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. The vision of the service was not yet well developed, however, the consistent objective was regarding admission avoidance and improved patient flow. The sustainability of service improvement changes since our unannounced inspection in March 2015 remained a challenge. We were not assured that the changes were fully embedded and that the ED could successfully manage patient demand during times of surges.Although quality measures were monitored, effective governance and performance management was not yet well enough established to make significant improvements. Action plans in response to audits were not always in place or did not consistently provide assurance, evidence or progress updates to show how improvements had been achieved. Staff told us that they were encouraged to complete incident reports via the electronic reporting system. In the main, lessons learnt and actions taken as a result of incidents were shared with staff. However the actions taken and lessons learnt as a result of incidents that caused patient harm, were not clear on the incident report spread sheet provided by the trust. Most staff spoke positively about the interim chief executive officer, staff felt able to raise concerns to him and felt the trust was moving in the right direction. Staff felt that the matron was visible but during surges in activity the divisional management team were rarely present and this made them feel that they were not fully supported. The ED was tidy and visibly clean and staff followed the trusts infection control policy. There was enough stocked

Summary of findings

equipment that was clean, serviced and in date. The hospital had appropriate systems in place regarding the safe handling and administration of medicines. The pharmacy department operate an innovative seven day clinical service in the ED which had shown patient benefits. Compliance with mandatory training was not always upheld and a significant number of staff had not received all mandatory training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide safe care and treatment. Consultant cover did not meet with the College of Emergency Medicine's (CEMs) emergency medicine consultants' workforce recommendations. There was one consultant on site after 5pm covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This meant there was a risk of patients receiving suboptimal care and treatment due to lack of senior leadership if two trauma patients were admitted at the same time on each site. Care and treatment was delivered in line with current evidence based guidance and best practice and there was a clinical audit plan for 2015/16. In the main, patient outcomes were better than the national average. Patients were treated with compassion, dignity and respect. All of the patients we spoke with told us that they were happy with the care provided by staff. The trust used the Friends and Family Test to capture patient feedback. 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%.

Medical care **Requires improvement**

Medical staffing was in line was national guidance but was a significant concern for staff; both in terms of effective recruitment at consultant level, and also for out of hours and weekend medical cover provided. Doctors felt overstretched and said the level of medical cover in the evenings and weekends was not sufficient. There were reported delays to the timeliness of medical assessments at times of high demand but there were no reported incidents reported where patients' care and treatment had been affected. There was not an

Summary of findings

effective system in place for medical handovers and these did not occur in the mornings. The service had not yet implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) in line with national guidance. Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people.
Appropriate systems were in not always in place for the storage, administration and recording of medicines. The environment was generally well maintained but some potential risks to patient safety had not been addressed such as safe storage of chemicals. All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance but there was not an effective quality and safety dashboard in place specific to the medical care service.
Not all staff had had the mandatory training required, including safeguarding children's training and resuscitation training.Medical care wards were found to be generally clean and well maintained. There were generally low rates of infections.
Nursing staffing levels met patient needs at the time of our inspection but there were not always effective systems in place for agency staff inductions. Performance boards across the wards were seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Regular audits were being carried out on the main risk areas. Wards generally had effective systems in place to minimise the risk of infections. Records were generally well maintained. People did not always have good outcomes as they did not always receive effective care and treatment that met their needs. Mortality ratios were higher than those of similar trusts. Performance and outcomes did not meet trust targets in some areas. There was little evidence of progress to providing seven day a week services.
Most staff said they were supported effectively, but there were no opportunities for regular formal supervisions with managers. Care planning effectiveness was variable, and care plans were not generally person-centred. Care plans for people

Summary of findings

living with a dementia were not always effective as they did not provide sufficient details for staff to follow to meet patients' needs. Care was mostly 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. Pain relief, nutrition and hydration needs were assessed appropriately and patients stated that they were not left in pain. Multidisciplinary team working was effective. We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was generally good. People were supported, treated with dignity and respect, and were involved as partners in their care. Overall, medical inpatient 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 not consistently met through the way services were organised and delivered. Cancer referral to treatment times were below the national average. Medical patients in outlying wards were not always effectively managed. Some problems with the effective discharge of people were highlighted across the medical care service, from both staff and some of the patients we spoke to. The hospital was looking at plans to reduce the impact of patients with a delayed discharge but there was variable engagement from clinicians in this initiative. Concerns and complaints procedures were established and generally effective. Information was available for patients regarding how to make a complaint.

Summary of findings

The leadership, governance and culture did not promote the delivery of high quality person-centred care. Known concerns had not always been responded to and acted upon. The visibility and relationship with the management board was not clear for junior staff, not all of whom had been made aware of the trust's vision and strategy. The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, but there was not always effective leadership from senior managers. 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, and said work pressures, due to higher patient dependencies, was an area of concern. Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in improvements to the service and did not receive feedback from patient safety incidents. Some staff felt isolated. All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders were not visible.

Surgery **Requires improvement**

Risk assessments especially for risk of pressure ulcers were not always completed and used effectively to protect patients from harm.
An interim plan was in place for some patients requiring emergency surgery to be assessed at the Alexandra Hospital and transferred to Worcester Royal Hospital to have their operation. There was a lack of responsiveness to audit results, for example, the National Emergency Laparotomy Audit.
Approved countywide plans to improve patient outcomes requiring emergency surgery had not been fully implemented despite concerns raised by medical staff.
Information about effectiveness of care was reviewed at senior management level but was not always shared at all levels of the organization to improve care and treatment and people's outcomes.
Medical staff did not work effectively with the internal multidisciplinary team to ensure medical outliers (medical patients cared for on surgical wards) were assessed and treated in a timely manner.

Summary of findings

Referral to treatment time performance was below both the national standard and the England average for admitted patients between April 2013 and February 2015, in every service except ophthalmology.
Compliance with mandatory training for staff was below the trusts targets as were completion of appraisals. Patients told us they received a slow or unsatisfactory response to concerns raised. The trust performance data regarding complaints showed that 20% of the time the service did not respond to patients' formal complaints within 25 days in accordance with the trusts complaints policy.A consistent approach to governance and risk management within all surgical specialties had been established. However, information and actions from governance meetings had yet to be cascaded to ward level.

Critical care

Good 

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An interim plan was in place for some patients requiring emergency surgery to be assessed at the Alexandra Hospital and transferred to Worcester Royal Hospital to have their operation. There was a lack of responsiveness to audit results, for example, the National Emergency Laparotomy Audit.
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Summary of findings

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Maternity and gynaecology — **Inadequate** 

We found that the service routinely reported never events and safety incidents. However, we found that risks that had been identified were not being reviewed and managed appropriately. The service had a large number of outstanding incidents that had not been closed. This meant that these incidents may not have been fully considered and any actions or learning from them implemented. The department's strategy was not known by staff and the vision for maternity services was inconsistent and lacked clarity. Women and their families knew how to make a complaint, however the service did not always respond within agreed timeframes. The service informed people how to make a complaint but was not achieving targets with complaint responses. Medicines were not stored in safe environments. Caesarean section rates were above national averages and normal birth rates were below. 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.There was a less middle grade doctors employed by the trust than were needed to safely cover the medical rota. This meant there was an overreliance on locum doctors and consultant obstetricians 'acting down' to maintain a safe staffing levels, which was not sustainable. Women and patient's pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding. Women and patients were overwhelmingly positive about the care they had received. Staff were kind

and thoughtful. Women and their partners felt involved with their care and were satisfied with explanations that were given to them. Outstanding practice was noted with staff having thought about the caring needs of women and devising innovative solutions to support them. This was demonstrated by staff facilitating a teenage buddying system and developing bereavement care pathway for women who suffer pregnancy losses at any gestation. The patient experience midwife was available support women who were anxious or fearful about pregnancy and childbirth Services were arranged to meet people's individual needs, with specialist support staff for people with complex conditions.

Services for children and young people	**Inadequate** 	Care provided to patients was not always safe because incidents were not always reported and investigated promptly and lessons were not always learned. Patient records contained good detail although they were not always updated in a timely basis and some records were not securely stored, including safeguarding records. Some equipment had not been locked away securely, including sharp objects.There were predetermined staffing levels for each shift which had been set by the trust as a minimum. Review of the rotas and staffing audits confirmed that minimum staffing levels were not always met.Compliance with completion of mandatory training for nursing and medical staff did not meet the trust's target. Some important policies had not been developed, for example there was no policy on the use of restraint and staff were unsure of the correct protocol to follow. 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 weak 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.
End of life care	**Good** 	Staff at the hospital provided very compassionate care to patients leading up to the time of their death. Ward staff spoke highly of the care offered by

the palliative care, mortuary, chaplaincy and bereavement teams. Medicines were appropriately managed and equipment for end of life care was available and well maintained. The results of the 2013/14 National Care of the Dying Audit of Hospitals (NCDAH) highlighted a small number of areas for improvement. The hospital had since made some progress on the implementation of the action plan. Patients received good information regarding their treatment and care. The service took account of individual needs and wishes and their cultural and spiritual needs. The bereavement support staff provided good support to relatives after the death of a patient. The specialist palliative care team supported the provision of rapid discharge and rates of discharge within 24 hours were in line with the England average. Relatives were being invited to share their experience to learn and improve the delivery of end of life care.
There was good use of auditing to identify and improve patient outcomes and we saw measures in place to monitor key areas that had been identified. However, they were not routinely undertaking patients' preferred place of care/death audits. The trust did not have a risk register for end of life care services.
The trust did not have a current strategy for end of life care services; however, they participated in regional and locality groups in relation to strategic planning and implementation. There was an established governance system to monitor risk and quality and we found consistent leadership relating to end of life.

Outpatients and diagnostic imaging

Requires improvement

Improvements were required in both outpatients and diagnostic services to ensure that patients received safe, effective and responsive care which was well-led. Patients could expect to receive care which was compassionate as well as being emotionally supported. The premises were visibly clean however the environment was cramped and the seating arrangements were not sufficiently appropriate especially for patients attending the trauma and orthopaedic clinic following surgery to their lower limbs. Whilst staff were aware of their roles and responsibilities with regards to reporting patient safety incidents, the frequency with which

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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 poor with some patients raising concerns that communication from nursing staff was poor. Further, 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.

Worcestershire Royal Hospital

Detailed findings

Services we looked at

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

Detailed findings

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Background to Worcestershire Royal Hospital

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. Worcestershire has a greater number of older people than the rest of England; around 19 per cent of the population is aged over 65 compared to 16 per cent nationally and the number is expected to increase by 30,000 over the next 20 years. A quarter of the county's adults are obese and 40 per cent are overweight and while 60 per cent of the population live in the urban centres around Worcestershire, Kidderminster and Redditch the remaining 40 per cent is spread across the largely rural county covering 650 square miles. Worcestershire Royal Hospital is part of Worcestershire Acute Hospitals NHS Trust. The main hospital was built under the private finance initiative (PFI) and opened in 2002. It provides specialist services for the whole of Worcestershire including stroke services and cardiac stenting. The state-of-the-art Worcestershire Oncology Centre opened in January 2015, providing radiotherapy services for cancer patients, the first time these services have been available in the county. The hospital has a cardiac catheterisation laboratory. The 24/7 Primary Percutaneous Coronary Intervention (PPCI) service began in October 2013. It has 500 beds and serves a population of more than 550,000

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 CommissionThe 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.

Detailed findings

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, 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 also undertook unannounced inspections at Worcestershire Royal Hospital on 26, 27 and 30 July, 2015 and at Alexandra Hospital Redditch on 26 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:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

Worcestershire Royal Hospital was built under the private finance initiative (PFI) and opened in 2002. It serves a population of approximately 550,000 and has 500 beds. The emergency department (ED) at Worcestershire Royal Hospital provides a 24-hour, seven-day a week service. It saw 57,266 adults and 11,942 children up to 16 years old, between 1 April 2014 and 31 March 2015. Activity has increased by 6% on the previous year. Patients present to the department either by walking into the reception area or arriving by ambulance. If a patient arrives in the department on foot, they are seen after booking in at reception by a senior nurse who triages them to the appropriate area. If a patient arrives by ambulance, they are transferred to the main ED. The department itself consists of four main areas: 'paediatrics' with two cubicles and one seat, 'majors' with 12 bays, 'minors' with six seated spaces, and a four bedded resuscitation room. There is a separate triage area attached to the front reception and an eight bedded preadmission area.We spoke with over 35 members of staff including: nurses; doctors; administrators; pharmacists and senior managers. We spoke with 14 patients and 8 relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's ED performance data.Urgent and emergency services provided by this trust were located on three hospital sites, the others being Alexandra Hospital and Kidderminster Hospital and Treatment Centre. Services at the other sites are included in separate reports. Services on all hospital sites were run by one urgent and emergency services management team.As such they were regarded within and reported upon by the trust as one service, with some staff working at all sites. For this reason it is inevitable there is some duplication contained in the three reports.

Urgent and emergency services

Summary of findings

Overall, we rated the service as requiring improvement. It was rated inadequate for safety and as requiring improvement for responsiveness and being well-led. We rated the service as good for caring and effectiveness

Patients did not always receive timely care and treatment. The ED was consistently failing to meet the national treatment standards. Patients arriving by ambulance waited too long to be handed over to ED staff, between January and August 2015 an average of 34% of patients received an ambulance handover within 15 minutes, worse than the target of 80%. The trust failed to meet its aim of speciality referral time being less than 60 minutes between December 2014 and June 2015.Overcrowding in the ED was an on-going risk because of increasing demand. There was a trust-wide escalation policy which set out a range of triggers that helped the trust to mitigate risks associated with capacity and overcrowding.

The vision of the service was not yet well developed. The sustainability of service improvement changes since our unannounced inspection in March 2015 remained a challenge. We were not assured that the changes were fully embedded and that the ED could successfully manage patient demand during times of surges.

Although quality measures were monitored, effective governance and performance management was not yet well enough established to make significant improvements. Action plans in response to audits were not always in place or did not consistently provide assurance, evidence or progress updates to show how improvements had been achieved. Most staff spoke positively about the interim chief executive officer, staff felt able to raise concerns to him and felt the trust was moving in the right direction. Staff felt that the matron was visible but during surges in activity the divisional management team were rarely present and this made them feel that they were not fully supported.

The ED was tidy and visibly clean and staff followed the trust's infection control policy. There was enough stocked equipment that was clean, serviced and in date. The hospital had appropriate systems in place regarding the safe handling and administration of medicines. The pharmacy department operate an innovative seven day clinical service in the ED which had shown patient benefits.

Compliance with mandatory training was not always upheld and a significant number of staff had not received all mandatory training in the last 12 months. This placed patient safety at risk because there were not enough suitably skilled staff to provide safe care and treatment.

Consultant cover did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations. There was one consultant on site after 5pm covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This meant there was a risk of patients receiving suboptimal care and treatment due to lack of senior leadership if two trauma patients were admitted at the same time on each site.

Staff told us that they were encouraged to complete incident reports via the electronic reporting system. In the main, lessons learnt and actions taken as a result of incidents were shared with staff.

Care and treatment was delivered in line with current evidence based guidance and best practice and there was a clinical audit plan for 2015/16. In the main, patient outcomes were better than the national average.Patients were treated with compassion, dignity and respect. All of the patients we spoke with told us that they were happy with the care provided by staff. 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%.

Urgent and emergency services

Are urgent and emergency services safe?

Inadequate

Overall, we rated the service as inadequate for safety.

Consultant cover did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations. There was one consultant on site after 5pm covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This meant there was a risk of patients receiving suboptimal care and treatment due to lack of senior leadership if two trauma patients were admitted at the same time on each site.

There had been 6658 (22% of patients) 15 minute time from arrival to initial assessments breaches between January and June 2015. During April 2015, some patients were waiting up to 200 minutes for initial assessment, with a maximum wait of 340 minutes. In June 2015, the maximum wait was 68 minutes. This demonstrated that actions taken to improve access and flow through the ED and the hospital had reduced the time patients waited for initial assessment. Although they still did not meet RCEM guidance, waiting times had reduced since our unannounced inspection in March 2015There were delays in handover time from ambulance crew to the ED team. The hospital had not met the target of 80% of patients admitted via an ambulance having handovers carried out within 15 minutes since June 2014. The average hospital handover time between 1 April and 12 July 2015 was 30 minutes. Only 3.4% of nursing staff were paediatric trained. This meant that there was a risk that children who attended the department were not cared for by staff that had undergone training into their specific health needs. This did not meet the standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing. Mandatory training was not completed in line with the trust target of 95% and a significant number of staff had not received all mandatory training in the last 12 months. Medical staff had a 64% overall compliance rate. Resuscitation training was 70%. This placed patients at risk because staff may not be suitably skilled to provide safe care and treatment.

The pharmacy department operate an innovative seven day clinical service in the ED which had shown patient benefits.

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 had been an increase in incident reporting since our unannounced inspection in March 2015.
- Since March 2015 staff told us that they had started incident reporting all episodes of overcrowding. There had been a further 24 patient safety incidents categorised as resulting in patient harm between 1 April and 6 September 2015. These were due to overcrowding in the ED and the pre admission area (PAA), which resulted in poor patient flow and delays in treatment. For example, mixed sex bays in the PAA with no room between trolleys to safely move around bed spaces and give care to patients; 29 patients waiting for admission in the ED; and ambulance service cohorting patients on corridor for over one hour. This meant that the ED could not always provide timely, safe care and treatment to patients during surges in activity.
- There was a dedicated clinical governance lead who investigated all critical incidents. A thematic analysis was sent out after investigations via a newsletter to staff.
- Examples of incidents were displayed in the staff room, such as a recent medication error. Lessons learnt and actions taken as a result of the incident were also displayed.
- Patient safety incidents were discussed at the emergency medicine cross county meeting, including serious incidents, NHS England new guidance and safeguarding issues.
- There have been no "never events" reported in urgent and emergency services between January 2014 and December 2014. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The morbidity and mortality meeting formed part of the ED cross county and senior department meetings. However, we could not find within the January,

February and April 2015 meetings minutes where morbidity and mortality had been discussed. The trust did not provide us with minutes for the March 2015 meeting.
- 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

- The ED was tidy and visibly clean. Cleaning was in progress throughout our visits.
- In the CQCs 2014 ED survey 8.7 out of 10 patients described the EDs (trust wide) as clean.
- We observed staff followed the trust's infection control policy. Staff were 'bare below the elbow', used sanitising hand gel between patients and used personal protect equipment.
- The department cleanliness handover folder held checklists of when equipment such as blood glucose monitoring machines, had been cleaned. A cleanliness handover should have taken place between the three daily nursing shifts (early, late and night). However, we found that 22 out of 45 (49%) times from 1 July until 15 July this had failed to happen between shifts.
- There were an assessment/treatment room in majors where infected patients could be isolated and barrier-nursed to prevent the spread of infection.
- The clinical waste storage room was open despite having a lock on the door. This presented a risk that patients and visitors could have access to this room as staff were not always present.

Environment and equipment

- The hospital did not provide a section 136 suite. The county policy was that all patients were assessed in the section 136 suite in the Elgar unit, on the WRH site which was provided by Worcestershire Health and Care NHS Trust. If the medical triage at time of detention by the police determined that there was a physical condition that a patient required treatment for, then the patient was transported to ED. Then once physically stable patients were transferred to the Elgar unit for a mental health assessment.
- There was a room in ED where patients with mental health problems who have self-presented or brought in by ambulance without police detention could be safely treated. It had two exits to promote the safety of staff to ensure that they always had an exit route from the room.
- We inspected two resuscitation trolleys and saw that they were centrally located, clean, and defibrillators had been serviced. Daily checks were documented and also handed over to the nurse in charge.
- The paediatric resuscitation trolley and resuscitaire had documented daily checks and were fit for purpose.
- The airway management trolley in the resuscitation room also had daily checks documented and was fit for purpose.
- ED assistant posts had been recruited to since our unannounced inspection in March 2015. Part of their role was to ensure that there was enough equipment in stock and that it was serviced and in date.
- 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 the equipment was cleaned.
- We found equipment was serviced and where required had received a portable appliance test (PAT).
- The eye room door was open despite having a lock on it. There was equipment and medication such as solution administration packs that were not securely stored to prevent theft, damage or misuse.
- Sixteen out of 23 patients (70%) we audited across two days could reach their call bell. This meant that not all patients could alert staff for help if needed.
- Security arrangements were adequate. In the CQCs 2014 ED survey, 9.9 out of 10 patients said they did not feel threatened in the ED.
- The ED door for entrance of patients brought in by ambulance was used as a shortcut into the hospital by other staff despite a notice on the door clearly stating that this was prohibited. During a five minute observation, three doctors and administration staff used

the entrance as a shortcut. We challenged one radiologist who said that they were too busy to stop and needed to use the entrance to gain access into their department.
- One ED administration support assistant had no trust badge visible on them to help visitors and staff establish their identity.

Medicines

- The hospital had appropriate systems in place regarding the safe handling and administration of medicines.
- However, oxygen cylinders were in the corridor and not securely stored to prevent theft, damage or misuse.
- In the open eye room there was medication, such as eye ointment and intravenous sodium chloride that were not securely stored prevent theft, damage or misuse. We reported this to a sister who told us that they could not find the keys to the room to lock it, as it was never locked but understood the risks of having medication in the room. They assured us that they would report this and relocate the medication to ensure it was securely stored.
- The nurse in charge kept the controlled drugs cupboard keys.
- The register for the controlled drugs were completed at the beginning and end of each nursing shift, and tallied with the actual medications in the controlled drug (prescription medicines that are controlled under the Misuse of Drugs legislation such as morphine) cupboard. Staff told us that if there were any discrepancies these were reported and there was an escalation policy to follow.
- The pharmacist also checked the controlled drugs on weekdays.
- Patients own medication was recorded in a book and stored securely to ensure these were monitored.
- The pharmacist worked as part of the ED team. The ED team inform the pharmacist about any medicine issues and patients who should be seen as a priority. We observed the pharmacist counselling patients about their medicines, taking a drug history and confirming that the patient had the correct list of medicines prescribed. In the first six months of the clinical pharmacy service it led to a reduction in some direct admissions to hospital. Between April and June 2015 missed doses had reduced from 376 to 312, take out medication which was completed in 14 minutes or less had increased from 104 to 109 patients as a result of reducing direct hospital admissions; and 90% of patients were counselled regarding their medication.
- The trust had developed prescription charts for medicines that require extra checks and monitoring, for example, oral anticoagulants and insulin. The insulin prescription chart had won an award in 2014 by the Safe Insulin Prescribing Group on behalf of the Joint British Diabetes Societies. A double checking system ensured that the correct monitoring had been completed before patients were given the prescribed dose. These charts were detailed and provided extra information to support staff on ensuring patients were safe from harm.
- Medicine incidents were recorded onto a dedicated electronic recording system. A nurse we spoke with explained that all medicine incidents were recorded. In particular these were used to help train junior nurses.
- The pharmacist told us that if they identified any medication errors or missed doses they spoke immediately with the staff member in charge of the patients care. They commented this had been culture change for staff but now feedback was received positively.
- We saw staff check with patients if they had any allergies to medication before administering pain relief in triage.

Records

- The white board in the department that recorded patient names to track their location was kept up to date; this was the responsibility of the ED administration support assistants. This meant that there was oversight for the whole department, allowing the charge nurses and doctors to reliably identify where all patients were, at any given time.
- The department 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.
- All healthcare professionals used the medical notes to record patient care. Medical notes and care plans were up to date.
- We looked at 15 patient records. All records included the time a patient arrived in the department and when they received their initial assessment. Initial observations were recorded, including the SSKIN care bundle which assessed risk of pressure damage.

- We witnessed a nurse take a phone call and politely refuse to discuss confidential information with the caller.

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, the registrar or consultant would assess the child rather than a junior doctor.
- However, the child protection register was not stored safely and securely to prevent theft, damage or misuse. We reported this to a registered nurse who locked it away.
- The ED provided a waiting room for paediatric patients in a room opposite triage. There was an alarm to alert help if required.
- There were three cubicles for children requiring treatment. These were in the majors section of the department. There was a swipe card access into each paediatric treatment room. This meant that the treatment rooms were secure to protect children from harm.
- All medical and nursing staff had received children's level one safeguarding training. Twenty seven (7) per cent of medics and 47% (46) of nursing staff had received level two children's safeguarding training; and 31% (8) of medics and 5% (5) of nursing had received level three training. This did not meet the trust target of 95%.Seventy-six per cent of medical staff and 81% 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 not always upheld and a significant number of staff had not received all mandatory training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide safe care and treatment.
- Medical staff had an average 70% compliance rate with resuscitation training. There was an 82% compliance with advanced paediatric life support training, 56% compliance with paediatric intensive life support, but none of the medical staff had received training in newborn life support. Nurses had a 3.4% compliance rate with child branch training and a 56% compliance rate with paediatric intensive life support training. This meant that a significant number of staff had not received any life support training in the last 12 months. This placed patients at risk because there were not enough suitably skilled staff to provide care if they needed life support.
- Medical staff had a 64% overall compliance rate. 57% of medical staff had received mental health training, 44% information governance training, 61% fire training and 61% infection control training.
- Nursing staff had a 90% overall compliance rate. Only 81% of nursing staff had completed information governance training and 86% fire training. This did not meet trust target of 95% compliance. Reception staff had a 96% compliance overall, with all required areas having at least a 94% compliance rate.
- Medical and administrative staff had received conflict resolution training which did include an element of breakaway training. 65% of nursing staff had received conflict resolution training. Most staff we spoke with felt they were able to manage patients who became aggressive and violent.

Assessing and responding to patient risk

- Overcrowding in the ED was an on-going risk. However, during our inspection we did not witness overcrowding of the department. Staff told us that the introduction of the pre-admissions area (PAA) had reduced overcrowding in the ED but that during times of surges in activity overcrowding was still a risk.
- There was a trust-wide escalation policy which set out a range of triggers that helped the trust to mitigate risks associated with capacity and overcrowding. Staff had become familiar with escalating risks to the executive team and were open to asking for support.
- Within this policy, the ED did not have a separate escalation plan but sat within the acute plan. This

meant that is was not always clear at a glance how the escalation plan was to be implemented in ED. The West Midlands Ambulance Service had a clear separate escalation plan for bringing patients to the trust. A series of triggers and subsequent actions were outlined to manage key risks related to patient safety; ensuring an effective workforce; and achieving performance targets.

- Trigger factors included the number of patients in the department, the space available in majors and resuscitation, delays in ambulances handover and triage times. The nurse coordinator in the ED was responsible for reviewing the status of the department.
- There were a series of action cards for medical and nursing staff to follow in the event of escalation. Actions included reallocating staff, diverting patients to other EDs and liaising with the patient flow centre regarding patient pathways.
- Staff told us that they had recently implemented a system where during times of surges in activity, a bleep would go out to all nurses in charge of wards to redeploy a registered nurse to ED. They told us that this had worked well since it had been implemented, although we did not see this in action.
- There was one dedicated triage nurse who assessed all the self-presenting patients. Nursing staff told us that in times of surges in activity, another nurse from ED would be redeployed to triage patients.
- Guidance issued by the RCEM (triage position statement dated April 2011) states 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.
- During April 2015, some patients were waiting up to 200 minutes for initial assessment, with a maximum wait of 340 minutes. In June 2015, the maximum wait was 68 minutes. This demonstrated that the actions taken to improve access and flow through the ED and the hospital had reduced the time patients waited for initial assessment.
- The average time from arrival to initial assessments performance against the 15 minute standard ranged from 22 to 37 minutes between April and June 2015. There had been 6658 (22% of patients) 15 minute breaches between January and June 2015.
- After our unannounced inspection in March 2015, all patients who were not assessed within 15 minutes of arrival were assessed to ascertain if this delay in care had caused them any harm. This was initially by retrospective case review; however from April 2015 the trust began use the Global Trigger Harm Tool, which is a nationally recognised tool which uses reviewers to conduct retrospective reviews of patient records using triggers to identify possible adverse events. This tool was also used to identify any themes of substandard care, and in June 2015 these themes were compared to the care received by patients who were assessed within the 15 minutes and the themes compared. Of the 10 patients sampled who did not received an assessment within 15 minutes, no harm was detected, however documentation errors were identified in both groups, and these themes were captured on the patient care improvement plan (PCIP) in order for plans to be put in place to make and monitor improvements in care.
- The PCIP demonstrated that a triage training package had been completed by all ED nurses to re-energise focus on the 15 minute time to initial assessment.
- This demonstrated that although the trust was not able to assess all patients within 15 minutes, they had a process in place to assess and respond to risk of harm, and to review and improve care.
- Clinical risk assessments and care plans were completed and followed for each patient. These included assessments for pressure damage and the potential for patients to deteriorate.
- We reviewed 15 patient notes and saw assessments for pressure area care were assessed within 30 minutes of arrival using the SSKIN care bundle (a tool used to prevent pressure damage). If patients stayed in the ED for four hours or longer, we saw they were assessed using the Waterlow Score (a nationally recognised practice tool to identify pressure damage). Trolleys had a level of pressure relieving mattresses and patients who were at high risk of developing pressure damage were transferred to beds.
- 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 actions would be followed by staff.

- There was no formal process to rapidly assess and treat patients by a senior doctor, as there was insufficient consultant numbers to consistently complete this. We found that this was completed informally and inconsistently by certain doctors.
- Patients who had allergies were given a red wrist band to wear to highlight the potential risk to staff. Patients at risk of falls were given a green wrist band to highlight the falls risk.
- There was no systematic screening to identify patients who misused alcohol. The team feared that not all patients who needed the alcohol misuse service were always referred. The last alcohol liaison nurse service evaluation was conducted in 2013. It recommended that the trust considered using the Audit C screening questionnaire (a three question screen that can help identify people who misused alcohol) however; this pilot was still in the planning phase. The screening could facilitate all patients who attend the ED for alcohol consumption receiving a brief intervention and signposting.
- Staff told us that they had a good working relationship with the critical care team and they were able to escalate patients promptly who needed higher dependency facilities.
- A mental health liaison nurse was available seven days a week between 8am and 10pm. There was consultant telephone cover out of hours. Some doctors and nurses had concerns that did not meet service demand. Out of hours cover was available if a patient needed to be sectioned; otherwise patients were kept in ED overnight and seen by the mental health team the following day. This had been categorised as a high risk on the risk register since February 2014. Incidents and breach occurrences were escalated to the clinical commissioning group (CCG), via monthly reports. There had been 133 breaches between 1 April to 13 October 2015, 56% of which occurred between out of hours (10pm and 8am).
- The trust had been liaising with the CCG to expand the mental health provisions. 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.
- 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.

There was a risk matrix to use for patients with mental health concerns. It helped staff to decide if a patient needed to be sectioned or if they were safe to be discharged.

Ambulance Handovers

- The local ambulance service trust had a policy for managing patients in the ED whilst awaiting formal handover to the hospital's ED staff. These patients remained under the care of the ambulance trust until formal handovers had been completed. The local ambulance trust also provided a senior paramedic who monitored the number of patients awaiting handover and liaised with the trusts ED staff regarding handovers and patient flow.
- The trust and the local ambulance service had a written agreement that when the ED was 'in extremis' (extremely difficult situation or circumstances that cannot be managed by extreme escalation), that the ambulance service would supply their own staff to look after any extra patients. The agreement included protocols to ensure that ambulance staff would look after patients who were at lower risk, for example, had not received morphine or had observations that demonstrated that the patient was clinically stable.
- Every two hours the safety matrix was completed by the ED teams to monitor the safety of the department. The trust were unable to provide information on the frequency of cohorting when the ED was 'in extremis'.
- The ambulance crew alerted ED staff prior to patient arrival if the resuscitation room was required.
- Ambulance crew and ED staff told us that they felt handover times had improved since our unannounced inspection and now were usually within ten minutes. However, there were delays in handover time from

ambulance crew to the ED team (see below). This meant that patients remained under the care of the ambulance crew longer than expected which delayed initiation of treatment.

- The board meeting minutes for July 2015 showed that the trust's EDs performance metrics overview report had not met the trust target of 80% of patients admitted via an ambulance having handovers carried out within 15 minutes since June 2014. Between January and August 2015 an average of 34% of patients received an ambulance handover within 15 minutes.
- The hospital had not met its target of having 95% of patient handovers being carried out within 30 minutes of arrival by ambulance since June 2014. Between January and August 2015 an average of 84% of patients received an ambulance handover within 30 minutes.
- The average hospital handover time between 1 April and 12 July 2015 was 30 minutes. Data showed 1% (104/83701) of patients waited over one hour to be handed over to ED staff; and 5% (455/83701) of patients waited 45 to 60 minutes.
- The ambulance service provided evidence showing between the 1 July and 16 July 2015 the trust had been fined 130 times for 30 to 60 minute delays and fined ten times for delays over 60 minutes. In total this cost £36,000. Between 1 April and 16 July 2015 the hospital had been fined 843 times.
- The trust had commissioned an internal audit which claimed that the information provided by the ambulance service did not accurately measure handover times. The conclusion of the audit was that reported breaches were overstated and an improvement plan was in place to improve data collection.

Nursing staffing

- The current ED workforce plan was endorsed by trust board in October 2014. Staffing levels were calculated using the Royal College of Nursing's BEST tool to calculate safe staffing requirements for emergency departments. The ED was following the BEST recommendation headcount with a mixture of staff at different bands in dedicated roles. This staffing model was reviewed and supported by the TDA workforce lead in May 2015. During our inspection there were enough nurses on shift to meet patients' needs.
- However, only 3.4% of nursing staff were paediatric trained. This meant there was a risk that children who attended the department were not cared for by staff that had undergone training into their specific health needs. This did not meet the standards set by the Royal College of Paediatrics and Child Health 2012 or the Royal College of Nursing who recommend a minimum of one registered paediatric nurse to be present at all times, which was not possible in the ED due to the low numbers of staff trained. Guidance states that the ability to provide a registered paediatric nurse does not detract from the emergency care setting's responsibility to ensure that all staff had a minimum competence to care for children. Data for July 2015 showed that 94% of nursing staff had received paediatric immediate life support or European paediatric life support training; 94% of nursing staff had received training in assessing a sick child and the assessment tool, paediatric early warning score (PEWS); and 97% had received training in child pain management. Only 40% of nursing staff had attended the paediatric study session which covered anatomical differences between adults and children,common presentations and distraction techniques.
- There was a 6% vacancy rate for band 5 to 7 nurses. Nurses told us that the aim was to over recruit by 10% as agreed by the division, to reduce the number of agency staff covering shifts.
- There was an 18 % vacancy rate for health care assistants.
- There was a staff escalation plan for ED, to be used in times of altered staffing arrangements such as unplanned staff leave or high vacancy rates. There was a minimum standard staffing chart, for example the minimum staffing for a late shift was 12 registered nurses (with a minimum of two band 6s or 7s) and three health care assistants.
- The ED risk register highlighted since 2012 there was a lack of nursing staff and a recruitment programme was on-going.
- Between July 2014 and March 2015 the average qualified nurse agency cover was 5%. During our unannounced in July inspection four of the 11 qualified nurses were agency staff, all of whom regularly worked within the ED and had received an induction.

- There was a white board in the unit that clearly displayed what staff were on shift and when they were due to have a break.
- Workforce planning had resulted in the recruitment of three administration support assistants who supported the shift coordinator and ensured the tracking of patients throughout the unit was accurate on the electronic and white board system.
- A hospital ambulance liaison officer (HALO) was on shift 10am to 4pm each day. They cared for ambulance patients in times of surges in activity.
- Three registered nurses and one healthcare assistant staffed the PAA. If PAA was not able to be staffed to this level then staffing of the ED took priority and the staffing level on PAA would be reduced as would the number of patients for example, for two trained staff in PAA would care for up to 10 patients. Staff told us that they had not yet seen an impact of reduced staffing in PAA but potentially this could cause patient overcrowding in majors due to a reduced number of beds being available in PAA.

Medical staffing

- There were 5.0 whole time equivalent (WTE) consultants for the department, which met the trust's planned establishment. This did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in all EDs for 16 hours a day, 7 days a week as a minimum. The view of the RCEM is that such rotas require a minimum of 10 WTE consultants in every ED.
- Each consultant completed one weekday on-call a week at their allocated site, plus one cross county on-call every nine days. Consultants were on site 8am to 5pm weekdays and one consultant worked from 8am to 7pm on weekends, covering both the Worcestershire Royal and the Alexandra Hospital. The hospital that did not have on-site consultant cover at the weekend received senior medical support from a locum doctor from 9-5pm.
- The ED risk register highlighted since June 2014 there was a lack of consultant presence seven days a week. The urgent care transformation leads told us that the urgent care redesign plan was due to be completed by the end of September 2015, within which was a proposal of a seven day rota.
- There was one consultant on site after 5pm and at weekends covering both the Worcestershire Royal Hospital and the Alexandra Hospital site, including trauma calls. This was raised as a concern during 2013 a peer review from NHS England. If two trauma patients were admitted at the same time on each site, the protocol was that one of the trauma calls would be led by the orthopaedic doctor. This meant there was a risk of patients receiving suboptimal care and treatment due to lack of senior leadership if two trauma patients were admitted at the same time on each site.
- A county-wide consultant on call rota was planned as part of the ED transformation programme.
- There was a 0.24 WTE (1%) vacancy rate at other levels, except consultants, of medical staff.
- Between July 2014 and March 2015 the average locum cover was 17%. These were long-term regular locums who had received a local induction. The reasons for the over-establishment and additional locum use were to provide additional cover at weekends and increase senior decision making in the ED.
- There was an ED recruitment and training (Deanery) work stream that monitored the medical workforce changes across both EDs. This was discussed fortnightly at the ED task and finish group

The trust's 'Breaking the Cycle' week (a week that focused on patient flow and gave the trust and their health and social care partners, an opportunity to try something different with the aim of improving patient care by improving patient flow) in July 2015 was supported by the ED transformation team which included a senior acute medical physician and a senior nurse. Staff told us and the debrief presentation showed that this senior support helped facilitate leadership and patient flow within ED. As a result, a three month trial was due to start by the end of July where a locum consultant would be on shift each night to mirror the skills displayed during the 'Breaking the Cycle' week.

Major incident awareness and training

- Staff could describe the major incidents' policy and what they would do if a major incident occurred.
- Staff were aware that 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. There was a telephone tree of staff that needed to be contacted to provide support to ED.

Urgent and emergency services

- Staff told us that they had a major incident practice in March and September each year to ensure staff were familiar with the process. At the last practice the team was 89% complaint.
- Staff reported receiving Ebola training. There was an adequate equipment kit with information detailing the actions to be taken if required.
- Staff were 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. This was in line with the Public Health England 2013 'Infection Control Advice: Possible or Confirmed MERS-CoV' guidance, as staff were 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 on the risk register.

Are urgent and emergency 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. There was a clinical audit forward plan 2015/16 including participation in national audits, National Institute for Health and Care Excellence (NICE) guidance audits and clinician interest audits. It was aligned to other areas of monitoring such as the corporate risk register and serious incidents that were frequent within the trust. In the main, patient outcomes were better than the national average for severe sepsis and septic shock, asthma in children, ED mental health and initial management of the fitting child audits. There was learning disseminated from national audit reports. There was induction and competency training for staff. Most staff told us that they received one to ones with their manager. Staff, including agency staff, could access the information they needed to assess, plan and deliver care. Staff, teams and services mostly worked well together to deliver effective care and treatment. Staff offered pain medication and explained medications to patients in preparation for discharge home. Not all patients who were able to drink had access to fluids. The department did not meet the standard that requires the percentage of patients re-attending (unplanned) the ED within seven days to be less than 5%.

Evidence-based care and treatment

- There were a range of care pathways that complied with National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM's) clinical standards for EDs.
- Patients were assessed using recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow score, a nationally recognised practice tool and we saw evidence that risks were monitored in line with the assessment outcomes.
- There was a clinical audit forward plan 2015/16 documented for the EDs to ensure the trust corporate priorities were taken into account when improving quality. These included participation in national audits, National Institute for Health and Care Excellence (NICE) guidance audits and clinician interest audits. The plan was aligned to other areas of monitoring such as the corporate risk register and serious incidents that were frequent within the trust.
- There was no specific research plan for the urgent and emergency services but the trust told us the service was keen to participate in research programmes. They had discussed participating in the Enhanced Peri-Operative Care for High-risk patients (EPOCH) trial and the Rapid Assessment of Potential Ischaemic Heart Disease with Computed Tomography Coronary Angiography Study, although had not yet committed to participate in these studies, due to the reduced consultant numbers.
- The hospital had a sepsis care bundle pathway for management of patients presenting with suspected sepsis (blood infection). A sepsis box was available to provide access to immediate antibiotic treatment.

Pain relief

- The CQC accident and emergency survey 2014 showed that Worcestershire Acute Hospitals NHS Trust was about the same as other trusts with regards to pain relief responsiveness and staff helping with pain control.
- Pain medication was offered in triage.
- None of the patients we spoke with reported they were in pain when we spoke with them

- We heard doctors explain treatment and pain medications to patients in preparation to being discharged.

Nutrition and hydration

- We audited whether patients had a drink within their reach on the unit and found that eight out of 23 patients (35%) could reach a drink. This meant that not all patients who were able to drink had access to fluids.
- The CQC's A&E survey 2014 showed that Worcestershire Acute Hospitals NHS Trust was about the same as other trusts regarding patients having access to get suitable food or drinks.
- The kitchen was well stocked with milk, bread and cereal. Cold snacks were available for patients to access.

Patient outcomes

- Despite the concerns we had about the safety of the ED, in the main, patient outcomes were better than the national average for severe sepsis and septic shock, asthma in children and initial management of the fitting child audits. There was learning disseminated from national audit reports.
- In the RCEM 2013/14 audit published in September 2014 of severe sepsis and septic shock, all indicators scored in the upper national quartile, demonstrating positive outcomes. These included the measurement of blood cultures, administration of intravenous crystalloid fluids and antibiotics. There was an action plan in place following the audit that had two actions on it. One was to use the sepsis proforma better. To achieve this, the plan was to provide weekly updates and training to nurses, we saw evidence of this being completed. The other action was to re-audit in 12 months.
- In the RCEMs 2013/14 asthma in children audit most indicators scored in the upper national quartile, signifying positive outcomes. These included initial observations and subsequent observations following beta 2 agonist administration. One indicator scored in the lower England quartile, which was the non-administration of beta 2 agonist given by spacer or nebuliser. There was no audit action plan in response to the audit of asthma in children.
- In the RCEMs 2013/14 paracetamol overdose audit most indicators scored between upper and lower England quartiles. Two indicators scored in the lower quartile, indication worse than the average outcomes. These included in all cases decline of treatment and where dose exceeded 6g and was over eight hours since ingestion. The audit showed the hospital scored better than the average for patients receiving N-acetylcysteine (NAC) within eight hours of ingestion. We requested an action plan for this audit but the trust only submitted one for the Alexandra Hospital and not Worcestershire royal.
- The RCEMs initial management of the fitting child audit 2014/15 showed that the ED met standards of the management of active seizures and recording clinical information. The ED did not meet the standard for checking and documenting blood glucose; and providing written safety information to patients and/or carers. There was an action plan following the audit which included feedback to the department to record a blood sugar however, did not address the lack of safety information provided.
- On the 3 August 2015 the trust had not signed up to the RCEMs future national clinical audits of Vital Signs in Children, Procedral Sedation in Adults or VTE Risk in Lower Limb Immobilisation
- The department was not meeting the standard that requires the percentage of patients re-attending (unplanned) the ED within seven days to be less than 5%. No month from January to August 2015 met the target, with 5.7% being the average re-attendance rate.
- The alcohol liaison service did not collect patient outcomes as standard. The last briefing paper in in 2013 showed that between 1 January and 31 March 2012 ED attendances (across both EDs) pre and post intervention reduced by 38% and total bed days were reduced by 5%.
- In the RCEM's 2014/15 ED mental health audit showed that the ED was in the upper quartile of results, indicating better outcomes compared to other audited EDs. This included patients receiving a mental state examination. However, results did not always meet RCEM standards, despite being better than other audited EDs. For example, patients receiving a risk assessment which was recorded in the clinical record was 96%, better than the audit median of 97%, but did not meet the RCEM standard of 100%.

Competent staff

- As of the 31 August 2015 all consultants and administrative staff had received appraisals in the last

12 months. Eighty per cent of specialty and associate specialist medics and nursing staff had received appraisals. This meant that most staff had had their performance reviewed and objectives set.
- There was ED specific training for senior house officer doctors each week. This included lessons learnt from incidents and complaints along with clinical topics.
- There was learning disseminated from national audit reports. For example, there was a dedicated teaching session organised on treatment of paracetamol overdose, in response to results from the national audit.
- New doctors were given a three week induction that included familiarising themselves with departmental policies, layout of the department and had an educational supervisor to help guide them.
- Most staff told us that they received one to ones with their manager.
- The specialist alcohol liaison nurses provided training sessions for junior doctors and new nurses, as well as local university and GPs.
- The specialist alcohol liaison nurses received clinical supervision from the local community health team.
- The triage nurse must be qualified between 12 and 18 months and complete role specific competencies before they were able to triage patients, such as interpreting x-rays.
- There was in-house paediatric training for all nurses every year.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment. There was an effective and cooperative relationship with the acute physicians who managed the medical assessment unit and these staff had jointly developed care pathways.
- Doctors and nurse reported a good working relationship with each other. There was supportive collaborative working.
- The pharmacist told us that they took a 'hands on' role within the ED and would help patients with other practices, such as helping patients to the toilet, alongside medication. Staff we spoke with told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times.
- Ambulance crews and HALOs told us that they had a good working relationship with ED staff and there was effective two way communication.

Seven-day services

- The pharmacy department operate an innovative seven day clinical service in the ED. This was commissioned as part of the Clinical Commissioning Group strategy in order to reduce demand on the trust.
- Radiology was available seven days a week, 24 hours a day.
- The specialist alcohol liaison team was not available at weekends.

Access to information

- Staff, including agency staff, could access further clinical guidelines and pathways on the trust intranet.
- There were resource folders in ED to guide staff, such as tissue viability.
- Junior doctors were given handbooks with updated NICE and the RCEM guidelines and clinical standards for EDs.
- There was an IT system, which was real time and allowed tracking of patients through the department. The status of both of the trust's EDs could be viewed on either site, thus enabling an overview of the workload. The system also allowed for statistical analysis and reporting of activity.
- A discharge summary was sent to GPs when patients were discharged from the department.

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.
- We observed staff obtained verbal consent and check identification wrist bands before carrying out interventions.
- Staff we spoke with knew how to make an application under Deprivation of Liberty Safeguards (DoLS).

Are urgent and emergency services caring?

Good

Overall we rated this service as good for caring. Patients were treated with compassion, dignity and respect. There

was positive patient and staff interaction. All of the patients we spoke with told us that they were happy with the care provided by staff. The trust used the Friends and Family Test to capture patient feedback. 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 explained the treatment and care they were delivering to patients in a way that they could understand. Relatives were kept informed of their family member's condition and what was happening at all times. The chaplain visited the ED each Thursday to support staff and provide mindfulness training. The chaplain also spoke with patients and relatives to provide emotional support.

Compassionate care

- Patients were treated with compassion, dignity and respect.
- There was positive patient and staff interaction. We saw staff speak with patients in a respectful way, introducing themselves and engaging with them.
- All of the patients we spoke with told us that they were happy with the care provided by staff.
- We spoke with two relatives who told us that their loved ones were receiving good care and that staff were very helpful.
- One relative was with a family member who was living with dementia. They told us that the staff had been compassionate and sensitive to the patients' needs.
- 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.
- We spoke to a relative who had accompanied a family member to the ED. They told us they had been kept well informed of their family member's condition and what was happening at all times.
- We saw the pharmacist clearly explain medication to patients, including what it was for and how to administer it. They checked patients understanding before the patient was discharged.
- We saw documented in one patient's notes a doctor state "I'm happy to speak with relatives (of the patient) when they arrive" to help explain the patients treatment plan.
- In the CQC's 2014 A&E survey, the trust generally scored the same as other trusts within England for care and treatment. However they scored better than other trusts on staff explaining why patients needed tests in a way patients could understand; staff explaining the danger signals of illness; and staff reassuring patients when feeling distressed.

Emotional support

- The chaplain visited the ED each Thursday to support staff and provide mindfulness training. The chaplain also spoke with patients and relatives to provide emotional support.
- Staff told us that could contact the chaplain to provide support for patients and families.
- Occupational health was available to provide emotional support for staff.

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

(for example, to feedback?)

Requires improvement

Overall we rated this service as requires improvement for responsiveness.

There were problems with patient flow from the ED into other departments in the hospital, causing overcrowding in the department.

Patient flow meetings between the trust and local organisations aimed to support health and social care teams to deliver safer patient care and discussed the availability of beds, the flow of patient treatment and what could be changed to support discharge.

Patients did not always receive timely care and treatment. The ED was consistently failing to meet the national standard which requires that 95% of patients are

discharged, admitted or transferred within four hours of arrival. There had been no 12 hour breaches since May 2015, which showed an improvement in patient waiting times compare to January 2015.

The trust failed to meet its aim of speciality referral time being less than 60 minutes between December 2014 and June 2015.

The department consistently achieved the national target which requires that the percentage of patients who leave the department before being seen by a clinical decision-maker should be less than 5%.

There were examples of where the ED were trying to meet patient needs, for instance, a specialist alcohol liaison service, translation services and a family room, for relatives to wait while their relatives were receiving care.Examples and learning of complaints and compliments were shared with staff.

Service planning and delivery to meet the needs of local people

- The trust had created a patient care improvement plan (PCIP) as a result of the CQC unannounced inspection in March 2015. The objective of this was to put actions in place to improve patient care, including addressing capacity issues, redesigning patient emergency care pathways, and creating standard operating procedures aligned with best practice.
- 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. 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 ED and we saw better flow within ED compared to the unannounced inspection in March 2015.
- The British Red Cross had been commissioned by the City Council to help transport appropriate patients home and facilitate discharge during the day. In the June 2015 urgent care and oversight meeting it was estimated that approximately 2000 patients could benefit from the scheme. Between 5pm and 8am front line ambulance crews did this where they had capacity. Social care community night time services met ambulance crews at the patients home to assist with social care where required.
- At the Worcestershire Acute Hospitals NHS Trust board in July 2015 the Interim Chief Operating Officer (COO) presented the integrated performance report which set out the current position of the trust's performance against key targets and highlighted three main areas of concern. The COO explained that improvement was needed for emergency admissions (either via the GP or ED) to reduce crowding in the ED. Patient flow was an issue, for example, there were 41 patients in the hospital at the end of May awaiting health or social care packages. The trust was working with health and social care organisations to resolve this issue.

Meeting people's individual needs

- We noticed staff struggling to pull curtains around four patient bays. This was because the beds were too long for the bay and curtains to stretch around. This put patients' privacy and dignity at risk.
- There was a family room with sofas and equipment such as a kettle, for relatives to wait whilst their relatives were receiving care. This room was also used for breaking bad news. There was an adjoining door into a viewing area for relatives to view loved ones that had died.
- There was a specialist alcohol liaison service which supported the ED Monday to Friday 8.30am to 4.30pm. Patients attending the ED who were identified as having harmful and dependent drinking behaviours were offered assessment, brief intervention and signposting to relevant services. Out of hours, ED staff assessed patients and, where appropriate, offered them a referral into the service.
- Staff told us how they adapted their approach to people living with learning disabilities and dementia and some staff had attended dementia training. They told us that they would try to fast track patients through the ED to prevent patients becoming anxious in such a busy environment.
- A translation service was available for non-English speakers.
- The bus service timetable was displayed on a television in the patient waiting area, providing live updates of the service patients could access. Local taxi information was also provided in the waiting area.
- The waiting area had some magazines and plasma screens to keep patients entertained; however, these were not always switched on.

- We saw volunteers confirm with nursing staff if patients could eat and then help distribute a choice of meals to appropriate patients. One patient told us "the meals are nice".
- There were vending machines in the waiting area so that patients and visitors could access food and drink. We noted these also included healthy snacks, such as salad packs.
- There was a privacy line in the reception area to help protect patients' privacy and dignity when arriving at ED.

Access and flow

- Patients did not always receive care and treatment in a timely way. The trust was consistently failing to meet key national performance standards for EDs.
- The emergency access four hour target of 95% of patients being seen within four hours, had not been achieved since September 2014, with the lowest percentage being 69% of patients in February 2015. There had been 8695 (27% of patients) four hour breaches between January and June 2015. The ED performance over this period in 2014/15 was worse compared to the same period of the previous year. Attendances at the ED had been 18% higher than 2013/14. A process was being agreed with the CCG to deliver 95% by October with a range of actions identified
- The percentage of emergency patient admissions via ED waiting between four and 12 hours from the decision to admit until being admitted averaged 47% between January and June 2015. Waiting times had deteriorated, in January 44% of patients were waiting compared to 52% in June 2015.
- There had been 16 (0.35%) 12 hour breaches between January and June 2015. January accounted for six of these and February accounted for nine. There was one in May 2015. There had been none since, which showed an improvement in patient waiting times.
- Since the unannounced March 2015 CQC inspection, the trust had been closely monitoring breaches and investigating why they occurred. For example, a spike in breaches was noted on 20 July 2015. On further investigation, this day had higher than average ambulance arrivals (129 arrivals), combined with a high rate of cubicle hours occupied with patients awaiting admission (438 hours).
- Discharge training was underway, with twenty one sessions being rolled out across the trust to facilitate patient flow and improve ED capacity.
- While waiting no more than four hours from arrival to departure is a key measure of ED performance, there are other important indicators such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The trust had met this target between April and June 2015, the average wait was 38 minutes.
- The department consistently achieved the national target which requires that the percentage of patients who leave the department before being seen by a clinical decision-maker (which is recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait) should be less than 5%. Between January and August 2015, the proportion of patients leaving before being seen averaged 1.6%.
- There were problems with patient flow from the ED into other departments in the hospital, causing overcrowding in the department. During our inspection there were up to 22 patients waiting for a hospital bed. Waits ranged from 1 hour 22 minutes to 16 hours.
- Lack of available bed capacity may cause overcrowding in ED which could lead to suboptimal care and a poor patient experience. This was categorised as a high risk on the risk register since 2010. A variety of actions had been implemented to overcome this but had not yet solved the problem completely.
- Patients referred by GPs were admitted if required via the medical assessment unit. This had relived some patient flow pressure and demand in ED.
- The clinical decision unit (CDU) had been converted into the PAA to create short term additional ED trolley spaces to enable timely off-loading of patients conveyed by WMAS, avoiding patients waiting in the ED corridor. It provided capacity of up to 14 beds, although the ED team were trying to limit patient numbers to prevent the risk of breaching patients' privacy and dignity in small area. The area was for patients who had been assessed and treated by ED staff and referred onto a specialty team for admission (waiting for a bed) and patients who had been referred by GPs directly to a specialty team and were stable. When bed numbers did increase staff told us that they used portable screens to separate patients. We did not see this during our inspection because increased bed numbers were not required.
- The PAA was managed under the same guidance as the ED corridor and the "clock" continued therefore

standard ED targets applied including the four and 12 hour breach targets. This impacted on the four hour target as patients remained on a trolley and the clock continued, therefore they were often breaching the target. When the previous CDU was in place, short stay patients would have been admitted and hence, the clock stopped and the target may have been met.

- The future plan was to close the PAA and return the area to a CDU. However, the ED had become dependent upon the PAA to prevent patients being treated in the ED corridor.
- Between January and June 2015 on average it took patients who required a Mental Health Act (2005) assessment 14 minutes from arrival to assessment. With eight minutes being the quickest wait for assessment and 26 minutes being the longest wait.
- There was no formal "in-reach" from specialities to the ED. There was a local aim of speciality referral time being less than 60 minutes. Referral times averaged 72 minutes between January and August 2015 which did not meet the target.
- The delay in patients being reviewed by a medical doctor from the on-call team had been highlighted on the risk register since December 2012. The latest action to overcome this was part of the medical workforce review, which outlined an increase in consultants which should enable patients to be medically reviewed quicker.

There was a whiteboard behind the reception staff that displayed the waiting time, however, this was difficult to see and self-presenting patients we spoke with did not know how long they would have to wait to be seen. On the 17 July 2015 at 9.30am we found that the board had not been undated since 5.45am therefore did not represent the latest waiting time information.

Media campaigns encouraged the public to think carefully before coming to the ED and to consider other sources of care and support.

Learning from complaints and concerns

- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display.
- Examples of complaints were displayed in the staff room. Common themes included poor staff attitude and long waits. Lessons learnt and actions taken as a result of the complaint were also displayed.
- We saw an ED complaint was discussed at the July 2015 board meeting. This concerned a missed diagnosis, the consultant had apologised and the learning was for the consultant to share how the diagnosis was missed with the medical team.
- The department collected compliments and shared these with staff.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Are urgent and emergency services well-led?

Requires improvement

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

The vision of the service was not yet well developed.

Although quality measures were monitored, effective governance and performance management was not yet established to make significant improvements. Action plans in response to audits were not always in place or did not always provide assurance, evidence or progress updates to show how improvements had been achieved.

Most staff spoke positively about the new chief executive officer, staff felt able to raise concerns to them and felt the trust was moving in the right direction. Staff felt that the ED matron was visible but during surges in activity the divisional management team were not responsive and this made staff feel that they were not fully supported.

The sustainability of service improvement changes remained a challenge. We were not assured that the changes were fully embedded and that the ED could successfully manage patient demand during times of surges.

The pharmacy department operated an innovative seven day clinical service in the ED. This had shown patient benefits. The pharmacist told us that they often lectured at healthcare events and had other pharmacists visit the service to share the good practice.

Vision and strategy for this service

- The consistent vision was regarding admission avoidance and improved patient flow. However, most staff did not know exactly how this was going to be achieved or change the unit.
- After our unannounced inspection in March 2015, the trust had created a patient care improvement plan (PCIP) in order for plans to be put in place to make and monitor improvements in care. Improvement had been made but there was still work to be done.
- 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.
- There was a plan to extend the ED by December 2015 to enlarge the major's area and create a rapid assessment area. Staff had been consulted on this and information had been cascaded to all staff levels.
- The was a business case being presented to trust board regarding the implementation of a older persons assessment and liaison (OPAL) team, to facilitate care and treatment of older people with the aim to avoid admission where possible or reduce length of stay. Senior staff told us that the team had been trialled in 2010/11 with success but that changes had not been implemented as a result. Staff hoped the business case would be accepted to provide a cross county servile.

Governance, risk management and quality measurement

- Minutes of the urgent care and oversight monthly meetings showed that there were discussions and actions were planned around the patient improvement plan, the risk register and performance metrics.
- Patients did not always receive timely care and treatment. The ED was consistently failing to meet the national treatment standards, for example the 15 minute time from arrival to initial assessment. Targets were being more vigorously monitored since our unannounced CQC inspection in March 2015, for example, each day the ED nurses conducted validation of the waiting time data and reviewed the causes of breaches. The leading cause of breaches were surges in activity, with capacity also being an issue. However, could not be assured that effective governance and performance management had been fully established and embedded to create significant improvements in the quality measures until this was tested in times of activity surges.
- There was a root cause analysis action plan as a result of the ED not meeting treatment targets that was incorporated into the patient care improvement plan (PCIP). There were sections of the PCIP worksheets relating to the CQC unannounced inspection and work regarding urgent care and patient flow were captured. The PCIP was reviewed by the urgent care oversight team fortnightly.
- Urgent and emergency services had their own risk register that fed into the corporate register. This was reviewed at governance meetings. Staff were aware of the risk register and how to raise a risk to be included. However, the risks on the risk register did not always reflect the risks on the PCIP. For example, within the PCIP it stated that in house patient transfer assessments were not always completed for each patient and that actions were only 40% completed. This meant that there was a risk that not all patient information would be transferred, however, this did not feature on the risk register.
- Quality measures were shared on the staff notice board, such as Friends and Family Test results, breaches and patient footfall. For example, on the 13 July the board showed that 196 patients were seen with 15 patients breaching the 15 minute target and 64 patients breaching the four hour target.
- The alcohol liaison service did not collect patient outcomes and therefore could not measure the quality of the service. Nurses told us that they were not asked for reports by their manager to monitor the service.
- CEM audit data in the main showed positive patient outcomes. However, action plans were not always in place or did not always provide assurance; evidence or progress updates to show how improvements had been achieved.

Urgent and emergency services

Leadership of service

- Senior staff told us that they welcomed the unannounced CQC inspection in March 2015, one commented "the visit was what we needed to give us a kick"; and "we expected someone else to solve the problem". They felt that their voices were now being heard and positive changes were being implemented.
- Most staff spoke positively about the interim chief executive officer, staff felt able to raise concerns to them and felt the trust was moving in the right direction. One senior staff member commented the interim chief executive was "inspirational".
- Staff in the department reported that the matron visited ED each day and was accessible. Divisional leads told us that they aimed to walk around each site each week. However, during surges of activity, staff felt the divisional management team was not as visible as they would like and this made them feel that they were not fully supported.
- Most staff knew who the executive team were, however, some junior nurses did not.
- Senior nurses told us that they supported one another. They said that the divisional nurse was visible in the ED and that they could contact them via phone.
- 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 with team building.

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 in ED, whilst enthusiastic and passionate about their service and its potential to make a difference, had been demoralised by recent staff pressures and departmental overcrowding.
- Between July 2014 and March 2015 the average qualified nurse sickness rate was 3%, which was better than the trust target of 3.5%

Public engagement

- There were 'You said, we did' comments on a display board. For example, one comment from a patient stated that they wanted access to food and drink more regularly. In response the ED has supplied bottled water for patients and increased meal rounds. However, nurses told us that the bottled water was not always available as it was locked in a staff member's office.
- 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.

Staff engagement

- Staff received weekly emails with ED updates.
- Staff told us that they were now encouraged to raise concerns and they felt they were listened to.

Innovation, improvement and sustainability

- The pharmacy department operate an innovative seven day clinical service in the ED. This had shown a reduction in some direct admissions to hospital, patient's treatment had been optimised, patients had been counselled about their medicines to prevent readmission and a significant amount of patients (25%) benefitted from an intervention from the clinical pharmacist to prevent a future admission. The pharmacist told us that they often lectured at healthcare events and had other pharmacists visit the service to share the good practice. The service was planning to roll this practice out to other parts of the trust.
- There was an immediate response to the CQC unannounced inspection in March 2015. Senior staff acknowledged that sustainability of these changes will remain a challenge. However, they were keen to keep implementing improvements for patient safety and staff wellbeing.
- There were problems with patient flow from the ED into the hospital and that risked overcrowding in the department. The trust were trying to address this problem and during our inspection we did not see evidence of overcrowding. However, staff recognised that the sustainability of managing patient demand, especially during times of surges was going to be tested.
- The trust was chosen to be a study location for the Randomised Evaluation of modified Valsalva Effectiveness in Re-entrant Tachycardias (REVERT) study looking at treatment of patients with supra-ventricular arrhythmias.

Medical care (including older people's care)

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

Information about the service

Worcestershire Royal Hospital is part of Worcestershire Acute Hospitals NHS Trust. The main hospital was built under the private finance initiative (PFI) and opened in 2002. It provides specialist services for the whole of Worcestershire including stroke services and cardiac stenting. The Worcestershire Oncology Centre opened in January 2015, providing radiotherapy services for cancer patients, the first time these services have been available in the county. The hospital has a cardiac catheterisation laboratory. The 24/7 Primary Percutaneous Coronary Intervention (PPCI) service began in October 2013. It has 500 beds and serves a population of more than 550,000.

The Medical Specialty includes which provide cardiology, stroke, dermatology, diabetes and endocrinology, gastroenterology, neurology, and respiratory services. The hospital has 12 medical care wards including general medicine, gastroenterology, geriatric medicine, cardiology, respiratory, haematology and stroke wards. It also has a Medical Assessment Unit (MAU), a discharge lounge, a cardiac catheter laboratory and a high care and short stay unit.

During our inspection, we visited all ward areas and discharge lounge. We spoke with 35 patients, 52 staff, and 16 people visiting relatives. We also looked at the care plans and associated records of 24 people. We held focus groups with nursing, medical staff and ancillary staff, as well as speaking to senior doctors and nurses.

Summary of findings

Overall, we rated the service as requires improvement. It was rated inadequate for being well-led and requiring improvement for safety, effectiveness and responsiveness. We rated the service as good for caring.

Medical staffing was in line was national guidance but was a significant concern forstaff; both in terms of effective recruitment at consultant level, and also for out of hours and weekend medical cover provided. Doctors felt overstretched and said the level of medical cover in the evenings and weekends was not sufficient. There were reported delays to the timeliness of medical assessments at times of high demand but there were no reported incidents reported where patients' care and treatment had been affected. There was not an effective system in place for medical handovers and these did not occur in the mornings. The service had not yet implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) in line with national guidance.

Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people.

Appropriate systems were in not always in place for the storage, administration and recording of medicines.

The environment was generally well maintained but some potential risks to patient safety had not been addressed such as safe storage of chemicals. All the wards were using the NHS Safety Thermometer system

Medical care (including older people's care)

to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance but there was not an effective quality and safety dashboard in place specific to the medical care service.

Not all staff had had the mandatory training required, including safeguarding children's training and resuscitation training.

Medical care wards to be generally clean and well maintained. There were generally low rates of infections. Nursing staffing levels met patient needs at the time of our inspection but there were not always effective systems in place for agency staff inductions.

Performance boards across the wards were seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Regular audits were being carried out on the main risk areas. Wards generally had effective systems in place to minimise the risk of infections. Records were generally well maintained.

People have did not always have good outcomes as they did not always receive effective care and treatment that met their needs. Mortality ratios were higher than those of similar trusts.

Performance and outcomes did not meet trust targets in some areas. There was little evidence of progress to providing seven day a week services.

Most staff said they were supported effectively, but there were no opportunities for regular formal supervisions with managers.

Care planning effectiveness was variable, and care plans were not generally person-centred. Care plans for people living with a dementia were not always effective as they did not provide sufficient details for staff to follow to meet patients' needs.

Care was mostly 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.

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

Multidisciplinary team working was effective.

We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was generally good. People were supported, treated with dignity and respect, and were involved as partners in their care.

Overall, medical inpatient 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 not consistently met through the way services were organised and delivered. Cancer referral to treatment times were below the national average. Medical patients in outlying wards were not always effectively managed.

Some problems with the effective discharge of people were highlighted across the medical care service, from both staff and some of the patients we spoke to. The hospital was looking at plans to reduce the impact of patients with a delayed discharge but there was variable engagement from clinicians in this initiative. Concerns and complaints procedures were established and generally effective. Information was available for patients regarding how to make a complaint.

The leadership, governance and culture did not promote the delivery of high quality person-centred care. Known concerns had not always been responded to and acted upon. The visibility and relationship with the management board was not clear for junior staff, not all of whom had been made aware of the trust's vision and strategy.

Medical care (including older people's care)

The medical care service was generally well-led at a ward level, with evidence of effective communication within staff teams, but there was not always effective leadership from senior managers. 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, and said work pressures, due to higher patient dependencies, was an area of concern.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in improvements to the service and did not receive feedback from patient safety incidents. Some staff felt isolated. All staff were committed to delivering good, safe and compassionate care. Some staff said senior leaders were not visible.

Are medical care services safe?

Requires improvement

Overall we rated this service as requires improvement for safety.

Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of avoidable harm to people.

Appropriate systems were in not always in place for the storage, administration and recording of medicines.

The environment was generally well maintained but some potential risks to patient safety had not been addressed.

All the wards were using the NHS Safety Thermometer system to manage risks to patients, such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections, and to drive improvement in performance but there was not an effective ward based quality and safety dashboard in place specific to the medical care service.

Not all staff had had the mandatory training required, including safeguarding children's training and resuscitation training.

- Medical staffing was in line was national guidance but was a significant concern for staff; both in terms of effective recruitment at consultant level, and also for out of hours and weekend medical cover provided. Doctors felt overstretched and said the level of medical cover in the evenings and weekends was not sufficient. There were reported delays to the timeliness of medical assessments at times of high demand but there were no reported incidents reported where patient's care and treatment had been affected.

There was not an effective system in place for medical handovers and these did not occur in the mornings. The service had not yet implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) in line with national guidance.

Medical care wards to be generally clean and well maintained. There were generally low rates of infections.

Medical care (including older people's care)

Nursing staffing levels met patient needs at the time of our inspection but there were not always effective systems in place for agency staff inductions. Some staff said that they felt pressurised, due to high patient dependencies.

Performance boards across the wards were seen as a positive measure by staff, but not all staff were fully aware of the significance of the issues reported on them. Regular audits were being carried out on the main risk areas.

Wards generally had effective systems in place to minimise the risk of infections.

Records were generally well maintained.

Incidents

- The service generally had a variable track record on safety over time and across the service.
- There was variation in the effectiveness of arrangements for reporting safety incidents.
- Staff told us they reported incidents using the trust's computer incident reporting system. There were clear accountabilities for incident reporting in most wards. Most staff could describe their role in the reporting process, were encouraged to report and were treated fairly when they did. Systems generally were easy to use and but there was an inconsistent approach to reporting across the wards as not all staff had had training in this area.
- The majority of staff were aware of how to report incidents and near misses and received feedback from reported incidents but not all staff said they received timely feedback from reported incidents. We saw that staff on Avon 2 ward had reported skin damage incidents appropriately using the trust's electronic incident reporting systems.
- No never events (incidents that are defined as "wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers") were reported by the trust for medicine in the past year.
- There were 51 serious incidents reported across the medical care service during the period May 2014 to April 2015. Pressure ulcers at grade 3 were the most commonly reported type of serious incident (20), followed by slips, trips and falls (17).
- The trust told us that in the three months prior to the inspection, 10 serious incidents had occurred within the medical service between 10 April and 20 July 2015. Four occurred at Worcestershire Royal hospital, with three being falls: all these were still being investigated. The trust's target for completion of serious incident investigations was 60 working days: one of these four investigations had not been completed by this target timescale.
- Quality Assurance meeting minutes, dated 21 April 2015, detailed one serious incident being investigated as a patient continued to take oral chemotherapy medication from their bedside locker as well as receiving it as an inpatient. Plans were in place to prevent his reoccurring and were being monitored.
- Senior staff told us there were regular quarterly meetings within the medicine division that reviewed service safety and quality issues, including complaints, the risk register, and patient mortality and morbidity concerns. Wards did not maintain their own risk registers and serious risks were included on the divisional risk register. Senior staff said the main risks identified for the service were regarding staffing pressures and patient flow concerns.
- Most, but not all, wards had regular team meetings where patient safety and quality issues were discussed.

Safety thermometer

- The trust had a service wide 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 trust had implemented a SKIN "care bundle" with a collection of five interventions to promote effective skin care and senior staff said they undertook in depth investigations and had accountability meetings with

nursing staff for all cases of grades 3 and 4 pressure ulcers to learn from any errors or omissions made. Wards carried out monthly audits on pressure ulcer prevention.

- The medical care service had achieved the trust target of 95% for the completion of VTE assessments in the year ending March 2015.
- Wards carried out the "matrons' audit" which had patient safety goals showing performance regarding falls, pressure ulcer prevention, complaints and patient feedback and related to overall staffing levels on individual wards. This audit was emailed to matrons on monthly basis for cascade to staff. Ward managers said this "matrons' audit" did not 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.
- Senior managers told us the new service specific online safety dashboard was a work in progress and not yet fully effective at identifying risk to patient safety and the quality of care. We saw that the service had a ward quality dashboard delivery plan dated June 2015, which stated that a phased roll out of a proposed new safety dashboard should begin at the end of September 2015.
- Matrons told us there was not an effective safety dashboard and that it was in development. Not all ward sisters had access to the trust's shared drive where audit results and safety outcomes for wards were stored, staff told us.
- Not all staff were fully aware of the current quality dashboard and therefore there was a limited understanding of patients' safety concerns and areas of risk, and in what actions needed to be taken to address these risks.
- Each ward also used the NHS Safety Thermometer (which is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm-free' care). Monthly data was collected on pressure ulcers, falls and urinary tract infections (for people with catheters), and blood clots (venous thromboembolism, VTE). Not all staff were aware of the findings from these audits and how changes had been made on the wards to improve outcomes for patients.
- NHS Safety Thermometer information from (March 2014 to March 2015) showed 66 incident of pressure ulcers at grade 2, 3 or 4; 21 falls with harm and 126 catheter associated urine infections across the medical care service.
- For June 2015, the Safety Thermometer audit showed that five out of 10 ward areas at the hospital were below the trust target of providing 95% harm free care. Main reasons for not achieving the 95% harm free care target were pressure area care and catheter associated urine infections.
- Not all staff with whom we spoke were able to explain clearly what actions were being taken to prevent pressure ulcer development.
- Avon 4 ward had clear signs next to patients' beds with different coloured leaves (for example, a red leaf meant a recent fall in hospital, and a green leaf meant a history of falls) indicating patients' risk of falls. Staff said this was an effective system for highlighting risks whilst also respecting patients' dignity. Staff were able to tell us of how falls presentation strategies were an integral part of providing safe patient care.
- Wards had noticeboards showing recent safety and quality information. For example, Laurel 3 ward had not had a hospital acquired pressure ulcer for 15 days and the last fall was two days ago. Laurel 1 ward displayed performance data that showed there had not been a hospital acquired pressure ulcer for 31 days and it had been 29 days since the last patient fall. Avon 4 ward's performance notice board showed it had been 142 days the last hospital acquired pressure ulcer and 62 days since the last patient fall.
- Some ward offices had posters on display giving staff guidance on reporting patient safety concerns and duty of candour.
- Staff we spoke with had an awareness of duty of candour and were able to tell us the ward protocols for supporting patients regarding incidents.

Cleanliness, infection control and hygiene

- Ward areas were generally visibly clean and tidy and sanitising hand gel was available throughout the units.
- Posters about effective hand hygiene were also on display. Equipment had 'I am clean' stickers on them which were easily visible and documented the last date and time they had been cleaned.
- Patients told us that they thought the ward areas were clean and saw the cleaner regularly. Generally staff

worked in accordance with best practice for infection control, this included good hand hygiene, wearing Personal Protective Equipment (PPE) when appropriate and being bare below the elbows.
- Infection control audits were carried out monthly, including checks on bed mattresses.
- We observed staff on Avon 2 and Avon 4 ward followed appropriate infection control precautions at all times and appropriate personal protective equipment was available.
- Ward's performance noticeboards showed the outcomes of infection control audits and when the last cases of infectious diseases were. For example, Laurel 3 ward had not had a case of C. difficile (Clostridium difficile) for 15 days and the outcomes of the infection control audit for June 2015 showed 98% compliance. Laurel 1 ward had not had a case of C.difficle for 31 days and the June 2015 ward cleanliness audit score was 99% compliant with trust standards. Avon 4 had not had any cases of C.difficile and MRSA (Methicillin Resistant Staphylococcus Aureus) for 280 days.
- Wards general had appropriate facilities to nurse patients with infectious diseases in side rooms. We saw appropriate signage on display on side rooms and personal protective equipment was available for staff to use.
- The medical care service had a quality and outcome metric dashboard that collated service wide data. It showed that the number of cases of C.difficile was 20 in the year ending March 2015. The number of cases in the previous year was 23.
- This dashboard also showed that the number of MRSA cases in the year ending March 2015 was zero, an improvement from the previous year when there had been one case.
- This dashboard also showed that the number of E.coli (Escherichia coli) cases (classified as attributable to the trust) in the year ending March 2015 was 29, an improvement from the previous year when there had been 35 cases.
- This dashboard also showed that the number of MSSA (Methicillin-sensitive Staphylococcus aureus) cases (classified as attributable to the trust) in the year ending March 2015 was 4, an increase from the previous year when there had been 3 cases.
- 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 local trust policy.
- Nursing staff were observed to challenge other staff within the endoscopy unit when they entered into "Bare below the Elbow" zones, whilst wearing jackets and long sleeve shirts. 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

- Emergency equipment, including equipment used for resuscitation was generally checked every day. Most wards had robust systems in place for ensuring resuscitation equipment was checked daily. However, we found in the Coronary Care Unit that the cardiac arrest trolley had no record of being checked for seven days in June 2015. This represented a significant risk given the type of patients that the unit cared for.
- The hospital had plans to reconfigure the Discharge Lounge to extend the facility and to split the Discharge Lounge and Medical day case area into separate areas as the single area supported both immunocompromised patients (in the day case area) with patients awaiting transfers that were being treated for chest infections, including pneumonia. This concern had been on the divisional risk register for over two years and staff said whilst plans were now being considered for the extension, they did not know the likely timescales for completion.
- Access to some staff only areas in the wards was not secure presenting potential risks to people living with a dementia. For example, the wards' Dirty Utility rooms (or sluices) were not lockable. Staff were not aware of plans

to have these areas made secure. We checked the environmental risk assessment for Laurel 1 ward, and the issue of these staff only rooms not being lockable had not been risk assessed.

- In the MAU dirty utility room (or sluice room), we found that chemicals hazardous to health had not been locked away, which was not in accordance with trust policy and presented a potential risk of a patient or visitor was to have access to these chemicals. This was brought to the attention of a senior nurse, who took action to address this concern.
- In Laurel 1 ward, in an open storeroom, we found chemical hazardous to health had been locked away. We brought this to the attention of the nurse in charge who removed the chemicals.
- Pressure relieving equipment was available for patients. We checked a random sample of equipment in all areas and noted that all equipment was labelled when it was last seen which indicated if it had been tested, had received pre-planned maintenance and had been safety tested.
- Firefighting equipment had been tested regularly on all wards that we visited.
- Portable electric equipment had been tested regularly to ensure it was safe for use and had clear dates for the next test date on them.
- Staff on Avon 2 ward told us that there were no delays in obtaining pressure relieving equipment when requested and it was usually provided within half an hour.
- We found that the main door to the Discharge Lounge was propped open with a door wedge. The door retractor mechanism was faulty and had been reported to the trust's estates team but as this was a fire door, this presented potential fire safety and also security risks. We brought this to the attention of the nurse in charge was took action to inform the estates' team that this repair was a priority. The doors were due to be replaced in October 2015 we were informed. The trust's fire safety office had been made aware of the risks.
- The Discharge Lounge had a series of shelving units that were open and not capable of being locked that contained a variety of clinical supplies and equipment including dressings, needles and cannulas. There was a risk that these items could be tampered with or stolen. We brought this to the attention of the nurse in charge who said this had not been identified as a risk but would take action to resolve this.
- The nurses' station in the middle of the Discharge Lounge, situated between the lounge and the medical day case unit was not enclosed and staff said doors to this area had been requested but did not know when they would be installed. This presented risks that patients or visitors may overhear confidential discussions between staff and other patients. The lounge did not have access to piped oxygen but had oxygen cylinders on appropriate stands.
- There were radiation warning signs and lights outside any areas that were used for diagnostic imaging including room 3 within the endoscopy suite where a portable c-arm was used for procedures (c-arms are a form of mobile x-ray technology which is used to produce medical images). Lead aprons were available for staff; these were routinely checked and screened for damage.

Medicines

- Appropriate systems were in not always in place for the storage, administration and recording of medicines.
- During our inspection, three incidents regarding the prescription and administration of medicines were reported as incidents and the trust took action to investigate these incidents.
- Medicines requiring cool storage were stored appropriately in locked medicine refrigerators and records showed that they were kept at the correct temperature. However, there were no temperature records available for medicine storage rooms. We found that the temperatures of some medicine store rooms were above the recommended safe temperature storage range. The trust recognised this was an issue for safe medicine storage. Following our inspection the trust agreed to set up a 'Task and Finish' group. No dates for this group to meet were available at the time of the inspection. The temperature of the medicine room on Silver ward was not recorded. It was not possible to determine if medicines were stored at the correct temperature. In the discharge lounge, we found five gaps in 17 days in the recording of the medicines' fridge which was not in accordance with trust police which required daily fridge temperatures to be recorded.
- In the MAU, we found that the medicine fridge was left unlocked so we brought this to the attention of the nurse in charge. We also found that the medicines' fridge temperature recording chart had shown temperature in excess of 8 degrees Celsius for three days

a row in July 2015. The recorded actions to resolve this was to "leave the door open" which was not in accordance with trust policy for the safe storage of medicines.

- In MAU and Discharge Lounge, we found that we found that intravenous infusion bags were not securely locked away in the storeroom, which had open access, presenting risks that these could be tampered with. On the stroke ward, we found that the storeroom containing intravenous infusion bags was did not have a lock although staff told us a security lock had been requested for the door to this storeroom.
- On Laurel 1 ward, we found medicines marked for disposal in an unsecure container within the locked medicines store room. However, staff confirmed trust policy was for these medicines for disposal should be locked away within the storeroom.
- A recent medicine incident had been identified and reported. However, the incident involved a patient being given a penicillin containing antibiotic despite records documenting that the patient was allergic to penicillin. We observed that the patient was wearing a red hospital wrist band which further identified the penicillin allergy. We further noted that the medicine incident had not been recorded in the patient's medical notes.
- We observed nurses administer medicines on a drug round on Avon 2 ward and all required protocols were followed to ensure patients received the correct medicines at the correct time.
- Pharmacists visited wards regularly to review medications and carry out reconciliations.
- In the MAU, we found that a dedicated pharmacy team based on the MAU were actively involved in all aspects of a person's individual medicine requirements from the point of admission to MAU through to discharge or transfer to another ward. The pharmacy team were part of the daily ward round which helped identify medicine issues and therefore they could be dealt with immediately. We observed a pharmacist checking a patient's medicine history and ensuring that the discharge medicines were correctly written up before sending the prescription direct to pharmacy. We spoke with the Medicine Management Link Nurse on MAU who said that having a pharmacist on MAU as part of the team was really beneficial and reduced the time taken for patients' medicines to be available for discharge. The pharmacy team were hoping to increase this service to seven days a week from September 2015.
- In Avon 3 ward, we found clinical pharmacists were actively involved in all aspects of a person's individual medicine requirements. The pharmacy team were part of the daily ward round which helped identify medicine issues and therefore they could be dealt with immediately. We observed a pharmacist checking a patient's medicine history and ensuring that the information was accurate which was then recorded directly onto the patient's prescription chart.
- A pharmacy technician ensured that all the patients' medicines were available for discharge including checking that a sufficient supply of at least 14 days was provided.
- On Silver ward, we found clinical pharmacists were actively involved in all aspects of a person's individual medicine requirements. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed patients were getting their medicines when they needed them.
- 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

- During our inspection we observed that medical records were securely stored in either a locked cabinet or dedicated rooms.
- In some wards, patient care plan files were kept at the end of the patient's bed so they could be accessible to the patient and their visitors. The trust had systems in place to ensure patient records remained confidential.
- During our inspection we looked at the care records of 24 patients across inpatient services. Most records were well organised, information was easy to access and records were complete and up to date and included transfer of care assessments forms, biographical details and contact details for next of kin. For example, out of six patient records we looked at on the stroke ward, including risk assessments, fluid charts, observations charts, catheter care plans, mobility assessments all have been completed accurately and reviewed regularly apart from in one instance where a skin body chart had not completed.

- We looked at six sets of patients records on Avon 4 ward and found all nursing records, including food and fluid charts, observation charts and NEWS scores, and drug charts and all were fully completed and up to date.
- We saw evidence that units were using a patient passport document called "About Me" to support care planning for people with dementia. Screening for dementia assessments were being carried out in the wards.
- Wards carried out a monthly audit on documentation in 10 sets of patients' records and outcomes were included in the monthly "matrons' audit".
- Some ward offices had posters giving guidance for staff on completing documentation records, for example, on completing a fluid balance chart.
- In the Discharge Lounge, we found patient confidential information left unattended on the desk by the main door. This meant that confidential patient information could have been viewed by other patients and visitors.
- In the MAU, we saw that a confidential drug chart for a patient had been left unattended by staff on a desk, with the potential risk that other patients or visitors may have been able to view patient confidential information.

Safeguarding

- Generally, we found there were effective safeguarding policies and procedures which were understood and implemented by staff.
- Staff were able to tell us the process for reporting safeguarding concerns and knew where they would access the safeguarding policy and procedures; safeguarding information was displayed on the wards.
- 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.
- The majority of staff had received safeguarding training. However, not all staff were able to tell us how they report a concern outside the organisation if required.
- Ward managers had access to the trust's electronic staff training database. For example, on Laurel 3 ward, 94% of staff had had safeguarding adults training and 86% had had safeguarding children training. The trust's target for compliance with this training was 95%. On Laurel 1 ward, 100% of staff had had safeguarding adults training but only 86% of staff had had safeguarding children's training. This was below the trust target of 95%.

Mandatory training

- Most wards were below the trust's target for 95% of staff having had mandatory training.
- The percentages for staff having had mandatory training across the service did not meet the trust's target of 95% in all eight of the mandatory training areas. Service wide, 85% of staff had had resuscitation training, 75% had had information governance training, 82% had had fire safety training, and 85% had had manual handling training.
- Staff told us that mandatory training generally met their needs.
- Ward 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 Laurel 3 ward's staff training records which showed most staff were up to date with the trust's mandatory training for the year. 94% of staff had had mandatory manual handling training (the trust target was 95%) and that 85% of staff had had mandatory resuscitation training. We saw training sessions had been booked for those staff still requiring this training.
- Laurel 1 ward's staff training record showed that 95% of staff had had the trust's information governance training, but only 84% of staff had had mandatory infection training and 86% had had manual handling training.

Assessing and responding to patient risk

- In accordance with the trust's deteriorating patient policy, staff used an early warning system, the National Early Warning Score (NEWS) to record routine physiological observations such as blood pressure, temperature and heart rate, and monitor a patient's clinical condition. This was used as part of a "track-and-trigger" system whereby an increasing score triggered an escalated response. The response varied from increasing the frequency of the patient's observations up to urgent review by a senior nurse or a doctor. We looked at 10 sets of NEWS scores for patients and found they had all been completed in accordance with trust policy.
- The hospital provided four beds for patients requiring Non Invasive Ventilation (NIV) and this service was therapist led. These patients were cared for by a nurse at band 6 or above and all clinical decisions about

treatment were made by respiratory registrars and general doctors that had been trained in NIV management. Doctors said NIV patients were supported by registrars and consultants' support would be requested for potential resuscitation concerns or for when transfers to critical care beds was potentially needed. This was in line with current guidance published by the Royal Thoracic Society.

- In the Medical Assessment Unit (MAU), no formal clinical triage assessment tool was used. GP patient referrals and the prioritisation for medical assessments was based on assessment information by a senior nurse and the patient's observations. Staff had not received formal training in triaging of patients.
- Clinical judgement was used and if a patient had a high PAR score (The Patient at Risk Score (PARS) was designed to enable health care professionals to recognize "at risk" patients and to trigger early referral to medical staff, so that early intervention can help to prevent deterioration), then an urgent medical review was sought. Doctors were present in MAU day and night so patients could be referred for an urgent medical assessment when needed.
- Once transferred from the hospital's Emergency Department of the hospital to a general ward, patients were not always reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, as only newly admitted patients were seen by a consultant during the weekends. A respiratory patient on the high care and short stay unit had not been seen by a respiratory consultant in the five days since they had been admitted.
- The MAU provided the facility for cardiac monitoring of up to three patients and staff confirmed they had had appropriate levels of training to be able to monitor electrocardiograms. The electrocardiogram (ECG) is a diagnostic tool that is routinely used to assess the electrical and muscular functions of the heart.
- Falls assessments were carried out to identify those patients at risk of falls and care plans were in place to minimise the risk. All falls were recorded and reported and care plans and assessments reviewed to minimise risk of further falls.
- The hospital had on-site access to levels 2 and 3 critical care (intensive care units with full ventilator support).

Nursing staffing

- Wards 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. Patient dependency levels were reviewed as part of staff rota planning.
- Senior managers and matrons said that there were only 28 to 30 nursing vacancies out of 600 posts service wide, which was less than 5%. The number of nursing vacancies had halved in the past five months and recruitment drives had been successful.
- MAU usually had a supernumerary senior nurse acting as shift co-ordinator and a qualified nurse to patient ratio of 1 to 6.
- Avon 4 ward had 2.4 WTE qualified nursing vacancies. This ward provided 22 beds and at nights the qualified nurse ratio to patient ratio was 1 to 11. The ward had 2 nurses and 2 health care assistant on duty at nights.
- Laurel 3 ward (haematology) had four nurses and two healthcare assistants during the day to care for 15 patients, giving a nurse to patient ratio of 1:4. The ward was fully staffed when we visited. The night shift was due to have three qualified nurses and three healthcare assistants, but at the time of our visit, the ward was still trying to cover two nurses and two healthcare assistant shifts.
- The medical high care and short stay unit had 14 WTE qualified nursing vacancies. Agency staff were used to fill these posts and we saw that this unit had in place an agency staff induction system and a record of these inductions was maintained. This unit also had support when required from the critical care outreach nurses.
- The cardiology ward (Laurel 1) had three WTE qualified nursing vacancies out of a staffing establishment of 24 and all three had been recently recruited to. The ward had an induction folder for all agency and temporary staff with an induction checklist but there was no ward specific written induction information available for staff. Four out of six agency induction checklists we looked at had been completed and signed in accordance with trust policy.
- Staff said nurses and healthcare assistants were moved between wards when required to cover vacancies when required.

Medical care (including older people's care)

- Senior staff said plans were in place to "grown their own" trained cardiology and stroke nurses using a skills competencies based training programme.
- The ratio of qualified to unqualified nursing staff on wards was generally 60% to 40%.
- Ward leaders aimed to be supernumerary for 80% of their shifts. On the cardiology ward, this was about 40% of the time staff told us.
- Senior staff said the hospital had escalation plans so that nurses could be moved to work in other wards when there were staffing concerns and that most staff understood the need for this flexibility.
- At nights, an advanced nurse practitioner, at band 7, who had been intensive care trained, worked to support the doctors at night.
- The Discharge Lounge, which supported seven patients and up to 17 medical day case patients, had two and a half qualified nurses usually with two or three health care assistants throughout the day. Staff said usually there was a member of staff to look after up to six patients each. Actual staffing levels met planned staffing according to the rota on the day of our visit.
- We observed a nursing handover in the morning on Avon 4 ward and found it to be very thorough and respectful of patients. Clear guidance was provided for all staff with the focus on patient safety and dignity.
- We observed a nursing handover on Laurel 2 ward and found it was comprehensive and all relevant patient documentation was reviewed to ensure staff had clear guidance to provide appropriate care for patients.
- Staff told us that extra staff could be provided if patients needed 1:1 care and reported no difficulties in obtaining extra staff when required.
- Rolling adverts for recruitment were in place, flexible working was being promoted and the trust had increased the number of assessment days.

Medical staffing

- Medical staffing was in line was national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication "Quality standards in the AMU" dated June 2012, but was a significant concern for staff; both in terms of effective recruitment at consultant level, and also for out of hours and weekend medical cover provided. Doctors felt overstretched and said the level of medical cover in the evenings and weekends was not sufficient at times.
- Doctors we spoke to considered that at times the medical cover at nights was not always sufficient. There was not a consultant on site out of hours and doctors stated that at times, the length of time for a patient who had transferred from ED to the medical care service to be assessed varied from seven hours up to 12 hours (with Monday nights being particularly busy). We looked at recent incident forms and also asked the trust if there were any reported incidents whereby patients care and treatment had been affected by this reported delay, but there was no evidence of any such incidents being reported.
- This concern had been escalated several months ago to senior managers but doctors were not aware of actions having been taken to address this concern. The trust confirmed that it did not have an effective electronic system to record the average length of time for medical assessment once patients had transferred to MAU from the ED. However manual records were being maintained in MAU and that a system was being developed to link this data capture to the ED activity.
- Out of hours during the evenings, there was a registrar and one junior doctor (F2) in the MAU (called the "take" team) with a second junior doctor (F1) covering the general medical wards. Until from 12 midday to 12 midnight, there was a second junior doctor (F2) to support the team in MAU. There was a separate rota of doctors for the surgical wards. However, at times doctors would provide cover for the other speciality when needed. A Advanced Nurse Practitioner (ANP) was also rostered to support the medical team at night, but doctors said this role was frequently diverted to support bed management and patient flow issues rather than support doctors with patients' reviews. This resulted in doctors having to leave the medical team in MAU to go and review deteriorating patients on medical wards.
- The Health Education England (HEE) Deanery visit in June 2015 highlighted a range of safety concerns raised by junior doctors including the pressures in the MAU and lack of handovers. The service devised an action plan in response to concerns which was implemented by the end of June. This included a review of the medical staffing establishment across the service which was due to be completed by October 2015. We raised this concern with members of the trust's executive team, who took action to arrange a review of the out of hours medical cover. When we returned to the hospital on our unannounced inspection, we saw that the level of cover

was meeting patients' needs. The trust confirmed that a medical workforce review was in progress with the clinical teams and that it was planning to release the ANPs (ANP) from their Clinical Site Manager duties by recruiting to Bed Manager posts to cover the Out of Hours period. This would enable the ANPs to use their clinical skills within the out of hours service to support doctors in the medical care service with the timescale for completion being the end of October 2015.

- Staff in the MAU completed a risk matrix to assess the balance of risk in the MAU including the time taken for doctors to assess patients. The trust confirmed that no incidents had occurred due to delays in these medical assessments in June to 17 July 2015. We looked at the risk matrix forms being completed in MAU and found that in nine of 14 days prior to our visit, not all the risk matrix scores had been completed as was trust policy.
- Senior staff confirmed the service had not yet implemented a multi-speciality hospital at night team (which would include anaesthetists and surgical staff) as recommended NHS Patient Safety toolkit in June 2005 "Hospital at night". In the service's action plan in response to the recent HEE Deanery visit, plans were being implemented to ensure a consultant led handover took place at nights with the target timescale for implementation of an enhanced hospital at night team being December 2015.
- There was no system in place to allow a formal medical handover in the mornings. Junior doctors said they were reliant on wards telling them about new patients and changes in patient conditions overnight. Junior doctors generally considered that medical handovers at night were effective. The medical handover at night that we observed was efficient, and there was effective communication displayed regarding people's conditions. However, there was not an electronic system in place for recording and handing over those patients at risk of deterioration. Most handovers were not routinely attended by consultants. The trust confirmed there was no written policy for medical staff handovers at night but was working on a developing an effective policy that would include the development of an electronic handover system.
- The hospital had not yet implemented the recommendations for improved, standardised handover protocols as detailed in the Royal College of Physicians "Acute care toolkit 1: handover" dated May 2011. In the service's action plan in response to the recent HEE Deanery visit, plans were being implemented to pilot an electronic patient tracking system which would then be used as part of a revised handover process. Subsequent to the inspection, the trust told us that the electronic tracking and medical update system for all patients was implemented in September 2015 and that all doctors had had training on the new system.
- Junior doctors on the stoke ward worked a six week rota with four weeks on the ward, then two weeks being on call: the two week on call period was "very tiring" and doctors said they could work up to 180 hours over these two weeks when on call. Some doctors expressed concern that at weekends, one doctor would carry the "bleep" for all medical beds and had to deal with a significantly high volume of calls over the weekends (ranging from 70 to over 100 calls a day). The HEE Deanery visit also registered these concerns and the trust's action plans in response to the visit including plans to reduce the impact on doctors.
- Staff told us that there was one consultant on call during the day over the weekend and would carry out a daily ward round for the patients newly admitted. There was no separate respiratory rota for the weekends. A cardiology consultant was on call over the weekends.
- The proportion of consultants was similar to the England average, and the proportion of junior doctors was higher than the England average. Proportion of consultants was 36% compared to England average of 34%; the proportion of registrars was 31% lower than England average of 39%; junior doctors were 28% against England average of 22%.
- Consultants carried out daily ward rounds during the week. Newly admitted patients were seen by the on call consultant at the weekends.
- The stroke ward had three substantive consultants, one locum consultant and two vacant consultant posts. The two registrars were also locums. Staff said recruitment of consultants was an ongoing concern. The recruitment of consultants was on the divisional risk register as well as the trust wide risk register. The medical high care and short stay unit had had four consultants, all of whom were locums. We saw evidence that inductions had been carried out. The cardiology ward had four cardiology consultants normally during the week and there would be one consultant on call for out of hours and weekends.
- Staff said the extensive reliance on locum doctors in the High Care and Short Stay unit led to inconsistency of

care and a lack of familiarity with the hospital's systems and process led to delays in treatment and also discharge planning. No specific incidents regarding this concern had been reported on the trust's electronic record systems for incidents.

- Staff in the Discharge Lounge said that support from doctors was generally good, but at weekends, there was reduced service in the medical day case area as no medical procedures were being carried out due to the level of doctors staffing cover.

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. However, staff at all levels were not fully aware of these plans.
- All the ward sisters 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, on Laurel 3 ward, 83% of staff had had the mandatory fire safety training against the trust target of 95%.
- Wards had ward specific based evacuation plans in place in the event of a fire. However, not all wards had access to the fire risk assessment for their own ward.
- Some doctors said the escalation areas used to cope with increased demand over the winter pressures were not always the most suitable but had raised these concerns. A new plan was in the process of being developed.

Are medical care services effective?

Requires improvement

Overall we rated this service as requires improvement for effectiveness.

People have did not always have good outcomes as they did not always receive effective care and treatment that met their needs. Mortality ratios were higher than those of similar trusts.

Performance and outcomes did not meet trust targets in some areas. There was little evidence of progress to providing seven day a week services.

Most staff said they were supported effectively, but there were no opportunities for regular formal supervisions with managers. Appraisal rates for doctors had improved.

Care planning effectiveness was variable, and care plans were not generally person-centred. Care plans for people living with a dementia were not always effective.

Care was mostly 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.

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

Multidisciplinary team working was effective.

We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was generally good.

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 would take 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 and 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 person centred.
- We saw a patient on Avon 2 ward who had been admitted to the ward with skin damage and found that all required assessments and documentation was in place to provide staff with the appropriate guidance to manage this patient's care effectively. Appropriate pressure relieving equipment was in place and we saw that the patient had also been reviewed by a tissue viability nurse (TVN).
- The hospital was not providing an effective Chronic Obstructive Pulmonary Disease (COPD) in-reach service and were not yet using the national care bundle, although staff said plans were in place to introduce this within the next two months. The COPD in-reach service would be county wide and particularly in-reaching to review and support patients in the MAU at both hospital sites staff told us.
- The hospital following the trust policy for management of sepsis (blood infection) and a sepsis bundle care pathway could be implemented if sepsis was suspected. The care pathway for suspected sepsis would usually be commenced in the emergency department. Wards did not have "sepsis boxes" available but did have access to appropriate antibiotics when required to facilitate immediate antibiotic treatment for those patients with suspected sepsis.

Pain relief

- Patients said that they received pain relief medication when they required it.
- Wards 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.
- We saw that patients' pain was assessed on NEWS charts on wards and on PARS assessments in the MAU. 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 of inpatient 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 most care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment.
- Most 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.
- The Discharge Lounge provided sandwiches and drinks to patients awaiting transfers but did not generally have access to hot meals.
- We saw that the trust's system of using red trays and red jugs, to indicate when patients were at risk of malnutrition or dehydration, were being used in ward areas.
- We spoke with a relative of a patient on Avon 2 ward who said they supported their relative with their meals as they felt "there was not always enough staff around".

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.

- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In the most recent publication of the SHMI indicator, which covered the 12 month period January 2014 to December 2014, mortality was within the expected range with a value of 1.10. However, publications of this indicator have indicated a steady rise in mortality since 2013.
- In the Hospital Intelligent Monitoring (IM) report for May 2015, the Trust was flagged as an elevated risk for its Dr Foster Hospital Standardised Mortality Ratio.
- The trust also flagged as a risk for the national stroke audit (Sentinel Stroke National Audit Programme or SSNAP) with poor results for stroke discharge (Band E) and speech and language therapy (Band D). Overall the most recent published SSNAP audit (July to September 2014), the overall score was Band E. This was the worst score in the audit with A being the best and E being the worst. The service had an action plan to address these concerns which included the recruitment of clinical staff.
- 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 had higher than average rates of readmission.
- Worcestershire hospital performed better than the England average in eight out of 11 indicators in the Heart Failure Audit for 2012 to 2013. An action plan was in place to enhance this service and progress was being monitored by senior clinicians.
- Worcestershire Royal Hospital performed well in the most recent published Myocardial Ischaemia National Audit Project (MINAP) audit for 2013/14. For the 2013 to 2014 audit, the number of nSTEMI (non-ST-segment-elevation myocardial infarction, a common type of heart attack) patients seen by a cardiologist or a member of team was 100% which was better than the England average of 94%. The number of nSTEMI patients admitted to cardiac unit or ward was 94% which was significantly better than the England average of 56%. The hospital also was significantly better for those patients who were referred for or had angiography (with 97% of patients having angiography compared to the national average of 78%).
- For the most recently published National Diabetes Inpatient Audit (NaDIA) in September 2013, the Worcestershire Royal hospital performed better that the national average in 16 out of the 21 audit measures. One of the five areas where hospital performed worse than the England average was insulin errors at 31% against the England average of 20%.
- The National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme commissioned by the Health Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Programme (NCA), sets out an ambitious programme of work that aims to drive improvements in the quality of care and services provided for COPD patients in England and Wales. In audit report in October 2014, Worcestershire hospital scored 32 against the average score (for participating trusts) of 33. An action plan was in place to enhance this service and progress was being monitored by senior clinicians.
- Senior staff said that the service had reviewed the performance for treatment of medical alcoholic hepatitis concerns, as identified as an outlier by CQC in 2014. The outcome of this review was that no significant concerns were found regarding the treatment options and delivery but rather down to miscoding issues. The coding system for reporting performance in this area had now been changed to better reflect the co-morbidities of the patient group.
- Local audits were carried out by wards to assess compliance with completion of nationally recognised assessments such as the VTE and the Malnutrition Universal Screening Tool (MUST).

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. We looked at a newly staff member's personnel file on Laurel 1 ward and saw a comprehensive induction process had been completed. A competency framework was in place for nurses in cardiology.

- 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. Some senior staff said they had not had operational supervision for over a year.
- 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.
- Junior doctors said senior support was effective and that generally the quality of teaching was very good. However, some junior doctors told us they had to attend learning sessions in their own time due to workload pressures. Some said the on call rota system for medicine prevented them from attending training sessions at times.
- Junior doctors on the stroke ward said they received weekly teaching session regarding stroke care and felt well supported by senior doctors.
- Appraisal rates for doctors across the trust were reported as 67% for the period April 2014 to March 2015 compared to 95% of organisations nationally. The trust Board meeting minutes of 22 July 2015 showed that in the medical care service, 73% of doctors and 91% of consultants had had an appraisal as at the end of May 2015. In terms of revalidation, the revalidation recommendation status from 1 April 2014 to 31 March 2015 was 125 positive recommendations, 30 deferrals and five instances of non-engagement with revalidation. An action plan was in place to continue to embed the appraisal and revalidation processes within the service.
- Nurses generally had had an appraisal that linked their training needs to personal development plans. For example, on Laurel 3 ward, 81% of nurses had had their appraisal, which was below the trust target of 100%, but we saw that appraisal had been booked on a rolling basis for the other staff. On Laurel 1 ward, 82% of staff had had an appraisal.
- 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 wards. We observed effective MDT working in the wards we inspected. MDT meetings took place on the wards on a regular basis to review the progress of each patient towards discharge. MDT assessments on complex cases generally took place within 24 hours.
- Across all of the wards within inpatient services communication between the MDT team was integral to the patient's pathway.
- We observed a comprehensive, effective multidisciplinary team discussion regarding a patient's condition and their treatment option on the stoke ward.
- We saw effective MDT working with excellent rapport and contribution from all members of the team on the respiratory ward (Laurel 2).
- Nurses said that relationships with doctors and other professionals were inclusive and positive and facilitated effective MDT working.
- Pharmacists generally attended wards rounds and were a visible presence on wards.
- Therapists were an integral part of the M|DT on the stroke ward.
- Daily MDT meetings were held on Silver ward (care of the elderly) with the focus on appropriate discharge planning and liaison with community support services and social services.
- 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.
- There was a consultant on call 24 hours a day, seven days a week to respond to urgent cases of gastro-intestinal bleeds and a consultant on call to respond to urgent cardiology cases including chest pain and for those patients requiring coronary angioplasty (a procedure used to widen blocked or narrowed coronary arteries).
- The stroke ward did not have on site consultants at the weekend and cover was provided by the on call general medical team. Staff told us the hospital did not have

enough stroke consultants to provide a seven day a week service. Patients needing acute stoke care therefore would have to travel to other nearby hospitals for treatment at the weekend.
- The hospital did not provide a weekend Transient Ischaemic Attack (TIA) clinic.
- The cardiology ward did not have consultant led ward rounds at the weekends. This meant not all patients had a timely consultant cardiologist review.
- Laurel 3 ward had haematology ward rounds seven days a week, but this did not include general medical patients that were also on the ward. Laurel 2 ward provided general medical cover at the weekends for these outlying medical patients on the haematology ward.
- Therapists worked weekends to support patients on the respiratory ward requiring Non Invasive Ventilation (NIV) only. There was not effective cover for therapists to support the stroke ward at weekends as the therapists' service was "overstretched" staff told us.
- Patients on the stoke ward told us that physiotherapy was "not available" at the weekend and one patient said that they "had lost four days of critical rehabilitation" due to this.
- Staff said there was a lack of speech and language therapists over the weekend.
- The Discharge Lounge was open on Saturdays and Sundays from 10am to 6pm.
- The MAU did not operate a GP referral service direct to MAU for patients at the weekends.
- Diagnostic services were available over the weekend and out of hours.

Access to information

- Junior doctors said that the Information technology (IT) systems were not supportive for effective sharing of information and that all systems for documenting patient treatment and care options were paper based, including handovers.
- On Laurel 3 ward, staff showed us the shared patient record folder called "personal folders" for haematology and oncology patients which contained shared medical information and treatment and care plans. Patients took this folder with them on discharge so that any other professional would have access to necessary documentation when required.
- Doctors completed Electronic Discharge Summaries (EDS) to ensure appropriate information was available to healthcare professionals regarding patients' discharges.
- Generally, nursing staff said all the information needed to deliver effective care and treatment was available to in a timely and accessible way.
- 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 endoscopy reports.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Some 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.
- Therapists told us that a patient's verbal consent was always obtained before carrying out treatment plans.
- We did not see robust evidence of meaningful mental capacity assessments being carried out and recorded on the trust's own capacity assessment documentation in most areas.
- Junior doctors said that they had, at times, been asked to assess patients' consent for radiology procedures, despite their lack of knowledge and experience in that area.
- On the stroke ward, we found that mental capacity assessments that were date and decision specific had been completed where required to inform referrals for Deprivation of Liberty safeguards (DoLS) requests. We also found in five cases that appropriate mental capacity assessments had been carried out and recorded accurately to inform decisions about whether or not to attempt cardiopulmonary resuscitation.
- On Laurel 3 ward, we saw that consent forms for chemotherapy were completed accurately and patients' mental capacity to make informed decisions was assessed and recorded in accordance with trust policy.
- Ward offices had posters on display giving staff guidance on mental capacity assessments and DoLS.

Are medical care services caring?

Medical care (including older people's care)

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 inpatient 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.

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. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- We observed outstanding care in the early morning whilst visiting Avon 4 ward and found the staff approach to patients was extremely respectful, compassionate and caring. All patients had drinks and call bells to hand. The atmosphere on the ward at this early hour was relaxed and calm with appropriate low levels of lighting, and staff spoke with each other in low tones to ensure patients were not disturbed whilst asleep.
- 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 35 patients and 16 people visiting relatives. 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 Avon 2 ward; "staff are marvellous and I cannot fault them at all".
- Patients on the stroke ward told us; "the care has been excellent" and "I could have not asked for more support".
- Staff were proud of the positive feedback they received from patients.
- Some staff said that handovers did not always respect patients' confidentiality as sometimes staff talked about confidential matters in front of other patients.
- We did observe one doctor talking to a patient in the corridor of MAU about their treatment options and we noted that other patients and visitors were within hearing range of this confidential conversation.
- Some patients on Avon 2 ward told us that at times staff did speak about patients in front of other patients.
- All wards had a performance noticeboard on display with showed the most recent Friends and Family Test (FFT) scores. For example, Laurel 3 ward's score for June was 100% positive. Laurel 1 ward's score for June 2015 was 96%.
- The trust was in the top 20% for one of the 34 indicators in the 2013/14 Cancer Patient Experience Survey, and in the bottom 20% for seven indicators.
- The trust's average response rate in the Friends and Family Test (FFT) was close to the England average.
- In February 2015 most wards at both main acute sites scored well in the FFT.

Medical care (including older people's care)

- The trust participated in the 2012/13 National Cancer Experience Survey; 1269 eligible patients from the trust were sent a survey, and 765 questionnaires were returned completed. This represented a response rate of 66% once deceased patients and questionnaires returned undelivered had been accounted for. The national response rate was 64%. The trust scored in the top 20% nationally for six of the questions including those relating to staff asking what name the patient preferred to be called by and getting understandable answers to questions from the Cancer Network Service.
- However, there were four questions for which the trust's responses were in the bottom 20%. These included the questions relating to patients not being given easy to understand written information about their investigations, and not being given information about support groups.

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 observed therapists supporting and involving patients appropriately with their therapy assessments on the stroke ward.
- Wards had a named nurse system so patients and their relatives generally knew who was looking after them.
- 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 rehabilitation or changes of arrangements were required prior to safe discharge. Not all patients said doctors explained their treatment options for them.
- Patients and relatives on the stroke ward said they had been fully involved in decisions about their care.
- Some patients were not always clear about their plan of care.
- We found there was little activity for patients who had been admitted for many weeks.
- We found that generally, patients were not closely involved in the multidisciplinary meetings and decision making about their plan of care and discharge.
- There was no consistent routine for including patients or informing them about the multidisciplinary decision making.

Emotional support

- Most patients we spoke with were very positive about the support they had been offered by the multidisciplinary team.
- We saw some evidence in care records that communication with the patient and their relatives was maintained throughout the patient's care.
- 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?

Requires improvement

Overall we rated this service as requiring improvement for responsiveness.

People's needs were not consistently met through the way services were organised and delivered.

Cancer referral to treatment times were below the national average.

There was an elevated demand on bed availability at times, and the way medical patients were supported in outlying wards was not always appropriate. There were high numbers of patient moves daily.

Medical patients in outlying wards were not always effectively managed. There was not a policy in place regarding the management of outliers.

Some problems with the effective discharge of people were highlighted across the medical care service, from both staff and some of the patients we spoke to.

Whilst the trust had implemented a dementia care strategy, there was more work to do in terms of effective care planning to provide effective person-centred dementia care.

Medical care (including older people's care)

The hospital was looking at plans to reduce the impact of patients with a delayed discharge but there was variable engagement from clinicians in this initiative.

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

Service planning and delivery to meet the needs of local people

- The service generally understood the different needs of the people it serves and acted on these to plan, design and deliver services.
- The service generally planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible, 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.
- The centralisation of stroke services in the summer of July 2013 had led to all stroke services being located on the Worcestershire Royal hospital site. However, the lack of a seven day TIA service meant that some patients needed to be seen at other nearby trusts at the weekends. The trust was working to recruit stroke consultants to provide the commissioned level of cover at the weekends.
- Senior managers told us that an Acute Services Review with local commissioners was underway at the time of the inspection and that this included bed capacity remodelling across the trust. Senior managers told us that the medical care service was a lack of bed capacity the hospital needed and that strategic planning for the service was dependant on the outcomes of the Acute Services Review.
- Proposals for the hospital to introduce an Ambulatory Care Unit were discussed with local commissioners in early 2014, but this model service for diverting hospital inpatient admissions had not been introduced by the service at the time of our inspection.
- We observed an integrated approach to care delivery across all the wards 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 both hospitals and the trust was also planning to expand the sleep service for patients with ongoing respiratory health conditions.
- In MAU, some patients were seen and assessed by doctors in the corridor area, due to lack of available side rooms and cubicles at times of high patient demand. Staff had screens to use but these did not always allow for patients' dignity and confidentiality to be respected. Doctors said this lack of space, at times, impacted on dignified, effective patient care.
- The Discharge Lounge could not accommodate patients requiring hoisting as there was not a hoist provided so patients referred needed to be independently mobile, with or without a walking aid.

Access and flow

- Due to bed capacity and high level of patient admissions, at times there was ineffective patient flow through the hospital. There were high numbers of patient moves between wards at night and high numbers of patients awaiting discharge.
- The patient flow team staff said the patient flow management system was not yet fully effective and that 8am board rounds were not yet fully established practice on all medical wards. Consultant engagement with the process had improved staff told us but there was more work to be done to fully embed the systems to facilitate timely discharges.
- Junior doctors had raised concerns to the senior managers that with the reconfiguration of the hospital's Emergency Department (ED), and establishment of the Pre-Assessment Unit (replacing the Clinical Decision Unit), meant that patients that were previously cared for in the corridor area of the ED at peak times of demand, were now in effect being cared for in the corridor area of the MAU, and that the concern had been moved from ED to the MAU. Whilst we were on site on two occasions, we did not see patients being treated in the corridor. We observed people sitting in this corridor area that had been seen by a doctor, but not being actively treated. Staff said at peak times, low risk patients would be treated in this are provided they had been seen by a doctor and it was appropriate for them to wait in this corridor area. Incident forms we looked at showed no evidence of patient safety being compromised by being in the corridor area.

- A patient on Avon 2 ward told us they had been moved onto the ward at 11.30pm as "their bed was needed on the other ward". The patient said that staff had explained the reasons for the move at the time. Trust policy stated that patients' moves at night should not occur after 9pm, unless a critical condition meant it was necessary. In August 2015, there were 594 patients' moves after 9pm at night, which was an average of 19 per day. The information we were given by the trust did not specify which moves were for urgent clinical reasons or which were for bed management issues. 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.
- Bed management "Hub" meetings were held three times a day 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.
- Staff told us morning consultant ward rounds mostly included discussions about patient discharges. This generally allowed for an early assessment of the patients plan of care, discussions with the patient and their relative and, to identify any potential barriers to discharge. Junior doctors said there was still a significant problem with patient flow despite the recent introduction of the bed management team.
- There were 25 medical patients outlying in other speciality beds on the day of inspection. The trust said there was not a written policy in place governing the management of outlying medical patients. Staff said these patients were discussed during ward rounds but not always seen as part of the round. Avon 2 ward staff said that there were 10 gastroenterology patients in outlying beds on other wards on the first day of our inspection. These patients were seen as part of the consultant's ward rounds doctors told us. We saw from medical notes that patients were reviewed by doctors, but not consultants daily at the weekends. Staff on Laurel 2 ward said some respiratory patient had to be cared for on other wards due to a lack of beds on their ward. They felt this contributed to a slower discharge process for those patients. Plans were being devised to extend the capacity of the respiratory ward staff said but timescales for this were not known.
- Staff said the gynaecology ward (Lavender) ward was used for medical outlying patients. Some doctors said the ward staff team was not always able to manage complex medical cases. We visited this ward and found that there was not clear written guidance for the admission of medical patients to this ward and that at times, staff were not able to manage the needs of some patients effectively, particularly patients with cognitive impairments and displayed difficult behaviours. We raised this as a concern to senior managers. When we returned to this ward as part of our unannounced inspection, we saw that new written guidelines were now in place giving guidance for staff to assess the appropriateness of referrals for medical patients to this ward.
- The average length of stay in the MAU was 24 hours for those patients cared for in the beds provided and for up to 12 hours for those patients that were being cared for on a trolley. The MAU provided 18 cubicle spaces (nine male and nine female) with space for up to six patients on a hospital trolley. Staff said the trust had a policy for patients being cared for on a trolley and it would be for up to 12 hours. Hospital beds could be provided if required. Individual risk assessments were not carried out for patients being cared for on a trolley but staff said the medical and nursing assessments and treatment plans did reflect when this care was being provided. Medical notes for two patients we looked at reflected the fact that they were being supported on a trolley and there was evidence of a risk assessment having being carried out.
- On the day of our inspection, there were 41 patients who could have been discharged, with two thirds being at Worcestershire Royal hospital,
- We visited the Discharge lounge as part of the inspection. This lounge was open from 8am to 8.30pm Mondays to Fridays and at weekends from 10am to 6pm. The lounge also supported medical day case patients. The Discharge Lounge provided seven chairs but had no facility to accommodate patients on beds, although

plans were being looked at to increase the capacity of the unit to allow this. The medical day case area provided three bed spaces and 14 chairs and staff said it was full on most days. The average length of stay in the lounge was four hours. The numbers of patients using the Discharge Lounge varied each day, but in the two days prior to the inspection, there had been six patients on one day and five patients the second day using the lounge. Staff said there used to be many more patients using the discharge Lounge three years ago, but the focus was currently on supporting medical day case patients so the Discharge lounge had a minimal impact on patient flow at the time of inspection.

- Avon 4 ward was designated ward where most patients that were experiencing a delayed discharge were cared for. The ward had appropriate systems in place to manage admission and ongoing care of these patients whilst awaiting discharge.
- The home oxygen service provided support to patients that had returned to the community and this service was effective in provided pulmonary rehabilitation and was meeting all its performance indicators.
- 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.
- "Awaiting further NHS non-acute care" was more than twice as prevalent as a reason for delayed transfers of care for the trust compared to the England average. "Completion of assessment" was also a more prevalent reason for delayed discharge than the England average.
- In the period April to June 2015, bed occupancy levels for acute and general medical services were the same as the England average, at 88%.
- The trust had consistently met the Referral to Treatment time 18 week target for admitted patients at trust level.
- 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 Worcestershire Hospital was 4.9 days, which was slightly higher than the England average of 4.5 days for elective treatment. It was the same as the England average for non-elective treatment at 6.6 days compared to 6.8 days.
- The Medical Assessment Unit (MAU) took referrals from GPs from 8am to 8pm. At other times, and at weekends, there was no GP referral service to the MAU so patients were required to present at the hospital's Emergency Department at times when attendances were usually higher.
- The hospital did not provide an Ambulatory Care Unit and doctors told us this resulted in unnecessary admissions for patients, who could, provided the appropriate care pathway was followed, be managed either as day case, or in the community.
- The Discharge lounge had little pharmacy team input. We were told by staff in the discharge lounges that they would welcome support from the pharmacy team. In particular to help with counselling patients and to improve the waiting times for medicines when patients are discharged. This would help the overall flow of patients through the discharge lounge process. The pharmacy team recognised that this would be beneficial and are looking at future plans to enable this facility.

Meeting people's individual needs

- Care plans were not consistently personalised or holistic to enable people to maximise their health and well-being. Not all patients were able to describe what their care was and how it was being delivered to meet their needs. The needs of people living with a dementia were not always detailed in care plans and assessments and most assessments and care plans lacked a person centred, individualised approach apart from on Silver and Avon 2 wards where more guidance for staff was available in the written records.
- Some nursing care plans focused on specific identified needs, for example: falls, nutrition, pressure area care. Information from the trust's "About me" documentation for care of people living with a dementia, was not consistently transferred through to meaningful nursing care plans to provide clear guidance for people living with a dementia.

Medical care (including older people's care)

- 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.
- 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, particularly regarding documentation.
- 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 said sometimes it took time for these information books to be completed as they were reliant on families to complete them. On the stoke ward, we found that two out of four of the "About me" documents that we looked at had been completed.
- Laurel 3 ward staff said they received appropriate support from a dementia link nurse when required.
- On Avon 2 ward, we saw staff had effectively communicated with a patient with a learning disability about their treatment options by use of large pictorial information sheet. The ward had also received appropriate support from a specialist learning disability liaison nurse.
- 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 wards 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.
- Whilst all wards had information boards showing a range of information for patients and visitors, these boards did not provide any information in different language formats.
- Some of the information regarding people living with a dementia was in a small, hard to read format for both visually impaired patients and people living with a dementia. There was a lack of pictorial information leaflets for people with a learning disability.
- Staff on the stroke ward told that if patients required information in other formats, they could request communication aids from therapists.
- 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 and staff told us they were given to patients on admission.
- Patients said there was lack of stimulation for patients waiting in the Discharge Lounge as there was no television to watch. There was a radio and magazines available.
- Visiting times could be flexible to allow for relatives of elderly patients to maintain family contact throughout long periods of admission.
- In most wards patients had minimal stimulation or activities provided beyond access to a television or radio. In addition some patients were in the wards recovering from an illness or injury which meant a level of change of their abilities and likely future lifestyle.
- 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.
- The Discharge Lounge could not accommodate patients requiring hoisting as there was not a hoist provided so patients referred needed to be independently mobile, with or without a walking aid.
- Patients generally said the meals provided were good and most people said they were offered a choice appropriate to their dietary preferences.

Learning from complaints and concerns

- 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.
- Complaints procedures and ways to give feedback were in place.
- 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.
- We saw many examples of compliment letters and thank you cards displayed in ward areas.
- There was a complaints procedure on display in most of the wards. Staff told us that during their admission process patients were routinely given a leaflet containing information on how to make a complaint.
- Patient feedback was generally very positive about the staff and service.
- Staff said complaints and incidents were not 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.
- Staff said senior nurses investigated complaints and the outcomes were usually discussed with staff. Wards had performance boards on display so visitors and patients could see how their comments were being acted upon.
- On Laurel 3 ward, we observed a nurse supporting a patient effectively and respectfully who was wishing to make a complaint. Appropriate advice and information was given to the patient.
- From the trust's Patient Advice and Liaison Service (PALS) annual report for April 2104 to March 2015, the medical service had had 223 complaints in total for the year of which 66% had been responded to within the trust target for a response of 45 days. Matrons recorded complaints for specific wards as part of the "matron's audit". Some staff did not receive feedback or information from complaints or what had been done to address the concern.

Are medical care services well-led?

Inadequate

Overall we rated this service as inadequate for being well-led.

The leadership, governance and culture did not promote the delivery of high quality person-centred care. Known concerns had not always been responded to and acted upon.

The visibility and relationship with the management team was not 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, and said work pressures, due to higher patient dependencies, was an area of concern.

Most staff felt valued and listened to and felt able to raise concerns. However some staff felt they weren't involved in improvements to the service and did not receive feedback from patient safety incidents. Some staff felt isolated.

The medical care service was generally well-led at a ward level, with evidence of effective communication within ward staff teams, but there was not always effective leadership from senior managers and clinical leaders as concerns raised were not always acted upon in a timely manner.

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

- The trust overall had a forward looking statement of vision and values, but not all staff were fully aware of this vision.
- 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.
- Consultants said the trust's reconfiguration plans for the two main hospitals were instrumental in providing the way forward for the whole service development and without this reconfiguration, there would be "no way

forward" and that longstanding difficulties in recruitment of doctors would not be resolved. They said this presented risks to all specialities due to lack of permanent doctors at middle and senior grades. Subsequent to the inspection, the trust provided further information giving detailed actions being put in place to resolve longstanding service reconfiguration concerns and staff recruitment.

- Seniors managers told us of the service's aspirations for cross county integrated working with effective links to community care support.
- All the ward sisters told us they felt part of the trust and some staff described a trust that listened to, valued and supported staff.
- All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed.
- Not all staff were aware the trust's values and vision, though some were very aware and stated that the vision and values had been part of their interview process.

Governance, risk management and quality measurement

- Senior staff said there was not an effective service specific safety dashboard available for all staff and that the trust wide safety and quality dashboard was not yet effective in identifying risks and quality concerns. Matrons said there used to be a ward based dashboard in place "last year", but this had ceased a new one was in the process of being developed. Matrons did get a monthly email with safety performance information which was cascaded to staff teams.
- Local wards did not have their own risk registers in place. Ward 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. However, junior staff did not have a full awareness of this governance process. Not all staff were aware of the service risk register Doctors had escalated concerns about the lack of space in MAU, meaning at times patients were assessed and treated in the corridor area, in the previous autumn, but no action had been taken. Health Education England had carried out a Deanery visit in June 2015 and the report highlighted a number of concerns raised by junior doctors including the pressures in MAU and the Pre Assessment Area (PAA), an incident whereby a junior doctor had been required to act up as a registrar, that not all outlying patients were always identified to the medical team, the unstructured nature of handovers, and concerns about junior doctors being "pressurised" into taking consent for patient procedures. Consultants said that handovers were still not robust and that the work pressures issues in MAU and PAA were unresolved and it had not been communicated to them what actions were being taken to address these issues.
- Junior doctors said they had raised concerns "several months" ago to the trust's senior managers regarding the insufficient medical cover at nights but that no action had been taken to resolve this concern. Staff said an extra junior doctor had been on the rota for the week of the inspection visit during the nights, but there had been no change for the night cover.
- Subsequent to the inspection, the trust provided further information with defined actions and timescales being in place to address the above concerns, including the PAA returning to become a Clinical Decision Unit, handovers to be formalised, enhancement of the out of hours medical cover rota and the implementation of an electronic patient tracking system to monitor outlying patients.
- Ward sisters across all wards demonstrated some awareness of 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. However, on some wards we found that there was a lack of understanding in relation to how learning from incidents was implemented as not all staff were aware of learning from incidents being regularly discussed at team meetings.
- At a local level, there was variation in arrangements to investigate and learn from incidents.
- Matrons said senior nurse meetings were held monthly and issues discussed would be special mortality reviews, patient concerns, serious incidents and how to implement ward based changes to learn from incidents. An example of this was the introduction of a bed space audit checklist that was competed daily and included checks on oxygen supplies.
- Wards 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. Staff said performance information and learning from complaints was discussed regularly at team meetings, but this was not consistent across the service.
- The trust's Board Assurance Framework dated 16 June 2015 showed a significant risk of the failure to redesign services in a timely way will have negative impact on recruitment of adequate numbers of clinical staff to ensure safe, high quality care will be delivered.

Leadership of service

- Staff and leaders in the wards generally prioritised safe, high quality, compassionate care and promoted equality and diversity. A recent change in the leadership within the division had provided a fresh impetus in terms of resolving some longstanding concerns in the division. Work was in progress to address the concerns from the HEE deanery visit but overall quality and safety systems were not well defined and understood across the service. The SHMI was high and the service had not been proactive in managing this risk.
- Senior leaders understood what the challenges were to delivering high quality care and but had not always took action to address them.
- The majority of staff felt respected, valued and supported. Local leaders communicated effectively and were visible to teams and staff.
- Junior nurses spoke highly of the support and leadership they received from the matrons. However, most staff said senior leaders were not visible. Most staff said feedback from senior managers was improving.
- Consultants said there was a reasonable relationship with managers, some of whom were new, but that felt that some of the main challenges to the trust had not been resolved at local level for many years.
- Matrons had met some, but not all of the executive team, and some felt there were not visible on the wards. Senior staff met the divisional managers regularly, but junior staff said this was infrequent.
- Junior doctors said there was a supportive culture on the stroke ward, with senior doctors being available and approachable.
- Almost all staff felt able to raise problems and concerns without fear of being penalised, bullied or harassed.
- Local teams generally had clearly defined tasks, membership, roles, objectives and communication processes.
- Staff on Avon 4 ward demonstrated effective and considerate team working during our visit and said their ward leaders were very supportive and treated all staff inclusively.
- Doctors and nurses on Laurel 2 ward (respiratory) said senior support was excellent and communication was very effective.
- Nursing staff reported that they generally felt supported by their manager within 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.

Culture within the service

- Across all wards staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered. Most 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.
- Senior staff said the recent visit by the HEE Deanery (in June 2015) had raised concerns from junior doctors, that had been not been identified as such by the consultants in the in the medical care division.
- Consultants spoke of the positive relationship with consultants at the trust's other main hospital and the open sharing of views regarding the planned reconfiguration of the medical care service across the two hospitals.
- Some speciality consultants said their views were under represented in the service.
- Senior staff said there was generally a cohesive style throughout the division. Staff did not express concerns about bullying or harassment. Senior staff complimented the attitude and dedication of all staff in the service.
- Nurses told us that working long hours due to their commitment to patient care and their wards did present work/personal life challenges at times. Not all staff were able to take regular breaks and many worked frequently above their contracted hours.
- Staff on Silver ward said they felt isolated and not listened to or involved with the service.

- The staff survey carried out in 2014 reported some concerns with staffing levels and the working of extra hours.

Public engagement

- The trust and all staff recognised the importance of the views of patients and the public. A standard approach was taken to seek a range of feedback with participation and involvement with both the public and staff including surveys, comment cards and questionnaires.
- The voices of staff were not always encouraged, heard and acted on, including all equality groups. Information on patient experience was reported and reviewed alongside other performance data but not all staff felt patient feedback was used to make informed d decisions about the service.
- Patients were asked for their views about the care they received. Views were displayed on a performance board in patient areas. Some wards show examples of making changes as a result of feedback received.
- Most staff said the main way that patients' views were gathered about services was via the ward questionnaires.

Staff engagement

- Staff generally did not feel actively involved in making decisions about the service. There were instances of effective ward leadership and support but not all staff felt their views were being heard at more senior levels. Some staff said there was a culture of "silo working" and that best practice was not effectively shared across the trust.
- Staff in the Discharge Lounge said that they had not yet been fully consulted about the proposed new design of the Discharge Lounge and Medical Day Case unit but that their matron was taking action to ensure they would be involved in the planning of this reconfiguration.
- We saw information displayed on the wards advising staff of the whistleblowing procedure.
- Staff generally felt communication was "top down" and didn't always feel their views were listened to at senior levels in the service.
- An example of effective change management was on Avon 3 ward, where following staff concerns about the effectiveness of the cleaning service, the service was changed to give dedicated areas to ward domestic staff, which improved the overall standards of cleanliness in the ward.

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.
- Not all staff were able to tell us about the trust's strategic plans for their service and did not feel they could contribute effectively.
- Some consultant said their plans for improvement strategies were not heard at senior levels in the trust.
- MAU staff had implemented an initiative for an early review of patients with diabetes and had reducing the number of medication errors by a proactive approach to assessing medicine treatment options. Staff told us the number of diabetic related medication errors had reduced to only two such incidents in the past seven months. The diabetic team had also reducing the number of hypoglycaemia episodes (low blood sugar events) by 40% by actively reviewing all patients whose blood sugar tests had been below 3 mmol. The diabetes team had also won a national award for the promotion of education about diabetes.
- A dedicated helpline was available for haematology and cancer treatment patients.
- The hospital had joined with another nearby NHS trust to act as a satellite service in a shared bone marrow transplant service which allowed patients to be treated closer to home.
- Laurel 2 ward had focused on admission avoidance as some treatments were provided in the ward's treatment (for example a pleural drain to remove fluid from the lung) so that some patients could return home quickly with appropriate community support and ongoing ward liaison when required.

Surgery

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

Information about the service

The Trust provides services to a resident population of 550,000 people in Worcestershire. This report relates to surgery services provided at Worcestershire Royal Hospital (WRH) which consists of 8 surgical wards, plus a surgical clinical decisions unit (SCDU) and 9 theatres to provide planned (elective), emergency and day case surgery. The SCDU provides interim care for patients either referred by their general practitioner or admitted via the emergency department, requiring an urgent surgical clinical assessment.

Surgery services provided by Worcestershire Acute Hospitals NHS Trust are located on three other hospital sites, those being Alexandra Hospital (AH) Kidderminster Hospital and Treatment Centre (KH) and Evesham Community Hospital (ECH) (Burlington Ward only).

Services at AH, KH and ECH are reported on in separate reports. However, services on all four hospital sites are run by one management team. As such they are 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.

As part of our inspection we spoke with 23 patients, 3 relatives and 60 staff. We spoke with a range of staff including nursing staff, junior and senior doctors, administrative staff, and physiotherapists and housekeepers. We observed care and the treatment patients were receiving and viewed all or part of nine care records. We sought feedback from staff and patients at our focus groups and listening events.

Surgery

Summary of findings

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

Risk assessments especially for risk of pressure ulcers were not always completed and used effectively to protect patients from harm.

There was a lack of responsiveness to audit results, for example, the National Emergency Laparotomy Audit.

An interim plan was in place for some patients requiring emergency surgery to be assessed at the Alexandra Hospital and transferred to Worcestershire Royal Hospital. The trust's Risk and Options Impact Assessment for this change identified that there was an ongoing risk of a potential delay in care due to the additional ambulance transfer

Information about effectiveness of care was reviewed at senior management level but was not always shared at all levels of the organization to improve care and treatment and people's outcomes.

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 opthalmology. The proportion of patients whose operation was cancelled that were not seen within 28 days following the cancellation had been increasing during 2014 to 2015 and been above the England average since October 2013.

Although patients were involved in the initial planning of their discharge they were not offered a choice about where they were discharged to for continuing care.

Compliance with mandatory training for staff was below the trusts targets as were completion of appraisals. Patients told us they received a slow or unsatisfactory response to concerns raised. The trust performance data regarding complaints showed that 20% of the time the service did not respond to patients' formal complaints within 25 days in accordance with the trusts complaints policy.

A consistent approach to governance and risk management within all surgical specialities had been established. However, information and actions from governance meetings had yet to be cascaded to ward level.

Surgery

Are surgery services safe?

Requires improvement

Overall we rated this service as requiring improvement for safety.

Patients were not protected from avoidable harm. Risk assessments were not completed and used effectively to prevent the development of pressure ulcers. There had been 18 serious incidents reported in the previous 12 months of Grade 3 pressure ulcers, of which eight were reported as avoidable, however at the time of our inspection there were no patients with grade 3 or 4 pressure ulcers.

The overall quality of medical record keeping was found to be poor although actions had been taken to address this to ensure patients received safe care.

The need to provide a sustained 24-hour interventional radiology service as identified by the 2014 National Emergency Laparotomy Audit (NELA) had not been addressed despite being recorded as a moderate risk on the radiology risk register in April 2015.

An interim plan was in place for some patients requiring emergency surgery to be assessed at the Alexandra Hospital and transferred to Worcestershire Royal Hospital. The trust's Risk and Options Impact Assessment for this change identified that there was an ongoing risk of a potential delay in care due to the additional ambulance transfer

There was a lack of experienced doctors to cover the trauma and orthopaedic service during out of hours (weekends and nights). This was noted on the surgical department risk register

Staff received some feedback about incidents and there was evidence of lessons learnt in response to incidents. Medicines and equipment were appropriately managed.

Staff received mandatory training including training to understand and respond appropriately to safeguarding concerns however compliance with mandatory training for staff was below the trusts targets as were completion of appraisals.

Infection prevention and control measures were well practised.

The environment and equipment were safely managed. There were arrangements to respond to emergencies and major incidents.

Incidents

- There had been no reported never events in the surgical wards or theatres at Worcestershire Royal Hospital (WRH) 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.
- Between April 2014 and May 2015 there had been 24 reported serious incidents; of these 18 were Grade 3 pressure ulcers. The pressure ulcers had been assessed and confirmed by the Tissue Viability Nurse as hospital acquired Grade 3 pressure ulcers, of which eight were reported as avoidable,however at the time of our inspection there were no patients with grade 3 or 4 pressure ulcers. A nationally recognised grading system was used to determine the severity of these ulcers; Grade 3 indicated full thickness skin loss and Grade 2 partial skin loss. The other reported serious incidents mostly related to slips, trips and falls.
- Serious incident reports and their analysis were well documented. They provided detailed information about the incidents, analysis of the cause and recommendations to prevent further incidents.
- Serious incidents requiring investigation were reported, investigated and escalated to senior management. These were reviewed at the monthly Safe Patient Group and Quality Improvement Meetings.
- Staff were aware of the risk register and were able to give examples of items that were on the risk register such as the high demand for medical beds resulting in outliers on surgical wards. (Outliers are medical patients being cared for on surgical wards) This was classified as a very low risk and had been on the register since 2004. We asked for, but did not see any evidence of reported incidents where the patient's safety had been compromised as a consequence of this issue.
- Nursing and medical staff understood how to use the hospital's electronic incident reporting system and were aware of their responsibility to raise concerns and report near misses and safety incidents.

- Staff were able to describe changes that were made as a result of learning from incidents. For example theatre staff and anaesthetists were able to tell us about changes to the storage of medicines in the anaesthetic rooms in theatre following a medication error involving the use of and antibiotic for a patient allergic to penicillin. Penicillin based antibiotics were no longer kept in the anaesthetic room but had to be requested in order to prevent the accidental administration of penicillin to a patient who was allergic to penicillin.
- We looked at three sets of minutes of ward meetings but we did not find evidence incidents were consistently reviewed with staff to ensure shared learning. Serious clinical incidents did not appear as a standing agenda item for ward staff meetings. However staff received some feedback about incidents through the issue of an electronic newsletter provided by the hospital.
- Staff understood their responsibilities with regard to the Duty of Candour legislation. The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient and any other relevant person within 10 days. Staff in most areas we visited told us involving potential mistakes in patients' care or treatment were investigated and findings were shared with patients, and where appropriate, their relatives. They also described the need for patients involved in incidents to be given an apology.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Information was displayed in the ward corridors for patient's relatives and staff. This included information on falls, pressure ulcers and infections. Staff we spoke with were aware of the data and used this as an indicator of the safety of the care they provided and where risks had been minimised.
- At the time of the inspection, there had not been any incidents of falls in the past month, no new Methicillin-Resistant Staphylococcus Aureus (MRSA) infection in the past year and there had not been any reported hospital acquired pressure ulcers in the previous month.
- Mortality and morbidity cases were reviewed at the divisional governance meetings. We saw minutes of meetings where cases had been presented and reviewed. There was evidence of actions taken in response to findings reported by the coroner such as the introduction of auditing compliance with the completion of risk assessments of patients for Venous Thrombolytic Embolism (VTE).

Cleanliness, infection control and hygiene

- The wards and theatre departments were visibly clean and odour free.
- Staff had received training about infection prevention and control during their initial induction and during annual mandatory training. We saw that 83% of eligible nursing staff had completed their training in infection prevention and control and 96% of staff had completed their hand hygiene training.
- There was a specific cleaning schedule in place. Cleaning staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor and we saw evidence that regular checks had been completed.
- Audits were completed when a case of Clostridium Difficile was reported to the infection prevention and control team to ensure staff were compliant with protocols to minimise the risk of spread of infection. Recent audits showed a compliance score of 94 out of 100.Where non-compliance had been identified recommendations were made to improve compliance such as ensuring the patient has sufficient information to understand their diagnosis and the care provided. There was also a rapid risk assessment process completed for patients with symptoms of vomiting or diarrhoea to ensure immediate measures were taken to minimise the risk of spread of infection.
- We observed that staff followed the trust's policy regarding infection prevention and control. This included being 'bare below the elbow', hand washing and the correct wearing of disposable aprons and gloves.
- Practice relating to measures to prevent infection such as hand cleaning were regularly audited and showed a compliance rate of 98% or more for surgical wards.
- Hand cleaning was well promoted. Hand washing facilities and hand wash gels were readily available for patients, staff and visitors in all areas and were being used consistently. There was a prominent hand cleaning station in the main reception of the hospital for visitors to use when entering the premises.

- Patients commented staff were always cleaning their hands. They said, ''they constantly remind us to clean our hands.''
- Rates for methicillin resistant staphylococcus aureus (MRSA) and Clostridium Difficile for the trust were within acceptable range nationally.

Environment and equipment

- The ward and theatres were spacious and well-lit and corridors were free from obstruction to allow prompt access.
- In theatres where storage of supplies and equipment in corridors was necessary, because of lack of space, the areas had been risk assessed. As a consequence suitable closable containers had been purchased to ensure safe clean storage of supplies. These corridors were not used for the transporting of patients to and from the department. Safe storage of equipment and its cleanliness was audited on a monthly basis
- Resuscitation equipment was clean and daily checks were made and consistently recorded to ensure equipment was complete and fit for purpose.
- There was a difficult airway trolley in theatres. The Association of Anaesthetists AAGBI Safety Guideline 2012 for Checking Anaesthetic Equipment 2012 recommends 'Equipment for the management of the anticipated or unexpected difficult airway must be available and checked regularly in accordance with departmental policies. A named consultant anaesthetist must be responsible for difficult airway equipment and the location of this equipment should be known. This equipment was checked and there was evidence anaesthetists took responsibility to ensure equipment was fit for purpose. This meant staff could effectively respond in an emergency situation. Study days were held to ensure medical and nursing staff understood how to respond and manage difficult airway situations
- Bed areas were checked on a daily basis on the wards to ensure the equipment such as suction and emergency call bells were in working order. This meant the bed areas were in a state of readiness for the safe admission of new patients being admitted to the ward and fit for purpose for those patients occupying a bed.
- To improve safety, some equipment has been standardised, such as the provision of anaesthetic machines. The same machines were used in every anaesthetic room and operating theatre throughout the trust.

Medicines

- Medicines were delivered in secure containers to temperature controlled locked rooms. We saw records of the daily checks of ambient temperatures in the medicines storage room had been routinely completed. Stock was listed per locked cupboard to enable staff to quickly access medicines required. Pharmacists ensured stock levels were adequate to meet the needs of the ward and stock rotation was managed effectively, with those items to be used first clearly marked. Unwanted medicines were removed by pharmacist for safe disposal.
- Medicines requiring refrigerated storage were stored appropriately. We saw that the temperatures of the refrigerators were checked and recorded each day. Staff were aware of what action to take if the fridge temperature was outside safe parameters.
- Controlled drugs were stored and managed appropriately. Entries in the controlled drug registers were made as required in that the administration was related to the patient and was signed appropriately, new stocks were checked and signed for, and any destruction of medicines were correctly recorded. In the theatre department where ampoules of medicine were frequently only partly used there were registers to allow specific recording of how much of an ampoule had been used, how much disposed of. This meant there was a clear system of traceability of controlled drugs. Emergency medicines were available for use and there was evidence these were regularly checked.
- Specific trays were provided for the transportation to the patient bedside of injections and intravenous drugs which included sharps bins. This meant needles could be safely and correctly disposed of to ensure risk of needle stick injuries for staff and patients were minimised.
- Medicines were recorded and administered accurately. We observed the preparation and administration of intravenous infusions. These were administered safely and correctly in accordance with the hospital's policy.
- Staff had access to up to date medicines information such as British National Formularies (BNF's) and the trusts medicines policy. BNF's were managed by the pharmacy team to ensure staff only used the most recent version to ensure patient safety.

Records

- We reviewed nine sets of nursing and medical records. The use and completion of risk assessment tools was variable. Analysis of incidents recorded by the Tissue Viability Nurse had shown there were on occasion gaps in the use of the Waterlow risk assessment tool and skin maps to assess patient's risk of developing pressure ulcers and this had been reported as a contributing factor to patients with avoidable Grade 3 pressure ulcers.
- The quality of medical record keeping was found to be variable. We spoke with a patient who had been told they would require chemotherapy as a result of metastases (secondary cancer) identified during surgery. We looked at the patients operation notes which were very difficult to read and could find no evidence of this finding in the operation notes.
- Prescription drug charts were clear and complete. Medicines were signed for appropriately. If medicines were discontinued, the charts were signed and dated on the date of discontinuation and crossed through.
- There was evidence in the medical records of discussions with the patient and their relatives regarding progress and treatment planned. Pre-operative assessments had been correctly completed. We reviewed risk assessments, including those to assess risk of pressure ulcers and found these to have been fully completed.
- Staff used sheets containing patient identifiable information for their daily handovers. To ensure confidentiality shredder bins were provided in each ward area to allow safe disposal of this information.
- The patient notes and all associated clinical work, such as medicine administration, were all completed on paper records then scanned on to the trusts electronic record system. There was a record keeping group formed to ensure the effective implementation and management of electronic records.
- Medical notes were scanned after a patients discharge but the most recent episode of patient care was retained in hard copy for staff to access. At the time of the inspection there was no protocol regarding the correct management of electronic notes and limited training for staff to use the system. However there were quality controls to ensure records were complete before being scanned and archived.
- A member of the records team was on call to respond to urgent requests for medical records.
- The nursing and medical notes were stored away from public view, for example in ward offices to ensure patient confidentiality but were easy for staff to quickly access. Daily care records such as fluid balance records and care plans were stored in folders at the patient bedside. We looked at samples of records which were fully completed, legible with entries timed, dated and signed.
- Records were designed in a way that allowed essential information, for example allergies and medical history, to be recorded and easily viewed.

Safeguarding

- Staff were able to describe the process for making safeguarding referrals. Staff were knowledgeable about the identification of safeguarding concerns and the actions they should take.
- Staff had received training to understand and respond to safeguarding concerns for adults and children. The trusts target completion rate for training about safeguarding concerns for adults was 95%.There was a training completion rate for staff in the surgical division of 84%. There were safeguarding policies and procedures available to staff on the intranet. There were safeguarding policies and procedures available to staff on the intranet.

Mandatory training

- Mandatory training provided by the trust covered a variety of subjects, including, infection prevention and control, moving and handling and resuscitation.
- The trusts training figures for January to March 2015 for the surgical division showed that nursing and medical staff were below the trusts target of 95% compliance for mandatory training. For example
- 78% of staff had completed resuscitation training, and 75% had completed manual handling training. However there was a 100% compliance for all mandatory training for nursing staff in theatres and 98% for medical staff which exceeded the trusts target. To manage this risk training figures and due dates for each staff member were displayed on wards indicating when staff were due to attend their next mandatory training sessions
- Staff, who had recently been appointed, such as housekeeping staff, were able to describe the induction they had received and post induction orientation and training, on such issues as correct waste management and patient confidentiality.

Surgery

Assessing and responding to patient risk

- The National Emergency Laparotomy Audit (NELA) for 2014 at WRH identified the need to provide a sustained 24-hour Interventional radiology service, which is essential for units providing an emergency general surgery service. This issue had recently been recorded on the radiology risk register in April 2015 as a moderate risk with a review date in 2016 but senior managers were unaware of this.
- Other non-compliances included lack of audit of emergency theatre provision within previous 2 years and lack of explicit arrangements to review patients for surgery by Elderly Medicine. An emergency surgical care pathway had subsequently been developed to address these issues. Other proposals to address the non-compliances included the need for early input by senior clinicians so that all patients with a predicted mortality above 10% were discussed with anaesthetic and surgical consultants before booking the emergency theatre and appropriate plans were made including where post-operative care would be provided in liaison with the critical care consultant.
- As a result of a review undertaken in 2014 by the Royal College of Surgeons in response to a higher than average mortality rate within the trust, the trust had moved specific high risk emergency acute abdominal surgery to Worcestershire Royal Hospital.
- Patient's assessments for risk of pressure ulcers using the Waterlow tool were reported as being at times incomplete. This meant appropriate actions required to prevent the development of pressure ulcers were not identified. Where patients were identified as being at risk of pressure ulcers staff reported they were able to quickly obtain devices such as special mattresses to assist in the prevention the development of pressure ulcers. Staff on most wards reported there was strong support and promotion of good practice including specific training in the care and management of patients to prevent and treat pressure ulcers by the tissue viability team.
- Staff on Chestnut ward which cared for patients requiring head and neck surgery had reviewed incidents where patients had previously developed pressure ulcers underneath their tracheostomy tubes. They had subsequently changed the type of tubes from rigid plastic to soft, flexible plastic to help minimise the risk of pressure ulcers.
- To aid early identification of deteriorating patients the trust used a Patient at Risk Score (PARS) observation tool in accordance with the trust's policy, 'Recognising and Responding to Early Signs of Deterioration in Hospital Patients.' This meant that staff could use the observation tool to alert doctors or the outreach team of a patient's potential deteriorating condition to ensure early intervention and treatment. The purpose of the outreach service was to support all aspects of the acutely and critically ill patient. this included early identification of patient deterioration, timely admission to a critical care bed and delivery of effective follow up of patients care on discharge from critical care to the ward. At risk patients were handed over between these teams at the commencement of each shift. The service was available to all staff in all wards who were caring for "at risk" patients.
- To ensure the tool was correctly used, training was provided to staff and completed Patient at Risk Score documents were audited. The 2015 audit showed an improvement compared to the 2014 results. In 100% of cases when a PAR Score was 3 or more an appropriate referral had been made and there was evidence in the notes of referral, assessment and management plan. This was an increase of 50% compliance from October 2014.
- The Five Steps to Safer Surgery checklist should be used at each stage of the surgical pathway from when a patient is transferred to theatre until return to the ward. We observed patients being checked in to theatre and the use of the five steps to safer surgery being used correctly. Audits from April 2015 to June 2015 showed there had been 100% compliance in the use of Five Steps to Safer Surgery checklist for all surgical specialities.
- Patient records contained guidance about the safe management Peripheral Vascular Devices, (otherwise known as cannulas), which are used for the administration of intravenous fluids and medicines. There were forms with a list of checks that were completed twice a day and a full review of the device

was completed every 3 days to assess if the device required replacement or could be removed. These were found to have been completed in the nine records we reviewed.
- The theatre department had a well-stocked Difficult Airway trolley. The anaesthetists took responsibility for the maintenance and use of the equipment in addition to providing training for staff in difficult airway management
- Staff on the head and neck surgical unit provided training and packs for staff to use for patients with tracheostomies in emergency situations. For example to be able to effectively respond if a tube became displaced or blocked which could potentially result in a patient having inadequate ventilation.

Nursing staffing

- The directorate used an acuity tool to assess and plan staffing requirements to determine appropriate staffing levels. Safe staffing guidelines were adhered to. There was a flow chart and guidance for staff to use to escalate concerns about staffing shortages.
- Staff we spoke with explained they had regular meetings with the matron and human resource team to review progress with recruitment to any vacant posts and develop business cases for additional staffing posts where required.
- Between February and July 2015, the average sickness rate for nursing staff in the surgery team was 4.9%, above (worse than) the trust wide target of 3.5%. The trust told us there was an increase in the use of agency staff within the surgical departments and wards during 2015, as the qualified staff vacancy rate in theatres was 9.6wte out of an establishment of 71wte (13%). The high number of vacancies, along with the challenges of recruiting nursing staff was graded was assessed as high risk and documented on the surgical risk register.
- Where agency shifts were requested, 89% of shifts were filled, meaning that there was a full complement of staff to care for patients on 89% of shifts. Where agency staff were used there was a documented orientation to the ward provided.
- Between February 2015 and July 2015 there had been 30 reported incidents relating to about staffing shortages. Lessons learnt were mostly about the need to forward plan however some incidents were as a result of unplanned staff absence such as agency staff cancelling their shift at short notice.

Surgical staffing

- During out of hours (weekends and nights) staff reported there was lack of experienced doctors to cover the trauma and orthopaedic service. We saw one incident reported that 'Patient safety was put at risk because there was no trauma and orthopaedic doctor to cover the night shift and surgical on call doctors were refusing to cover the ward.' The incident had been escalated to senior managers and an agency had been contacted to provide cover and the rota reviewed to prevent future similar incidents. There was no patient harm reported as a consequence of this incident
- There was a strong reliance on non-training grades of and locum doctors due to difficulties experienced with recruiting doctors to the trust. There was an ongoing recruitment campaign to address this. At the time of the inspection there were eight whole time equivalent vacancies.
- The trust overall employed a higher percentage of junior doctors (16% against the England average of 13%). This reliance on junior medical staff was entered as a risk on the risk register and there were incidents reported where this was reported as a contributing factor.
- Surgical consultants for all specialities were on call and available to provide 24hr countywide consultant led care.
- Sickness rates for medical staff within the surgery directorate were very low at 0.04% between February and June 2015.

Major incident awareness and training

- There were hospital wide contingency and major incident plans. There were also specific protocols for deferring elective activity to prioritise unscheduled emergency procedures. The theatre manager explained annual leave was planned with the theatre manager at the Alexandra Hospital to ensure there was always a theatre manager available in the event of a major incident.
- We discussed the contingencies made by the trust for loss of essential services with staff. They were able to give examples of types of affected services and their response, for example they described how they would access gas cylinders and where they were located if there was a loss of gas supply.

Surgery

- There was a major Incident file for staff to refer to, detailing communication arrangements and different staff roles in relation to an incident.
- The theatre team were able to describe the annual mock fire evacuation they had participated in

Are surgery services effective?

Requires improvement

Overall we rated this service as requires improvement for effectiveness.

Nutrition and hydration management was variable in that people were not always appropriately risk assessed to ensure their needs were met.

Outcome measures were mostly met but it was not apparent that where these were below the national average what actions were being taken to improve outcomes and how this was communicated at ward level.

Appraisals were provided but the completion of these was below the trust target of 100%.

Although the hip fracture audit results for 2014 had shown an improvement overall there had been a drop in percentage of scores for some measures compared to the trust's 2013 results and these were below the England average.

There was limited evidence about how information about patient outcomes were used and action taken to make improvements

Pain relief was well managed.

Staff were supported in their roles and received appropriate training and development to provide safe effective care.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

Deprivation of liberty safeguards were understood and only used when it was in a person's best interests and to ensure the patients safety.

Evidence-based care and treatment

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Policies provided by the trust were based on NICE/Royal College guidelines.
- Audits had been commenced in April 2015 to assess compliance with NICE guidelines but there were no results available as these were not planned to be completed until March 2016.
- There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as infection prevention and control and environmental audits
- Accurate and up-to-date information about effectiveness was shared internally and externally at senior management level but there was no evidence of how the information was to be cascaded and shared at all levels of the organization to improve care and treatment and people's outcomes.
- We saw an example of an improvement introduced as a result of feedback from the coroner. This involved audit of compliance with NICE guidance regarding Venous Thrombo embolism (VTE). Initial results showed there were 65 occasions of non-compliance with patient assessments for VTEs which occurred mainly in the SCUDU however this was reported to have decreased at the subsequent surgical division meeting in October 2014 but there were no figures available to show to what degree. We saw evidence through minutes of meetings for April 2015 compliance had been continued to be monitored and there were no concerns reported for Worcestershire Royal Hospital.
- The use of peripheral intravenous cannula care bundle was introduced to improve the quality of care. A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. Multidisciplinary teams work to deliver the best possible care supported by evidence-based research and practices, with the ultimate outcome of improving patient care.
- People had assessments of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. Risk assessments, care and treatment were reviewed and updated although some assessments were was not always complete or adequate to prevent harm to patients.

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcomes.
- National guidelines and the enhanced recovery program were used where relevant.

Pain relief

- Patients were assessed pre operatively for post-operative pain relief in order to effectively anticipate their needs dependent on their condition and planned treatment.
- Patients told us they received pain relief promptly when requested but felt their needs were mostly anticipated by nursing staff. They said their pain was effective and well controlled.
- There was a dedicated pain team to support patients with epidurals who were being cared for on the surgical wards. The acute pain service was consultant led with the support of three countywide acute pain nurses.
- All patients receiving a spinal, epidural or a patient controlled analgesic device (PCA) were routinely followed up. There was also access to four consultants who specialised in chronic pain.

Nutrition and hydration

- Patient's nutrition and hydration status was assessed and recorded using the Malnutrition Universal Screening Tool' (MUST) although this was not consistently done for all patients. There were reported incidents where the patient's weight had not been recorded and poor nutritional management of some patients, with failure to request dietary advice. These factors were reported as contributing factors to the development of Grade 3 pressure ulcers
- Patients who were on special diets told us they received the correct food. They said, 'The food is always hot and if I don't like something staff sort it out form me, there is always an alternative.' Another patient told us they missed a meal whilst having tests but the nurse quickly arranged for a meal to be provided.
- Patients appreciated there were frequent tea rounds and that they could have extra hot drinks when they asked for them.

Patient outcomes

- Information about people's care and treatment, and their outcomes, was routinely collected and monitored. Patient Reported Outcomes Measures (PROMS) performance was in line with the England averages.
- The pre-operative PROMs questionnaire was administered by the pre-operative assessment (POA) service for patients having hip replacement, knee replacement and groin hernia surgery. Because varicose vein surgery was performed under local anaesthetic they had not received a POA. The trust were aware of this and to ensure that there was a standard process for the administration of the pre-operative PROMs questionnaire for patients having varicose vein surgery the matter had been raised with the vascular surgeons and matrons in the division. A Business Analyst had also recently been engaged to develop a database to ensure that all patients that are eligible for a PROMs questionnaire are captured.
- PROM's results are 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 appointment of a central coordinator for the PROMs database is proposed to coordinate the process and share the data with the Consultant Surgeons and their teams
- Although the hip fracture audit results for 2014 had shown an improvement overall there had been a drop in percentage of scores for some measures compared to the trust's 2013 results and these were below the England average. For example patients were not admitted to orthopaedic care within four hours (a fall to 33.7% compliance compared to 61.6 % in 2013) and below the England average 48%. Staff confirmed surgical treatment was often delayed for those patients admitted with a confirmed fractured hip to non-trauma and orthopaedic beds. This matter had been reviewed at a divisional meeting in April 2015 with proposals to make admission to a trauma and orthopaedic bed a priority and to provide additional theatre sessions to accommodate the needs of the service.

- We reviewed minutes of clinical governance meetings. These included limited evidence about how information about patient outcomes were used and action taken to make improvements. We did not see evidence of measures being taken to improve the outcomes for patients with a hip fracture.
- The National Emergency Laparotomy Audit (NELA) was established by the Royal College of Anaesthetists to examine the inpatient care and outcomes of patients undergoing emergency laparotomy. Emergency laparotomy is a term used to describe the group of abdominal surgical procedures that are commonly performed at short notice to treat certain conditions. Standards have been developed that are intended to safeguard the quality of care of all patients undergoing an emergency laparotomy. The NELA results for 2014 at Worcestershire Royal Hospital showed a number of areas of non-compliance. We saw evidence of proposed actions in response to the report but they did not include any action in response to provision of a 24 hour service for interventional radiology. We looked at minutes of divisional and surgery service clinical governance meetings but did not see any evidence to show how the proposed actions were being monitored to ensure effective and timely implementation
- The trust results for the bowel cancer audit for 2014 were positive compared to the England average scores.

Competent staff

- New staff (clinical and non-clinical) received a structured induction to ensure they were supported in their role and safe to practice in the relevant environments. Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Staff were supported to deliver effective care and treatment through meaningful appraisal.
- Staff were supported to deliver effective care and treatment through meaningful appraisal. 74% of non-medical staff and 76% of nursing staff had received an appraisal which was below the trust target of 100%. The learning needs of staff were identified at appraisal and training plans agreed. Staff were supported to maintain and further develop their professional skills and experience. We saw examples of detailed structured training plans for staff to meet essential service needs both clinical and non-clinical. For example, training to develop skills in effective recruitment of staff and safe management of epidurals.
- Although nursing and other ward staff had received appraisals and there was a policy for clinical supervision in place we did not see evidence that this was embedded in practice. Staff had been trained as mentors to support student nurse placements on the surgical wards and in theatres.
- Relevant staff were supported through the process of revalidation. There was a clear and appropriate approach for supporting and managing medical staff when their performance was poor or variable. From trust wide data provided for 2015 for the surgical division 84% of medical staff had received an appraisal. To address any non-compliances monthly emails were sent to medical staff reminding them when appraisals were due or overdue. Where medical staff had not attended or completed appraisals in a timely manner the trust had applied sanctions to those practitioners, requiring a more frequent review of practice.
- We observed examples of good practice where staff had their competency assessed to ensure they could safely receive, care for patients and discharge them from theatre and recovery. The competencies assessed staffs' abilities regarding a range of skills such as safe use of equipment, accurate documentation, handling specimens and use of correct infection control measures.

Multidisciplinary working

- We observed multidisciplinary team working on the wards we visited.
- All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment and mostly worked collaboratively to understand and meet the range and complexity of people's needs.
- Patient care on surgical wards was supported by teams from a variety of disciplines including physiotherapists, dieticians, pain team, speech and language therapists and pharmacists.
- Care plans used included the planning of discharge and assessment of patient's needs at the time of admission.
- People were discharged at an appropriate time and only when all necessary care arrangements were in place.

Surgery

Seven-day services

- Consultant-led ward rounds were undertaken daily including weekends but medical staff told us that occasionally this was not always achieved and would depend on the level of medical cover available. If a consultant was not available the ward round would be led by a registrar. There were no incidents reported regarding this and we were therefore unable to ascertain an exact figure of how frequently this occurred.
- Although the interventional radiology service was not available out of hours seven days a week there were imaging, /pharmacy and physiotherapy services available at weekends and an on call service out of hours.
- The outreach service operated from 8am to 8pm**,** seven days a week. "At risk" patients were handed over between these teams at the commencement of each shift.
- Nurse Practitioners were available at night to provide clinical advice and support to ward staff.
- There was access to the pain team seven days a week.
- There was an on call service for weekends and out of hours to meet urgent requests for care records

Access to information

- We observed staff was able to easily access trust wide policies on the intranet.
- Staff could access the information they needed to assess, plan and deliver care to people in a timely way. There were different systems to hold or manage care records and these were coordinated.
- Staff used printed sheets with included details of each patient's current diagnosis and care needs to handover care between practitioners each shift.
- Most nursing staff we spoke with were not able, or were not aware how to, access results of audits or governance meetings.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.
- Patients received written information about their proposed treatment and what to expect after their operation which they found useful.
- Appropriate checks were made that consent forms were correctly completed prior to patients being transferred to theatre for surgery, in accordance with the trust's consent policy.
- Staff explained if they had a concern or required advice regarding an application for Deprivation of Liberty Safeguards (DoLS) they could contact the senior nurse on duty via a bleep. They also were able to name the surgical team's safeguarding lead. There were DoLS application forms available on the trusts intranet for staff to use.
- Staff were able to briefly describe how DoLS might be required; they gave an example of how a patient might become confused following anaesthetic and need to be cared for in a controlled environment to ensure their safety.

Are surgery services caring?

Good

Overall we judged rated this service as good for caring.

Feedback from patients who used the service and those who are close to them were positive about the way staff treated people. Patient's privacy and confidentiality were respected and measures taken to ensure patients dignity was maintained when receiving care. The Patient Led Assessment of the Environment (PLACE) score for ensuring patients were treated with privacy and dignity at the hospital was 90% during 2015 and the hospital had achieved a similar score of 96% in 2014.

People understood their care, treatment and condition and were involved in making decisions about their care. Staff responded compassionately when patients needed help and support to meet their basic personal needs.

Staff helped people and those close to them to cope emotionally with their care and treatment.

Compassionate care

- During our inspection we witnessed patients being treated with compassion, dignity and respect. We observed good interaction between nurses, allied

professionals and patients. Staff spoke quietly with individual patients to ensure confidentiality and used screens when providing care to patients to ensure their dignity was maintained.
- People were spoken to in a courteous manner and their permission was sought before providing treatment, for example helping a patient to have a shower.
- Friends and Family test results were positive for the surgical wards at Worcestershire Royal Hospital (WRH). They had a response rate of 33.5% with results showing that patients were satisfied with the care they received. This was higher than the national average of 31.7%. Results showed a satisfaction rate of mostly 96% or above.
- The Patient Led Assessment of the Environment (PLACE) score for ensuring patients were treated with privacy and dignity at the hospital was 90% during 2015 and the hospital had achieved a similar score of 96% in 2014. This meant there was a consistency in ensuring this aspect of patient care was met.
- Patients told us call bells were answered promptly, that staff were kind and caring and they would be happy for their family to come to the hospital for an operation. During our inspection call bells were being answered promptly.
- Comfort rounds (where nursing staff regularly check on patients every few hours) were undertaken and recorded.

Understanding and involvement of patients and those close to them

- Patients told us they understood the treatment planned and were involved in discussions about their care. They felt they had been given sufficient verbal and written information about their planned treatment and their questions were satisfactorily answered.
- Patients were involved in decisions about their planned discharge and where relevant the community nurse arrangements for continuing care. One patient said, 'I have been treated exceptionally well and couldn't ask for a better group of nurses to care for me.' Another patient told us, the doctor explained everything to them and what to expect following their planned surgery. They said, ''Doctors keep me informed, I've seen them regularly in the nine days I have been here.'',
- Theatre staff arranged for carers to accompany the patient to theatre where they had specific needs such as a learning or sensory disability.

Emotional support

- Clinical nurse specialists were employed by the hospital to provide support and advice to patients.
- Where indicated assessments for anxiety and depression were undertaken and there was a counselling service available.
- Staff had access to an on call Chaplain and list of spiritual advisors to meet patient's needs. In addition there was a help desk in the main reception manned by a team of volunteers to provide assistance and support to patients and their visitors.

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 for admitted patients between April 2013 to February 2015 in every service except opthalmology. 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%.

The proportion of patients whose operation was cancelled that were not seen within 28 days following the cancellation had been increasing during 2014 to 2015 and been above the England average since October 2013. More operations were cancelled than the national average.

Patients were not always put on wards that were best suited to meeting their needs for specialist treatment and care. Surgical and medical patients with different conditions and risk were mixed together on all the surgical wards we visited.

Patients and their relatives told us that they were involved in the planning of their discharge however they were not always offered a choice about where they were discharged to for continuing care. The trust used the 'Discharge to Assess' process, where patients were assessed for long term care in determined care homes where the decision about their final destination is taken in to discussion with the patient and their family.

Surgery

Patients told us they received a slow or unsatisfactory response to concerns raised. The trust performance dashboard showed that 20% of the time the service did not respond to patient formal complaints within 25 days in accordance with the trusts complaints policy.

Service planning and delivery to meet the needs of local people

- The trust had recognised issues that were impacting service delivery. The issue of insufficient out of acute hospital capacity to meet the needs of patients with on-going healthcare needs was on their risk register. 'Out of acute' refers to those patients who require continued care in the community by other care providers in different care settings. The potential consequences of this were that patients would be forced to stay in an acute hospital bed for longer. This was detrimental to their clinical outcomes, ongoing independence and experience of care. Measures had been introduced to address this, including the review of patient care pathways and operating theatre capacity.
- Side rooms were available on surgical wards for patients. We saw situations where patients had been moved to side rooms based on their needs
- The needs of the local population had been identified and taken into account when planning services and where there were shortfalls, such as provision for unplanned medical admissions. There was evidence of a continued high demand for medical beds which was impacting on the effectiveness of the surgery services. This matter was registered as a risk. It had been recognised that if emergency demand (medical admissions) continued to increase it would result in insufficient elective (planned) capacity to deliver the 18 week referral to treatment target. One measure used to address this had been that the trust had ensured it had maximised the theatre capacity available within the local independent hospitals.

Access and flow

- Some people were not able to access services for assessment, diagnosis or treatment when they needed to. There were frequent delays or cancellations. The number of patients whose operation was cancelled at the last minute and were not treated within 28 days had increased significantly in the preceding 12 months. At WRH there had been an increase from 14% in 2014 to 20% in 2015.When a patient's operation was cancelled by the hospital at the last minute for non-clinical reasons such as lack of beds, the hospital should offer another binding date within a maximum of the next 28 days. (Last minute means on the day the patient was due to arrive, after the patient has arrived at the hospital or on the day of the operation or surgery). Staff explained the majority of delays and cancellations were due to the unplanned admission of medical patients to the surgical wards. For example Beech ward (a general surgical ward) had received14 unplanned medical admissions in the previous ten days.
- During 2015 7913 operations were performed at Worcestershire Royal Hospital of which 317 elective (planned) operations were cancelled, representing a 4% cancellation rate against a national average of 0.8% for April-June, 2015 (NHS England)
- We observed patients were not able to be admitted to beds on surgical wards for elective (planned) surgery prior to their operation. During our inspection patients were prepared for surgery in the ward treatment room (with their prior agreement) prior to going to theatre with an assurance there would be a bed available for them post operatively. During the preceding six months theatres reported 38 occasions of late starts in theatre which had resulted in a loss of 47 hours due to a lack of a ward bed either on admission or post operatively.
- We observed operating lists being frequently reviewed by the surgical bed coordinator and consultant to ensure those patients who needed urgent care such as cancer patients were given priority and that theatre capacity was maximised where possible.
- The theatre dedicated for emergency surgery had insufficient capacity to meet the increasing workload resulting in delays to the treatment of emergency surgical patients. This was on the trust's risk register and there had been a proposal by the surgical team for the number of emergency theatre sessions to be increased, aiming for 24/7 emergency theatre access.
- The average length of stay (LOS) for both elective and non-elective treatment for the trust were similar to the England average LOS. There was an enhanced recovery nurse whose role and aim was to help get patients home within reasonable time frames. Patients were followed up after discharge and if any issues were identified the patient's general practitioner was contacted.
- Patients and their relatives told us they were involved in the planning of their discharge. However, they were not

offered a choice about where they were discharged to for continuing care which was sometimes located a long distance away from family and friends.The trust advised us they were following the 'Discharge to Assess' process where patients are assessed for long-term care in determined care homes where the decision about the final destination is taken in discussion with the patient and their family.

- A 12 bed / trolley surgical clinical decisions unit (SCUDU) had been established to receive adult emergency general surgery admissions to help improve the access to services. We saw a draft protocol about the unit which stated the service was designed to accept direct general surgical referrals from GPs however staff advised this was also used for medical overflow patients.
- There was an emergency surgical practitioner nurse who worked with doctors to undertake patient assessments. The scope of the nurse's role included prescribing and ordering of some x- rays. They were also responsible for co coordinating the patient's discharge plan.
- There were daily ward rounds with handovers from night team including review of patients in SCUDU.

Meeting people's individual needs

- There were arrangements in place to respond to patients with special needs. Theatre staff told us they encouraged carers to escort patients to theatre and collect them from recovery. Staff ensured patients with hearing difficulties had their hearing aids available to ensure they could adequately receive explanations about their care pre and post operatively.
- Staff received training for caring for patients living with dementia. Although there was usually a lead nurse for promotion of care of patients with dementia, the post was vacant at the time of the inspection. The patient records contained specific documentation to promote planning and delivery of appropriate care for people living with dementia.
- We observed the transfer and communication between staff when taking patients to the discharge lounge. Communication was poor. One patient had been discharged following orthopaedic surgery but had not been told or taught how to self-administer anti-coagulant injections prior to discharge. This matter was immediately addressed and reported as a near miss incident.
- An interpreting service for patients who did not speak English was available and staff knew how to access it.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information posters were displayed in main reception and ward corridors. The posters informed patients how to raise concerns or make complaint. Complaints were dealt with locally where possible. Staff told us they tried to resolve concerns as quickly as possible and notified the nurse in charge of any concerns raised by patients or their relatives to ensure all appropriate actions were taken. If staff were unable to resolve the complaint advice was given to the patients how to make a formal complaint in writing.
- Patients told us they did not find it easy to, or were worried about, raising concerns or complaints. When they did, they felt they received a slow or unsatisfactory response. The trust performance records showed that 20% of the time the service did not respond to patient formal complaints within 25 days in accordance with the trusts complaints policy.
- Complaints were discussed at clinical governance meetings and points of learning disseminated to staff at team meetings. For example it was identified that for one patient the Duty of Candour had not been correctly applied and this was subsequently addressed.

Are surgery services well-led?

Requires improvement

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

Although some action had been taken to strengthen the delivery of emergency abdominal surgery by relocating abdominal surgery from the Alexandra Hospital to the WRH, there had been lack of progress in implementing a sustainable solution to deliver emergency surgery. The trust told us this was due to delays in decision making relating to the configuration of services.

There had been a recent review of the governance arrangements and the strategy for surgical services. The

arrangements for governance and risk management operated effectively at senior management level but were yet to be cascaded to ward level. Risks and incidents were dealt with appropriately and in a timely way.

Staff satisfaction was mixed. Staff did not always raise concerns about service developments or feel actively engaged in the developments and changes to services. Staff perceived clinicians did not always work cohesively which negatively impacted on the access and flow to surgical services.

Vision and strategy for this service

- There was a countywide surgical division strategy for 2014 – 2019 based on the trust's values which were Patients, Respect, Improve, Dependable, and Empowered (PRIDE) which most staff were familiar with. Staff had an understanding of the values and were able to explain briefly what they meant. For example, patients were central to everything they did and patients were treated with privacy and dignity and compassion. Another example they gave was dependable and that this meant ensuring they get things right first time and learn from mistakes.
- The strategy had key business themes including addressing capacity and demand, ensuring quality and safety and sustainability of services.

Governance, risk management and quality measurement

- A clear divisional framework for governance arrangements for each directorate within the surgical division had been introduced. This meant that there was a process for information to be shared at each level within the organisation. However cascading and sharing of information had not become established at ward level at the time of the inspection.
- There was a consistent approach to governance and risk management with all surgical specialities using the same standard agenda for governance meetings.
- Monthly surgical speciality meetings to review governance had been established. The minutes of the meetings showed that all areas of risk and governance were reviewed including serious incidents, audit results, risk registers, complaints, staff training and lessons of the month and clinical staff of all grades were encouraged to attend and contribute to meetings.

Leadership of service

- The non-compliances identified in the 2014 NELA report had not been responded to and implemented in a timely manner.
- There had been lack of progress in implementing a sustainable solution to deliver emergency surgery. The model has been ready for implementation since November 2014. Although some action had been taken to strengthen the delivery of emergency surgery by relocating abdominal surgery to the WRH trust site.
- We did not see evidence of action taken to address the referral to treatment time performance which was below both the national standard and the England average for admitted patients between April 2013 to February 2015 in every service except opthalmology.
- The proportion of patients whose operation was cancelled that were not seen within 28 days following the cancellation had been increasing during 2014 to 2015 and been above the England average since October 2013 and there was no evidence of action taken to improve performance.
- Each ward had a manager who provided day to day leadership to staff members. There were Matrons for the different directorates within surgical divisions who staff found to be responsive and supportive. Matrons kept staff informed of trust wide developments through ward meetings and provided guidance where required.
- Agreed plans such as countywide management of emergency abdominal surgery were not fully implemented despite concerns being raised by medical staff about potential the risks to patients.

Culture within the service

- Staff felt the culture was developing and improving to ensure quality and safety of care and they found the current senior management team more visible and approachable than the previous team. Staff were positive and optimistic in that they felt there was clear direction. Staff said, 'Things now seem more controlled and the managers are pulling things together.'
- Minutes of meetings included praise and thanks to staff where particular achievements had been made, for example, clearing back logs of incident investigations and improved clinical audit results.
- We found examples in surgical services of good teamwork. Staff in the wards and theatres were proud of the service they provided but were frustrated by the frequent cancellation of operations due to the presence of medical outliers.

Surgery

- The culture encouraged candour, openness and honesty. There had previously been concerns raised about bullying of staff within the surgical division. Staff said they had been supported within their units to raise concerns and they felt this had mostly been resolved.

Public engagement

- Trust Board meetings were held in public and the venues rotated round the three main hospital sites. Minutes of the meetings were also published on the trust website.
- People's views were gathered through compliments, cards and letters to the services. The surgical wards were part of the NHS Friends and Family Test and comments were mostly positive. Results showed 96% of patients would recommend the hospital to friends and families which was above the national average of 94.5%.

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
- Staff surveys were undertaken. The results from the most recent survey in 2014 indicated staff satisfaction with the quality of work and patient care they were able to deliver had decreased since 2013 and the result of 73% was below the national average of 78%, however overall findings were positive.

Innovation, improvement and sustainability

- There was evidence of good practice being disseminated across wards. For example the sister of Chestnut Ward had developed sets of equipment and specific training for staff to improve patient outcomes for the management of patients with tracheostomies in emergency situations.
- The electronic communications board in theatres was innovative and provided staff with up to date information including medical alerts and local information such as minutes of meetings.

Critical care

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

Information about the service

Worcestershire Royal Hospital (WRH) has three separately located and discretely managed units providing critical care. The 14-bed main critical care unit is a general intensive and high dependency care service. There is a four-bed high dependency unit for vascular surgery patients and a four-bed high dependency unit for general surgery patients. Critical care unit (CCU) The CCU was opened in its current configuration in 2002. It provides a service to patients who need intensive care (described as level three cares) or high dependency care (described as level two care). Patients will be admitted following complex and/or serious operations and in the event of medical and surgical emergencies. The unit provides support for all inpatient specialities within the acute hospital and to the emergency department. The unit had 14 beds which were used flexibly with the eight beds at Alexandra Hospital, Redditch. The service was led by a consultant in intensive care medicine with support from the consultant team and senior nurses. In the six months from October 2014 to March 2015, the department admitted around a third of its patients from elective (planned) and emergency surgical procedures. The other two-thirds were non-surgical patients. Of the surgical procedures, around 6% were high-risk elective surgery and 27% emergency surgery. At the time of the inspection the hospital was experiencing unprecedented pressure on the service. This reflected themes and trends nationally. Admission to the unit was limited by the number of bed spaces, but the service was usually busy and often full. The number of patients treated had increased over the past five years and there had been some increase in bed numbers to meet this. In 2014, the CCU cared for approximately 660 patients aged 16 years and above. Surgical high dependency units (HDUs) The hospital provided advanced care for vascular surgery patients. The HDU unit on Severn ward was a four-bed high dependency area for patients who needed extra support post vascular surgery. In 2014, the vascular HDU cared for approximately 400 adult patients. The hospital also provided advanced care for general surgery patients in a four-bed high dependency unit on Beech ward. In 2014 the surgical HDU cared for approximately 380 adult patients. On this inspection, we visited the CCU on Wednesday 15 and Friday 17 July 2015 and returned for an unannounced visit in the late afternoon and evening of Thursday 30 July 2015. We visited the vascular HDU on Friday 17 July and the surgical HDU on Wednesday 15 July 2015. We spoke with a range of staff, including consultants, doctors, trainee doctors, and different grades of nurses, healthcare assistants and a member of the housekeeping team. We met with the consultant intensivist clinical lead and the matron who ran the critical care nursing teams at this hospital and Alexandra Hospital. We spoke with the members of the physiotherapist team, the specialist nurse for organ donation, the pharmacist lead, and the ward clerks. We met with patients who were able to talk with us, and their relatives and friends. We checked the clinical environments, observed care and looked at records and data. General critical care services provided by this trust were located on two hospital sites, the other being Alexandra Hospital, Redditch. Services at Alexandra Hospital are reported on in a separate report. However, general critical care services on both hospital sites (excluding the HDUs in Worcestershire Royal Hospital) were run by one critical care management team. As such they

were regarded within and reported upon by the trust as one service, with many of the staff working at both sites. For this reason it is inevitable there is some duplication contained in the two reports.

Summary of findings

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

There was a good track-record on safety. There were reliable systems, processes and practices to keep people safe. This was supported by safe, clean and well organised environments and staff working in an open and honest culture. There were low rates of infection and avoidable harm to patients. There were good levels of nursing, medical and allied health professional staff, although, when compared with guidance, the trainee doctors were under-resourced at times. There was a daily presence of experienced consultant intensivists and doctors, and rarely any agency nursing staff or locum cover used. Patient records were clear, legible and contemporaneous. Medicines and other consumables were stored safely, seen to be in date, and recorded accurately. In terms of improvements in safety: some of the updates for mandatory training compliance was below trust targets; support and guidance for staff investigating serious incidents was poor; the evidence of learning and sharing from mortality and morbidity reviews was not well reported; and although delivering safe care, the HDUs were not meeting the Department of Health guidelines for modern critical care units. Treatment and care by all staff was delivered in accordance with legislation, standards, best practice and recognised national guidelines. There was a holistic, multidisciplinary professional approach to assessing and planning care and treatment. Innovation, high performance, and high quality care was encouraged and acknowledged. The CCU achieved good outcomes for patients who were critically ill and/or with complex problems and multiple needs. The CCU achieved good outcomes when benchmarked against other organisations by the Intensive Care National Audit and Research Centre (ICNARC). The HDUs, however, were not contributing to ICNARC so their outcomes were not being benchmarked against their critical care peers. There was respected and high quality training and development in the CCU, but not always enough time dedicated to it. The experienced nursing staff team in the HDUs did not, however, meet the recommendations of the Faculty of Intensive Care Medicine in few had a

Critical care

post-registration qualification in critical care nursing. Patients were truly respected, valued and understood as individuals. Feedback from people, who had used the service, including patients and their families, had been exceptionally positive. Staff delivered care with kindness, dignity, respect and compassion. Patient's cultural, religious, social and personal needs were respected and those close to them were involved with their care. The critical care service responded well to patient needs, but aspects of patient flow outside of the control of critical care required improvement. There were bed pressures in the rest of the hospital that too frequently meant patients were delayed on discharge from the unit. Too many patients were discharged onto wards at night, when this was recognised as less than optimal for patient wellbeing. The units were also exceeding recommended levels of occupancy and national averages. Despite this, the CCU team were organised, flexible and prepared to move heaven and earth to ensure patients needing a bed were admitted. The countywide approach to the CCUs at both Worcestershire Royal and the Alexandra Hospital gave staff flexible working and bed space capability to respond to patient need. There were good facilities in the CCU for patients, visitors and staff, and these met most of the modern critical care building standards. The facilities in the HDUs were not unsafe but they failed to meet many of the modern standards. There were no barriers to prevent people voicing concerns and making complaints but there had been no complaints within critical care within the last two years. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with a shared purpose promoting an open and fair culture. There was strong evidence and data to base decisions upon and drive the service forward from a good and improving programme of audit. A high level of staff satisfaction was found throughout the services. They spoke highly of the positive culture and consistently high levels of constructive engagement, support and encouragement. Innovation and improvement was celebrated and encouraged with a proactive approach to achieving best practice and sustainable models of care.

Are critical care services safe?

Good

Overall we rated this service as good for caring.

People were protected from abuse and avoidable harm. There was a good track-record on safety with lessons learned from incidents and improvements made when things went wrong; however, some 'everyday' incidents were not being reported as they should. Staff responded appropriately to changes in risks to patients and produced and completed appropriate observational information, updated assessments and care plans being followed. There was a critical care Outreach team providing a hospital-wide support service, although this was only from 8am to 8pm and not 24 hours. There was high-quality well maintained equipment and a safe environment, although some of the environment did not meet modern standards, particularly within the HDUs. The units were visibly clean and well organised and staff adhered to infection prevention and control policies and protocols. This led to low rates of infection. There were safe staffing levels and wide-ranging and appropriate experience and skills among the teams of nursing staff. There was a strong commitment of experienced surgeons in the HDUs and the consultant intensivists, who extended their oversight to patients in the surgical and vascular HDUs. The provision for pharmacist and physiotherapist services did not always meet the recommendations of the Faculty of Intensive Care Medicine Core Standards in terms of cover, but the dedicated team prioritised critical care patients and provided a safe service. Patient records were comprehensive, well maintained, clear, and contemporaneous. There was an outstanding example of a patient observation chart in use in the CCU. Medicines and consumable stocks were managed, stored and used safely. Areas for improvement included there being poor support and guidance given to staff around investigating rare but serious incidents requiring investigation. Duty of Candour had been introduced and staff were aware of their duties to explain and apologise on the rare occasion when things went wrong. The reporting of this, however, in the one event recently, did not meet the requirements of the regulation. Mortality and morbidity

was being openly reviewed and discussed among the teams, but actions and learning were not evident within reporting. Some of the mandatory training targets for staff updating their knowledge had not been achieved.

Incidents

- The safety performance of the CCU and HDUs was good. There were low numbers of incidents of avoidable patient harm, unit-acquired infections, and errors leading to patient harm. Of the 38 incidents reported from the CCU through the electronic system from 1 December 2014 to 31 March 2015, eight led to minor harm to a patient (although two of these were inherited pressure ulcers, in that the patient came to the unit with them) and three led to moderate harm. None led to severe harm to patients.
- Staff were open, transparent and honest about incidents and reporting them, although there was some incorrect categorisation or misunderstanding of a 'near miss' incident. All staff we spoke with said there were no barriers to reporting incidents or near misses and they were encouraged and reminded to do so. Some of the more junior-grade nursing staff did, however, say they reported incidents to a sister on the ward and not directly themselves. An electronic incident reporting system was used to record incidents, and staff said it was uncomplicated to use. Both incidents taking place but also some near misses were reported. In the report provided to us for December 2014 to March 2015, some of the incidents were categorised as 'near misses'. Some of these were, however, actual incidents, and therefore wrongly categorised. Those we read that were wrongly categorised appeared to have been misunderstood as a 'near miss' as no harm came to a patient. In one example, a patient received the wrong dose of a medicine due to a prescription error. The incident report said the patient came to no harm, but this was categorised as a 'near miss', despite the wrong medicine was actually administered.
- Staff told us they were not blamed for errors or omissions leading to incidents or near misses. All staff we asked said they were not afraid to speak up when something went wrong or could have been done better. They were listened to, able to be fully honest and open, and treated fairly by their peers and managers. Staff said there would be open discussions and, where identified, reminders to all appropriate staff, additional training, mentoring and learning made available. We saw examples of this in the actions taken following incidents. This included extra training at staff induction as well as to existing staff. Incidents around medicines and patient falls were recent examples of staff being reminded about practice and provided with refresher training.
- Incidents were generally recognised by staff, but some 'everyday' incidents for the CCU were not being routinely reported. The incident reporting log did not, as would be expected, include any failures, delays or night time discharges of patients. As discussed below within the 'Access and Flow' section, the CCU, through no fault of its own, had significant delayed or night time patient discharges while awaiting a bed for the patient elsewhere in the hospital. The report for December 2014 to March 2015 did not contain an incident report for any of these circumstances.
- The CCU was proactive in describing for staff what would constitute an incident. The clinical lead for governance had recently developed and produced a trigger list for staff to use. This was to enable staff to have guidance as to what events or near misses must be reported. The list was not exhaustive and staff were expected to continue to use their judgement around reporting incidents. The 'everyday' incidents of delayed discharges were now on this list, although the discharges at night had not been included. The CCU incident report for December 2014 to March 2015 described a range of incidents being recognised and reported by staff. This included reporting from both medical and nursing staff and covered incidents from avoidable patient harm (such as falls and pressure ulcers) and errors with medicines. However, at times there was a low rate of incident reporting and this did not appear to have been picked up at any governance meetings. The overall hospital trust was below the NHS England average per number of admissions for reporting incidents. This could be taken as an indicator of staff not reporting all incidents proactively as and when they should. The CCU 'dashboard' stated only two incidents had been reported in February and four in March 2015. In January, April and May 2015 there had been between nine and 12 each month, so February and March appeared low. The minutes of the Intensive Care Medicine Forum or governance committee relating to February and March 2015 did not mention these anomalies in reporting data.

Critical care

- Most staff felt they had good feedback from reporting incidents, but not all. Some of the junior-grade nursing staff said they did not get much feedback about any incidents. When a trend or pattern was recognised with some incidents, this was fed-back to staff in a number of ways. One was through the Critical Care Safety News – a recently developed publication about incidents occurring. We saw how some of the incidents in the electronic system had been identified, lessons learned, and actions taken. This involved changes to equipment to reduce the risk of pressure ulcers around the patient's mouth; a reminder about the correct way to deliver blood cultures to the laboratory; and errors with drug administration routes. Other feedback was through staff meetings (minutes showed this); handover sessions; and teaching and development courses.
- The units learned from serious incidents requiring investigation, but although written reports were detailed, they did not comprehensively describe or pick out some of the lessons to be learned. Serious incidents were rare in the CCU and HDUs. There was one serious incident in early 2015 which had been classed as a 'Never Event' (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented.) The patient involved was not, however, caused severe harm from the incident.
- An investigation commenced by a consultant intensivist who was not directly involved with the incident. The investigation produced a preliminary report and continued to a detailed root cause analysis. Learning from the case was identified, although the way these were described in the report did not address some of the problems identified. One of the factors identified, for example, related to carrying out complex procedures at night. There were no comments in the lessons learned as to how to improve the circumstances and human factors around this event. The CCU had also found it was not following latest trust protocol and National Patient Safety Agency guidance in relation to one of the key pieces of equipment used. There were no comments in the lessons learned about how or why this guidance had not been followed (although the recommendations of the report included replacing this key equipment with the latest devices – which was done immediately after the problem was recognised and within a few days of the incident occurring).
- A comprehensive action plan had been approved. It showed who was accountable for delivering the action; when it should be completed; how the outcomes would be measured; and when the actions had been completed. Learning had been disseminated to those staff that needed to be made aware. This included: open and honest explanation of events through the Critical Care Safety News (shared with the CCU and anaesthetists throughout the trust); publication trust-wide through the Sign up to Safety newsletter; and training sessions (for which there was positive staff feedback).
- Incidents were reviewed and, where necessary, investigated, although the trust support and guidance for staff for investigating serious incidents was poor. Staff expected to undertake serious incident investigations were not provided with specialist training in effective root-cause analysis or given support from clinical governance experts. There were no guidelines about who should conduct the review to ensure it was as independent as required, and how to decide who should be asked to contribute. There was also no guidance about who should approve or review the final report. In a recent investigation, for example, the report was approved by a senior nurse although the incident was a medical incident.
- Duty of Candour had been introduced to staff, although the review of an investigation into a serious incident did not record how this regulation had been met. Staff we spoke with were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong, and apologise to them. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. In the serious incident discussed above, the investigation report recorded conversations with the patient's relatives "in line with the Duty of Candour". The report did not, as the regulation requires, say if an apology had been given or whether a written record of the Duty of Candour discussions had been made. This was despite the incident being subsequent to these new regulations coming into force.
- Patient mortality and morbidity (M&M) went through a structured review, although documented minutes describing learning points were only recently developing. A comprehensive mortality review form was

used by consultants to record and describe, among other things, the patient assessments, care given, surgical or invasive procedures, any infections, and medication used. The consultant then graded the patient's death against the classification of care from the National Confidential Enquiry into Patient Outcome and Death. If the care was graded anything from B to E (where there was room for improvement in care, or at worst (E) care was less than satisfactory) the shortcomings were described. Cases had been discussed at the June 2015 meeting of the well-attended Intensive Care Medicine (ICM) Forum but not, minutes recorded, in any detail at the July 2015 meeting. The ICM Forum was an internal multi-professional programmed-activity internal meeting for the CCU consultants, extending to members of the senior nursing team and allied health professionals). Although consultants we spoke with talked positively about the quality and depth of the M&M reviews, the minutes we saw did not record if any learning had been identified, if any actions were required, and by whom. There were M&M reviews in the surgical division, although one of the lead surgeons admitted the sharing of learning across teams could be improved.

Safety thermometer

- As required, the hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from the CCU and HDUs. It covered hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). During the period from July 2014 to June 2015, the CCU had reported 100% harm-free care for eight days. The general HDU had been reporting since April 2015. In the three months to June 2015, there had been 100% of harm-free care for patients on the snapshot days. The vascular HDU had five snapshot days of 100% harm-free care, but the majority of events reducing the results were from pressure ulcers not acquired in the HDU.
- In accordance with best-practice, the CCU published avoidable patient harm data within the unit for patients, relatives and staff to see. Other audit data was also displayed in public places in the spirit of openness and transparency.
- Patients were mostly free from avoidable harm and risk assessed for developing conditions. In the CCU in the five months from January to May 2015 there had been no pressure ulcers of the more serious categories. There had been one unavoidable grade 3/4 pressure ulcer reported in the vascular surgery division, one avoidable and one unavoidable 3/4 in the general surgery division. However, the HDU data for these divisions was not produced separately, so this could have been a patient not admitted to the HDU and on the main ward. A senior sister on the surgical HDU told us there had been no pressure ulcers on the unit in over 500 days, which was supported by hospital data. None of the HDUs or the CCU had reported any falls with harm from January to May 2015. The CCU had, however, not achieved 100% for risk-assessing patients for venous thromboembolism. The average was 89.2%. Neither HDU were reporting compliance with this risk assessment on their surgery division dashboard, although this should be undertaken on 100% of patients in line with the guidance from the National Institute for Health and Clinical Excellence (NICE) statement QS3 Statement 1.

Cleanliness, infection control and hygiene

- Rates for unit-acquired infections were low. Data reported by the CCU to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland) supported this evidence. All rates of infection had mostly been below (better than) the national average over the past five years. There were no unit-acquired methicillin-resistant Staphylococcus aureus (MRSA) infections in the 12 months to March 2015 (the most recent data available). There was one patient with unit-acquired Clostridium difficile in the same period, which was better than the national average. There had been four unit-acquired bacteraemia infections (not MRSA) in the year to March 2015 which occurred in one month and was above average. Otherwise these infections were rare on the

CCU. There were no MRSA infections in blood for the past three years. There was no data of this level of detail for the HDUs, but the infection rate in the overall hospital was also low.

- Patients were effectively screened for methicillin-resistant Staphylococcus aureus (MRSA) on admission and again each Monday. Patient records demonstrated this level of screening was taking place.
- At the time of our inspection and on our unannounced visit the environments and equipment in the CCU and HDUs were visibly clean, well-organised, and tidy. Bed spaces were visibly clean in both the easy and hard to reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. The notices, signs and posters were laminated and stuck to walls or noticeboards with pins or reusable adhesive. There was some sticky tape used on the inside of cupboards in the clinical room which had become worn and the exposed adhesive surface attracting dirt and dust. When this was pointed out it was removed and replaced where required with reusable adhesive. There were cleaning audits performed, but these were long, complicated and not easy to follow. Those we were provided with all had good results, but they were at least eight months old.
- Equipment was stored and sealed to prevent cross-contamination. All disposable equipment was in sealed bags and placed in drawers or cupboards where possible to prevent damage to packaging. Equipment at the patient's bedside, such as oxygen or other tubes were plastic-wrapped to protect them from cross-contamination. Any large equipment stored in cupboards had dust covers used where they were available. Equipment returned the equipment stores or elsewhere within the unit was marked with a green sticker to show it had been cleaned, before being stored, to prevent cross-contamination. Staff said they would clean any equipment brought back into the unit again to ensure it was dust-free. Equipment in store cupboards was on racks so the floor area beneath was easier to keep clean and equipment did not need to be constantly moved to allow for cleaning.
- There were protocols and procedures to minimise the risk of infection from the use of urinary catheters. There were care plans for the safe insertion and maintenance of the catheter. Evidence from patient records and care plans showed they were removed as soon as no longer needed. There had been only one urinary catheter infection on the CCU in the period July 2014 to June 2015 in data provided to the NHS Safety Thermometer data collection (snapshot of one day per month). There had been one reported for the general surgery HDU, but as this data was for the whole ward, this may not have pertained to an HDU patient.
- Hand sanitising and personal protective equipment rules for staff were followed on all units. This met guidance around safe hand-washing from National Institute for Health and Clinical Excellence (NICE) statement QS61 Statement 3. We observed a high standard of practices from doctors, nursing and all staff. They were following policy by washing their hands between patient interactions and using anti-bacterial gel. They wore disposable gloves and aprons at the bedside when working with a patient or, for example, fluids or waste products. Staff also used gel when entering and leaving the unit or moving between clinical and non-clinical areas. All staff were bare below the elbow (had short sleeves or their sleeves rolled up above their elbow) when they were within the units.
- Visitors were required to follow infection control protocols. Staff requested them to use alcohol gel on arrival and explained why. Hand gel was freely available, clearly signposted and visible. Staff told us they would increase their infection control procedures for visitors by providing them with personal protective equipment (gloves and aprons) when circumstances dictated this was the correct thing to do.

Environment and equipment

- Equipment and the environment was monitored each day for safety. Patients' safety in terms of the equipment and the patient environment was a significant feature of regular nursing observations. The CCU patient observation chart required checks of equipment and the environment to be recorded each morning, afternoon and at night. For example, oxygen, suction, the ventilator, monitors, pumps, the bed and patient bed space were checked for different safety elements. So for the pumps, for example, the electrical supply and alarms were checked and tested, and then whether they were clean and within their service date.
- The units had appropriate equipment for use in an emergency. There were resuscitation drugs and equipment including a defibrillator and a difficult airway intubation trolley in the CCU. Standard resuscitation

equipment was located close enough to the HDUs to provide a fast response. Resuscitation equipment was checked daily (twice daily in the CCU) with records in place showing completion. The resuscitation trolley containing the emergency equipment had closed drawers but it was not fully secured to prevent or indicate tampering with the contained drugs or other equipment between checks.

- The facilities in the CCU met most of the Department of Health 2013 guidelines for critical care facilities (Health Building Note 04-02) but, due to the set-up being 13 years old, it didn't meet all of them. Some of the ways the unit did meet guidelines were:
  - The main theatre complex was located close to the critical care department for accessing emergency support. The Accident and Emergency department (and its resuscitation unit) was also located adjacent to the critical care unit as recommended.
  - The bed spaces were of a suitable size for giving up to five staff enough space to work safely with a patient in an emergency. There were separate buttons for patient call bells and emergency calls. The bed space had a suitable flat screen monitor. The equipment around the bed space was located on ceiling-mounted pendants for optimal safety. Most patients could get access to a suitable high-backed tilting chair in which to sit.
  - There were sufficient oxygen, four-bar air, and vacuum outlets. As recommended for safety at bedside, the unit had three oxygen outlets, two four-bar outlets, and three medical vacuum outlets.
  - There was a good level of mobile equipment available including three haemodialysis/ haemofiltration machines, an electrocardiography machine, and a bedside echocardiography machine. There was a portable X-ray, ultrasound, defibrillator, non-invasive respiratory equipment (CPAP and BIPAP), patient warming equipment, and a bronchoscope and laryngoscope.
  - There were two patient isolation rooms to minimise infection cross-contamination. Each had air change facilities. These were located at the far end of the unit and could be accessed without entering the main part of the unit.

The ways the unit did not meet the guidelines were:

- Although there had been no incidents reported connected with this, the unit did not have the recommended minimum safe level of infusion pumps (minimum of three) and syringe pumps (minimum of four) for each bed space. If all 14 beds were in use, the unit needed 42 infusion pumps (there were 26 on the equipment register) and 56 syringe pumps (there were 53 on the equipment register). One of the technical team told us there were new infusion pumps on order.
- Because of the layout of the unit (a long narrow ward) not all patients were visible from the central nurses' station, although patients were cared for with close nursing supervision, so this did not result in any risks.
- All electrical sockets on the pendants had switches as opposed to being the type that were without switches. This gave rise to a risk of equipment being inadvertently switched off.

- The surgical and vascular high dependency units did not meet many of the recommendations of the Department of Health building guidelines for modern critical care units, although there was no evidence to suggest patients were not safe. The recommendations were produced by the Department of Health for all units managing the care of patients who met the level two (HDU) or level three (ICU) classifications. It did not differentiate between HDU and ICU equipment and environmental recommendations. Although the surgical and vascular high dependency units looked after patients who were generally assessed as at less risk than those in the CCU, they did not meet many of the equipment or environmental recommendations for modern units. For example, there was insufficient space around the patient's bed; monitoring equipment was not on ceiling-mounted pendants; there were no isolation facilities with specialised air handling. There were, however, sufficient syringe pumps in the vascular HDU and triple infusion pumps and each of the four beds. In practice, however, if patients deteriorated to the extent they needed care in a unit with more appropriate specialist equipment arrangements would be made to move the patient to the CCU.
- All the equipment in the CCU and HDUs were maintained in accordance with manufacturers servicing guidelines. The safety of the equipment was covered by the trust's medical devices policy. The policy stated equipment would receive planned preventative maintenance (servicing) in line with manufacturers guidelines or the government's Medicines and Healthcare Products Regulatory Agency. We reviewed

the maintenance records for equipment in the CCU including ventilators, syringe pumps, infusion pumps, defibrillators, haemodialysis machines, and the blood gas analyser. Of just over 200 different items of equipment there were 14 items which had recently fallen due for service and therefore just marginally out of date for review.

- Clinical waste was effectively and safely managed. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. There was a full range of disposable equipment in order to avoid the need to sterilise equipment and significantly reduce the risk of cross-contamination. We saw staff using and disposing of single-use equipment safely at all times. None of the waste bins or containers for disposal of clinical waste or sharp items we saw were unacceptably full. Nursing staff and the housekeeper we met said they were emptied regularly.

Medicines

- Medicines were stored appropriately, although the temperature of the clinical room in the CCU was not being monitored. Medicines were stored in locked cupboards in a locked clinical room and were well organised. Fluids stored in bulk storage were also locked away as required. When we entered the clinical room in the middle of the unit it felt warmer than it should be. Most medicines, excluding those requiring refrigeration, must be stored below 25°C. There was no thermometer to measure the ambient temperature, which could rise in some circumstances where the ventilation system needed to be reset.
- Medicines required to be refrigerated were kept at the correct temperature, and so would be fit for use. We checked the refrigeration temperature checklists in the CCU which were signed to say the temperature had been checked each day as required. The checklists indicated what the acceptable temperature range should be to remind staff at what level a possible problem should be reported. We looked back to May 2015 months and records were completed each day. All the temperatures recorded were within the required range.
- Controlled drugs were managed in line with legislation and NHS regulations. The drugs, in terms of their booking into stock, administration to a patient, and any destruction, were recorded clearly in the controlled drug register. We checked drugs in tablet (all boxed) and liquid form and stocks of liquid potassium chloride 15% W/V all of which were stored appropriately as a controlled drug. Stocks were accurate against the records in all those we checked at random in the CCU. We cross-referenced one of the drugs with a patient drug chart and found the drug had been documented as administered on the occasions and at the dosage stated on the record.

Records

- The CCU observational records were designed internally by experienced critical care staff to meet the needs of the patients they cared for. The large patient observation chart was an outstanding example of a record of this type. The version in use was now the 17th iteration and it was updated each time something needed to be changed, removed or added. This made the chart as relevant and current as practically possible. It included all the areas we would expect to see and other guidance and prompts such as consultant plans, a pocket to keep the blood results, patient agitation scores, confusion assessments, and written guidance for patient safety goals. All those observational charts we reviewed were completed as required and timed, dated, signed, legible and clear. This was also the case on our unannounced visit.

The charts in the vascular HDU were more basic and did not include some aspects of care. They did not, for example, have prompts for the patient safety and risk reviews, or environment checks.

- Medical records were written and managed in a way to keep patients' safe. There were clear, legible and ordered patient notes in paper-based files. Doctors' notes were written on yellow paper in order to make them distinguishable from other notes. We reviewed two sets of notes in the vascular HDU. The nursing and medical notes were well completed and there were regular timed and dated reviews. We reviewed four sets of notes in the CCU. Documents were clearly written in chronological order, and were dated, timed and signed. Contributors printed their name and added contact details. The nursing proforma documents were well completed. We saw completed entries for example, for bedrail management, malnutrition screening, any visual

or hearing impairment, mobility, oral care, and dignity needs. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided.

- Patient notes were stored in open rails at bedside which could compromise their security and confidentiality at times. They were kept this way in order to make patient notes immediately available to the multi-professional team. These were confidential records containing personal details the patient may not have permitted to be shared with unauthorised people. The notes were supervised most of the time by staff. But they were not fully secure to prevent them being removed or accessed by an unauthorised person. At no time did we see patient confidential information left visible and unaccompanied on any screens or boards.

Safeguarding

- Staff were trained to recognise and appropriately respond in order to safeguard a vulnerable patient, although a small number had not updated their mandatory training by the trust deadline. Safeguarding training covered vulnerable adults and children, so gave staff direction to safeguard any young people (anyone between 16 and 18 years of age) admitted onto the units. It would also give staff guidance to safeguard children of any age associated with a patient or visitor. Mandatory update training was delivered to all staff and most were up to date with their knowledge. Results from data supplied by the trust (as below) were against a trust target of 95% of staff having completed this within the deadline.
  - For the CCU (121 staff) compliance at the end of June 2015 was 93% for the adult safeguarding course (eight of the 58 nursing staff were not up-to-date with their training) and 98% for the child safeguarding course.
  - For the surgical HDU (47 staff listed) compliance at the end of June 2015 was 100% for the adult safeguarding course, and 87% for the child safeguarding course (five of the 35 medical staff had not completed their update training).
  - For the vascular HDU (35 staff listed) compliance at the end of June 2015 was 89% for the adult safeguarding course (four of the 12 staff described as 'additional clinical services' had not completed their update training) and 80% for the child safeguarding course (four of the 10 medical staff and three of the 12 additional clinical services staff had not completed their update training).
- There were policies, systems and processes for reporting and recording abuse. The policies included explanations of the meaning of abuse and the responsibilities and duties of staff to report any suspicions for vulnerable people (adults and children). The policies included how and when to involve the police in safeguarding concerns and the systems and protocols around sharing concerns. There were clear checklists and flowcharts for reporting concerns for both adults and children, whom, as required, were subject to different procedures. The checklists included the requirement to raise an internal incident report alongside any safeguarding referrals.
- Staff were aware of their responsibilities to report abuse and how to find any information they needed to make a referral. We spoke with a range of doctors and nurses who were able to describe those things they would see or hear to prompt them to consider there being some abuse of the patient or another vulnerable person (such as a child in the care of the patient or a visitor). This included some of the obvious signs such as bruising or broken bones. It extended to the less obvious markers including the patient or another vulnerable person being withdrawn, scared or uncertain. Staff recognised how abuse could be physical, but also emotional or neglectful. Staff were aware of their statutory duty to report their concerns. Most were aware of the teams within the hospital to contact, and others demonstrated where the information could be found on the trust intranet.

Mandatory training

- Not all staff were meeting the trust target and up-to-date with the latest mandatory training refresher courses. Staff were trained on induction and expected to update this training at certain intervals set by the trust. There were ten mandatory training courses for all staff ranging from health and safety subjects, equality and diversity, to infection control. Each unit had achieved the following results at the end of June 2015 against a trust target of 95%:
  - Of the 121 staff in the CCU, 82% had updated their mandatory training. None of the three staff groups

(medical, nursing and additional clinical services) had achieved 95%. None of the medical staff had undertaken their update training in equality and diversity, which included harassment and bullying. Only 30% of the medical team (nine of the 30 staff) had completed their refresher course in fire, despite there being concerns about fire safety on the unit risk register. Otherwise, medical staff were meeting the 95% target for around half of the courses.

- Of the 47 staff reported to us as working in the surgical HDU, 72% had updated their mandatory training. The majority falling behind were in the medical staff group. Only 23% (three out of 13) of the nursing staff had undertaken their update training in equality and diversity, which included harassment and bullying. Otherwise, the nursing staff were meeting the 95% target for around half of the courses. Only around 50% of the medical staff had completed their equality and diversity, hand hygiene, and infection control courses.
- Of the 35 staff reported to us as working in the vascular HDU, 78% had updated their mandatory training. The majority of staff falling behind were in the additional clinical services group and only the nursing staff had achieved 95% for any of the courses (they had fallen behind on health and safety and infection control). All staff had completed their equality and diversity and fire training. The staff group predominantly falling behind in courses were the additional clinical services staff. For example, only two of the 12 staff had completed their infection control and information governance updates.

Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded well to patient risk through regular review. Ward rounds in the CCU took place twice daily in the morning and evening and led by the consultants on duty. The ward rounds formed part of the consultants' job plans. There was input to the ward rounds from unit-based staff including at all times the doctors and the nurses caring for the patient. The supernumerary senior nurse (sister or charge nurse) would attend the whole ward round.
- Patients were closely monitored at all times so staff could respond to any deterioration. Patients in the CCU and HDU were nursed by recommended levels of nursing staff. Patients who were classified as needing intensive care (level three) were nursed by one nurse for each patient. Patients who needed high dependency care (level two) were nursed by one nurse for two patients. Where possible nurses would be placed with the same patient throughout the patient's stay so there was consistency of approach. An indication of something starting to change for the patient may then be picked up faster as patient care and response was closely supervised by a nurse at all times.
- Patients were monitored for different risk indicators. Each ventilated patient on the CCU was, for example, monitored using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Equipment was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions.
- 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 ward-based patient triggered a high risk score from one of a combination of indicators, a number of appropriate routes would be followed by staff. One of the triggers would include a review of the patient by the critical care Outreach team. This team had been established to support all aspects of the critically ill patient, including early identification of patient deterioration. The Outreach team or the patient's medical team were able to refer the patient directly to one of the CCU or HDU consultants for support, advice and review. This was captured in the policies for the PARS tool and the Outreach team operational policy.
- There had been a recent snapshot audit of the hospital's use of PARS by the Outreach team (October 2014). This was carried out with 10 patient records from each ward. Results were categorised by ward and compliance with the use of the PARS tool. The report said there had been improvement in WRH with use of the tool, although recognised there had been recent reconfiguration of wards so comparison was not straightforward. There were recommendations and action plans which met the areas found to require improvement. This included induction and education of bank staff. With explanation

as to why, the recommendations, however, set an upper target for compliance with the tool at 95%, and not 100% where all patients at risk of deterioration would therefore be responded to safely.

- The hospital did not provide 24 hour cover from the critical care Outreach team. The Outreach service was not available at all night when it became the responsibility of the hospital out-of-hours team. The service was provided by experienced and skilled nurses from 8am to 8pm, 365 days a year. The Guidelines for the Provision of Intensive Care Services 2015 (Faculty of Intensive Care Medicine, Intensive Care Society, and others) recommended Outreach services be provided 24 hours a day. It went on to state the hospital should "ensure an appropriate response always occurs and is available 24/7." The out-of-hours hospital at night team were skilled practitioners, but they had a multiple focus across the whole site and were not critical care trained. There was a risk therefore to patients of care or transfer not being timely when there were competing priorities.
- There were risk assessments and safety goals for each patient in the CCU. The unit used 10 core care plans relating to risk assessments and how to reduce or manage the risks. These included, for example, risks from altered levels of consciousness; risks from decreased nutritional intake; risks of pain; and risks from anxiety. Each was assessed alongside a set of recognised nursing care plans covering areas such as the extent or escalation of monitoring and recording of results (such as heart rate or fluid output); techniques for certain procedures (such as around use of feeding tubes or neurological assessments); and areas to observe against specific changes (such as changes to body temperature or pallor).
- Patients in the HDUs would be admitted to the CCU in the event of their condition deteriorating. The policies and procedures for the HDUs included escalation plans for patients needing intensive care. The surgical leads and the CCU team had strong relationships and worked collaboratively. The CCU consultants reviewed patients each day on the surgical and vascular HDUs and this provided an early warning of a patient potentially deteriorating. These patients and those in the vascular HDU were also reviewed by the Outreach team and the CCU kept informed about potential admissions.

Nursing staffing

- There were safe nursing staff levels in critical care and the HDUs in line with professional standards. Patients were nursed in accordance with the NHS Joint Standards Committee (2013) Core Standards for Intensive Care. Therefore patients assessed as needing intensive care (described as level three care) were cared for by one nurse looking after that one patient at all times. Patients assessed as needing high dependency care (described as level two care) were cared for by one nurse looking after two patients. The nursing rotas demonstrated this nursing ratio was met although sometimes with the use of agency or bank staff. When shifts were unfilled there was a request for any of the unit's own staff to offer to cover before going out to the bank of agency.
- Patients were kept safe by limiting use of agency staff (or bank staff who were not the trust's own staff) to a minimum. The Faculty of Intensive Care Medicine (FICM) Core Standards recommended there were not more than 20% of bank or agency staff on each shift. The rotas we reviewed for the last three months did not show any shifts had reached this level of temporary staff use.
- There was good handover among nurses. Nurses handed the patients over to the new shift following a set protocol. Patients were discussed in relation to updates on their risks, including communication, hygiene, malnutrition, fluid balance, pain, elimination, psychological markers, sleep or ability to rest, and risk of falls.

Medical staffing

- The CCU was led by an experienced consultant clinical lead supported by a skilled team. The clinical lead was a consultant in intensive care medicine and Fellow of the Faculty of Intensive Care Medicine (FICM). All sixteen consultants working on the primary rota were consultant intensivists and therefore highly experienced in delivering care to some of the most critically ill patients in the hospital.
- The level of cover provided by medical staff was mostly in line with professional standards, although the presence of trainee doctors in the CCU fell below the recommended requirement if the unit had a high numbers of patients. The experienced consultant presence on the CCU followed the recommendations of the FICM Core Standards. There were sixteen (soon to be increased to eighteen) consultant intensivists (consultants trained in advanced critical care medicine)

working in rotation in critical care, supporting the general HDU, and on call. There was a good consultant to patient ratio. There were two consultants on duty or on call across the CCU for an absolute maximum of 15 beds, although the average bed number was closer to 10 beds, with a maximum of nine patients at the highest level of critical illness (level three). This was significantly better than the core standards recommended ratio of one consultant for a maximum of 15 beds. The cover extended to the nurse-led surgical HDU and the CCU ensured the consultant/doctor cover was risk-based to provide a safe level of care.

- The consultants in the CCU were on duty from 8am to 6pm, or later to complete the evening ward round, then on call at home in the evening.Consultants attended the units out of hours when needed and often took calls from staff. This arrangement was in place seven days a week with no difference in the level of cover on the weekends. When consultant intensivists were on duty or on call, this was only for critical care and not extended elsewhere in the hospital.
- As recommended, there were no foundation year one trainee doctors on the unit working outside of daytime hours or counted in the medical staff numbers. This gave them the opportunity to learn and receive effective supervision. In the weekdays there was a specialist registrar doctor (with advanced airway skills) with a foundation year two or other specialist registrar on duty. This met the recommendation of the Core Standards for there to be a trainee doctor for no more than eight patients, and the unit could admit up to 14 patients. At weekends and public holidays, however, there was one specialist registrar in the unit from 8am to 8pm and one from 8pm to 8am. They were supported by two consultants present during daytime hours, but not at night. The specialist registrars were also covering calls for the crash team, the emergency department, and the hospital-at-night team where they picked up the Outreach work (which was not provided for 24 hours). The single specialist registrar on duty at night did not meet recommended safe levels of cover when there were more than eight patients on the unit, which with high occupancy level, there often were.
- There were also periods with a lack of continuity for trainee doctors. In the rota we reviewed during our unannounced visit, we saw that the specialist registrar doctors were only working one or two shifts during the week, and not necessarily consecutively. Due to the way their placement worked the trainee doctors were not working countywide in the same way as the consultants and nurses. They were therefore not benefiting from the same level of exposure to different patients, environments and circumstances.
- There was a good commitment of consultant time on the unit. The FICM core standards required consultants to have a minimum of 15 programmed activities of consultant time committed to critical care each week and this was met at the very least and generally far exceeded. There had been minimal use of locum doctors, and one who was a regular in the unit was well known to the consultant body.

Allied Health Professional staffing

- There was a safe level of cover from the pharmacist team. The CCU and HDUs were strongly reliant for medicines advice and guidance from the experienced and knowledgeable lead pharmacist and their team. One consultant described the lead pharmacist as “invaluable” and another as “highly respected.” For the CCU the cover provided mostly met the Faculty of Intensive Care Medicine (FICM) Core Standards. The recommended cover level was a consensus of critical care pharmacists, the UK Clinical Pharmacy Association, and the Royal Pharmaceutical Society. If the unit was full, however, with 14 patients and patient levels of care were high, the FICM Core Standards recommended there be two senior grade (band eight A or above) pharmacists providing a full service to the unit. As there was only one senior pharmacist working on the unit, and they were also providing services elsewhere in the hospital, this would have been stretched at times. Due, however, to prioritising work in the CCU, the senior pharmacist reviewed every patient each day. The pharmacist team provided a routine on-call service to make sure advice was available and provided at all times. The staff on the vascular HDU and surgical HDU said a pharmacist usually joined the ward round each day.
- There was safe provision of physiotherapy for patients, although not enough therapy staff to fully meet the requirements of the FICM Core Standards. A physiotherapist team attended the CCU each weekday and the mornings of the weekends and prioritised critical care patients in among their other

responsibilities elsewhere in the hospital. They were available if needed when they were on other wards. There was an on-call service out of hours including nights and the rest of the weekends. HDU patients were also seen by the physiotherapist team each day and available as needed on call.

- There was a good regular service in the CCU and HDUs from dieticians and speech and language therapists (SALTs) on weekdays. The dietician visited the CCU each day and would attend at other times when needed. An emergency parenteral nutrition protocol had been produced for staff to use on the weekends or out-of-hours should a naso-gastric regime need to be commenced and a dietician was not on site. Speech and language therapists did not attend the units unless requested, but were always available if needed for a patient review. There was, however, no nurse trained in dysphagia (swallowing difficulties) within the hospital so there could be delays to some therapies over a weekend or out-of-hours when there was no SALT available. There was a nutrition team on site at the hospital for additional support and a consultant gastroenterologist with a special interest in nutrition available for advice.

Major incident awareness and training

- The trust had a major incident plan dated reviewed in January 2015 which covered critical care. 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. This included action plans for the clinical lead critical care consultant. Actions included identifying patients who could be discharged to a ward in order to make beds available for critically ill or injured patients. Other areas to support critically ill patients, such as operating theatres and recovery units were to be identified. There was action plan for the nurse in charge of critical care. As well as working with the clinical lead, the nurse in charge would review nursing staff levels and stocks of consumables were to be checked for safe levels. The action plans also held details of how to stand the unit down after an incident had been safely brought under control.
- There was a business continuity plan for critical care, but this was in draft version and not yet finalised. The draft document took account of failures of equipment, the building becoming damaged or uninhabitable, loss of supplies, and loss of information and communications technology. There were risk assessments with the plan identifying which functions were the most critical to re-establish or manage in the event of any lack of business continuity. The care and safety of the patient was the most urgent priority.

Are critical care services effective?

Good

Overall we rated this service as good for effectiveness. Patients had good outcomes because they received effective care and treatment to meet their needs. Treatment and care was delivered in accordance with best practice and recognised national guidelines. There was a strong multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the CCU and HDU services and the overarching priority for staff. Good outcomes were achieved for patients who were critically ill with complex problems and multiple needs. Data for the CCU was being submitted to the Intensive Care National Audit and Research Centre to reveal outcomes for patients compared with similar units. The CCU was performing well with clinical outcomes when benchmarked against other units by ICNARC. This information was not, however, being captured or reported for the HDUs which therefore failed to meet a recommendation of the Faculty of Intensive Care Medicine Core Standards. The mortality rates within units showed, over time, more people than would have been expected survived their illness due to the effective care provided. The CCU met recommendations for competent staff, although this was not the case in the HDUs as fewer than 50% of the nurses had a post-registration qualification in critical care nursing. Local audit work was routine and prioritised to ensure outcomes and effectiveness of care were well understood, could be improved, or celebrated as necessary. There was a dedicated and successful contribution to the national organ donation programme. Patient needs in relation to pain, nutrition and hydration were well managed. Services required to meet patient needs were available across all seven days of the week. The effective discharge for patients was improving with the

introduction of better systems. There was, however, a poor response from the medical teams to requests for admitting doctors to accept patients ready to be discharged, or provide advice or assistance.

Evidence-based care and treatment

- Patients' needs were assessed on admission and their care planned and organised to meet evidence-based standards. The CCU had an evidence-based admissions policy supported by guidance from the Department of Health (in relation to the categorisation of the patient and the definition of needs); the Faculty of Intensive Care Medicine (FICM) in relation to time to admit; and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviews in relation to early communication with relatives and loved ones.
- The policy went on to describe the referral process for a patient admission. This, as per Department of Health guidance, included, for example, consultant to consultant referral; the health and survival status of the patients (patients with significant comorbidities and poor prognosis such that critical care will no longer benefit the patient would remain on the ward); and any advanced directives or wishes of the patient (who may have requested they are not admitted to the CCU). This enabled the most appropriate patients to be admitted. The policy went on to guide staff on how to provide support to an critically ill patient awaiting transfer from the ward; booking for elective surgery patients; and what should happen when a patient arrived in the CCU.
- The admissions policy followed the FICM Core Standards and the recommendations of the NCEPOD review 'An Acute Problem' (2005). It stated a patient should be reviewed by a consultant within 12 hours of admission to intensive care and this should be audited and reviewed. The 12-hour criteria were now written into consultant intensivists' objectives within their job plans, which were referenced to the Core Standard 2.6. Data we were provided with from a review in October 2014 said this was achieved for 66% of CCU patients. The average time to review was within the standard at just under 10 hours, but the range of review (from what was due to poor record keeping) was 45 hours at most. An action plan, including improving record keeping, particularly with records being timed, had been presented to the unit's Intensive Care Medicine Forum. All those patients we saw when we visited the unit had, however, been reviewed within 12 hours of admission. This was being made more achievable and therefore improving with a second consultant now on duty each day. The unit would be re-audited in October 2015.
- Patients' care and treatment was assessed during their stay and delivered mostly along national and best-practice guidelines. The CCU, for example, met the requirements of the key National Institute of Health and Care Excellence (NICE) guidance appropriate to critical care units. These were NICE 83: Rehabilitation after a critical illness, and NICE 50: Acutely ill patients in hospital. The CCU had reviewed itself against these standards. Most elements of NICE 50 and 83 were being met. There was an element, however, of NICE 83 not being met in relation to rehabilitation post discharge from the unit or hospital. This had been escalated to the risk register. This was in the area of providing patients with a structured and supported self-directed rehabilitation manual for use for at least 6 weeks after discharge from critical care (recommendation 1.1.18). There was also no follow-up clinic for patients to determine if they needed further input after two to three months (recommendation 1.1.25). We were told by senior staff and read in the review of the unit against FICM Core Standards that there was work in progress to address rehabilitation. Booklets had now been provided by the Midlands Critical Care Networks and were to be trialled shortly.
- The units had up-to-date policies and procedures, although the vascular HDU and surgical HDU operational policies were still in draft form. The CCU policies were comprehensive, approved and in date. Those we asked to see were provided and included the operational policy; analgesia, sedation, and management of delirium in critically ill patients; critical care unit discharge policy; critical care admissions policy; and the outreach service operational policy. These were available on the trust intranet for all staff to be able to access. Policies referenced published academic studies and relevant bodies including the Department of Health; the FICM; the Resuscitation Council (UK); and NCEPOD. The policies we saw were, however, approved at local level and not through a clinical governance committee. There was no evidence provided as to the trust's requirements as to whom or what committee should review and approve policies.
- Patients were treated without discrimination through the use of staff mandatory training and policies

assessed and approved for equality and diversity. This included no barriers to patients on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief, and sexual orientation. From talking with staff and hearing about the patients who had been admitted to the CCU, there was no evidence of any discrimination on any of the above grounds. There was provision, for example, for pregnant or post-natal women to be admitted to the unit for advanced care. This would be done with the full support of the obstetrician team and midwives from the maternity unit. The lack of any discrimination extended to any visitors to the unit, who were given full access rights while required also to act in the best interests of the patient. Staff spoke about respecting people's wishes, rights and beliefs. They were able to describe a wide range of different needs and would often talk about patients' individuality and right to be different.

- In the CCU there was a daily audit review of patient care and treatment. The critical care observation chart daily record was extensively detailed. It included a daily audit tool developed in-house designed to support the twice daily consultant-led ward rounds. This was called FASTHUGFIDDLE with each letter prompting a review of a certain aspect of care to be checked for completion and signed off each morning and evening. For example, the F stood for 'feeding'; the A for 'analgesia'; the U for 'ulcer prophylaxis'; D for 'drug review'; and the L for 'line review'. This meant each aspect of care was reviewed and a record made to check everything that should be done for a patient had been completed appropriately. In those records we reviewed on all our visits, the audit elements were checked and signed. Completion of this audit tool at ward rounds was also part of the consultants' job plans.
- Patients were staying on the unit for an average length of time. It has been recognised through research as sub-optimal in social and psychological terms for patients to remain in critical care for longer than necessary. Patients' length of stay was submitted to the Intensive Care National Audit and Research Centre (ICNARC: an organisation reporting on performance and outcomes for intensive care patients). The measure was benchmarked both nationally and against other adult critical care units of a similar type and patient group participating in the ICNARC programme. The mean average length of stay for all admissions in the CCU in the six months from to October 2014 to March 2015 was 4.8 days, compared with the national mean average of around five days. Over the last five years the mean average for the department was around five days against a national mean average of the same over this longer period.
- Patients were safely ventilated using recognised specialist equipment and techniques. This included mechanical invasive ventilation to assist or replace the patient's spontaneous breathing using endotracheal tubes (through the mouth or nose into the trachea) or tracheostomies (through the windpipe in the trachea). The unit also used non-invasive ventilation to help patients with their breathing using usually masks or similar devices. All ventilated patients were constantly reviewed and checks made and recorded hourly.
- The CCU followed NHS guidance when monitoring sedated patients. Sedation is one of the most widespread procedures used in critical care. It is used to help deliver care and treatment safely and try to ease the patient though a distressing time. Maintaining light sedation in stable adult patients in critical care has been shown to improve outcomes (Faculty of Intensive Care Medicine). Research has shown advantages to patient outcomes, their length of stay, evaluation of neurological conditions, and reduced levels of delirium from limiting the use of sedative drugs. In the CCU each sedated patient was assessed each day according to the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the assessment of the patient for different responses, such as alertness (scored as zero) and then behaviours either side of that from levels of agitation (positive scoring) to levels of sedation (negative scoring). Any scores below the baseline of zero (or below the score desired by the prescribing doctor) would indicate the need for a discontinuation of the sedation infusion (termed a 'sedation hold') to monitor the patient's response. Sedation was then withdrawn, continued or adjusted dependent upon how the patient reacted to the change. The results were recorded in the patient's notes and on the daily care record used for each patient. The CCU policy followed best practice and referred to research and guidance to provide the optimal level of sedation for the patient in all circumstances.
- Patients admitted to the CCU were formally assessed using recognised tools for delirium: a state of confusion and altered brain activity that can cause delusions and hallucinations which is not uncommon in critical care

patients. The FICM Core Standards recommended all patients were screened for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM – ICU). Clinical staff recognised the need for delirium screening as the condition was often one of the first indicators of a patient's health deteriorating. CAM – ICU assessment had recently been introduced in the CCU to be part of the daily observations and patients were reviewed hourly for any signs of not being completely themselves. The test required was a simple assessment of whether a patient could respond to simple instructions. Positive scoring (a patient was exhibiting signs of delirium through failing the tests) was managed through an approved protocol within the delirium policy. If medicines were used to reduce hallucinations or delusions, these were usually those recognised in clinical trials to be the optimal choice.

- Patients were assessed for risks of developing deep vein thrombosis from spending long periods of time in bed or immobile. There was a twice daily review of patients for risks of developing VTE (or deep vein thrombosis). Where needed, patients were provided with preventative care such as compression stockings and sequential compressions devices.
- The CCU took advice and guidance in relation to best-practice for patients with Acute Respiratory Distress Syndrome (ARDS). This is a condition where the lungs do not provide enough oxygen for the rest of the body. After discussions and advice from the local Extra Corporeal Membrane Oxygenation (ECMO) team (specialist ARDS care provided in just five nationally designated centres in England) the CCU changed its approach. On the basis of guidance and advice from the ECMO team the CCU had stopped the use of one traditional ARDS therapy (oscillation) for extra corporeal carbon dioxide removal. This had been presented and discussed at the Intensive Care Medicine Forum meeting and met with approval from the team. The CCU also sought advice from the ECMO centre for other treatments for patients with ARDS, including the use of steroids and rescue plans for refractory hypoxemia (too little oxygen in the blood).
- The CCU met best practice guidance by promoting and participating in a programme of organ donation led nationally by NHS Blood and Transplant. As is best practice, the CCU led on organ-donation work for the trust. In the NHS there are always a limited number of patients suitable for organ donation for a number of reasons. The vast majority of suitable donors will be those cared for in a critical care unit. The trust had appointed one of the experienced consultant intensivists as the clinical lead for organ donation. There was a specialist nurse for organ donation who was employed by NHS Blood and Transplant, but was based at the hospital to directly support the organ donation programme and work alongside the clinical lead. The specialist nurse also supported a regional and community programme for promoting organ donation which was supported by the trust organ donation committee.
- The hospital trust followed NICE guideline CG135: Organ donation for transplantation and had policies and strict criteria in place since 2009. We met with the specialist nurse for organ donation and reviewed data about donations from WRH for the period from 1 April 2014 to 31 March 2015. There had been 18 patients eligible for organ donation during this period. Of these, 14 families were approached to discuss donation. Eight of these families (57%) were approached with the involvement of the specialist nurse, against a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved with discussions with the family.
- Nine patients went on to be organ donors and 32 organs were retrieved and transplanted to 27 people. The average number of 3.9 organs donated per donor (even if not all went on to be suitable for use) was better than the UK average of 3.4 and 2014/15 had shown a significant rise in this figure at WRH. Each non-referral, non-approach, refusal, and non-proceeding case for organ donation was reviewed by the specialist nurse and presented to the trust and organ donation committee for discussion and to look for ways to improve. The specialist nurse and clinical lead commented upon the strong support for organ donation from the CCU department and the trust.

Pain relief

- Patients were given effective pain relief and strategies were based upon best practice. A scale was used to determine a patient's pain score based around an uncomplicated assessment. A score of zero was the patient saying they had no pain. A score of one, two, or three described mild, moderate, or severe pain respectively. Pain scores were recorded on the

observational chart by the nurse each hour. There was clear guidance in the analgesia policy as to how to manage patient pain with a number of different approaches linked the patient's underlying illness or other problems. Use of morphine, for example, was to be administered to particularly elderly patients with renal (kidney) failure with great care. This was due to recognition that morphine can be difficult for patients with renal failure to effectively excrete from the body through the kidneys. The CCU policy had therefore indicated use of another longer acting opiate-based pain killer for patients with renal failure. Other recommended pain strategies were those based upon tried and tested regimes with standard pain medicine such as paracetamol and short-acting opioids.

- There was consideration for patients who were unable to communicate if they were in pain. This was carried out through subjective observation of pain (including movement or facial expressions) or through physiological monitoring systems. The change in these observations was then recorded following administration of pain relief or practical solutions (such as a change in the patient's position) to review their effectiveness.
- There was access to an acute pain team. This included support from a consultant and nurse qualified in specialist pain management. The pain team worked with patients throughout their hospital treatment. Patients were able to be identified by the pain team in the theatre recovery unit; followed through into critical care; and when they were discharged to the ward. Staff in critical care said they had an excellent relationship with and support from the pain team who were available during normal working hours for advice and guidance. Guidance and support was provided for patients in relation to epidural management, patient-controlled analgesia and different infusions available for use. Out of hours, the anaesthetists on duty could provide specialist pain advice and treatment.

Nutrition and hydration

- Patient nutrition and hydration needs were assessed and effectively responded to. The patient records we reviewed in the CCU and HDUs were well completed, and safe protocols followed. Fluid intake and output was measured, recorded and analysed for the appropriate balance, and any adjustments necessary were recorded and delivered. In the CCU there was hourly measurement of fluid intake (whether oral or intravenous) and output, however that was delivered. The method of nutritional intake was recorded and evaluated each day. Any feeding through tubes or intravenous lines (enteral or parenteral feeding) was evaluated, prescribed and recorded.
- Risks from acquiring pressure ulcers from dehydration or malnutrition were assessed and managed. The Malnutrition Universal Scoring Tool (MUST) was used for all patients. This evaluated the standard risks from a patient's Body Mass Index (BMI) and any recent weight loss, continence state, skin evaluation, mobility, age and sex. This was then considered against specialist areas such as: tissue malnutrition from the patient being a smoker or having organ failure; any neurological deficit (such as suffering a transient ischemic attack); any major surgery performed; and prescribing of cytotoxic drugs such as long term/high dose steroid or anti-inflammatory medicines. All the scores appropriate to these tests were then added up and the risks to developing pressure ulcers were addressed through use of preventative therapies or treatments.
- The units had guidance, protocols and support for specialist feeding plans. A dedicated dietician attended the CCU on weekdays and the HDUs on request to support patients with naso-gastric tubes, total parenteral nutrition feeding (nutrients supplied intravenously through a central line), and Percutaneous Endoscopic Gastronomy (PEG) feeds. There were dietician-designed and approved protocols for nursing staff to commence enteral feeding on weekends. Nutrition careplans were drawn-up for all patients to identify patients who needed further supplements. Energy drinks and food supplements were prescribed and used for patients who needed them. We reviewed the nasogastric feeding tube insertion and care guidelines produced by the trust's chief dietician. These were approved by the clinical management committee and followed evidence-based guidance and researched practice.
- Staff were competent in giving intravenous fluids. Adults receiving intravenous fluid therapy were cared for by staff competent in assessing patients' fluids and electrolyte needs, prescribing and administering intravenous fluids, and monitoring the patient. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 Statement 2: intravenous therapy in hospital.

- Patients could take their own food and fluids if they were able. For patients who could help themselves, particularly in the HDUs, drinks and any meals were available on bedside tables and within reach of patients. There were 'protected mealtimes' in the daytime where visitors were asked to give patients the opportunity for a quiet time over the lunch period.

Patient outcomes

- Patient outcomes were routinely captured and monitored against those achieved nationally, although only for the main critical care unit and not the HDUs. The CCU demonstrated continuous patient data contributions to ICNARC for at least the last five years. Data contribution therefore met the recommendations of the FICM Core Standards: a set of recognised guidelines for intensive care units to achieve for optimal care. This participation provided the CCU with data benchmarked against other units in the programme and similar units. Thedata returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to come through the results. The CCU had been contributing a high standard of data: meaning the records submitted were mostly complete and could be evaluated and compared.
- Most patients were able to be admitted to the CCU at this hospital when they needed to be. It has been recognised through research as sub-optimal to move a patient to another hospital critical care unit without careful planning and management. According to ICNARC data, some CCU patients were transferred to other units for non-clinical reasons, although infrequently and much the same as the average when compared over time with other similar units. If this did happen usually this was due to a bed not being available in the CCU at the right time. Although involving very small numbers of patients, there were only a few quarters in the last five years where a transfer had not taken place. ICNARC data showed nine patients (1.3%) were moved in the 12 months from April 2014 to March 2015. However, closer review of the patients listed for the last three months showed an error in coding (the information given to ICNARC). These patients were moved for clinical reasons. Taking this into account would mean the rate of non-clinical transfers was around the national average of around 1% of patients moved in that 12-month period.
- Patients were assessed for their risk of death. The recognised SOFA scoring system (Sequential Organ Failure Assessment) was used to determine the risk of the patient not surviving. The physician or surgeon who was otherwise responsible for the patient would then be involved in the multi-professional approach to the patient's care. The end-of-life care pathways were well developed in the unit and the trust. The trust had recently appointed two palliative care consultants who provided support to the unit.
- Mortality levels for patients admitted to the CCU had recently been reported as above expected levels, although this measure was similar to the national average over time. Further interrogation and investigation of these recent increases by the CCU intensivists (data for January to March 2015) had shown there to be some coding errors with the data provided to ICNARC. This meant the data was not completely accurate and should have been better than reported. The cause of these errors had been addressed. The data for April to June 2015 had subsequently been analysed by the unit. Although this had not yet been processed by ICNARC, the data now showed there were no more patients dying on the unit than expected (1.0)
- The CCU senior staff were fully aware of issues around patient mortality and had recently undertaken a study into patients who went on to die in hospital post CCU discharge. The study going back over patient mortality from January to June 2014 identified that none of the patients who went on to die had been discharged too early to provide beds in the CCU. Secondly, none of the deaths of the patients who were discharged to a ward at night were seen as avoidable in the circumstances. Otherwise, the cohort studied was limited (21 patients) and nothing of concern was learned. There was a recommendation based upon the known factors around night time discharge that all patient discharges between 10pm and 7am were stopped, but this was not taken forward.
- The HDUs were not producing ICNARC data so their mortality levels were not available in the same context. Mortality for the HDUs was captured internally as part of the speciality (general surgery and vascular surgery) they supported. The mortality figures for both those specialties reported more patients were surviving their treatment than would be expected given their illness (below 1). A review of the data from the Vascular Services Quality Improvement Programme showed for

both elective abdominal aortic aneurism (AAA) repairs and carotid endarterectomy (unblocking of a carotid artery) results were well within those achieved nationally. These were complex and sometimes emergency procedures where the patient may have needed HDU care during their recovery period. For AAA repairs, 420 of the 425 patients were discharged without suffering a stroke or death, and for carotid endarterectomies, 200 of 203 patients were discharged without suffering a stroke or death

- Few patients were discharged before they were ready. Statistics from ICNARC for the CCU described a small number of patients discharged prematurely.
  - One indicator of patients being discharged too early was post-unit deaths and these were below those of similar units. These were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care. For most of the last five years, these had been below (better than) the national and similar unit averages.
  - Early discharges were consistently low.
  - Early readmissions to the unit (those readmitted within 48 hours of discharge to a ward) for the 12 months to March 2015 were much the same as the national average in each quarter. There were three, for example, in January to March 2015 which was the same as the national average of around three patients per quarter. Also, most early readmissions in the last five years had been below the national average.
  - The late readmissions (those readmitted later than 48 hours following discharge but within the same hospital stay) was around 2% in the first quarter of 2015 (7 patients) which was just below the national average of around 3%. Previous to this, and for the last five years, the CCU had been mostly below (better than) the national average for late readmissions.
- Early or late readmissions can indicate a patient was discharged too early. Due to the nature of critical care illness, it is recognised however, that a number of these patients would return to the unit for conditions unrelated to their original admission.
- There was participation in the local Critical Care Operational Delivery Network, national and local audit and research, but the CCU had not had a recent external peer review. In terms of national audit, the unit had contributed to the National Confidential Enquiry for Patient Outcome and Death (NCEPOD) 'On the right Trach': A review of the care received by patients who underwent a tracheostomy (2014); and the ICNARC National Cardiac Arrest Audit. The tracheostomy review led to changes including introduction of longer tubes, use of signage at the bed head and delivery of sessions for 'altered airway management'. As with recommendations also from the NHS Commissioning Board, the CCU was an active member of the Midlands Critical Care and Trauma Network. The FICM Core Standards recommends a critical care unit participate in "regular peer review" (Standard 2.14) but there had not been a review in the previous five years. The HDUs did not participate in the local Network although they met the criteria to be represented, as they provided level two care and therefore to be subject to benchmarking and review.
- There was a programme of audit of patient outcomes in the CCU and review at the monthly Intensive Care Medicine Forum meetings. The audits included, for example, reviews against NICE guidance; central venous catheter/peripheral line insertion; delirium and sedation; fire safety; ventilator-associated pneumonia; patient safety (Matching Michigan and FASTHUGFIDDLE reviews – see Evidence-based Care and Treatment section); and high-impact intervention. Previous audits of these areas had led to improvements in patient outcomes through the introduction of best-practice guidance (delirium screening for example) and daily review of essential clinical markers (FASTHUGFIDDLE). Although there were uncertainties within intensive care medicine about its efficacy the CCU was reviewing ventilator associated pneumonia. This had led to development of an ideal-weight body chart and ongoing work to develop or improve the use of this audit. The audit results of documentation, such as line insertion, catheter care, and hand hygiene, for example, had all scored 100% for June 2015.

Competent staff

- Staff were assessed each year for their competency, skills, and development. A high proportion of staff had been given an annual review of their competence and performance. All staff knew who was responsible for their appraisal and staff in lead roles knew who was in their team and due an appraisal. This was recorded and

available from the electronic staff system. Reports could be produced at any time and this included a list of all staff that were falling due for appraisal. Appraisal data for the staff teams were as follows:

- Overall, 88% of the CCU nursing staff had been appraised, although neither of the two staff described as additional clinical services were in date for their annual review.
- Of the medical staff, 10 of the 12 doctors listed as eligible (83%) had received their annual review.
- Overall, 98% of the nursing staff in the surgical HDU had been appraised.
- Of the medical staff in the surgical HDU, 14 from 17 eligible staff (82%) had received their annual review.
- Overall, 81% of the nursing staff in the vascular HDU had been appraised. Only eight out of 12 staff (67%) of the additional clinical services staff and 26 out of 30 (87%) of the nursing staff were in date for the annual review.
- Of the medical staff in the vascular HDU, all (100%) had received their annual review

- Medical staff were evaluated by their professional body for their competence. The consultants we met said the Revalidation Programme was well underway. This was a recent initiative of the General Medical Council (GMC), where all UK licenced doctors are required to demonstrate they are up to date and fit to practise. This is by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years. Appraisals of medical staff were carried out each year and evidence demonstrated they were up-to-date.
- There was reasonable commitment to training and education within the CCU, although the clinical nurse educator (CNE) was not a dedicated role. The (CNE) had extensive experience in critical care but was only providing around 18 hours a week of training and development at most countywide. The FICM Core Standard 1.2.6 recommended one dedicated CNE for around 75 staff, which on a pro-rata basis was not being achieved. The CNE was providing about 50% of a whole-time-equivalent post to training and development, and sometimes was unable to meet this commitment due to changing priorities. The CNE had developed a 'training drawer' which was a set of written resources for relevant subjects which all staff could access. Those we saw included guidance on difficult airway management, non-invasive ventilation, delirium and sedation, and pressure ulcer care.

The CNE worked alongside trainee doctors and new nurses or those requiring identified or requested education or development. There was a rolling training session with the CNE planned for each Wednesday afternoon covering core and key subjects. Added to that were weekly training sessions delivered by the physiotherapists for all staff and the consultants would provide sessions as often as possible. The Outreach team also provided training sessions. This included involvement with the induction for year one trainee doctors, resuscitation simulation training for all staff, and emergency training with the trainee doctors. The dietician team provided teaching to staff on naso-gastric and total parental nutrition, including foundation year one trainee doctors.

- There was good support for new nurses and healthcare assistants in the CCU. The nurses had to have one year of nursing experience before joining the CCU team. They received between three and six weeks of supernumerary induction. They were required to complete workbooks and have these signed-off by their band six nurse-mentor. This ensured they were competent in the use of equipment and skills needed to safety care for patients. Nurses were also provided with mentorship courses to ensure they were able to provide competent advice and support.
- There was an experienced nursing team in the CCU line with the FICM Core Standards, but the requirement for post-registration training did not extend to the HDUs. As recommended by the Core Standard 1.2.8, more than 50% of nursing staff should have a post-registration qualification in critical care nursing. There were just over 50% of nurses in the CCU with this qualification (30 from 58 staff), but only three nurses of 18 had a post-registration qualification (1 ICU, 2 HDU) in the vascular HDU. We were told the course was currently not available and had not been offered for at least 18 months. The nursing staff in the HDUs were, however, experienced and long-standing nurses many of whom had worked in the units for many years.
- There was good support to junior and more senior trainee doctors. Those we met said they felt valued members of the team. The consultants were approachable and provided good supervision and support. More senior trainee doctors agreed, and said they were encouraged to make decisions, ask for advice and support, and mentor each other. The more junior trainee doctors told us they had good support. They

were able to have hands-on teaching and experience in skills around, for example, ventilator support, and use of inotropes (cardiovascular medicines), tracheostomies, lines, ultrasound use, and renal replacement therapy. The feedback from trainee doctors to their Deanery had been universally positive. Comments made to the Deanery included: "Loved Worcestershire. Great consultants, taught me a lot…busy enough but not too busy so you can actually be taught and learn ITU…Nursing staff lovely to work with here and teamwork was good." Another said: "very friendly unit…lots of experience. Very good training ethos and built confidence to independently make decisions." One of the year one trainee doctors we met on our unannounced visit said of the unit and staff: "I feel like part of a family."

Multidisciplinary working

- Good multidisciplinary work produced effective care. The units had input into patient care and treatment from the pharmacist team, physiotherapists, dieticians, speech and language therapists and other specialist consultants and doctors as required. There was daily support on a Monday to Friday from a microbiologist ward round (a healthcare scientist concerned with the detection, isolation and identification of micro-organisms that cause infections). The microbiologist also reviewed the patients in the CCU once a week in the company of a doctor specialising in infectious diseases.
- The CCU had developed tools to underpin and support effective multi-disciplinary review of the patient. The FASTHUGFIDDLE tool referred to above was described in consultant intensivist job plans as the tool to "underpin supportive care aspects of the multi-disciplinary ward round." The multi-disciplinary approach of this tool meant aspects of care were considered at each ward round including medicine reviews (taking account of the pharmacist input), food and fluid reviews (taking account of the dietician input), sedation (taking account of the physiotherapists input), diagnosis (taking account of consultant intensivist input), and the others which would require full input and guidance from the nursing team.
- On admission to the CCU, all patients had a treatment plan discussed with a consultant intensivist, although this procedure had not been adopted in the same way in the HDUs. The admission policy stated this as a requirement and it was an objective in the consultant intensivist job plans. The admission policy also had clear criteria for which patients would or would not benefit from an admission to critical care. The HDU operational policies were different and there was no mention of 'treatment plans', which is the usual term within critical care. The vascular HDU policy did not state how and when a consultant should review their patient, but all patients would be under the care of their surgeon. The surgical HDU policy stated the patient should be reviewed each day by the consultant or their designated trainee doctor. The policy also stated all surgical HDU patients would be reviewed every day by a consultant intensivist from the critical care team.
- Discharge of patients from the CCU to a ward, in relation to handover, was sometimes suboptimal for the patient and the staff. Some of the factors within this had been addressed by the CCU and was improving. Discharge of patients from the HDU was well managed with those units being co-located with the likely admitting ward. There was a policy within the CCU for discharging patients to a ward which recognised the handover was after an often complex episode of care, and how handover to a ward could involve anxiety for a patient. A full multidisciplinary approach was therefore important for reassurance and safety.
- The surgery team were (we were told by the CCU and surgical staff we met) collaborative in their approach to the patient and recognised the need to have a structured, formalised, timely and effective handover. This was working well. There were, however, some unacceptable responses in terms of timeliness (one of which we observed) from the medical team receiving the CCU patient who was ready for discharge. When a patient in the CCU had to be handed over or back to a medical team, there was no well-functioning or efficient system to do this. Consultants in the CCU sometimes had to spend several hours with a patient ready for discharge in order to determine which doctor would admit the patient to the medical ward. This problem extended to trying to determine a medical doctor to review an unplanned patient admitted to the CCU (such as through A&E, for example). Time spent on these tasks was diverting the consultant intensivist from higher priority clinical work.
- There was a poor response to the CCU needing information or support from the medical teams. There were difficulties with determining the physician

responsible for a medical patient in the CCU when a review was required. There was no consistency in the 'parent ownership' of the patient. Patients in critical care were predominantly discharged to a ward, and may have been admitted from elsewhere in the hospital (as opposed to a trauma or emergency admission). These patients were therefore the responsibility of the admitting surgical or medical team. All the consultants we met said the relationship with the parent surgical team or surgeon was good and worked well, but it was unsatisfactory with the medical team. One of the consultants spent two hours of their time trying to find a medical doctor to arrange an outpatient appointment for a patient who had been discharged home. This was due to new information from a test carried out before the patient was discharged becoming available and needing review with the patient.

- Patients discharged from the CCU and the HDUs were reviewed by the critical care Outreach team. The Outreach team would be made aware of patients prior to discharge in order to receive and review current information. Patients would then be visited by an Outreach nurse once they had settled into the new ward. There was no limit to the reviews and these would be done as often or as little as required. The team also supported staff caring for patients on wards with tracheostomies, having continuous positive airway pressure (CPAP) management (for patients with breathing problems) central lines (for delivery of fluids, medicines, nutrients, or blood products) or receiving non-invasive ventilation therapies. These aspects of the Outreach Service were all part of its operational policy.
- There was a multi-disciplinary approach to weaning plans for complex and long-stay ventilated patients. Weaning is the gradual decrease in duration of mechanical ventilation with the goal of the patient becoming breathing independently as quickly and safely as possible. The physiotherapist team had experienced staff able to contribute/construct a suitable weaning plan in collaboration with the multi-disciplinary team.

Seven-day services

- A consultant intensivist was available in person at the CCU or on call across the whole week, and to lead the two ward rounds every day. There were surgeon-led ward rounds in both the vascular and surgical HDU once each day, every day. The consultant intensivists also visited the surgical and vascular HDUs to provide input and oversight each day, every day. When they were not on duty in the unit, there was good cover from the consultant intensivist team. Consultants lived within a 30 minute journey of the unit when they were at home but on call or would otherwise be resident in the hospital. Trainee doctors said the consultants frequently took calls or attended the unit when needed.
- There were arrangements for pharmacist services across the whole week for the CCU and the HDUs. In weekdays, the pharmacist team were available on site in the day time. Arrangements were in place for the supply of medicines when the pharmacy was closed. The pharmacist team worked to ensure those medicines used regularly or infrequently, but needed for a complex patient, were available for supply out of hours. A pharmacist was also available on call in the evenings, at night and on weekends.
- Access to clinical investigation services was available across the whole week. This included X-rays, magnetic resonance imaging (MRI) scans, computerised tomography (CT or CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, endoscopy, and echocardiograms (ultrasound heart scans). The catheterisation laboratory (or Cath Lab) was also available across the whole week.
- Therapy staff were available in person or on call across the whole week. If therapy staff were off duty, there was access to certain staff out-of-hours through on-call rotas. Otherwise, therapy staff (including physiotherapists, occupational therapists, speech and language therapists and dieticians) were on duty on weekdays. Physiotherapists were also on duty on weekend mornings. Therapy staff organised plans for patients needing specific therapies to be continued over the weekends or at night.

Access to information

- Most information needed to deliver effective care was available and accessible, and discharge paperwork from the CCU was improving. The largely paper-based patient record systems in the hospital meant discharge paperwork for CCU patients had been laborious and not always completed to a high standard by staff, particularly the medical staff. This had been recognised as unsatisfactory and escalated to the local risk register where it still sat, rated as a high risk, since 2012. An audit had been undertaken of discharge information in 2015.

This had led to unit-driven improvements and modifications to the electronic patient record system used for data collection. Some of the discharge data and information to handover was now being produced electronically. This included letters for GPs. These had been significantly improved and contained helpful and important information which a GP needed to know for ongoing care of their patient.

- There was also a redesigned discharge form being trialled based upon the SBAR (Situation, Background, Assessment, Recommendation) model. This was based on the Guidance for Provision of Intensive Care Standards and other appropriate organisations, so had a basis in best practice for CCU patients. The 'assessment' criteria was, for example, based on the recommendations of the UK Resuscitation Council. The presence of a second consultant on duty in the CCU was providing more time to complete the medical handover paperwork.
- Access to patients' diagnostic and screening tests was good. The medical teams said results were usually provided quickly and urgent results were given the right priority.
- Patient notes and records were usually available in good time. Staff said records available at the hospital were provided relatively quickly in emergency admissions (all patient records were on paper for patients coming from other wards or new admissions). Patient notes, once the patient had been discharged, were scanned to an electronic database. This meant past notes were relatively easy to find, review and research.
- There were limited electronic systems in use, but good intranet-based guidance. The trust intranet was open and available to all authorised staff. The data within it was locked so it could only be amended, deleted or changed by authorised personnel. The staff in the CCU had good levels of access to their own information. There had been a significant improvement in protocols, policies and guidance for clinical and other patient interventions and care. This remained a work-in-progress, but most of the clinical guidelines we would expect to see were now produced, approved and available for staff to read and follow. These included sepsis prevention, anaemia care, sedation management and end-of-life care. The CCU had an electronic database for some information which was providing improvements to efficiency and content of, for example, patient transfer information and ICNARC data submissions. The HDUs did not have access to this system and therefore were not gathering or submitting ICNARC data or other benchmarked patient outcome data.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with legislation and guidance when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled. A review of consent forms in patient notes showed they had been correctly completed by an appropriate member of the medical team.
- Staff had a good understanding of the Mental Capacity Act 2005, although the patient notes did not guide doctors or nurses to assess the patients' mental capacity when or where this may be lacking. We reviewed a set of notes for a specific patient to determine if the patient's capacity to make their own decisions had been formally assessed and documented. There was no section in the notes to guide staff to make this assessment leading, if capacity was not sufficient, into considerations of how decisions were then made in the patient's best interests. Those records we reviewed where a Mental Capacity Act assessment would have been appropriate were acceptable, although did not lead from a clear prompt to do so. Staff told us there were arrangements within the hospital to provide an Independent Mental Capacity Advocate (IMCA) if a decision was needed in a patient's best interests and the patient had no family or friends to speak for them at the time.
- There was a good understanding among staff of the Deprivation of Liberty Safeguards (DOLS) and when to apply them. Staff described circumstances when this might be appropriate and how any decision would be made. Senior staff in the CCU had recently had training from the trust lead for DOLS. The trust policy on DOLS was clear and followed the statutory framework of the Mental Capacity Act 2005 and supporting Codes of Practice. It included a checklist for staff to 'think about' and flowchart to guide decision making about making a referral for an authorisation to deprive a patient of their

liberty. The policy went on to recognise how the managing authority (here the NHS trust) was able to make urgent authorisation to keep a patient safe through the use of DOLS, while simultaneously applying to the local authority for a standard authorisation.

- Staff understood the difference between lawful and unlawful restraint and minimised its use, although the trust had no policy or guidance on the use of restraint. The CCU had low-impact aids to protect patients if restraint was needed, although not guided by a policy or protocol. There were 'mittens' for use as a last resort when a patient was known to be or assessed as at risk from pulling out their medical devices, such as tubes and lines. Details of the use or approval of any restraint techniques would be recorded in the observation charts and the patient's notes.

Are critical 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. Feedback from people we met in the CCU and HDUs and who had written to the staff, including patients and their families, had been overwhelmingly positive. Patients said staff were caring and compassionate, treated them with dignity and respect, and made patients feel safe. Patients, their family or friends were involved with decision making. They were able to ask questions and raise anxieties and concerns and receive answers and information they could understand. We observed staff treating patients with kindness and warmth. The units were busy and professionally run, but staff always had time to provide individualised care. Staff talked about patients compassionately with knowledge of their circumstances and those of their families.

Patient diaries, designed to provide comfort to patients and relatives during a stay in critical care had been introduced, but were not being used to their full potential.

Compassionate care

- All the patients and relatives we met spoke highly of the care they received. Due to the nature of critical care units we often cannot talk to as many patients as we might in other settings. However, patients we were able to speak with said staff were caring and compassionate. Patients said they felt safe and supported. One patient said they rated staff as "11/10." Another patient said of staff: "they can't do enough for you." They continued to say: "I can't rate ICU and the staff highly enough." All patients said their privacy and dignity was maintained. They said curtains were drawn around them for intimate care or procedures. On our unannounced visit a family member said the staff were "simply marvellous."
- Where they were completed, there were positive results from NHS Friends and Family Tests (FFT) although due to the nature of critical care, there was a small return from patients. FFT were questions asking patients if they would recommend the ward to their family and friends. These questions were usually asked when the patient was discharged from the hospital. As very few of the patients were discharged from critical care (they usually went to a ward before ultimate discharge) the CCU was not participating in the test. The HDUs (which were four-bed units) had some results from their small number of patients. In May to the middle of July 2015 five people had reported back on the general HDU. Four said they would be extremely like to recommend the unit and one said they were neither likely nor unlikely to recommend it. Seven people had reported back on the vascular HDU and all had said they would be extremely likely to recommend the unit.
- We observed good attention from all staff to patient privacy and dignity. Curtains were drawn around patients and doors or blinds closed in private rooms when necessary. Voices were lowered to avoid confidential or private information being overheard. The nature of most critical care units meant there was often limited opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity.
- Patient's preferences for sharing information were respected. When a patient was able to communicate, staff would review with them how, when and what information could be shared with the patient's partner, family members, and carers. If a patient could not communicate, staff used their best judgement and previously available information to share information appropriately and sensitively.

- Staff made sure patients knew who the staff were and what they did. All healthcare professionals involved with the patient's care introduced themselves to patients, explained their roles and responsibilities. We witnessed this from many of the patient interactions we observed, even if the patient was drowsy or confused.
- Visiting times could be flexible to meet the needs of the patient and their loved ones. Visiting times prioritised the needs of the patient, while being supportive to relatives. There were set times for visiting hours to the CCU and visitors were encouraged to visit from 11am to 2pm if possible and refrain from visiting then until after 3:30pm to allow patients to rest and staff to carry out rounds, essential tests and examinations, and meet with others in the multi-disciplinary teams. This would also allow patients a period of rest. There was limited space in the units and visitors were asked to restrict numbers where possible, as too many visitors had been recognised as tiring for patients in critical care. However, staff said they would accommodate visitors as much as possible at all times and those visitors we met agreed. Visitors said staff had indicated when they needed to support the patient and visitors had been asked to step outside or to the visitors' room for a short time. Visitors said the staff explained why this was necessary and it was also explained in the relevant leaflet.

Understanding and involvement of patients and those close to them

- Staff communicated with patients and those close to them so they understood their care, treatment and condition. Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing. They said they were encouraged to talk about anything worrying them. They told us communication was good, and this had extended to talking with their families. We observed staff, both doctors and nurses in the CCU and HDU talking inclusively with patients and their relatives. They were seeking verbal consent, discussing and negotiating care and treatment, and involving the patient to make their own decision. The views of relatives and carers were listened to and respected.
- Staff, including the approachable, friendly and helpful CCU ward clerks, made sure visitors were identified and only gave information to them if they were entitled to have it, or the patient was able to give permission. The ward clerks were made aware of any delicate or difficult situations with patients or their relatives in order to act promptly and sensitively. We observed this with one of the ward clerks who greeted a patient's relatives when they arrived and was aware of their situation. The ward clerks also worked seven days a week to ensure administration continued throughout the week and they were there to help support patients, their relatives and staff over the weekend as well.

Emotional support

- There was some support to keep CCU patients in touch with what was going on around them or tell them about what they might have missed when they were on the road to recovery. The CCU had introduced the use of the patient diary for longer-stay patients. Research has shown how patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. They have been shown to provide comfort to both patients and also their relatives both during the stay and post discharge. Diaries are said to not only fill the memory gap, but also be a caring intervention which can promote holistic nursing. Although these were available at the bedside of all patients, none of those we looked it had been started. Staff admitted they were not yet in as regular or automatic use as they could be and not yet used to their full potential.
- Relatives were approached with compassion when a patient was a possible eligible organ donor. We met with the specialist nurse for organ donation and were impressed with their knowledge, experience and genuinely warm character. This included their approach to the family, but also included a child or grandchild of a patient who had died or was at the end of the life. They had resources such as a kit for making hand prints and locks of hair for families to take if they wished. Young children had also been given a 'matching teddy'. This was a pair of identical soft toys of which one had stayed with the patient and the other had been given to the child to keep.
- Staff understood the impact a patient's care, treatment or condition might have on their wellbeing and on those

close to them both emotionally and socially. There was good support from the hospital multi-faith chaplaincy team who were on call at all times for patients, their family and friends and also staff.

Are critical care services responsive?

Requires improvement

Overall we rated this service as requires improvement for responsiveness.

Services did not always meet patient's needs. There were bed pressures in the rest of the hospital that meant many too patients were delayed in their discharge from the CCU to a ward. These delays were significantly worse than the national average. Some patients were discharged onto wards at night as a bed had become available, when this was recognised as less than optimal for patient wellbeing and mortality. The CCU was therefore rarely able to meet gender separation rules. The CCU and HDUs were also exceeding the recommended occupancy levels for much of the time. Despite this, the CCU was organised with flexible bed and staffing management so data showed it was rare that a high-priority patient did not get access to a bed when it was needed. The CCU ran a countywide service with the CCU at the Alexandra Hospital in Redditch (part of this NHS trust) to optimise its responsiveness to patient need. This ensured available beds and/or staff could be in the right place at the right time. Despite research and guidance into the sometimes poor psychological outcomes for patients in or discharged from critical care, there was no psychological support for them or those close to them. The HDUs were not designed around modern standards for units providing critical care.

In terms of areas where the critical care services responded well to patient needs, the facilities in the CCU had been thoughtfully organised by the team to support patients, visitors and staff. They met most of the modern critical care building standards despite being 13 years old. There was an outstanding example of responsiveness to patient need with the introduction of noise monitoring devices. This reminded staff about keeping noise to a minimum when going about their work. The CCU staff were able to respond to and receive support from the emergency department and operating theatres which were co-located.

There was a good response from consultants and nurses when new patients were admitted. Rotas were organised so all patients should be seen by a consultant within 12 hours of admission. Patients were treated as individuals and equalities, diversities, and patients with different needs were supported. There were no barriers to people to complain. There were, however, no complaints made to either the CCU or HDUs for several years.

Service planning and delivery to meet the needs of local people

- The service had been designed and planned to meet people's needs. The unit was located within the hospital to enable staff to respond to emergencies either within the CCU and the HDUs or in other related areas such as the operating theatres and emergency department. Despite issues with access and flow due to bed pressures in the hospital and elsewhere in the health economy, the CCU was responsive to emergency admissions. This unit, in conjunction with the Alexandra Hospital, was rarely unable to provide a critically unwell patient with a bed and the care and treatment they needed.
- The CCU met the majority of the recommendations of the Department of Health guidelines for modern critical care units as they related to meeting patient needs and those of their visitors. These included:
  - Bed spaces were capable of giving reasonable visual and auditory privacy.
  - There was natural daylight (although no outside views) for almost all bed spaces, although not for a bed space at the far end of the unit. Natural light did, however, reach this area.
  - Artificial lights were dimmable but also of sufficient strength to enable surgical interventions and response to life-threatening situations at the bedside.
  - There were facilities for patients who were well enough to have a shower or use a toilet.
  - There were separate entrances to the unit from within the hospital corridors ensuring visitors did not observe patients arriving and leaving the unit. Deceased patients were removed through the patient entrance in order to attempt to protect visitors from observing this event.

  - There was intercom-controlled entry to all entrances with CCTV in use. Entrances were locked and could only be opened by authorised hospital staff.
  - Screening had been applied to the entrances to the clinical areas on the small glass panels in the doors. This improved patient privacy on the unit.

- There was, however, as recommended, no enclosed storage at the bedside for consumables or medicines, or limited patient property. There were no ceiling-mounted hoists for lifting patients (there were manual floor-level hoists available).
- The HDUs met some of these requirements, although access to the small units was not locked once people were on the associated ward. Patients were able to use the ward facilities for toilets and showers. There was only one entrance to the unit, shared by patients, visitors and staff alike.
- There was good and well thought-out provision of facilities for visitors to the CCU. There was a large waiting room just outside of the unit for visitors to wait or to enable visitors to step away from the unit if they wanted a break. There was a toilet for use by disabled people located directly outside of the CCU. Inside the unit there were additional facilities for visitors. This included a suite of rooms with a sitting/sleeping area (with room for a small put-up bed), a small kitchen, and a bathroom with a shower. There was another room for staff to meet with visitors to talk in private.
- The CCU had equipment to meet patient's health needs that could be unrelated to their critical illness or condition. This included, for example, haemodialysis machines to provide treatment for patients with kidney failure which might be unrelated to their critical illness. These machines were dual purpose and also provided haemofiltration. Patients therefore needing renal replacement therapy for acute kidney injury were able to be treated on the unit and not transferred elsewhere for this specialist therapy.
- There was no access to a Regional Home Ventilation and weaning unit as per the Faculty of Intensive Care Medicine Core Standard 2.15. Research had shown a small number of critically ill patients become ventilator dependent. These patients and others with difficulties coming off ventilator support (weaning) may be able to be cared for at home. All critical care units providing level three care should have arrangements in place for patients to be managed at home by Regional Home Ventilation services with the expertise and resources to provide this support.
- Patients and visitors were given good information about critical care, but only if they were present at the hospital. There was a good range of booklets, leaflets and information for both patients and families, but very limited information about critical care on the trust website. The leaflets explained aspects of the environment and specific treatments. There were, for example, leaflets and booklets about the unit, how patient notes and records would be used, pastoral and spiritual care, decisions relating to resuscitation, and a practical and supportive booklet about bereavement for relatives. There were instructions in the bereavement booklet about how to obtain the information in another language or format, but this had not been included in most of the other leaflets. To check if information was current, we telephoned the number for Patient Services in the bereavement booklet (which had been published in May 2015) on eight different occasions at different times of the day and it was not answered.
- At the time of our inspection there was no CCU follow-up clinic, although patients were telephoned by one of the Outreach team nurses to offer advice and guidance when they were discharged from hospital. Formal follow-up sessions were a part of NICE guidance for rehabilitation after a critical illness, but were recognised as taking time to arrange and hold, and with sometimes only a limited uptake from patients. This had been recognised by the unit and escalated to the risk register as a con-compliance with the NICE guidance for rehabilitation. The non-compliance was due for a review in 2015. One of the consultants told us patients were treated as individuals and there were examples of the team contacting a patient's GP to make them aware of certain, particularly psychiatric, concerns or needs.

Meeting people's individual needs

- Services were planned to ensure equality and diversity (E&D) was taken into account in the development of the service and the majority of policies and procedures. Provision was made to support people of all recognised UK faiths and cultures (or no faith) with a multi-faith chaplaincy. Families and patients were able to have privacy where possible and staff were aware of the requirements for some patients of different cultures or

beliefs. Most of the policies and procedures we reviewed in the CCU and the HDUs were reviewed to ensure they met E&D discrimination impact assessments. This was in accordance with trust policy. The policies were assessed to determine if they adversely affected one group less or more favourably than another on the basis of race, ethnic origins, nationality, gender, and culture, religion of belief, sexual orientation and age. Those we reviewed had been assessed as not adversely affecting any of these recognised groups. We noted, however, the CCU discharge policy and admission policy did not include the E&D checklist. A review of these policies did not indicate any issues with meeting E&D requirements, but the drafter's review had not been included in the document itself.

- The services reflected the needs of the local population. There were no apparent barriers to admission due to a patient's age or gender. The average age for patients admitted to the CCU was 65 years, which was similar to the national average and had been static for much of the past five years. ICNARC data for the six months from October 2014 showed a typical distribution of ages of patients admitted, and the unit, like other similar units, had treated eight patients in their late 80s and early 90s. Not untypically, the majority of patients admitted were male (around 60%). This information was not available for the HDUs, but staff we met both medical and nursing said they cared for adult patients of any age or gender who needed additional support following surgery.
- Care from the staff team was delivered with thoughtfulness as to the effects of the environment and hospital procedures. One outstanding example was from an awareness of how noise and the impact of some 'normal' hospital activities had on patients in critical care. The unit had established noise monitoring devices placed on the unit walls which would alert staff to levels of noise which could be intrusive, disturbing or cause anxiety. As a result, all the healthcare professionals talked quietly with patients and each other, but making sure they could still be heard and understood. The atmosphere was calm and professional, without losing warmth and reassurance for everyone concerned. All the bins in the CCU had also been replaced with soft-closing bins to reduce the noise from metal lids closing. The CCU had also obtained a catering trolley to keep food warm for patients if they were not on the unit or just not wanting to eat it when it was delivered.
- Obstetric patients were admitted to the CCU when necessary. The care of the patient would be shared with the obstetric team and the critical care doctors. The patient's baby was also able to come to the ICU to be with their mother. The patient would be stepped-down to the delivery suite or post-natal area as soon as they were well enough.
- Patients were treated as individuals when communication needed help. There were telephone translation services for both patients and relatives where English was not spoken or not easily understood. There were communication boards for patients with tracheostomies to write messages or point at symbols and images. In conversations with staff they spoke about treating patients as individuals and wanting the best outcomes for patients, including respect for their individuality.
- Patients' needs around orientation and therefore the time, day and date were to be improved. The CCU matron recognised how, under the recommendations of the Department of Health guidelines for modern critical care units, patients should be able to see a clock from any bed in the unit. The matron recognised how this could be extended to the day and date to help patients' orientate. There were some clocks in the unit, but they were not clearly visible to all patients and had only the 12-hour clock. The new clocks had been ordered and eight would be placed in the CCU so all were visible for all patients. The unit was above ground and sited on an external wall, so there was natural light to help with orientation to day and night for patients.
- Due to issues with patient flow on the wards, the CCU was rarely able to meet gender separation rules for patients. A patient would breach these rules when they were in a unit occupied by a patient(s) of the opposite gender and the first patient had been medically fit for discharge to a ward. Department of Health guidance recognised it was difficult to fully manage in units like the CCU and HDUs. Like many intensive care units nationally the CCU and HDUs had no provision of separate gender toilets or washing facilities to meet

some of the same-sex rules. The ICNARC data showing four-hour delays in discharge from critical care to a ward bed of around 75% of all patients meant the unit frequently breached the same-sex rules.

- Patients' rights were observed. Where possible in all the circumstances, there was fast-tacking for patients who were deemed at the end of their life and wanted to go home to die. Patient records prompted staff to enquire about advanced directives or resuscitation decisions in order to follow a patient's wishes.
- Although recognised by the consultants for its importance, there was no support available to patients in critical care with psychological problems or anxieties. There is increasing evidence showing the psychological impact of a critical care admission can be severe. Patients can experience extreme stress and altered states of consciousness. Patients will be exposed to many stressors in critical care and acute stress in critical care has been shown to be one of the strongest risk factors for poor psychological outcomes after intensive care. The National Institute for Health and Clinical Excellence (NICE) guideline CG83 stated that patients should be assessed during their critical care stay for acute psychological symptoms. There is also evidence that the critical care experience is difficult for families and a critical care psychologist can play a big role in communicating and working with distressed families.
- Patients with a learning disability were supported by trained and experienced staff. There was a hospital liaison nurse with a special interest and education in supporting people with a learning disability. The liaison nurse would be contacted if a patient with a learning disability was admitted to the CCU or the HDUs to provide guidance and support. Carers or care workers were also encouraged to stay with the patient when and where possible to also provide support. Patients who came to the hospital from a community care setting were asked to bring or produce a 'hospital passport'. This is a recognised document used for people who live with a learning disability, so staff are able to know as much about them as possible should they have difficult with communication. One of the senior nurses in the CCU remarked on how useful these documents were when they were provided and completed well.
- Patients living with a dementia were supported but without use of specific care plans linked to national strategies. All the staff we spoke with had good knowledge of the different needs of patients living with dementia or any other vulnerable circumstances. There were liaison nurses also within the hospital to provide support and advice. Local strategies in the CCU included using bed spaces which were in quieter areas, one of the two side rooms, or getting support from carers or care workers. The units did not, however, have specific care plans based upon national guidance, such as the Department of Health National Dementia Strategy 2009.

Access and flow

- Many patient discharges were delayed due to a bed elsewhere in the hospital not being available. Similar to most critical care units in England, ICNARC data reported a high level of delayed discharges from the CCU. In the last three years between 70% and 80% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. In the last reporting period of January to March 2015 the four-hours-plus delays were for around 75% of patients. That was above (worse than) the national average of around 60%. Four hours was theindicator used for comparison with other units usedto demonstrate the ability, or otherwise, to move patients out of critical care in a timely way. Although patients remained well cared for in critical care, when they were medically fit to be discharged elsewhere, the unit was not the best place for them. It also delayed patients who needed to be admitted or meant the unit was always at higher occupancy than recommended. The delays were, however, mostly less than 24 hours (66%) although some were longer. There were 8% of patients who waited between three and seven-plus days for discharge from the unit. The rate of delayed discharges had been high for the last five years and had not been better than the national or similar-unit average in the last five years.
- The discharge of patients from the CCU was not always achieved at the right time for the patient and a high percentage had recently been moved at night. This was due to pressures on bed availability elsewhere in the hospital. Studies have shown discharge at night can increase the risk of mortality; disorientate and cause stress to patients; and be detrimental to the handover of the patient. Data from the Intensive Care National Audit and Research Centre (ICNARC) for 1 January to 31 March 2015 for discharges made out-of-hours (between 10pm and 7am) showed the unit had been significantly above (that is worse than) the national average for similar units. In the first quarter of 2015 the out-of-hours

discharges were 18% of all discharges (32 from around 180 patients) against a national average of 8%. Rates had, however, fluctuated in different quarters. In the previous two quarters, covering July to December 2014, out-of-hours discharges had been below (better than) the national average. In the four quarters prior to that they were well above the average, and then prior to that, mostly below the national average.

- The CCU had higher occupancy levels compared with recommended levels and national averages. The Royal College of Anaesthetists recommend a maximum critical care bed occupancy of 70%. Persistent bed occupancy of more than 70% suggests a unit was too small, and 80% or more was likely to result in non-clinical transfers that carry associated risks. Detailed occupancy figures for the CCU for April 2014 to June 2015 showed the rate had not dropped below 80% in any of these 15 months. The average occupancy was 85.3% against an NHS average for the same 15 month period of 84.3%. The most recent monthly occupancy average rate for the CCU was 83.6% in June 2015 which compared with the NHS average of 82.7%. The high occupancy levels at this hospital were due to a lack of a ward bed into which to move a discharged patient, and, as with the national picture, an increasing demand for critical care beds which was not meeting rising demand. One of the lead surgeons working with the surgical HDU said the average capacity in the last year had been 87%, which was even higher than the CCU.
- Service and care was provided for patients with the most urgent needs. The flexibility of the system operated by the CCU involved the bed base for both WRH and the Alexandra Hospital being considered as one resource. The flexibility of the medical and nursing staff meant staff were moved to support patients where possible, without therefore moving the patient between sites unless this was the best option available. As a result it was rare for a patient to not be admitted to the CCU in both emergency and elective (planned) circumstances.
- The hospital was mostly caring for its own patients (as opposed to admitting them from other hospitals). In the ICNARC data from 1 October to 31 March 2015 there were fewer patients than average transferred into the unit from an HDU or ICU in another hospital.
  - The rate of planned transfers in was below, that is better than, the national average for similar units in the first quarter of 2015.
  - The rate of non-clinical transfers in (that is unplanned admissions from another adult critical care unit) was mostly low and had been the same as the national average in January to March 2015 (one patient) and was zero in October to December 2014. Therefore, the unit was mostly managing its own patients and predictable admissions.
  - Patients were sometimes transferred toother units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. Transfers had been similar to the national average for the last five years. There were eight patients transferred out (4%) in January to March 2015 which was similar to the national average.
- The hospital had the ability to temporarily increase its capacity to care for critically-ill patients in a major incident such as a pandemic flu crisis or serious public incident. This would involve primarily using the anaesthetic rooms and recovery unit in theatres which was adjacent to the unit. In these areas staff were trained in caring for critically ill patients and would be supported by the critical care team. The CCU would also be able to get support from the teams in the HDUs and from the staff and facilities in the CCU in the sister-hospital in Redditch, The Alexandra Hospital. There were also good relationships with the local Critical Care Network from where help, support and advice could be sought and provided.

Learning from complaints and concerns

- There had been very infrequent complaints to the CCU or HDUs. There were no complaints to the CCU or the HDU in the period we requested, the year April 2014 to March 2015. The surgical and vascular HDU staff said they could not recall a complaint for over two years. There was information available in visiting areas and on the trust website outlining how to make a complaint and how it would be dealt with. There was a policy which was recently reviewed, updated and approved and available to all staff to follow.

Critical care

Are critical care services well-led?

Good

We rated this service as good for well-led. The leadership, governance and culture promoted the delivery of high-quality person-centred care. All the senior staff in the CCU and HDUs were committed to their patients, their staff and their unit with an inspiring shared purpose. There was a cohesive culture of collective responsibility. In the CCU there was strong evidence and data to base decisions upon and drive the service forward from a clear, approved and accountable programme of audit. This contributed to local vision and strategy for achievable and relevant patient-focused objectives. The CCU participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC).Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance. There was, however, no contribution to this database from the HDUs. The performance, quality and outcomes of the HDUs were audited and understood internally, but not able to be benchmarked against similar units. There was a high level of staff satisfaction in all units with staff saying they were proud of the units as a place to work. They spoke highly of the units' culture and consistently high levels of constructive engagement. Staff were actively encouraged within the units to raise concerns through an open, transparent and no-blame culture. Innovation and improvement was celebrated and encouraged with a proactive approach to achieving best practice and sustainable models of care. There was a 'cabinet' approach to decisions so collaborative discussions delivered consistent models of care. There was a focus upon sustainability, innovation and improvement to continue to deliver a safe, effective, caring and responsive service. Areas for improvement included: the strategy for critical care was not included as part of the divisional future strategy and planning. Certain risks in the units had not been captured within the risk register and high level risks were not adopted by the trust corporate risk register for board consideration.

Vision and strategy for this service

- There was local vision and strategy for the CCU, but this did not appear in the overarching vision for the division (theatres, ambulatory care, critical care, and outpatients – called TACO) in which critical care sat. The division strategy included outpatient improvement, theatre efficiency, endoscopy development, sterile services, and pre-op processes, but nothing in the presentation relating to the CCU (the HDUs sat within the surgery division). Further evidence of some lack of consideration for critical care came from other documents associated with the TACO division. In a number we reviewed (for example, the clinical audit programme 2014/15) TACO was described as 'theatres, ambulatory care, and outpatients. Critical care was not mentioned.
- The local strategy for the CCU (countywide, so including Alexandra Hospital ICU) had already delivered on a number of plans. This included the matron and clinical director being countywide; consultants and nurses working rotas in both units; harmonisation across the units of nursing care records; provision of a second consultant on the daily rota to provide support for the surgical HDU and the CCU consultant/department.
- Future local strategies included a review of infection control with, for example, curtains replaced by appropriate resolutions (such as glass walls); a move to electronic patient records; improvements to the discharge summary (some of which had already been achieved); development of the consultant team in certain treatments and newer treatment methods (such as heart monitoring – echocardiography, advanced heart or lung support – ECMO, and carbon dioxide removal - $ECCO_2R$); and significant further expansion of the unit to meet patient need.
- The countywide working of the CCU and reorganisation of rotas, job plans, and, to an extent, the optimisation of location for the patient, had been a major project and strategic plan for the CCU. This had now been largely achieved. This was not, however, part of the five year strategic planning for the TACO division 2014-2019, although countywide pre-operative assessment procedures (which would be far easier to achieve) was captured.

Governance, risk management and quality measurement

- There were operational plans for critical care, but not all finalised and approved. There was an operational policy in place for the CCU with clear guidelines around the safe running of the service. The operational plans for the HDUs were still in draft form and not yet released.
- There was a structure for clinical governance in the trust, although CCU matters appeared in the minutes we saw only when a member of the team attended the clinical governance meetings. When critical care were represented, it demonstrated how the CCU fed into their service line structure and how assurance was made through the various committees into the trust board. There was time and resources given to governance and safety, quality and performance review and, in the CCU, a dedicated consultant governance lead.
- There was a range of audits and performance measures of aspects of care and safety within the units in accordance with an approved audit calendar. In the CCU there was a daily and monthly spot check audit of certain aspects of care delivery. This included the FASTHUGFIDDLE approach (see Evidence-based Care and Treatment section) and naso-gastric tube insertions, cannula care, hand hygiene, and central venous catheter care. There were important aspects of clinical governance with standing agenda items on the monthly divisional meetings. This included a discussion of the risk register and NICE guidance new alerts.
- The units understood, recognised and reported most of their risks, although had not included some environmental risks as recommended. The local risk registers were being used to capture those identified risks and concerns relating to critical care and the HDUs. Staff were proactive when raising risks and we saw these were monitored and actions taken to reduce them. The risks around delayed discharges had been escalated to the register, as well as capacity issues, and the non-compliance with NICE guidance 83 around patient rehabilitation. We identified none of the serious risks, graded as 'high' had been adopted on the trust corporate risk register for consideration by the trust board.
- There was some risk assessment against recommended best-practice and key guidelines but no entry on the risk register for non-compliance. The CCU had been risk-assessed against the FICM Core Standards, although had not included those areas where it did not meet the recommendations on the local or trust risk register. The HDUs had not been assessed against FICM Core Standards and these were mostly not incorporated in operational policies. The CCU or HDUs had not been risk assessed against the Department of Health guidance for modern critical care units (Heath Building Note 04-02, 2013). Audit against these guidelines was a recommendation of the FICM Core Standard 3.1 and any non-compliance (of which there was some for all units) had not been reported on the local or trust risk register. The Core Standards recommended any non-compliance was registered along with an indication of when facilities will be upgraded to comply with HBN 04-02.
- The CCU participated in a national database for adult critical care as recommended by the FICM Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported the data supplied was well completed and of good quality.
- The HDUs did not participate in a national audit reporting database. This was despite the FICM Core Standards not differentiating between ICUs and HDUs when recommending contribution to, for example, ICNARC. Participation would have meant the HDUs were able to show patient outcomes and other quality data benchmarked against other similar units.

Leadership of service

- The leaders of the services had the skills, knowledge, experience and integrity to lead the service. The clinical lead for CCU was a consultant specialising in intensive care medicine who had led the unit for six years. There was strong and respected surgeon and nursing leadership in the HDUs. The CCU matron was an experienced critical care nurse with many years of experience. They were responsible overall for all the nursing elements and supported by a team of sisters/ charge nurses with many years of experience between them. The consultant intensivist body was described by one of them as "interested and engaged" and "incredibly smart and driven people." The CCU looked to purposely recruit new members of staff with different strengths and skills. So there were skills in academic

areas, simulation training, renal medicine, research and clinical protocols, organ donation, governance, safety and quality areas, and representatives on the Faculty of Intensive Care Medicine.

- The leadership of the CCU by the clinical lead consultant intensivist and the team of experienced staff was strong and committed. This extended to the leadership of the HDUs. There was an outstanding commitment to delivering a safe service and saving lives. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and commented on how they worked as cohesive and collaborative teams. This was something we witnessed and observed throughout our visit. We spent less time with the staff on the HDU, but those we met spoke highly of the leadership of the surgeons and their teams. The clinical lead for one of the surgery teams told us they were "really proud of the surgical HDU." We also had comments of high praise for the vascular HDU and leaders of that service.
- The nursing leaders of the services were strong and committed. The matron and senior nursing staff demonstrated an outstanding commitment to their staff, their patients and each another. They were visible on theunits and available to staff. The CCU matron had been encouraged to have a strong voice and raise awareness of their unit with the nursing management. The consultants we spoke with had a high regard and respect for the matron, the nursing team, and the allied health professionals. There was clear mutual respect for each other's roles, challenges and talents. There was senior nursing oversight on all shifts. There was supernumerary nursing cover in the department by a band seven (sister/charge nurse) at all times.
- The leadership was fully supportive of their staff. We judged the leadership of the service would defend the staff when needed and take responsibility for any rare mistakes. They ensured staff were supported at these times and took the lead on making any changes to avoid errors in future. The clinical lead and matron spoke highly of the medical director and nursing director overseeing their division and the support provided by them. We also saw and heard about good support for the ward clerks and the other members of team, such as the housekeepers. All these staff said they felt part of the team. They were able to fulfil all their training requirements and were included in professional development. For example, one of the ward clerks said they were booked to attend an administration course.

Culture within the service

- There was a strong cohesive culture within the CCU consultant team and we understood this extended to the surgical team in relation to the HDUs. Decisions in the CCU were taken in a collaborative or 'cabinet' approach. The new Intensive Care Medicine Forum meetings (started in January 2015 and now monthly) were providing an environment to discuss both agenda items, but also new and emerging subjects, such as changes to practice, guidance, equipment, approaches to intensive care and opportunities for research. We saw how some of the recent changes, such as improvement to delirium screening and discharge paperwork, had been discussed and approved at the Forum. Consultants and others in the multi-professional team told us they felt confident to raise issues without concern, even if their views were at odds with the collective approach. There was then collective responsibility for decisions. So even if a member of the team did not fully support an approach, the view of the majority carried decisions and all the staff followed agreed protocols and practices.
- Staff spoke positively about the culture of working in the HDUs. A student nurse we met said the vascular HDU was the best placement they had undertaken so far. They were impressed with the "great team, great care and the teaching ethos."
- There were facilities for staff to work and rest in the CCU and the HDUs. In accordance with Department of Health guidance, there were staff offices and changing rooms. Senior staff often shared offices but they said there was always somewhere available for private conversations. In the CCU there was a reasonable sized seminar room within the unit and other rooms available for larger meetings. There was a staff rest room which included a kitchen for staff with access to hot and cold drinks and food storage/ preparation areas. The location of the staff rest room had been recognised by the unit staff as not ideal as it was directly off the central corridor and therefore in the middle of the unit. Staff were therefore not located far enough away for them to withdraw into some peace and quiet away from the unit, although

they were able to return quickly in case of emergency. The matron and clinical lead had identified another way of configuring the unit space to move the staff rest room to the far end of the unit and rearrange the way rooms were used. This would provide a more restful environment without compromising the ability to return quickly.

- Action was taken to address inappropriate behaviour and performance that was inconsistent with trust or unit values, regardless of seniority. There was an example of appropriate action taken to listen to and respond to a concern around disappointing behaviour from a senior member of staff. All sides of the story were being looked into and were going to be responded to after consideration of how it affected those involved, and trust procedures.
- The culture encouraged candour, openness and honesty. It was also centred on the patient and delivering the best care. Those staff we met said they felt supported within their units to raise concerns or anxieties. They said they would support one another and help their colleagues to raise concerns if needed. All those areas of concern for the leadership of the CCU and HDUs related to delivering safe and quality care.

Public engagement

- The trust's organ donation committee had agreed to and promoted the creation of a specially-designed garden called 'The Gift of Life' at the Malvern 2015 Spring Festival. This was to raise public awareness of organ donation, encourage conversation, and promote people signing onto the register as donors. The event was attended by staff from the trust and patients and their families whose lives had been transformed or saved by organ donation. The garden was awarded the gold medal at the show. The story made the centre pages of the local newspaper which also carried an interview with the specialist nurse we met, who talked about the need for more awareness of organ donation.
- People's views were gathered through compliments, cards and letters to the services. There was a follow-up call made to former patients by a nurse in the Outreach team. There was a quarterly report of comments from patients contacted circulated to staff, and those we read were overwhelmingly positive. Staff were confident that should any complaints or negative comments be received, these would be discussed and, where possible, learning and actions taken. One change that had come from using comments from former patients was around the effects of delirium. A number of the patients described the confusion they suffered during their stay, which is not uncommon in any patient being treated for a critical illness. Delirium screening, in line with best practice, was now part of the daily patient assessments. Another comment from a family made staff realise how they had been left to wait a long time in the relatives' room (although with good reason). Staff now made sure they kept in touch with a family or relative who had been asked to wait elsewhere in the unit and keep them reassured. The HDUs were part of the NHS Friends and Family Test and comments were also almost all fully positive.

Staff engagement

- Staff were involved with decisions for the CCU. There were regular meetings for staff, including the Intensive Care Medicine Forum meetings and nurse-led unit meetings. The Forum was developing and growing in content and quality. The nurse-led unit meetings were held quarterly. All nurses, healthcare assistants and ward clerks were asked to come when possible and to make sure they attended one meeting each year at the very least. Staff were considered in those areas directly and indirectly affecting them. Another example of inclusivity and a 'cabinet' approach to decision making was the involvement of some of the senior nurses and the lead pharmacist in the interviews for the new consultants.
- Staff were consulted about proposed changes. This included the move to a countywide approach for nurses and then consultants. Another, for example, was from the CCUs recognising how using different terms to describe their units in WRH and the Alexandra Hospital could be confusing for patients and visitors. The unit in WRH was described as ICCU on some signage, and in other places, Intensive Care Unit. The unit at Alexandra Hospital was described as Intensive Care Unit I.T.U., so using both possible names. It had been agreed, in a democratic approach, the units would both be called Intensive Care Unit and signs and other information amended accordingly.

Innovation, improvement and sustainability

Critical care

- The CCU recognised where it needed to improve and innovate for sustainability. There had recently been a business case accepted to increase the consultant intensivist body from 16 doctors to 18 whole-time equivalents. The business case was presented on the basis of providing a safe level of consultant to patient ratios across the full seven-day week on the countywide units; and allow a sustainable rota for consultants to work countywide and support the surgical HDU at WRH. The financial implications and risk assessment were also analysed and presented. The business case was accepted and recruitment to the two new posts had been completed. The service had also adopted a countywide approach to bed and staff resources in order to deliver a more flexible and responsive service.
- The sustainability of the services would depend on their future configuration and capacity. The capacity being at levels higher than those recommended for the safest levels of safe, effective and responsive care had not improved. There were some elective surgical operations cancelled due to the lack of an available bed in the CCU or the HDUs. Figures from NHS England for the Worcestershire Acute Hospitals NHS Trust (therefore both WRH and the Alexandra Hospital) reported 81 cancelled operations between December 2014 and May 2015. This represented 13.5 on average per month against an England average of less than 2 per month. We understand there were almost no cancellations, however, from vascular surgery in this period.
- There was a clear understanding of the financial position of the hospital trust and the budgets for the departments. The budgets were managed by the clinical lead and matron who had a full understanding of the figures. Both the clinical lead, one of the intensivists, the matron and one of the lead surgeons said they could not recall any circumstances where financial pressures had compromised patient care or safety.
- There were links with the local Operational Delivery Network (ODN) although no evidence of strong coordination of patient pathways over a wider area. There were plans within the CCU for a stronger focus and participation in the ODN in order to fulfil the recommendations of NHS England to strengthen local working and shared learning.

Maternity and gynaecology

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

Information about the service

Maternity and Gynaecology services provided by Worcestershire Royal Hospital NHS Trust were located on three hospital sites, the Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre. Services at Alexandra Hospital and Kidderminster Hospital and Treatment Centre 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.

At the Worcestershire Royal Hospital 3,677 babies were born between April 2014 and March 2015.

The services available to women included home birth, a midwifery led unit, (MLU) a consultant-led delivery suite, a triage area, antenatal clinics, a midwifery day assessment unit, and an antenatal and postnatal inpatient ward. Specialist midwives were available to support the women and midwives.

Community midwives (CMW) were employed by Worcestershire Acute Hospitals NHS Trust maternity services. They provided a home birth service for women who were deemed to be low risk. Four CMW teams working in partnership with general practitioners (GPs), health visitors (HVs), family nurses, children's centres all promoted healthy lifestyle choices during the woman's pregnancy and following the baby's birth.

The gynaecology service offered inpatient services, day care surgery, emergency assessment facilities and an early pregnancy assessment unit. Outpatient services included colposcopy, hysteroscopy, fertility management, and pre-operative assessment. A team of gynaecologists were supported by gynaecology nurses, general nurses and support workers.

During the inspection we visited all the wards and departments relevant to the service. We spoke with 30 midwives individually and 18 midwives in two focus groups. We spoke with 17 women, four relatives, five nurses, one operating department practitioner and 10 medical staff. We reviewed 12 sets of records.

Maternity and gynaecology

Summary of findings

Overall we rated maternity and gynaecology services as inadequate. It was rated as inadequate for safety and being well-led, and requiring improvement for effectiveness and responsiveness We rated the service as outstanding for caring.

We found that the service routinely reported never events and safety incidents. However, we found that risks that had been identified were not being reviewed and managed appropriately. The service had a large number of outstanding incidents that had not been closed. This meant that these incidents may not have been fully considered and any actions or learning from them implemented. The department's strategy was not known by staff and the vision for maternity services was inconsistent and lacked clarity. Women and their families knew how to make a complaint, however the service did not always respond within agreed timeframes. The service informed people how to make a complaint but was not achieving targets with complaint responses. Medicines were not stored in safe environments. Caesarean section rates were above national averages and normal birth rates were below. 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.There were less middle grade doctors employed by the trust than were needed to safely cover the medical rota. This meant there was an overreliance on locum doctors and consultant obstetricians 'acting down' to maintain a safe staffing levels, which was not sustainable. Women and patient's pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding. Women and patients were overwhelmingly positive about the care they had received. Staff were kind and thoughtful. Women and their partners felt involved with their care and were satisfied with explanations that were given to them. Services were arranged to meet people's individual needs, with specialist support staff for people with complex conditions.

Are maternity and gynaecology services safe?

Inadequate

Overall we rated this service as inadequate for safety

Staff recognised concerns, incidents or near misses and reported them. However, effective action was not taken to investigate or address these in a timely manner. Thirty incidents were initially graded as causing moderate harm and had been allocated to members of staff to review and close, however they remained open for a considerable amount of time. This meant a delay in the harm being investigated and the patient potentially being contacted in line with the Duty of Candour, and prevented staff learning from incidents in a timely way. There was a lack of understanding of the urgency of reviewing the backlog of reported incidents in a timely manner.

Investigations into serious incidents were delayed while waiting for post mortem results which meant they were not completed within national time frames. Not all staff could give examples of lessons learnt from serious incidents. Serious incident reports did not demonstrate that a robust multidisciplinary (staff from different professions) review took place. The quality of the root cause analysis process used during incident investigations was not effective.Intravenous fluids were not stored securely, which meant there was a risk that they could have been tampered with. The risk register was not effectively reviewed and updated. Risks were not managed appropriately and mitigated effectively because not all risks were monitored robustly. Compliance for mandatory training was poor. There were different compliance targets for trust wide and midwifery specific mandatory training; these targets were often not met. There were less middle grade doctors employed by the trust than were needed to safely cover the medical rota. This meant there was an overreliance on locum doctors and consultant obstetricians 'acting down' to maintain a safe staffing levels, which was not sustainable. Midwifery staffing was not in line with national standards to ensure adequate staffing. Delivery suite coordinators were not supernumerary in line with national

recommendations (NHS Litigation authority 2010) which meant they were not always free to support emergency situations and junior staff as they were providing care for women.

Incidents

- Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns, and near misses, and to report them.
- There were no never events reported across the sites between May 2014 and April 2015. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers
- Nineteen serious incidents for the trust were reported to the NHS strategic executive information system (STEIS) by maternity services between May 2014 and April 2015.
- There were 11 STEIS reportable incidents between February to May 2015. These were three intrauterine fetal deaths, two neonatal deaths, a stillbirth, an admission to intensive care, and two incidents involving gynaecology patients, a fall and a grade three pressure ulcer.
- We reviewed seven serious incident reports. We were told that incidents were reviewed by a multidisciplinary team (MDT); but this was not clear in the incident reports. The National Patient Safety Agency (NPSA) tools were not used to provide a detailed root cause analysis. Action plans were developed and actions implemented and closed. However when we spoke with staff, not all could recall a serious incident to describe if any lessons had been learnt. This meant that learning from incidents was not routinely shared to prevent similar occurrences.
- The senior team had performed a review of a cluster of serious incidents. One theme identified was misinterpretation of cardiotocograph (CTG) which monitors the fetal (baby's) heartbeat. There was an action plan formulated to mitigate this risk, but this had not been embedded in practice. One of the actions was for the midwives to complete a set of questions based on some examples of CTG's. This was done in an effort to ensure that staff were competent interpreting CTGs. We found that only 27% of staff had completed the questions, and the submissions were anonymous, therefore any evidence of misinterpretation could not be tracked back to the clinician to enable further training and support.
- We were told that in order to mitigate the risk which was identified from recent serious incidents relating to misinterpretation of CTG's, the trust was restructuring weekly case review/CTG meetings and they were taking place regularly on both sites. We found that from the beginning of 2015, only 11 of these meetings had taken place out of a possible 29, (37%). A total of 19 midwives and 55 doctors had attended, however as the attendance of individuals was not monitored, it could not be established whether these were the same clinicians attending several meetings. This meant we could not be assured how widespread the learning was and of the contribution the case reviews made to improving multi-disciplinary competency in safe CTG interpretation.
- A CTG monitoring should be reviewed and classified every hour (NICE Intrapartum care 2014) with a review from another colleague in accordance with local guidelines. We reviewed five CTGs that had hourly reviews but it was not clear that the colleague's review was completed. This meant that there was a risk that the CTG could be misinterpreted for an unacceptable length of time and the woman's care could be compromised.
- From September 2014 to July 2015, there were over 300 incident reports within maternity and gynaecology that had not been closed. Thirty were moderate incidents and had been allocated to members of staff to review and close, which remained open.
- A weekly incident review meeting had commenced, attended by the Deputy Head of Midwifery, Medical Director for Maternity and Gynaecology and lead Obstetrician. This was as a result of external agencies including the Clinical Commissioning Groups and the Care Quality Commission raising concerns following an increase in serious incidents. The weekly meeting's remit was to review the timeliness and quality of the investigation of serious incidents.
- Serious incident investigations that related to neonatal/perinatal deaths were often delayed due to an internal process called 'stop the clock'. This is when the usual timelines for completing an investigation are paused

pending the result of a post-mortem. The senior team waited for post mortem reports before finally approving the incident, resulting in a delay in actions being completed or learning disseminated.

- The management team were aware of the Duty of Candour Regulation, a new law from November 2014 for all NHS bodies. This requires NHS Trusts to be open and honest with patients when things go wrong. We saw that the trust incident reporting policy, dated April 2015 referenced this and was cross referenced to another, 'Being Open & Candid Policy.' However, midwives and nurses were not able to explain what this was. Medical staff we spoke with had a good understanding of the process. We saw evidence of feedback to the women who were involved in the serious incident reports.
- Risks identified within the service were agreed at divisional clinical governance meetings. Maternity and gynaecology had 24 risks on the risk register, some dating back to 2005. Eight risks had not been reviewed dating from 2014. For example the delay in identification of positive blood sugar test results done for pregnant women, had not been reviewed since September 2014.
- We saw from the minutes of the governance meetings that new guidelines or alerts were discussed and staff were informed by email.

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm which have occurred included; perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units and a baby having an Apgar score of less than seven at five minutes. (The Apgar score is an assessment of overall new-born well-being). The service did not use this system at the time of inspection.
- Maternity services had engaged with the trust wide safety thermometer (where relevant), which showed that harm free care was consistently providing 100% of the time. The results were not displayed in areas for the women and public to see.
- In the gynaecology service, safety thermometer data was added to the trust wide statistics. Between April 2014 and March 2015 the lowest level of harm free care was recorded at 91% with the highest at 96%. The service met the required national target of 95% harm free care on two occasions during this time. The results were not displayed in areas for the women and public to see.

Cleanliness, infection control and hygiene

- There were reliable systems in place to prevent and protect people from a healthcare associated infection.
- The areas we visited were clean and there were sufficient hand gel dispensers with instructions on how to cleanse hands. We observed that staff followed good hand hygiene and were bare below the elbow.
- We saw that equipment was labelled when cleaned, signed and dated. Rooms had notices on the beds which indicated if the room had been cleaned.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.
- Birthing pools were found to be well maintained. Staff were aware of the pool cleaning procedure in accordance with their 'Guideline for Use of Water during Labour and Birth'
- The most recent internal cleanliness audits, carried out by the infection control team between August 2014 to October 2014, showed overall cleanliness was rated between 86% and 90%. There were some actions, for example, where dust had been found, the action was to, 'Put on a cleaning schedule.' However, the audit did not specify how this should be done. There was no re-audit to ascertain if the measure put in place, had been effective.

Environment and equipment

- Directional signage was poor across the site. The maternity and gynaecology unit was difficult to find. This meant that people who needed to use the service may not have been able to find their way to the relevant department.
- The doors to gain entry to the ward areas were locked and staff gained entrance with swipe cards. Staff identified visitors and who they intended to visit, and then allowed them entry. We were asked to present our identification badges by most staff when first gaining entry to the wards.
- Staff checked the adult resuscitation trolley and baby resuscitaire daily. We observed that the checklists were completed, dated and signed. However, there was a

sealed red box on the trolley which contained medicines of which staff we spoke with did not know the exact contents. This meant there could have been delays in providing treatment in an emergency.
- Adequate equipment was available to run the service safely. All equipment we inspected had been tested annually and was in date.
- Cardiotocograph (CTG) machines were available for women whose babies needed monitoring in labour. All of the CTGs in progress were displayed allowing other staff to see them and take action, if they thought the trace was abnormal. However, the board was in a room not visible to staff working at the main desk, which meant an abnormal CTG was less likely to be identified by staff not providing care for that woman.
- We observed equipment to evacuate a mother from the birth pool in the case of an emergency. There were pool evacuation nets for water birth evacuation in each pool room. Training had been given to staff supporting women having a pool birth and emergency drills took place to embed into practice.

Medicines

- We observed that bags of intravenous fluids were not stored in locked rooms in all areas, which meant that they were not protected from the risk of being tampered with.
- Medicines were managed, administered and disposed of safely. We observed staff wearing a red, 'do not disturb' tabard when administering medication on medicine rounds.
- Controlled drugs had been checked according to trust policy in all areas. Staff were able to refer to their medicines policy, the up to date British national Formulary (BNF) or ask for pharmacy support if necessary.

Records

- Medical records were not always kept secure. Trolleys containing patients' notes were left unlocked and at times unattended at nurse's station in public view. We observed records were left on the desk unattended at times on both the gynaecology and maternity ward.
- The service had two different electronic systems for recording care during the woman's hospital admissions, one to record care given during labour and another to scan records from inpatient antenatal episodes on the maternity ward. The antenatal and postnatal care was recorded in the women's hand held records. Staff found it very difficult to review a woman's whole medical and care history because information was documented in various systems. This meant that inappropriate care could be given as the woman's full care record was not available in one place.
- We reviewed eight sets of maternity records. Handheld records were legible, dated and signed. Individualised care plans were documented and updated in the women's records.
- On the maternity ward we saw the individual maternity records being reviewed by midwives as part of the women's care. Child health records, known as 'Red Books', were distributed to mothers for each new-born baby.
- We reviewed four gynaecology care records which were legible, dated and signed.

Safeguarding

- Staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. Staff followed safeguarding legislation and local policy for reporting concerns to safeguard adults and babies from abuse.
- There were four specialist safeguarding midwives based in the community for maternity services who provided support and supervision. Midwives told us that they were able to raise concerns and knew how to report a safeguarding incident.
- If there were any known safeguarding issues, there was a pink folder in the woman's medical records to alert staff. We observed this in practice when we reviewed a set of records and this being discussed at the handover on the postnatal ward.
- Staff were aware of the trust's abduction policy, all ward doors were locked. CCTV cameras operated in all areas. Babies had electronic tags which set off an alarm if the baby was removed from the ward, providing an additional safety measure.
- The service did not have a female genital mutilation (FGM) guideline for staff to use if there was a woman identified in their care who had undergone this procedure. It has been mandatory to report identified cases to the Department of Health since September 2014. Staff told us that if they found a woman who had undergone this procedure, they would report it to the trust safeguarding lead.

- Safeguarding children's training was provided by the Lead Nurse for Safeguarding Children. In June 2015, it was reported that 95% of nursing and midwifery staff at WRH, and 96% of medical staff were compliant in safeguarding children's training, meeting the trust target of 95%, however for community midwives, only 80% were compliant
- 97% of nurses and midwives at WRH, 98% of medical staff and 96% of community midwives were reported to be compliant with adult safeguarding training in June 2015, meeting a trust wide 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.
- Newly appointed staff completed the trust induction programme. Newly qualified midwives completed a competency pack before progressing to a higher grade. Staff told us it took around 12 months to complete.
- 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 was reported at 100% for all middle grade doctors (excluding locums) and obstetric consultants. Hospital midwives were 90% compliant, with community midwives demonstrating 81%.
- In June 2015, the trust reported that nursing and midwifery staff (including maternity and gynaecology) at WRH had achieved the trust wide compliance targets for mandatory training in hand hygiene (99%), however they were not compliant in health and safety (81%) information governance (63%), fire training (81%), moving and handling (94%), resuscitation (90%), and infection control (83%)
- 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%)
- Medical staff across the three sites providing obstetrics and midwifery services met the trust training compliance standard of 95% in hand hygiene (100%). They were non-compliant in health and safety (87%), information governance (65%), fire training (87%), moving and handling (67%), resuscitation (91%) and infection control (93%)
- Medical equipment training for nurses and midwives (including community midwives) was reported as 48% compliant, against a trust target of 95%.
- This meant although goals were set with regards to mandatory and essential training, the trust policy had been evaded by senior staff and targets were not being met.

Assessing and responding to patient risk

- There were three triage beds to assess women who arrived with medical conditions or complications associated with pregnancy, to determine if they were in labour. Women attending were not always prioritised according to risk, seen promptly by a midwife within 30 minutes or medical staff within 60 minutes in accordance with their guideline. This caused delays with high risk women being seen and assessed in a timely manner, which meant that they were not observed more closely and could have led to delays in treatment.
- Early warning scores were used to monitor women to identify when their condition may be deteriorating. Early warning scores enabled early recognition of a patient's

worsening condition by grading the severity of their condition and prompting staff to get a medical review at specific trigger points. The charts we reviewed were completed and scored correctly.
- We were told that the obstetric anaesthetist supported midwives and medical staff with the care and management of critically ill women.
- We observed good communication and teamwork in the operating theatre on the delivery suite. The theatre staff followed the five steps to safer surgery (designed to reduce the number of surgical errors) appropriately to ensure patient safety. Monthly audit showed the service was 100% compliant with the five steps.
- The electronic system used for risk assessments would not allow access to the next page until all areas were populated; this ensured that all risk assessments were fully completed. We reviewed 12 records and the booking risk assessment and venous thromboembolism (VTE) score were completed.
- We reviewed four gynaecology patient risk booklets; all the risk assessments were completed.

Midwifery staffing

- 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'.
- There were four community midwifery teams which had a whole time equivalent (WTE) establishment for community midwives there was vacancies for five WTE's. They told us they were very busy and their moral was low due to their workload. However, recruitment was underway, interviews had been planned and the management team were confident that they would recruit to the vacancies. Bank staff were used and a midwife had been sent from the hospital to help the community team on a temporary basis. Senior staff told us that they would suspend home births if there were not sufficient community midwives to support this service.
- Expected levels and actual levels of staffing were displayed on notice boards in all ward areas.
- It was planned that delivery suite coordinators were supernumerary, so as to be able to have an oversight of the department and be available for any urgent or emergency situations. However this did not happen, because the labour suite was short staffed and although midwives were allocated to care for women safely, the coordinator was also responsible for the care of a woman. The coordinator was included in the staffing numbers every shift.
- The delivery suite used an acuity tool to determine staffing levels in response to the amount of care the women needed. The staffing tool calculated the required staff on each shift based on one to one care for women. The acuity tool identified staff shortages. Senior staff told us that this was escalated to divisional clinical governance meetings and recently to the trust board to explain the shortfall in staff within the service. We saw the report sent to the trust board, dated April 2015, which acknowledged staff shortages in nursing and midwifery staff, however, the shortfalls were not funded due to priorities in other areas.
- On both sites the acuity tool identified that midwives assisting the surgeon by passing instruments (scrubbing) for theatre cases was the most common reason they could not provide one to one care .The midwives had received comprehensive training; however this practice took the midwife away from other essential midwifery duties.
- Midwives rotated to delivery suite and the maternity ward, as this allowed flexibility when the unit was busy.
- Support workers were on duty in all areas to provide additional support to midwives. Support workers attended a specific maternity training day. They did not undertake extra duties unless trained.
- Sickness absence for June 2015 was 4.16% qualified maternity staff and 5.16% unqualified maternity staff, against a trust wide target of 3.5%. However, staff did work extra shifts in an effort to cover these shortfalls. Staff from an agency were also used; these were staff that were known to the unit.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one

registered nurse for eight patients. The staff on the gynaecology ward had been increased to staff the ward one nurse to six patients and when the gynaecology ward beds were used for patients from other specialities it increased to one nurse to seven patients which is better than the RCN recommendation of one nurse to eight patients.

Medical staffing

- The service employed slightly more consultants than it was funded for, (13.2 WTE against 12.6) as it employed one full time locum consultant on a permanent basis.
- Middle grade doctors worked countywide across the three sites that provided maternity care. The funded establishment for middle grade doctors was 16WTE, however the trust only employed seven WTE on a permanent basis, and four WTE (25%) long term locums. This left a vacancy rate of five WTE (31%) which was managed by short term locum and flexibility of existing middle grades doctors. Where this was not possible, consultant obstetricians would cover by acting down. This deficit in permanent, middle grade obstetricians and gynaecologists was listed on the Women's and children's and corporate risk register as a red (high) risk as an inability to sustain safe staffing levels could affect the trusts ability to provide safe patient care at all sites. The trust had set up a 'Task and finish' group to oversee recruitment of middle grade doctors and planned to employ junior consultants in order to fill these posts.
- Consultant obstetric cover on the delivery suite was 60 resident hours per week. There was a consultant on call at all other times.
- Dedicated consultant anaesthetic cover was available on the birthing unit from 9am to 5pm and out of hours using an on call system.
- The clinical director for the service told us there were significant problems covering the middle grade staff rota and locums were used very frequently. On occasions consultants had to provide middle grade cover. Locums were provided with an induction pack and performed a self-assessed detailed competency form. We witnessed a consultant reviewing this with a locum and supervising the locum's first caesarean section.

Handovers

- Medical staff and midwives' handovers were carried out twice during each day, morning and evening, which included discussion of inpatients, births and admissions.
- Medical staff handovers on the delivery suite followed the midwives' handover. At the morning handover a multidisciplinary approach was taken an anaesthetist attended. All the medical staff signed to record that they had attended the handover, and consultant presence was monitored by the trust. A consultant obstetrician was present at every handover observed by the inspection team, ensuring there was senior clinical oversight of the activity on delivery suite twice a day.
- We were told that the service had implemented effective handover following the 'situation, background, assessment, recommendation' (SBAR) format, following learning from serious incidents. We observed three handovers on the delivery suite, and the discussions for each woman did not follow the SBAR format. This meant essential information about a woman and her condition could have been missed.
- The handover on the postnatal ward we attended was structured, staff members documented the information they were given and they followed an SBAR format.
- We observed a multidisciplinary handover by the theatre team where the women on the elective caesarean section list, which followed World Health Organisation (WHO)safe surgery guidelines

Major incident awareness and training

- Staff were aware of the major incident policy, which covered items such as actions when there were no beds available and massive external emergencies.
- Practical obstetrics multi-professional skills drills training was developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the new-born.
- We discussed the evacuation procedures from the birthing pool in the case of an emergency with the practice development midwife. Midwives practised these within their 'skills and drills' programme. We were also shown evidence of live practise sessions.

Are maternity and gynaecology services effective?

Maternity and gynaecology

Requires improvement

Overall we rated this service as requires improvement for effectiveness

Staff competencies were not always in line with national standards. Staff did not receive training, to deliver some aspects of specialised care to women.

Actions for training and competency checks identified from serious incidents were not monitored to ensure all staff were compliant.

Completed appraisals were below the agreed trust target. There was no formalised plan to all ensure staff completed their annual appraisal in line with Trust targets.

Supervisors of midwives had above the recommended number of midwives to supervise.

A number of clinical outcomes were worse than the national average.

Guidelines and policy were in accordance with evidence based national standards and recommendations. Women's pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding.

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. This meant women were receiving evidence based care.
- We reviewed eight guidelines/policies which were all 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 updates.
- Staff had access to the policies and guidelines via the trust's intranet. Some staff found it difficult to find the guideline they required easily, which delayed access to information. We witnessed this on three occasions where staff typed in the name of a guideline and it could not be found first time using the search engine.
- The service met or exceeded two out of five of the indicators for the National Neonatal Audit Programme (NNAP) 2013. The two that were met or exceed related to babies having their temperature taken within one hour of birth (100% against a standard of 98-100%), and 50% of babies receiving mother's milk on discharge from a neonatal unit (72% against an average of 58%).
- The service did not meet the standards for indicators relating to babies receiving retinopathy of prematurity screening (to screen for a visual impairment) (86% against a standard of 100%), mothers receiving antenatal steroids (80% against a standard of 85%) and documented consultation with parents and a senior member of neonatal team within 24 hours of admission (61% against a standard of 100%). Although senior staff were aware of these results, there was no action plan to share with us.
- Maternity services used the Worcestershire observation warning score (WOWS) tool to identify a woman whose condition was deteriorating. We found this to be completed, scored and escalated appropriately.
- There was evidence that the service had reviewed their intrapartum (during birth) practice after the updated NICE guidance 2014 was published. The delivery suite changed the medicine used in the active management of delivering the placenta to meet the new guidance.
- 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. There was an audit midwife in place. Examples of audits and recommendations in gynaecology included the referral pathway of cancer patients and for obstetrics the use of aspirin for women at risk of pre-eclampsia (high blood pressure in pregnancy). Results were discussed at clinical governance meetings, but were not displayed for staff and the public to see.
- The gynaecology service provided care for women whose pregnancies did not continue due to fetal abnormality. We observed a consultation with a woman and the medical staff adhered with regulations required for consent, and tissue disposal. This included the completion of necessary forms.

Pain relief

- The midwifery led unit offered a range of options for pain relief for women in labour water births, aromatherapy, Entonox, (a medical pain relieving gas) and stronger painkillers by injection.
- Women attending the delivery suite were offered a pool birth, aromatherapy, Entonox, and stronger painkillers

by injection. An anaesthetist was available; women had the option to have an epidural inserted, which to numbed the body from the waist down to the toes. This was available 24 hours a day.
- Women we spoke with told us that they were able to access pain relief during birth and post operatively in a timely way. Analgesia was offered regularly and women felt their pain was managed well.

Nutrition and hydration

- The trust promoted breastfeeding and the important health benefits known to exist for both the mother and her baby. However, we observed a formula feeding representative promoting and giving free gifts to staff outside a staff canteen. We reported this to the senior team and they followed the breastfeeding policy, and the representative was asked leave.
- The service was awarded UNICEF Baby Friendly Initiative full accreditation in July 2015. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding.
- The infant feeding coordinator was qualified to divide tongue tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers.
- Women we spoke to told us that they were supported by staff on the maternity ward with feeding their baby day and night.
- Breastfeeding statistics for initiation were consistently better than the agreed target of greater than 70%, for 11 of the 12 months for which we saw data.
- Woman told us the meals were on time and were acceptable. The women could ask for snacks out of meal times if necessary.
- Drinks were available at all times, and fluid balance charts were completed. There were reminders of the importance of maintaining accurate fluid balance charts displayed in all areas.

Patient outcomes

- The service maintained a maternity dashboard which reported on the clinical outcome indicators including those recommended by RCOG. This document was not displayed for staff to see.
- The number of women who had a normal birth between 2014 and 2015 was 60.7%. This was 2.3% less (worse) than the year before. The home birth rate was 1.3% less than the national average of 2.3%.
- We saw that the trust wide induction of labour rate was 30%, which was higher (worse) than the national average of 25%. Staff were unable to explain to us why this was high.
- The emergency caesarean section rate was 11.4% and the elective caesarean section rate was 14.9%, the service had no targets set for this data.
- The trust wide total caesarean section rate of 27.3% was higher (worse) than the national average of 25.5%, and the trust target of 27%. The target was set higher than the national average as this had been agreed with commissioners. The midwifery led unit was opened in April 2015 and staff were confident that evidence based low interventional care for low risk women would increase normal births and decrease the number of caesarean sections performed.
- The trust wide instrumental delivery (forceps and ventouse extraction) rate was 10% in April 2015, which was less (better) than the national average of 12.9%.
- There were 128 third and fourth degree tears recorded, which was an increase of 25 from the previous year. There were no targets set to improve or monitor these incidents.
- Postpartum haemorrhage (bleeding after birth) was recorded in case numbers 26 which was three less than the previous year. There were no targets set to improve or monitor these incidents.
- The service performed the same as other trusts in all areas in the CQC Survey of Women's Experiences of Maternity Services 2013.
- Between January 2015 and March 2015 maternity services readmitted 0.85% postnatal women, this is lower (better) than the national average of 0.87%
- National antenatal key performance indicators were not reported for screening in pregnancy, because they did not have an electronic system to report captured data. There were plans in place to develop an electronic system to record antenatal data.

Competent staff

- Newly qualified midwives completed a competency pack before progressing to a higher grade. Staff told us it took around 12 months to complete.

- Supervisors of midwives (SoMs) help midwives provide safe care and are accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for a SoM is to have a caseload of 15 midwives. There were less SoMs than the national recommendation with 16 midwives each to supervise.
- Midwives reported having access to and support from a SoM. SoMs did not provide an on call service, at night staff called the manager on call for support.
- Midwives' competencies were maintained by working for three to six months at a time in each area of the service. A small number of midwives did not do this which enabled stability and expertise in that area.
- We were told by different members of the maternity team that during the day theatre staff managed the recovery of women following surgical procedures. Out of hours midwives occasionally would undertake recover women. They did not attend recovery training or competency assessment in order to undertake this task, in line with the 'British Anaesthetic and Recovery Nurses Association standards of practice' (2012).
- Midwives told us that they scrubbed for operative cases, there was structured programme with a theatre nurse, signed competencies and supported practice for three months after completion of training. Midwives we spoke with were confident to scrub for theatre cases.
- We saw that appraisal rates for the past year did not reach the trust target of 100%.
  - Midwives - 83%
  - non-medical staff - 77%
  - Medical staff - 77%
  - Consultants - 77%
- Four medical staff that were in training all had educational supervisors and had regular appraisals. They felt that they were well-supported by the consultants who they reported as being very approachable.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working, including antenatal services. Community midwives, health visitors, GPs and social services staff were all linked through joint working with women and their families to plan the women's care throughout the pregnancy and after birth.
- Physiotherapists supported mothers with third and fourth degree tears and after caesarean section.
- The physiotherapists and occupational therapists supported with patients after surgery on the gynaecology ward and for assessments prior to discharge home.
- There was joint working with the mental health teams, who held clinics alongside the antenatal clinics.

Seven-day services

- Maternity and gynaecology services were available 24 hours a day seven days a week. Women were able to access maternity care by telephoning the birthing centre or through referral from the antenatal clinic or their GP. Gynaecology patients could be referred by their GP or via the emergency department.
- Physiotherapists were available five days a week during day time hours. At the weekend midwives referred women to the physiotherapy department. If the woman remained in hospital the physiotherapist visited the woman on the Monday. If the woman was discharged home an out-patient appointment was sent to her home address.
- Portable ultrasound scanners were available in maternity and gynaecology which meant that medical staff could scan pregnant women, postnatal women or gynaecology patients out of hours.
- Occupational therapy services were accessible five days a week. Nurses left messages in their designated communication book over the weekend so that the patient was followed up on the following Monday morning.
- Staff worked mostly 12-hour shifts on the gynaecology and maternity wards. There was also flexibility for staff with certain requirements choosing to work shorter shifts.
- Community midwives provided an on call service to facilitate home births**,** and were called to attend the hospital to supplement the staffing when it was too busy for the existing staff on duty to manage.

Access to information

- There was a white board on the wall of the delivery suite; patients' names were not used. The woman's condition was written next to her room number. It contained the details of the reason for the woman's admission and any risk factors that they may have. This enabled staff to have a quick overview of the issues on the delivery suite.

- The service had implemented a touch screen electronic system to document care when women were in labour. Staff told us that they had escalated to their managers that it was difficult to use the touch screen when using the system. Plans were in place to order key pads to enable the staff to type more easily.
- There were paper antenatal and postnatal records. Senior staff told us this could be cumbersome when they were reviewing records with regards to complaints and incidents because there were three different systems in use to access information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women gave verbal consent for some of their care and treatment and we saw that this was documented in the women's records. We saw signed consent forms for operations in the gynaecology records we reviewed. We observed correct procedures were followed for obtaining consent from patients.
- Training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was part of the trust adult safeguarding training. 97% of nurses and midwives at WRH, 98% of medical staff and 96% of community midwives were reported to be compliant with adult safeguarding training in June 2015, meeting a trust wide target of 95 %
- Maternity and gynaecology staff had an awareness of the MCA. The majority of staff we spoke with were not familiar with Deprivation of Liberty Safeguards (DoLS) and could not describe what it was. They knew how to access help from the safeguarding adults nurse. However, they were not aware of how to seek authorisation from deprivation of liberty, how to make a best interest decision for someone or the difference between lawful and unlawful restraint.

Are maternity and gynaecology services caring?

Outstanding ☆

We judged that maternity and gynaecology services were outstanding for caring.

Overwhelmingly we received feedback that care was excellent and compassionate. Women reported being treated with respect and dignity and having their privacy respected at all times. Women told us that nothing was too much trouble for staff.

Outstanding practice was noted with staff having thought about the caring needs of women and devising innovative solutions to support them. This was demonstrated by staff facilitating a teenage buddying system and developing bereavement care pathway for women who suffer pregnancy losses at any gestation. The patient experience midwife was available support women who were anxious or fearful about pregnancy and childbirth.

The friends and family test was continually positive and scored very high consistently.

We observed staff demonstrating a strong, visible person centred culture throughout the service. Staff were highly motivated and passionate about giving exceptionally high standards of care.

Information was provided in ways that could be understood and women felt involved in making informed decisions about their care. Partners were involved and were made to feel comfortable and able to ask questions.

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 the overall national average. Between March 2014 and February 2015, 88 completed questionnaires were received which is a high response rate in comparison to national data. Of these 97-100% of women said that they would recommend the antenatal service to friends and family if they needed similar care or treatment.97-98% of women said that they would recommend the trust's postnatal ward to friends and family if they needed similar care or treatment, with 98-100% recommending the delivery suite or maternity, and 96-100% recommending the postnatal community service
- Women and their partners were very positive about the care they received. All the women we spoke with told us that they had been treated with kindness, dignity and respect.

Maternity and gynaecology

- We saw good interactions, for example staff explaining detailed admission processes to a woman and her partner to ensure anxieties were reduced.
- Women in all areas told us that staff were "wonderful", "brilliant", and "excellent".
- The trust scored similarly to other trusts in all of the questions in the 'Care Quality Commission Survey of Women's Experiences of Maternity Services 2013'.
- One woman had to be transferred to the hospital due to bed shortages in the hospital nearest to where she lived. The woman said if she ever needed gynaecology treatment again she would travel the distance to the maternity and gynaecology services because care was excellent. Another woman said she had her first baby at another trust a long distance away, and after she had her second baby at this trust if she moved back to her previous address, she would travel back if she was to have a third baby.
- We observed staff at the postnatal ward handover, requesting to care for specific women because they wanted to provide continuity of care to the family and give her further emotional support.
- All of the three women that participated at the focus group that we held before the inspection reported having good care and experiences when they had their babies at the trust.
- A woman was distressed with the options of care offered to her following a scan result. A member of staff researched other potential care pathways and arranged a home visit to discuss the other care pathways with the women.
- We observed a doctor talking to a young woman with consideration and compassion whilst gaining consent for a sensitive procedure.
- We spoke to a domestic who told us that she loved her job and although it was difficult she wanted to make a difference for all of the families.
- A woman who had recently given birth told us that she was 'very impressed with the care on the labour ward' and a midwife was always caring during her labour. All disciplines of staff we spoke with were extremely passionate about the care they gave to women and their families and care was agreed in partnership with the woman. Women we spoke with clarified that this caring culture embedded in practice.
- Partners and families we spoke with overwhelmingly told us that staff were caring and go the extra mile to care for their loved ones.

Understanding and involvement of patients and those close to them

- We heard staff support women to make informed choices and be involved with their care. Staff promoted a person centred culture and listened to women.
- Woman shared their birth experiences with us and told us that they were supported at all times by the midwife caring for them. Staff empowered women to make choices in their care and treatment.
- A gynaecology patient explained her pathway of care to us. She was able to explain the care she received before, during her stay and the plan for her discharge home.

Emotional support

- Birthing partners were encouraged to stay with the women after she had had her baby which provided extra support to women and enabled early bonding for the family unit. There was a leaflet which was given to the partners giving advice on expectations of behaviour when staying on the post-natal ward.
- Staff discussed with us how they cared for women following bereavement. It was clear that women of all stages in their pregnancy loss and their families were dealt with compassionately. Staff provided care and support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide extra support.
- The SoM's offered a listening service following birth to women who needed to talk through their experiences.
- The service had a designated bereavement midwife who supported staff, women and their families, and provided counselling services if required. The bereavement midwife supported women and their families whose baby had died. In addition, those who had early miscarriages and women having procedures for fetal abnormalities were supported by the bereavement midwife. We witnessed the midwife arranging to follow up a woman on her day off to ensure continuity of care was provided.
- Women we spoke with following labour told us that the midwives were friendly and supported them which made them feel calm and cared for throughout the birth.

Maternity and gynaecology

- 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. The specialist midwives we spoke with confirmed that they received referrals and this practice was frequently facilitated.
- We observed the domestic abuse midwife visiting the labour ward to support a woman on her caseload.
- All of the specialist midwives demonstrated having the women's emotional and social needs at the forefront of the care they delivered to the women and their families.
- Women with complex social needs staying with their baby's in transitional care had an agreed pathway of care with other services involved. Nursery nurses were seen in the ward area to be sensitive to the women with regards to their plan of care.
- Three post-operative women told us that they received 'excellent care' 'Brilliant care' and staff responded to queries and went 'above and beyond'
- A patient experience midwife offered appointments for women and partners to discuss their care during their pregnancy and birth, to allay any fears that they may have. Building these relationships during the antenatal period enabled women to trust the staff and overcome their anxieties.

Are maternity and gynaecology services responsive?

Requires improvement

Overall we rated this service as requires improvement for responsiveness.

Gynaecology services had a high number of operations cancelled every month and could not always provide appropriate facilities for women having sensitive treatments due to shortages of beds as patients from other specialities needed to be cared for on the gynaecology ward . Nurses on the gynaecology ward told us that elective patients often had to wait for several hours in a 'holding' area for a bed to become available. Women had to wait for long periods of time to be seen in the antenatal assessment unit because there was only one bed available so women were seen one at a time.

Complaint responses were not handled within appropriate timescales in line with trust policy.

Staff offered women an informed choice of care assessed on clinical need. Services were arranged to meet people's individual needs, with specialist support staff to support women with complex conditions. Women had a choice regarding the management of miscarriage and were supported by the nurses, chaplaincy and bereavement midwife.

Service planning and delivery to meet the needs of local people

- Women were given an informed choice about where to give birth depending on their assessment of clinical need. The community midwives offered an on-call service to support mothers who planned to have a home birth.
- The midwifery led unit was opened early in 2015. Women assessed as low risk had the choice of a home from home birth, facilitated by midwives.
- The antenatal clinic had boards which displayed pregnancy related information such as breastfeeding and why not to smoke in pregnancy.
- Babies who required extra monitoring were cared for on the transitional care unit based on the maternity ward. Mothers were able to stay with their baby until they were fit for discharge home.
- Women had a choice regarding the management of miscarriage and were supported by the nurses, chaplaincy and bereavement midwife.
- Antenatal education and breastfeeding groups in the community were available for women to access. The dates and times were advertised on the trust's internet.

Access and flow

- Maternity services reported no closures between October 2013 and March 2015.
- There were daily dedicated theatre lists for women booked to have a caesarean section on Monday to Friday. We were able to observe a women being prepared for theatre. She was seen by the medical team and the anaesthetist prior to transferring her to theatre.
- Trust wide 88% of women were seen by 13 weeks of pregnancy against a target of 90%. This information was not separated into the three clinic sites Worcestershire, Alexandra and Kidderminster to enable comparison by locality.

Maternity and gynaecology

- There was a pregnancy day assessment unit (DAU) that was open from 8am to 6pm based within the antenatal clinic. Women were given an appointment to attend, reviewed by midwives and medical cover was provided by the on call team.
- The DAU was not efficient because there was only one bay. This meant only one woman could be seen and treated at any one time. However, there were plans to develop the service further and the lead midwife for the DAU at the Alexandra Hospital was spending time with staff to share good practice.
- The post birth baby examination was performed mainly by the paediatricians, although some midwives were trained to undertake this. Staff did not report any delays getting the baby examinations performed before the woman was discharged home. A number of community midwives had been trained to perform baby examinations which enabled women having a home birth to have the baby examination performed at home.
- The service scored similarly with the England average in regards to the maternity survey question around length of time to answer call bells. Women told us that the midwives responded to them quickly. We did not observe anyone waiting long periods of time to have their call bell answered.
- The bed occupancy was 50% compared with the England average of 59.9% since October 2013.
- The Early Pregnancy Assessment Unit (EPAU) was open from 8am to 4.30pm Monday to Friday. Referrals were accepted from midwives, GPs, nurse practitioners and the emergency department. Staff told us that when a woman self-referred to the emergency department and it was close to breaching the four hour wait target women were transferred to the EPAU to wait for assessment.
- At both sites there were always a number of medical outliers on the gynaecology wards. From August 2014 to May 2015 12.6% of gynaecology operations were cancelled as there were no beds available. This meant women could not have their operation as planned and it had to be rearranged. This had been on the directorate risk register since 2005. The senior staff had continually escalated this to the divisional team. It was unclear what had been done to relieve this situation.

Meeting people's individual needs

- A number of specialist clinics were available which included: patient experience, diabetes, tongue tie release, fetal medicine and mental health.
- Women, who needed complex fetal medicine management, were referred to another maternity unit for specialist management.
- Interagency initiatives for vulnerable women, teenagers and domestic violence were facilitated by the specialist safeguarding community midwives.
- 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.
- Women who had experienced bereavement were cared for in a 'home from home' suite with a garden. It was situated at the end of the ward away from the main delivery suite so that the woman would not hear any babies crying
- We observed staff respecting the women's dignity by knocking and waiting to be invited in to rooms or behind the curtains around the woman's bed space.
- Nurses performed comfort rounds on the gynaecology wards included changing beds, offering pressure area care and enquiring about fluids and food requirements. These were documented in the gynaecology records we reviewed.
- A community psychiatric nurse provided a clinic alongside the antenatal clinic to provide specialist care for those women identified as having mental health issues.
- Gynaecology patients who had dementia were identified by a forget-me-not flower on the patient's board to facilitate care appropriate to their needs. Staff were aware of the 'this is me' initiative, a booklet completed by the patient with information about them. We observed a dementia assessment completed appropriately when we reviewed the records.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information posters were displayed in all areas and corridors. The posters informed patients how to raise concerns or make complaint. Women told us they knew how to complain should they need to.
- Complaints were dealt with locally where possible. If staff and the Matron were unable to resolve the complaint advice was given to the women how to make a formal complaint in writing. We were told that the senior team would arrange a home visit to discuss the woman's concerns.
- 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?

Inadequate

Overall we rated this service was inadequate for well-led

The senior team were unable to explain the future plan for the service. The maternity strategy lacked clarity and staff did not know of its existence and were unable to tell us the vision for the future. The strategy was not displayed anywhere in the service for staff and the public to see.

Key performance data was not being collected effectively due to electronic recording issues and therefore not always analysed. This lead to a lack of accountability and quality, performance and risk management were not fully understood.

The risk register was not up to date and some risks were out of date and not been reviewed for some time, many key risks were not reviewed.

Staff reported concerns however they were not assured that they were escalated by the senior team to the trust board. Staffing shortages had been escalated on a number of occasions with no clear vision of how to resolve the issue.

Action plans in response to national reports were not effective; the actions were not rag rated correctly with the progress made according to the actions identified.

Local leaders lacked vision and were not clear about the services future. Recent changes in divisional structures meant some leaders were overwhelmed by the size of their roles.

Staff were not aware of performance indicators, outcomes or risks within the service

There were identified management roles in the maternity services, and at 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 and 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
- All the staff we asked were not aware of the local strategy or vision for the future. Generally staff knew the trust had the strategy which included the word 'Pride', but were not able to explain its meaning.

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 which was chaired by the Divisional Medical Director and attended by the senior team. Staff told us they felt the meeting was effective but were not assured that exception reports were reviewed effectively by the trust board.
- 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. This role had a very large remit and was therefore very challenging to undertake effectively. This 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.
- Staff told us that they were not assured that issues escalated to divisional governance meeting were acted upon. For example reports of poor staffing levels had been escalated on a number of occasions to the divisional board with no action plan of how this would be addressed. However, it was only recently that the new executive team had listened to the staffing concerns.
- We saw that the maternity and gynaecology risk register was not updated regularly and review dates had passed by with no obvious action. This meant the risk register was not current or reflective of the level of risks in the service. In addition, the trust board did not have oversight of the true risks within the service.
- The divisional medical director told us that in the past they had not been good at monitoring action plans, but the service was making improvements. However, did not clarify any plans that were being monitored.
- The government had commissioned an independent investigation into maternity and neonatal services at Morecambe Bay NHS Trust to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The senior team had reviewed the report. We saw that the action plan produced in response, had a number of actions that did not have timeframes recorded for completion. Where there were timeframes, these had not all been achieved and the 'red, amber or green,' rating did not always match the priorities given to the progress documented.

Leadership of service

- The leaders of the service lacked vision and clarity for the service's future. The DDNM told us that this was because their role was too large and could not be achieved by one person. This had been compounded since the role of the head of midwifery had recently been expanded to cover paediatrics and neonates in addition to the previous remit.
- During our inspection a serious incident occurred, which was a similar to one from earlier in the year. We asked if the service had embedded the lessons learnt from the previous incident. It was clear lessons had not been learnt.
- 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.

Culture within the service

- All staff we met were passionate about their role and said they were happy working for the service. Staff were anxious about the future of the trust, particularly as reconfiguration plans were being discussed.
- Medical staff told us they were adequately supported by senior doctors and consultants. If the on-call consultant was busy, staff were confident to call another.
- There was a culture of openness, flexibility and willingness among all the teams and staff we met. Staff worked well together and positive working relationships existed between the multidisciplinary teams and other agencies.
- Staff told us that should they need to raise a concern they felt confident and supported to do so.
- We reviewed seven serious incident reports, each one had evidence that of Duty of Candour had been applied and that there had been honesty and openness with the patients involved.

Public engagement

- Staff told us that women could communicate their experiences via the trust website. This was available for the public to view. We reviewed the website and it invited people to share their experiences.
- We reviewed minutes from three meetings 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. The group fully supported the development of the maternity led unit.

Staff engagement

- Monthly unit meetings were held at each hospital site within the trust. We reviewed the minutes of each. They did not follow the same agenda or focus. This meant that staff at each site were not being communicated with the same information at the same time. In addition we saw they were poorly attended by midwives. They told us that it was very difficult to attend meetings due to staffing issues.

Innovation, improvement and sustainability

- Staff were very proud of the new midwifery led unit and felt it was a huge improvement, adding to the services and choices offered to women.
- The maternity services gained the award for the Trust team of the year in 2014.
- The bereavement midwife had been nominated for the specialist nurse/midwife award in 2015.
- The diabetic link midwife won the specialist midwife of the year 2014.
- The maternity ward sisters have been nominated for sisters of the year 2015.

Services for children and young people

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

Information about the service

Services for Children and young people at the Worcestershire Royal Hospital provides outpatient and inpatient facilities as well as emergency and elective surgery for babies and children up to the age of 18.

The hospital opened in 2002 and provides paediatric services on a paediatric ward which has 35 beds or cots, and a neonatal unit comprising of 18 cots.

The paediatric wards comprises of an assessment area with a four bedded room, a single cubicle and six single en-suite rooms, three of which are equipped for patients who require high dependency care. There is an adolescent area with two twin rooms and one single room, eight cubicles for babies and a four bedded bay for babies and children over six months of age. This area along with a further eight bedded bay is used predominantly for patients admitted for day case surgery.

Children aged 16 and over have the option of being treated on an adult ward if preferred.

The neonatal unit has two cots for babies who require intensive care. Four cots can be used for babies who require high dependency care, with a further 12, for babies who require special care. The cots can be flexed down depending on the level of care required by the babies in the unit.

During the inspection we spoke with 16 members of staff number of staff including medical 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 both during and after the inspection.

Children and young People's services provided by this trust were located on three hospital sites, the others being Alexandra Hospital and Kidderminster Hospital and Treatment Centre, 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 many 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 we rated this service as inadequate. It was rated as inadequate for safety and being well-led, requires improvement for effectiveness and as good for caring and responsiveness

Care provided to patients was not always safe because incidents were not always reported and investigated promptly and lessons were not always learned.

Patient records contained good detail although they were not always updated in a timely basis and some records were not securely stored, including safeguarding records.

Some equipment had not been locked away securely, including sharp objects.

There were predetermined staffing levels for each shift which had been set by the trust as a minimum. Review of the rotas and staffing audits confirmed that minimum staffing levels were not always met.

Compliance with completion of mandatory training for nursing and medical staff did not meet the trust's target. Some important policies had not been developed, for example there was no policy on the use of restraint and staff were unsure of the correct protocol to follow.

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 weak 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?

Inadequate

Overall we rated this service inadequate for safety

Not all incidents were reported and when they were there was a delay in investigating them along with a lack of subsequent 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 also a lack of information regarding the consistency of sharing details of the incident with the patient.

The environment was observed to be visibility clean and staff used appropriate personal protective equipment and followed trust guidance although completion of infection control and hand hygiene training was well below the trust's target of 95% at 46% and 64% respectively.

The treatment room was not sufficiently secure to prevent access, the room contained sharp items.

Medication was administered as prescribed, although we noted a small number of items were out of date.

Records were not stored suitably to ensure they could not be accessed by other patients or visitors. Electronic records with safeguarding details were not sufficiently restricted to only allow access on a 'need to know' basis. Records contained adequate detail, although were often written in retrospect without this being noted and some were illegible.

Although nursing and medical staff were compliant in some elements of adult and child safeguarding training, significant gaps in compliance were also identified. However, the staff we spoke with appeared knowledgeable about recognising and reporting safeguarding concerns in children.

Completion of mandatory training with the service was not compliant with the trusts target of 95%

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

There was good use of tools to detect deterioration in children's medical condition, although this was not the case for neonatal patients; sole reliance was placed on the expertise of the nurse caring for the patient.

Staffing arrangements were not sufficient because the minimum staffing levels set by the trust or nationally for the neonatal unit and the paediatric ward were not always met. This had been identified as a risk by the trust, although it was the perception of the staff we spoke with that patients were not placed at risk, because everyone 'pulled together' to work as a team. The trust told us that whilst current establishment did not reflect the optimum number of staff required, bed occupancy between April 2014 and July 2015 ranged from 30% to a maximum of 38%.

As sickness data for medical staff was not always recorded and the rota was not updated to reflect all sickness absences we were unable to undertake a meaningful analysis of medical cover. We saw evidence on their risk register as well as other documentation to indicate the agreed staffing requirements were not consistently met.

Incidents

- There were a total of 170 incidents reported within the children and young people's services between the period January and May 2015, with no incidents categorised as serious.

Although it was noted that a small number of serious incidents which related to paediatric patients had been reported by other departments, but these had not been reported by the paediatric department or directly linked to paediatrics or their reporting tool.

- The trust used an electronic incident reporting tool to report and record 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 the majority of incidents had been reported by nursing staff and raised this with the clinical director who confirmed 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 that 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 the investigation for 30 incidents had not yet started, six of which dated back to January and three that dated back to February 2015. The remainder all occurred in March, April or May 2015. Investigations had commenced within 30 days of being reported for 134 incidents. 29 incidents had taken between 30 and 90 days for the investigation to commence, with seven incidents taking between 90 and 148 days to start the investigation. A total of ten incidents had taken between 100 and 149 days to complete from the date the incident was reported.
- 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.
- Review of the summary information provided confirmed that most incidents had been categorised as no harm, with only a small percentage having been categorised as minor. None were categorised as moderate or major. From our review we noted that the seriousness of some of the incidents was not reflective of the potential harm which could have or did occur.
- Some of the incidents categorised as 'near miss' for example had been misinterpreted because no harm came to the patient.
- We selected a sample of incidents for further review and requested additional data. One of these incidents required a formal investigation and we were provided with a copy of the report. The incident reported that a child with an allergy to penicillin had been prescribed and administered the medication. Although the action plan had not been signed off as completed, we saw evidence that recommendations and lessons learned

were shared with staff on this unit as well as the paediatric ward at the Alexandra Hospital. Learning had not been shared with nursing staff who worked on the neonatal units.

- 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.
- No serious incidents had been reported by the paediatric team or aligned with paediatrics on their reporting tool. We saw, however, that there had been a small number of serious incidents relating to paediatric patients which had been reported by other departments, namely A&E and Surgery.
- We reviewed two of the serious incident reports provided to us and found that although weaknesses had been identified, the agreed actions did not always directly link with the concerns highlighted in the report. For example, one issue identified was that the competencies and extent of clinical practice of locum staff present were 'unknown'; the agreed action was to 'change the clinical pathway' but no further detail was provided to explain what this meant. The actions recorded did not address the issue of the locum's competencies or not knowing the extent of their clinical practice. A second serious incident related to a baby who had died at home and although it was accepted within the report that the trust were not responsible, it was recognised that community midwives needed to continue to emphasise importance of continued health education for parents. There were no other actions or recommendations for shared learning with paediatrics or the neonatal team.
- From a review of complaints made by patients and their relatives we identified that one complaint related to the death of a child. It is trust policy that all child deaths are reported as incidents regardless of whether the death was expected or not, however, this incident was not reported or investigated.
- 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, both medical and nursing were unable to provide examples of incidents 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; although staff all told us about the recent errors with prescribing and administering penicillin. We prompted staff regarding another incident which had occurred on the neonatal unit regarding a 'mix-up' of breast milk. Staff working on the neonatal ward were able to tell us about the error with the breast milk and how procedures had changed as a result but staff working on the paediatric ward were unaware of this incident.
- Paediatric mortality and morbidity meetings were held at the Worcestershire Royal Hospital. Cases were discussed in detail, although we noted that learning points were listed, agreed actions did not always address the learning points. Furthermore, there was no detail around how learning points or actions would be taken forward or monitored. For example, in the meeting 25th June 2015, a case which had occurred at the Worcestershire Royal Hospital identified that resuscitation guidelines had not been correctly followed, there were no action point to address this and it was unclear how learning points were to be shared with other trust locations.

Safety Thermometer

- As required, the hospital reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from the paediatric ward as well as the neonatal unit. It covered hospital-acquired (new) pressure ulcers (including only the two more serious categories: grade three and four); patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). From July 2014 to June 2015, the paediatric ward and neonatal unit had reported 100% harm-free care for the snapshot during this period.

Cleanliness, infection control and hygiene

- We observed that staff followed appropriate infection prevention and control practices during our inspection.
- 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 infection prevention and control practices and were bare below the elbow whilst in clinical areas.

- From review of training records, we noted that 64% of staff working in paediatrics had completed their hand hygiene training and 46% of staff had completed infection control training against a trust target of 95%.
- Equipment we reviewed was visibly clean and we saw that labels were used dating when equipment had been cleaned.
- Clinical and domestic waste bins as well as sharps bins were on the ward were used and stored appropriately.
- We were provided with two recent infection control audits although it was unclear whether they related to the Alexandra Hospital or Worcestershire Royal Hospital. One of the audits for June 2015 was for the paediatric ward. The audit demonstrated good compliance although highlighted that there was an issue with beds being dusty, there was no evidence of a re-audit having taken place.

Environment and equipment

- We saw that the resuscitation trolleys on the wards were checked daily and records maintained. New trolleys had recently been purchased and the medication box did not fit correctly on the trolley, the ward staff were aware of this problem and had requested a new box.
- We reviewed a sample of equipment items in paediatrics and neonatal wards and found that equipment had been serviced and Portable Appliance Test (PAT) tested in line with requirements.
- The treatment room on the paediatric ward contained a variety of equipment, including sharp items such as razor blades. We observed that the door was locked using a 'bolt' at the upper end of the door. This meant that adolescents and adults on the ward could access the room, with no suitable preventative measures in place. A number of patients admitted to the paediatric ward had self-harmed prior to admission and were recorded as previously had or having had suicidal thoughts. Therefore there was an increased risk if such patients could access sharp items. We reported this to the ward manager who immediately took action and a secure keypad lock was fitted within a couple of hours.
- There was a room available for patients to discuss confidential issues; this was also used as a lounge area for teenagers which meant that if a patient wished to discuss private matters, there was nowhere private for other teenage patients to relax.

Medicines

- We observed that medication was stored in appropriately locked cupboards.
- We observed that medication was in date and had details of the opening data recorded as applicable.
- Controlled drugs were stored in line with requirements and administration of controlled drugs had been recorded in the controlled drug register as well as the patient notes, for the sample we reviewed.
- We reviewed a sample of controlled drugs and saw that they tallied with the controlled drug register. We saw that daily checks were performed by staff.
- We noted that the keys for medication were stored in a combination safe and we were told that the nurse in charge held the keys for the safe which could also be accessed by other nursing staff.
- We saw that checks on fridge temperatures were carried out daily.
- All babies and children had a hospital wrist / ankle name band on as appropriate and allergies were clearly recorded. Children with allergies had a red name band on as per National Patient Safety Association guidance.
- From review of medication incidents, we noted that medication incidents included prescribing and administration errors. We also noted that three children had been prescribed antibiotics despite having an allergy to them. Action was taken to address these incidents and no further incidents had been reported since March 2015.
- A pharmacist visited the ward daily and checked all patient records to ensure medication had correctly been prescribed and administered.

Records

- We saw that records were not always stored securely and some patient notes were placed next to the patient's beds or outside their room in open trays. This could have compromised the security of the notes as well as patients' confidentiality.
- We also observed that a whiteboard was used displaying the full name of all patients currently on the ward. This was in full view of all patients and relatives who entered the ward.
- From review of a sample of patient records we saw that nursing notes were frequently recorded at the end of a shift, but it was not recorded that entries had been made retrospectively. Some notes in the patient files were not legible.

- We reviewed advance care plans for a sample of patients and saw that these had been completed and reviewed. Do not attempt cardio pulmonary resuscitation (DNA CPR) sections of the plan had been completed and signed by all appropriate parties.
- Patients who were admitted to the paediatric ward because they had 'self-harmed', taken an overdose or had suicidal intent were admitted to an anti-ligature side-room if available to ensure they were cared for in a safe environment. In addition, they were placed on 30 minute observations whilst awaiting assessment from a mental health specialist from the community team. However, an initial assessment could take a number of hours depending on the time of day the patient was admitted. We were told that the trust did not have their own risk assessment document to assess the patient's immediate risk until a full assessment was undertaken by a mental health specialist. In absence of an immediate risk assessment document, initial care provided may not have been suitable to prevent the patient from further self-harm.
- A records audit was in the process of being undertaken. We were provided with raw data for the work completed so far. Some elements of record keeping were well completed and others were inconsistent, for example, completion of the name of the health professional

Safeguarding

- There was a safeguarding children and safeguarding adult's policy in place. We noted that the policy did not include a section on the process to follow in deciding whether or not a safeguarding referral was required when a patient or their parent self-discharged before the patient was deemed medically fit. This may place the patient at risk if they leave hospital before they are medically fit to do so and could be an indicator of safeguarding concerns.
- We saw that 61% of all staff within paediatrics had been trained to level 3 safeguarding. This included 100% of nursing staff, but only 24% of medical staff. We requested data for neonatal staff, although this was not provided. The staff we spoke with all had a good understanding of how to recognise safeguarding concerns and confidently talked about example scenarios as well as the reporting process. However, most of the staff we spoke with were less confident in identifying and reporting on similar concerns for vulnerable adults who may still present on the ward as a parent or visitor. 100% of medical staff and 41% of nursing staff had completed safeguarding training for vulnerable adults.
- Staff who worked on the wards checked the child protection register for all children who attended the ward and lived in Worcestershire. This was not the case for children attending outpatients and we were told this was being addressed. For children who attended the ward and who lived 'out of area', staff telephoned the child's local social services to establish if a child protection plan was in place. We were told however, that relationships with other neighbouring counties were less well established so communication with them was not as efficient. The staff we spoke with were unaware if this had been addressed at managerial trust level and we were told that communication issues with other counties were, 'ongoing'.
- We reviewed a sample of patient records and saw that relevant checks had been made and referrals to social service completed as appropriate.
- Review of patient records who had safeguarding concerns identified by staff and reported were recorded in the patient's nursing and medical notes which meant all staff across the entire trust could access these notes as they were recorded electronically. This meant that safeguarding related concerns could be accessed by any member of clinical staff who worked within the trust, rather than on a 'need to know' basis. The electronic system used, contained a safeguarding folder where safeguarding records could be saved. Once stored, although the records could still be accessed by all staff across the trust, on attempting to open the notes, an 'audit box' was displayed requiring the member of staff to record their details and reasons for accessing the patient's safeguarding records. This folder was not utilised as intended and instead only used for 'additional' safeguarding information. Details about safeguarding concerns and referrals made were still recorded in the patients nursing and medical notes, where there was no audit function to monitor access to such highly confidential records.
- A Serious Case Review had taken place, following the death of a child at Worcestershire Royal Hospital in 2012: the report was published in April 2015. The trust reviewed the findings and actions required for the acute trust. The trust extracted eight learning points from the report and it was agreed at the Paediatric Quality

Improvement Meeting in June 2015 that a named consultant paediatrician would email all consultant paediatricians across the trust asking that, 'they respond, constructive/critically) to confirm that they had read an email, which continued learning points, the independent overview and the safeguarding synopsis. We requested the trust provide details of the learning points and action plan with achievement to date. We were provided with a list of eight learning points but there was no evidence how this had been communicated and shared with all staff or details of progress made. We were provided with an email sent in 2013 which reminded consultants of the need to perform a specific examination if certain concerns were apparent and to seek advice if necessary. There was no evidence an email had been sent out once the report had been received. This demonstrated a lack of shared learning in the case of serious safeguarding incidents because there was no evidence of communication or follow-up once the inspection report had been received.

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.
- The staff we spoke with told us that they had completed their mandatory training. Staff were allocated dedicated time to complete 'face to face' mandatory training, such as basic life support. Some of the mandatory training was completed on line and it was expected that staff complete this whilst working on the ward during quieter periods. The staff we spoke with told us that this did not pose any difficulties and that they found training provided by the trust helpful.
- The service had a target of 95% compliance with regards to mandatory training, which had been achieved for Equality and Diversity, Safeguarding Children and Health and Safety. The target had not been met for other mandatory training courses, some of which had a very low completion rate. For example, attendance at fire training was 54% for all staff within paediatrics, 44% for nursing staff and 14% of administration and clerical. Overall medical and dental staff achieved a high rate of completion for most of the mandatory training. However, this was based on only 25 (permanent) members of staff completing the training, which meant that middle grade (long term locum doctors) and junior doctors (on rotation) were not included in these figures. This meant that there was no evidence that doctors in this group had completed their mandatory training.
- We requested data on the percentage of staff at each location who had completed Basic Life Support (BLS), Paediatric Intermediate Life Support (PILS) and / or European Paediatric Life Support (EPLS) training. We were provided with a statement that 69% of nursing staff working on the paediatric ward were BLS trained, 90% PILS trained and 48% EPLS trained. Data was not provided for other areas including staff working on the neonatal unit.
- The trust also stated that Deanery rotational doctors had completed their APLS/EPLS during training but they may not have completed this at another trust and therefore records were not maintained centrally. Locum doctors were required to record on their CV whether they were up to date with required training. Therefore accurate records were not maintained by the trust to confirm which medical staff had completed relevant life support training.

Security

- There was a buzzer entry system for both the neonatal ward and paediatric ward and we observed staff asking visitors who they were visiting before entering. Exit from the paediatric ward and neonatal unit was also controlled and required a member of staff to release the door for patients and visitors prior to leaving the ward or unit.
- 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. The staff we spoke with told us they had not received training on restraint and that they have not ever needed to restrain a patient. Staff also told us they would try talk to a patient to calm them down and call the police if

necessary. However, if situations may have arisen which required a patient to be restrained or held and staff were not suitably prepared to deal with such an incident.

Assessing and responding to patient risk

- The paediatric ward was not commissioned to provide high dependency beds for children although the ward had a single side-room which was used for 'higher' dependency patients. The paediatric unit did not have a policy for higher dependency patients, although there were policies for specific conditions. We noted this did not include a local policy for the management of sepsis.
- The neonatal unit cared for up to 18 babies and included two intensive care cots, four high dependency cots and 12 special care cots.
- A paediatric early warning (PEWS) tool was used to monitor and manage deteriorating patients on the children's 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.
- An audit on the use of PEWS was last undertaken in 2012 and rescheduled to be re-audited in 2017. It was agreed at committee that this should be increased in frequency.
- The neonatal unit did not have an early warning tool available and although a specific national tool had not been developed for neonates, there was a risk that warning signs of a neonate's deterioration may not have been detected promptly.
- We saw an example of one incident reported in May 2015 where observations had not been recorded in the baby's notes. Had an early warning tool been in use, this would have helped minimise the risk of not recording and monitoring all required observations.

Nursing staffing

- For the paediatric ward in July 2015 there was a vacancy of 1.6 whole time equivalent (WTE) with sickness at 3.4% in May 2015 for nursing staff, which was within the trust wide target of 3.5%.
- A staffing needs assessment for the paediatric ward identified the ward required seven trained children's nurses for the early shift, six for the late shift and four at night; with support from one childcare assistant on each shift. Calculations were based on the assumed level of occupancy and complexity of patients admitted to the ward. On the paediatric ward, shifts were planned to include six trained children's nurses, with support from one childcare assistant, during the day and four nurses with support from one childcare assistant at night.
- We were told that during the day staffing levels were not always achieved but the staff we spoke with told us that it could become busy at times, but it was generally manageable. .
- Review of the nurse staffing audit data collected by all wards between the period 2nd and 27th June 2015 confirmed that the agreed staffing levels were rarely met. For a total of 40 day time shifts we found that none of the shifts had been staffed with seven nurses; 16 had been staffed with six, 19 had been staffed with five and four had been staffed with four registered nurses. For the same period, there were a total of 20 night shifts where six shifts had been fully staffed with four registered nurses and 14 shifts had been staffed with three registered children's nurses.
- The trust told us that whilst current establishment did not reflect the optimum number of staff required, bed occupancy between April 2014 and July 2015 ranged from 30% to a maximum of 38%.We were told that the skill mix worked well. When shifts were short of staff, cover was arranged by nurses working additional shifts including those on zero hour contracts. We were told that agency staff were rarely used although they were on occasions, as well as when a mental health nurse was required
- The neonatal unit was staffed by four nurses on every shift, which included a minimum of two nurses specially trained in neonatal care. Neonatal staff working at the Alexandra and the Worcestershire Royal Hospital worked on a rotational rota and the overall vacancy was 2.7%. In order to be compliant with the British Association of Perinatal Medicine (BAPM) guidance for safe staffing levels, the trust had assessed that they required six nurses for each shift. Review of the nurse staffing audit data collected between the period 15 June to 10 July 2015 confirmed that the majority of shifts were understaffed according to the number and acuity of babies on the unit. On occasions these staffing levels were significantly below BAPM recommendations. We noted that seven out of 52 possible shifts were assessed as having required eight or more nurses and cover was provided by four or 4.5 nurses during these shifts. The majority of other shifts were also understaffed. It is recognised nationally that neonatal

staffing is a challenge. The trust said they mitigate against the risk of understaffing by using bank and agency staff, daily escalation and risk assessments of the neonatal unit against set triggers.

- We only saw one reported incident in May 2015 of understaffing, which demonstrated that staff were not reporting incidents or following escalation procedures.
- Nursing requirements for paediatric outpatients did not currently meet the minimum standards in accordance with the Royal College of Nursing guidance. We were told that one day per week, the clinic was not supported by a nurse and that clinics on other days could be affected at short notice due to sickness. A healthcare assistant supported the consultant on this day but due to vacancies and sickness, nursing cover could not be provided. We were told that a business case has been drafted to increase staffing levels.
- Handovers took place three times per day on the paediatric ward and twice daily on the neonatal unit. We observed handovers and found these to be effective with good communication and discussions about patients, discussing any issues which had arisen during the previous shift.
- A standard checklist was used to provide a local induction for agency nurses who were new to the ward.
- We were told by healthcare assistants that on occasions they were transferred to other wards or departments to provide support. The healthcare assistants we spoke with told us that they did not feel competent to support adult wards because the expectations of support were different to that on the paediatric ward. We were told that this had happened less frequently in recent months but that it continued to happen on occasions. Healthcare assistants told us they felt anxious about coming in to work because they did not want to be sent to another ward where they did not have the training or skills to deal with requests made.

Medical staffing

- Each shift was covered by two Consultants with support from three middle grade and one junior doctor during the day. Out of hours there was one consultant, one middle grade and two junior doctors from 5pm until 9:30pm Monday to Friday and from 9am to 1pm at weekends. The sickness rate was reported as 0% during 2015 for medical staff. We were told that there was an issue with medical staff not following trust policy when reporting sickness and therefore the records were not an accurate reflection of the sickness rate. This had been discussed at the Quality Improvement Meeting and was being addressed.
- Because sickness data for medical staff was not always recorded and the rota was not updated to reflect all sickness absences, we were unable to undertake a meaningful analysis of medical cover.
- We were told by all staff that we spoke with that there were a shortage of middle grade doctors, with a 22% vacancy rate. Cover was provided by use of regular locums as well as consultants and we saw evidence of this on the rota. This had been recorded on the risk register as a high risk due to the potential impact on patients relating to locums not being familiar with the procedures and policies for the trust. We saw that the risk register lacked detail for the shortages at Worcestershire Royal Hospital with the focus being on the trust's other main location, Alexandra Hospital where the vacancy rate was much higher.
- The staff we spoke with told us that it put pressure on staff to work additional shifts, including the consultants covering some shifts for middle grade doctors, but that it had not impacted on the care provided to patients.
- We were told that it was difficult to recruit to middle grade doctors due to the uncertainty of the continuation of the service. A multi-agency task and finish group has been established in order to arrive at a countywide sustainable model for paediatrics. This was designed to address the staffing issues.
- When we reviewed the task and finish group action points for July 2015 it was evident that there were significant shortages of middle grade doctors. We saw that different options were being considered, with success in recruiting to one vacant post. Some recruitment possibilities had been followed up but were not viable and there were plans to look into recruiting overseas. The action points also raised a concern with regards to shortages of junior doctors from August 2015. Actions had not been agreed to improve staffing for junior doctors other than to add this to the risk register.

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 required improvement for effectiveness.

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

Pain assessment tools for babies and children were available but were not always completed.

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.

There were arrangements for referring patients to mental health colleagues, although these did not always work quickly and efficiently.

Multidisciplinary arrangements worked well to ensure patients' needs were met and we saw that consent to treatment was gained from patients or their parents.

There were play therapists six days per week which empowered children and gave them a 'voice' to ensure they were involved in their care.

Appraisal arrangements were in place and all members of staff had received an appraisal within the previous 12 months. There was a process in place to ensure medical and nursing professionals had a valid registration for their profession.

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

Evidence-based care and treatment

- We saw that the trust had a range of guidelines with regards to the care and treatment of paediatric patients and 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 depending 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 and local priorities and issues identified through complaints and incidents.
- The audit plan for 2014/15 listed 14 audits which had been planned for the year, of which six had been completed. The 2015/16 plan listed 15 audits for the year, one had been completed by the time of our inspection in July. 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 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. We were provided with copies of the presentations for two other audits which had been scheduled; the neonatal jaundice and the Review of Acute Paediatric Admissions audit. The audit presentations included details of the aims and objectives of the audit along with a summary of findings and conclusion. Action plans were provided separately.
- The neonatal jaundice presentation identified a low level of compliance with repeating specific tests within recommended timescales following phototherapy having been initiated; compliance with standards was between 5-25%. Full compliance was observed in stopping phototherapy in line with requirements. Timescale for implementation was October 2015. We were not provided with evidence that the audits had been presented at a relevant committee or lessons learned shared amongst staff. The Acute Paediatric Admissions Audit included samples of patient notes

from the Alexandra Hospital along with an action plan to update the proforma. This included a section to record the time the patient was first seen by the consultant or doctor who clerked the patient. The agreed action date was October 2015. Evidence of presentation at committee was not provided.

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. Through review of patient notes we saw that pain assessments were not completed consistently.

Nutrition and hydration

- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs.
- 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. Multiple faith foods were available on request.
- We observed a meal time and found that choice was supported and that children and young people got their preferred meal when they wanted it.
- The patients and parents we spoke with told us they were satisfied with the food and hydration provided.

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. There were additional columns to record admission data and compliance with criteria from the neonatal audit project, although these fields had not been populated with monthly data. The trust was achieving its target for referral to treatment for both admitted and non-admitted patients.
- Emergency readmission rates within two days of discharge was 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 it was reported that a decision had been made not to undertake this audit because an action plan was still in progress from the previous audit.
- The NICE Guideline CG15, states that all children and young people with diabetes over 12 years of age should receive seven key care processes in order to achieve optimum control over their diabetes in order to reduce the possibility in developing complications. The Worcestershire Royal Hospital performance compared closely to that of other trusts of a similar size.
- The national neonatal audit was included as an audit for 2015/16 but had not yet been completed. The 2013/14 audit, reported good compliance with following guidance and that where there were failings this was largely due to data entry which the trust was working on.
- The trust had slightly higher rates of multiple emergency admissions within 12 months among children and young people with asthma, epilepsy and diabetes compared to England averages.

Competent staff

- Staff completed an annual appraisal as part of their Personal Development Review. The staff we spoke with told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. Review of data provided, confirmed that 100% of all staff groups had completed their appraisal meeting the trust target of 100% compliance
- 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.
- Each shift was covered by a mix of nurses who had a post registration children's qualification and children's trained nurses. There was a minimum of two nurses with a post registration qualification working each shift. We saw one incident reported where there was only one nurse with a post registration qualification working the shift, supported by children's nurses.

Multidisciplinary working

Services for children and young people

- The staff we spoke with told us that there was good input from the rest of the multidisciplinary team, including physio-therapy, dietetics and speech and language therapy.
- Multidisciplinary team involvement in care was documented in children's notes.
- Play therapists were available on the ward six days per week, Monday to Saturday. They helped medical and nursing staff by supporting patients and developing plans to deal with managing pain or devising distraction techniques. In addition they ensured their wishes were catered for before and after surgery.
- Children's services used an electronic discharge system for children, which all staff could log in to and which supported the timely provision of information to local authorities and community services such as health visitors. A manual system was used for children who lived out of area.
- A dedicated pharmacist came to each ward daily to check supplies and review drug charts for patients on the ward.

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, although we noted a small number of incidents where patient records had been placed in another patient's record.
- Transfer, referral and discharge information was communicated effectively.

Seven day service

- There was pharmacy support seven days per week. A pharmacist attended the ward to check stocks and review patient files every week day with an on-call service out of hours.
- The x-ray department could be accessed seven days per week as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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 had a good understanding of Fraser guidelines and Gillick competencies for assessing a child's ability to provide consent.
- We noted that verbal and / or written consent was obtained for both medical and / or surgical interventions, with signatures obtained to confirm consent; consent was obtained from both the patient and their parent as applicable.
- Consent forms for surgical procedures included an explanation of any risks to the child from receiving treatment.

Are services for children and young people caring?

Good

Overall we rated this service as good for caring.

All of 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.

Throughout our inspections on all wards, we saw staff treat patients and their parents with dignity and respect. All of the parents and relatives we spoke with were positive about staff that they referred to as caring and friendly. They said the care they and their child received was kind, compassionate and supportive.

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.

We found evidence of multidisciplinary support being facilitated throughout children's services.

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.

Services for children and young people

- 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 stared being used within paediatrics. However, feedback from Friends and Family data was not yet available.
- Staff received cards and emails from patients and their families thanking them for the care they received.
- Privacy and dignity of patients was observed to be respected at all times.
- The trust performed about the same as other trusts for most of the indicators related to caring in the Children's 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 of the patients and relatives we spoke with on the ward and in the outpatient's 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.
- We were told by patients and staff that they understood where to seek further information if required and that children could talk to a member of staff without their parent present if they wished to do so.

Emotional support

- Children and young people received support from nursing staff or a play therapist before being taken for surgery, in order for them to discuss any concerns or worries that they had about their operation.
- Patients and their families could access support as required from the chaplaincy service which provided a service across the hospital.
- One of the play therapists based at the Alexandra Hospital had received specialist training in supporting bereaved parents and spoke with parents and members of staff at the Worcestershire Royal Hospital to offer support and advice.

Are services for children and young people responsive?

Good

Overall we rated this service as good for responsiveness

Arrangements were in place to accommodate the needs of patients, there were facilities for children and adolescents to occupy their time during an inpatient stay. Single sex arrangements were in place as well as side rooms for patients with higher dependency needs or who may require isolation.

Access to the service and flow through it, worked well. This was because there were short lengths of stay within the department and a low level of demand.

There were a small number of complaints received about the service; these were not always responded to in a timely manner.

There were good arrangements in place for transitioning patients from paediatric to adult services.

The paediatric ward did not have a communication tool in place for patients who were unable to communicate verbally and reliance was placed on the child's parents communicating on their behalf.

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.

- The paediatric ward had separate bays for younger children and single sex bays for adolescents as well as some side rooms.
- Comment cards were available for patients and parents to provide feedback. We reviewed a number of comment cards and found feedback was positive which were all positive.

Access and flow

- Paediatric patients were admitted to the ward either via a planned admission process, through emergency admission from a direct referral via their GP, or through A&E.
- Neonates were admitted via maternity as a planned or emergency admission. Babies could be transferred from other hospitals if required, although staff told us this did not happen very often.
- The average length of stay for paediatric patients at Worcestershire Royal Hospital was just over one day and for neonates was an average of 12 days between the periods April to June 2015.
- We were told that although the department could become busy at times but staff worked together to ensure patients' journey through the department worked well. Some patients with mental health needs could remain in the department longer than planned if they were waiting for a bed in a mental health unit but most patients were discharged back to the community team.

Meeting people's individual needs

- There was a playroom for young children which contained toys and books and a separate room for adolescents with a television, DVDs and books. A computer gaming system was available if requested.
- Parents had the option to stay overnight with their child in a chair. Alternatively there was a foldaway bed or reclining chair in a separate parent's room if required.
- Translation services were available either by using a telephone translation service or face to face interpreter services could be arranged during office hours if required. We were told there was limited demand for translation services.
- Patients with learning disabilities had an additional care plan which clearly set out their specific care needs. However the paediatric ward did not have a communication book to assist patients with a learning disability or who were unable to express their needs verbally. This meant reliance was placed on the parents or carers with the child to communicate on their behalf.
- The paediatric department had a number of nurse specialists, which included nurse specialists for respiratory, epilepsy, and allergies who provided emotional as well and clinical support.

Learning from complaints and concerns

- A small number of complaints were received about the paediatric and neonatal service. A total of seven complaints had been received across both sites for the period May 2014 to May 2015 inclusive.
- There were complaints leaflets available for patients and their parents, details of how to make a complaint is also on the trust website.
- We were provided with a detailed summary of complaints for 2014/15 up to and inclusive of March 2015. No complaints had been received about the neonatal unit during this period. Four complaints had been received about the paediatric ward, of which two had been responded to within agreed timescales of 25 days. However, two took between six and eight weeks for a response to be sent. We saw that one of the complaints should have been reported as an incident, but it had not been. A further three complaints had been received about paediatric outpatients although it was unclear which particular location the complaints related to. One of the complaints had taken three months to be resolved.
- We saw that complaints along with lessons learned were shared in the monthly risk bulletin.

Are services for children and young people well-led?

Inadequate

Overall we rated this service as inadequate for well-led.

There was an outline business case for the Acute Services Reconfiguration which was drafted in March 2015. The business case included objectives for children's services. The principle objective was to, 'progress service

reconfiguration'. The business plan included generic objectives; these were not specific to paediatric or neonatal 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. 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.

The risk register was not used to ensure all risks had been identified and that progress was being made with the recorded risks.

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. However, it was evident from meeting minutes that GP trainees were not satisfied with working relationships.

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 trust values 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.
- We were told that the paediatric / neonatal unit 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. For example, one of the six objectives was to develop safe, sustainable clinical service strategies. Objectives were underpinned by three business themes, patient experience, divisional philosophy and place of care. It was unclear which of these three attempted to 'develop safe sustainable clinical service strategies', or how the strategies would be delivered. The three business themes were underpinned by six delivery statements; again it was unclear how these supported the objective/s. We were not provided with any detailed plans which explained how the objectives would be delivered or measured. Therefore there was no evidence of how the service had been planned to take the needs of the local population into account.

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.
- The WCGM was tasked to ensure all aspects of governance were defined and monitored for paediatrics, neonatal care and obstetrics and gynaecology, in accordance with its terms of reference. Similar responsibilities were defined for the QIM at a departmental level.
- 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 meeting minutes confirmed not all items were discussed in accordance with its terms of reference, for example training and competencies of staff.
- Minutes lacked detail, for example the June 2015 meeting focussed on agreeing items to be brought to subsequent meetings rather than discussing the content of items presented.
- Discussion around reported incidents lacked detail and themes and trends were not documented within the minutes. Focus instead was on the timeliness in implementing actions of which only 10% of outstanding actions had been completed.
- 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 2015 meeting and it was reported that there was 100% compliance with closing complaints during the month of May, although there were some historic outstanding complaints. However, it was unclear whether these related to paediatrics of obstetrics and gynaecology. The May 2015 meeting reported complaints were not always responded to within timescales but there was no detail of the types of complaints being received, what timescales were and by how long they had been exceeded.
- Agreed actions to be completed for the next scheduled meeting were not always followed. For example, we noted that it was agreed at the April 2015 meeting that mortalities would be discussed at the June meeting. There was no evidence in the June meeting that discussion had been held.
- 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 2015 meeting but there was no evidence of approval.
- Clinicians undertook audits not on the plan before completing audits listed on the official plan.
- Very few complaints were received for the paediatric service, but those received were discussed at the QIM.
- A brief summary of potential serious incidents was 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 2015 minutes indicated the number of incidents reported during the previous month had been commented on as well as the number of incidents outstanding and in need of review. The focus appeared to be on the overall number and closing the incidents rather than identifying themes or trends. There was no discussion recorded around themes or trends.
- The risk register was included in the June 2015 governance report, although was not evident as having been discussed in the meeting minutes. A summary of the risk register was included, although risk categorisation was different to that in the risk register we were provided with.
- The risk register had been discussed at the May meeting, the emphasis on reviewing overdue risks prior to 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 the action required.
- 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 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 that 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. There were additional columns to record admission data and compliance with criteria from the neonatal audit project, although these fields had not been populated with monthly data. 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. Some risks had been described in detail, with good controls to ensure the risk was managed. We saw that a small number had been on the register for a considerable period of time and there was no concise action recorded. For example, it was recorded that there was a high use of middle grade locum doctors, which was added in 2012. The action was recorded as, 'Continue

exploring alternative recruitment possibilities,' and progress recorded as, 'Struggling to attract suitable candidates.' Progress against this risk was updated in 2012, and then not recorded as reviewed in May 2015.
- During our inspection we identified additional risks which had not been added to the risk register, for example, the treatment room containing sharp items was not suitably locked. In addition, there had been reported incidents at one of the other trust locations, of mix ups with breast milk and use of a shared higher dependency room which doubled as an anti-ligature room.

Leadership of service

- 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.
- Following the inspection, review of meeting minutes confirmed that concerns had been raised by GP trainees about working relationships with nursing staff. The minutes of the Quality Improvement Meeting (June 2015) recorded that, 'GP trainees won't work on the neonatal ward out of hours as they have been shouted at by nursing staff and that this was also an issue in paediatrics'. The minutes also stated that the previous cohort of GP trainees had also raised this as a concern. We asked staff and managers during the inspection if there were any issues with bullying and harassment but they were not aware of any. This demonstrated a lack of awareness by the managers of the working relationships between some staff groups and individuals. We saw no evidence in subsequent minutes that this had been addressed. We requested details from the trust and were provided with a statement that the division were aware of some behaviour within the nursing team that had been addressed by the matron and that not all concerns and their actions had been recorded.

Culture within the service

- The staff we spoke with in paediatrics and the neonatal unit told us that it 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.
- Most of the staff we spoke with did not know what duty of candour was, however, we saw evidence that incidents which had been reported were shared with patients' and their parents.
- There was an area for staff to rest and / or have private conversations if they needed to. Staff told us they were confident in sharing information with their manager if they needed 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 the paediatric and neonatal departments.
- We were told that staff were able to raise issues as part of the daily handover or as part of their annual appraisal.
- The staff we spoke with told us that they felt confident in raising concerns with managers.

End of life care

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

Information about the service

The Specialist Palliative Care Team (SPCT) at Worcestershire Royal Hospital both provided and supported general staff to deliver end of life care. Patients with palliative or end of life care needs were nursed on general wards throughout the hospital. There had been 1204 deaths at the hospital between April 2014 and March 2015.

Before our inspection we reviewed performance information from, and about the trust. Throughout our inspection we visited all of the wards where end of life care was provided, the mortuary, the bereavement centre and the multi-faith centre. We spoke with 32 members of staff, which included, the specialist palliative care team (SPCT), doctors, nurses, health care assistants, allied health professionals, senior managers, porters, administration staff, chaplaincy and bereavement staff and mortuary staff.

We reviewed documents relating to the end of life care provided by the trust and the medical and nursing care records of 16 patients receiving end of life care. We observed care and treatment being provided by medical and nursing staff on the wards. We spoke with three patients who were receiving end of life care and four family members.

End of Life care services provided by this trust were located on two hospital sites, the other being Alexandra Hospital in Redditch. Services at Alexandra Hospital are reported on in a separate report. However, end of life care services on both hospital sites were run by one specialist palliative care team. As such they were regarded within and reported upon by the trust as one service, with many of the staff working at both sites. For this reason it is inevitable there is some duplication contained in the two reports.

End of life care

Summary of findings

Overall we rated end of life care services were as good in all domains.

Patients and relatives all spoke positively about end of life care. Staff provided compassionate care for patients. Services were very responsive to patients' individual needs and those of their families and next of kin.

There were arrangements to minimise risks to patients with measures in place to safeguard adults from abuse, prevent falls, malnutrition and pressure ulcers and, the early identification of a deteriorating patient through the use of an early warning system.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

The results of the 2013/14 National Care of the Dying Audit of Hospitals (NCDAH) highlighted a small number of areas for improvement. The hospital had since made some progress on the implementation of the action plan.

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms we inspected were appropriately completed.

Patients received good information regarding their treatment and care. The service took account of individual needs and wishes and their cultural and spiritual needs. The bereavement support staff provided good support to relatives after the death of a patient. The hospital had a rapid discharge service for discharge to a preferred place of care.

The Specialist Palliative Care Team (SPCT) provided input on the junior doctors course and also attempted to provide short 'bite size' training for staff on the wards. On several of the ward there were nurse 'end of life champions' who provided advice and support.

Clinical and internal audit processes functioned well; however there was no risk register specific to end of life care, although risks had been identified by the team relating to syringe drivers and emergency bleeps.

We had concerns about the reliability of ten of the body storage units (fridges) in the mortuary. Some of the trays and doors were faulty and the temperature fluctuated outside of an acceptable range of between 4 and 6 degrees.

We also had concerns about the water temperatures in the mortuary, as hot water was not always available. This posed an infection control risk for staff working in this department.

End of life care

Are end of life care services safe?

Good

Overall we rated this service as good for safety

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Where incidents had occurred investigations had taken place and, where relevant, relatives had received an apology.

Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers and the early identification of a deteriorating patient through the use of an early warning system. We saw elements of good practice including the storage of patient identifiable information, clean clinical areas and good infection prevention and control practice. Do not attempt cardio-pulmonary resuscitation (DNA CPR) forms were completed consistently.

Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of life.

We had concerns about the reliability of ten of the body storage units (fridges) in the mortuary. Some of the trays and doors were faulty and the temperature fluctuated outside of an acceptable range of between 4 and 6 degrees.

We also had concerns about the water temperatures in the mortuary, as hot water was not always available. This posed an infection control risk for staff working in this department.

Incidents

- The trust used a recognised on line incident reporting tool. We spoke with staff across the wards we visited who understood what constituted an incident and what they should report in relation to end of life care. However nursing staff told us there were very few reported incidents relating to end of life care and could not recall the last time they had raised an incident.
- All staff we spoke to on the wards, in the SPCT and in the mortuary were aware of their responsibilities to raise concerns and report incidents.
- Incidents were discussed at the SPCT monthly meetings. We reviewed the minutes for the meeting held on 01 June 2015 and saw that there had been a recent incident where the hospital switchboard did not have the SPCTs new pager numbers. There was evidence that action had been taken as a result of the reported incidents and lessons had been learned. For example, the designated nurse 'on call' now checked the bleeps were working each morning and reported any problems to the switchboard
- There were 11 incidents reported in the mortuary relating to storage units, water related incidents and manual handling incidents.
- The majority of the incidents reported by mortuary staff related to 10 older body storage units where the temperature fluctuated on a regular basis. This meant that staff had to move the deceased to other units within the mortuary. The units were linked to an automatic temperature monitoring system which raised an alarm if the temperature fluctuated from a safe temperature. The trust were aware of these issues and the ten units were only used when the other units were full.

Duty of Candour

- Duty of Candour is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong and either severe or moderate harm has been caused.
- The Duty of Candour was discussed at a weekly hospital specialist palliative care team multi-disciplinary team and end of life care team meeting.
- Staff we spoke with had a good understanding of the Duty of Candour and their responsibilities around this.

Cleanliness, infection control and hygiene

- The mortuary was visibly clean. It was cleaned at the end of every day by a specially trained cleaner.
- The palliative care team were aware of their roles and responsibilities with regard to infection control. They wore clean uniform and were "bare below elbow" in clinical areas. The staff had access to personal protective equipment (PPE) and we saw they used them appropriately.
- Two patients and three relatives told us they observed staff wearing protective clothing and washed their hands between seeing patients.

Medicines

End of life care

- There were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients.
- The National Care of the Dying Audit 2014 showed the trust was in line with the England average for their clinical protocols relating to the prescribing of medication for the five key symptoms (pain, excessive respiratory secretions, breathlessness, nausea and vomiting and agitation) at the end of life.
- We reviewed the medication records and medical and nursing case notes of four patients identified as being in the last hours or days of life. We saw that anticipatory medications, which are medications prescribed for the key symptoms in the dying phase, for pain, agitation, excessive respiratory secretions, nausea and vomiting were prescribed appropriately.
- We were told by staff on the wards we visited that medication for end of life care was available on the ward and was easily accessible. This was confirmed by the sister on the acute stroke unit. We saw there were locks on all store rooms, cupboards and fridges containing medicines and intravenous fluids on the wards we visited. Keys were held by nursing staff.

Environment and equipment

- The safety of equipment was regularly maintained and checked to ensure it was safe to use.
- The same syringe driver model was in use across all wards and delivered consistent infusions of medication to support end of life patients with complex symptoms. A SPC nurse told us that they had introduced an updated syringe driver checklist for monitoring syringe driver use. We saw evidence of the checklist on one of the sets of nursing notes we reviewed.
- Staff told us they did not have any problems getting mattresses and syringe drivers for end of life care patients.
- Equipment used in the mortuary was maintained and checked regularly. The trolleys and refrigeration system were checked weekly by the mortuary staff and by annually by the external contractors. We were shown records of such checks.
- We looked at records of temperatures of fridges and saw they were recorded on a daily basis. Staff told us about systems in place if there was an electric failure with alerts to the trust estate's department being in place.
- A set of ten out of 80 refrigerated storage units were identified by the trust as being faulty. The doors don't always close fully, or just spring open affecting the temperature control. The trust advised that a capital bid to replace the faulty units had been submitted and that a replacement project after approval was expected to take up 10 months. We were advised that until this was completed these fridges were the last to be used, and we were assured that this risk was being dealt with safely and appropriately.
- We also found concerns relating to the water supply in the mortuary. Staff told us it could be either cold or very hot. This affects the staff showers and for washing deceased patients. We saw that this had been reported to the trust and we saw two incident reports relating to this for July 2015. We were informed by the trust that a water pump had been replaced and the decontamination shower had been repaired during our inspection.
- There were contingency plans in place for bariatric patients. Mortuary staff had received appropriate training in the storing of deceased bariatric patients. Porters had received specialist training in the removal of a bariatric patient from the ward.
- The bereavement office was small and we had concerns about patient confidentiality. Families collecting death certificates or being comforted by staff could find doctors with other patient notes using the same office. Doctors can also be overheard in the next room while they are on the phone speaking with families, as the office is not sound proof
- The viewing of deceased patients was carried out in the viewing room of the mortuary. Arrangements for the viewing were made directly with the mortuary staff by the ward or department staff concerned. This ensured that a time could be agreed for the viewing to take place. Mortuary staff told us every effort was made to ensure the viewing room was arranged sensitively. We saw where the viewing room was non-denominational and did not have any religious articles.

Records

- In all ward areas we inspected, we saw records were stored securely and could only be accessed by people who had the appropriate authority.
- The trust had introduced a new end of life care plan in August 2014; it had been used on some selected wards as a pilot. This was in response to the national

withdrawal of the Liverpool Care Pathway in July 2014. The feedback from this pilot had resulted in a revised end of life care plan, called Optimising Care at the End of Life, that is currently being rolled out across the trust.

- Initial feedback from ward staff has been that the revised end of life care plan is a much better tool for recording information and for providing continuing care to patients. This was also confirmed by ward nurses we spoke with.
- We reviewed the medical and nursing notes for 16 patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.
- In medical notes for patients approaching the end of their lives we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment whilst still supporting the patient and their families.
- We reviewed 13 do not attempt cardio-pulmonary resuscitation (DNACPR) forms. In all cases, we saw that decisions were dated and approved by a consultant and there was a clearly documented reason for the decision recorded on the form, with clinical information included. One of the forms did not include a detailed clinical reason; however, this was recorded in the patient's notes.
- Discussions about DNACPR with patients and relatives were recorded in sufficient detail within the patient notes.
- In January 2014 the hospital audited 56 DNACPR forms to assess if they were completed correctly. The results showed that 98% of the forms were completed in line with trust policy. A repeat audit for 2015 had not taken place at the time of our inspection.
- We were shown the record keeping system in the hospital mortuary. The system ensured that details of patients who had died and of their property were accurately recorded and promptly made available to the county Coroner's Officer if required. Records were kept secure in a locked filing cabinet.

Safeguarding

- Safeguarding training was mandatory. Staff from the specialist palliative care team had all undertaken safeguarding training and were all 100% compliant in both adult and child safeguarding training, exceeding the trust target of 95%. They were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.

Mandatory training

- We examined the training records for the palliative care team and found that all had received up to date training in mandatory subjects, however as a team they only reached the trust target of 95% compliance in Hand hygiene (100%). Compliance for the team was at 93% for Information governance, fire safety, resuscitation and infection control, with manual handling at 57% compliance

Assessing and responding to patient risk

- We reviewed the nursing notes of 11 patients. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow Scale. Risk assessments for patients were completed appropriately and reviewed at the required frequency to minimise risk.
- Staff used an early warning system to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores were used to monitor patients

Nursing staffing

- The specialist palliative care team consisted of a lead nurse matron and 4.2 whole time equivalent (WTE) palliative care clinical nurse specialists (CNS). There was also a funded post (WTE 0.9) for an additional specialist nurse.
- The palliative care clinical nurse specialists were available Monday to Friday. On a rotational basis individual members provided a visiting and advisor service at the weekend. This meant that a 7-day service was available at the hospital.
- Each ward had an identified end of life care link nurse. This helped to ensure that patients who were at the end of their life had early and on-going access to appropriate care and treatment. End of life link nurses had received additional training which helped them identify patients who required end of life interventions. They acted as a first point of contact for advice to other nursing staff in the area.

Medical staffing

End of life care

- The trust had two consultants in palliative care medicine. There was a 0.6 WTE consultant in palliative care medicine as well as a full time specialist registrar working at the hospital. They provided leadership and support to the team. Commissioning Guidance for Palliative Care published collaboratively with the Association for Palliative Medicine of Great Britain and Ireland, Consultant Nurse in Palliative Care Reference Group, Marie Curie Cancer Care, National Council for Palliative Care, and Palliative Care Section of the Royal Society of Medicine, London, UK recommends 1.0 WTE consultant per 850 acute beds. Based on the Trust having 1.6 WTE consultants for c. 920 general acute beds this level of consultant support for the service meets and exceeds current guidance.
- One consultant is available Monday to Friday and all palliative care consultants in Worcestershire share an on-call rota to provide out-of-hours specialist telephone advice 24 hours a day.

Major incident awareness and training

- There was a contingency plan for the mortuary to use Alexandra Hospital in Redditch if there was a major incident declared at the Worcestershire Royal Hospital.

Are end of life care services effective?

Good

Overall we rated this service as good for effectiveness

Patients received care and support based on best available evidence and care was appropriately tailored to meet the needs of the patient and their families. The trust had taken action to plan and develop services in line with national guidance, with the implementation of an 'optimising care at the end of life' care plan for the assessment and coordination of care and symptom management of patients at the end of life.

Nutrition and hydration assessments were carried out and staff we spoke with were aware of quality of life issues relating to nutrition and hydration at the end of life. The trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit and a number of areas had been addressed at the time of our inspection. There was a multi-disciplinary approach to care and treatment. Staff were appropriately qualified and competent to carry out their role.Where patients were identified by staff as lacking the mental capacity to be involved in DNA CPR decisions, family members were consulted and decisions taken in patients' best interests.

Evidence-based care and treatment

- End of life care services followed guidance by the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care, 2011, updated 2013. Standards were being met with the provision of a specialist palliative care team who provided seven day working and could be contacted in person or by telephone during all out of hours.
- The trust had introduced the AMBER care bundle and there was input and support from the end of life care team to help this implement on the wards. The AMBER care bundle is an approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that a patient may have a few months left to live
- A review of four medical and nursing records showed symptom control for end of life patients had been managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- The trust had an 'integrated care pathway for patient care after death' documentation sheet which encouraged staff to consider whether any precautions were required. For example, around infection control; religious, spiritual and cultural needs of the deceased; post mortems; and possible coroner cases.

Pain relief

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available, as needed, both during the day and out of hours.
- The wards we visited had adequate stocks of medicines in line with anticipatory prescribing guidance around the five key symptoms most commonly experienced at the end of life.
- Regular comfort rounds were carried out and included staff asking patients regularly about their level of comfort. Staff were also prompted to assess patients' pain as part of the 'optimising care at end of life' care plan.

End of life care

Nutrition and hydration

- A nutritional screening and assessment tool was incorporated into the patient admission record to assess patients' needs on admission.
- Nutrition and hydration risks were assessed and monitored on patients' records. Fluid balance and nutritional intake charts were held and completed at the patient's bedside.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in as much of the patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Staff we spoke with told us they were led by patient wishes in relation to oral intake of food and fluids and we were given examples of when patients had been able to access food and drinks of their choosing.
- We viewed guidance on the use of mouth care in the last days of life that included action to be taken in the event of a patient having a dry mouth, coated tongue or pain/ulceration.

Patient outcomes

- The trust had participated in the National Care of the Dying Audit 2014 and had performed better than the England average for six of the ten clinical standards and five of the seven organisational standards. The trust had an action plan to enable them to track the actions required to meet all of the key performance indicators of the audit.
- The trust performed above the national average in the clinical key performance indicators for their spirituality needs, review of hydration needs, number of regular patient assessments in the last 24 hours and care of the patient and relatives immediately after death to ensure dignity and respect.
- The trust used the AMBER (Assessment, Management, Best practice Engagement Recovery) care bundles to support patients that were assessed as acutely unwell, deteriorating, with limited reversibility and where recovery was uncertain. A care bundle nurse facilitator supported the implementation of the care bundle across the wards. Repeated audit by the trust indicated that use of the AMBER Care Bundle has reduced the 30-day hospital readmission rate
- The referral data produced by the trust showed that there was increased understanding that the end of life pathways were not just for cancer patients but for any patients diagnosed with life threatening conditions. The number of non-cancer related referrals for the 2014/2015 was 49% which was higher than the national average of 24%.
- An audit undertaken by the SPCT for 100 consecutive referrals during the period September to November 2014 evidenced that 18 patients under the care of team had died at the hospital. WRH was the preferred place of death for four of the patients. The remaining 14 patients had either become too unwell to move or died whilst awaiting alternative arrangements.

Competent staff

- Information given to us by the trust showed that 21 mandatory training sessions had been delivered to ward staff by the SPCT.
- All nursing staff spoken with told us they had received training to enable them to safely administer medications via an ambulatory syringe driver. Information received following our inspection showed that 175 staff, which included nurses and operating department practitioners, had completed this training in the 12 months preceding our inspection. The trust advised us that more staff had been trained than those recorded as trained, however, it was not possible to validate this with the current locally held records system. They advised that there was a discrepancy between data held locally and that which is held with the training department.
- The palliative care consultants provided training for the trusts medical staff. This included input on the junior's doctor's course. Records showed that 15 teaching sessions had been delivered.
- We saw that the SPCT had received clinical supervision and 75% had completed an annual appraisal. This was below the trust target of 100%
- Nurses on medical wards told us that they felt competent to provide end of life care for patients and were aware they could refer to the SPCT.
- We spoke with medical staff, including locum consultants, and all were aware of the palliative care team and knew how to seek advice and support.
- Mortuary staff provided annual training for porters about transferring the deceased, this included infection control and storage.

Multidisciplinary working

End of life care

- Members of the specialist palliative care team participated in multidisciplinary team meetings, working with other specialists to support good quality end of life care across clinical specialties.
- The specialist palliative care team told us they met daily to discuss patient care and workloads and had a weekly multidisciplinary clinical meeting attended by other professionals, including an occupational therapist and the chaplain.
- During our inspection we observed a ward multidisciplinary team (MDT) meeting. This included the matron, the ward sister, and the patients named nurse, a physiotherapist and the patient's doctor. We saw where each patient's condition and progress was discussed including mental capacity, best interest decisions and deprivation of liberty safeguards. Where an end of life patient had been identified the MDT discussed what communication had already taken place with the patient and/or their relatives.
- The weekly specialist palliative care MDT meetings had changed in February 2015 from being hospital site-specific to trust wide via video conferencing. This had resulted in many more cases to discuss with less time available per patient. The SPC team felt that the opportunity for holistic assessment had been compromised and representation from the extended MDT had fallen off considerably. As the system had only been operating for a short period of time the SPC team undertook to monitor and audit the effectiveness of the meetings. For example, the team wanted to ensure that the new system of MDT meetings did not have a negative impact on length of hospital stay if communication between the wider team was compromised.

Seven-day services

- Palliative care clinical nurse specialists provided a seven days service, 8:30am to 4:30pm.
- Palliative care consultants in Worcestershire operated an on-call rota to provide out-of-hours specialist telephone advice 24 hours a day. .
- Physiotherapy and occupational therapy provided a weekday service at the hospital. On Saturdays there were occupational therapists and physiotherapists available that provided treatment for urgent patients in the trust.
- Mortuary staff were on call out of hours for urgent cases, such as tissue donation.
- Bereavement services were open Monday to Friday 9:30am to 3:30pm.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover via an on-call system

Access to information

- Staff had access to electronic information, such as policies, national guidance, newsletters and minutes of some meetings.
- The SCNs visited the wards on a daily basis to review patients at the end of life and to support ward-based medical and nursing staff in planning and delivering care to patients
- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- If patients required support staff could access palliative support through the out of hour's service or review the information available on the intranet for guidance.
- There was information available for relatives on end of life care which was available in each ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 16 medical and nursing records of patients. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. Patients were supported to make decisions and where appropriate, their mental capacity was mostly assessed and recorded.
- Staff told us they received training on consent and Mental Capacity Act (MCA). When patients did not have capacity to consent to care and treatment, staff were aware of what actions to take. Training records seen evidenced that the SPCT had received training on the MCA.
- We looked at 13 DNA CPR forms across a variety of wards in the hospital. Eight forms were for patients who staff had identified as lacking mental capacity to be involved in resuscitation decisions. We saw a record in the patients' notes relating to their inability to be involved in the discussion, due to a lack of capacity. An example of documentation included details of the

person's inability to understand, retain or weigh information. In most cases, we saw that the decision was discussed with the patient's family in order to make a decision that was in the person's 'best interest'.

Are end of life care services caring?

Good

Overall we rated this service as good for caring.

Patients were supported, treated with dignity and respect, and were involved in their care. All the patients and relatives we talked with spoke positively about the care they had received.

Compassionate care

- We spoke with three patients and four relatives during our inspection. Feedback was positive about the way staff treated patients receiving end of life care. One visitor told us their relative was being well looked after and they could not fault the care being delivered. Another patient, identified as being in the last weeks of life, told us staff had ensured they were able to have a side room.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Medical and nursing staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- The trust offered a VOICES questionnaire between April and November 2014 to all bereaved relatives with the exclusion of where the death has happened in the emergency department, those referred to the coroner and paediatric deaths. The results of the survey showed that the majority of respondents rated the staff as excellent in terms of communication, emotional support and in particular, dignity and respect.
- 100% of respondents felt the personal wishes of the deceased were respected by staff.
- The National Care of the Dying Audit 2013/14 showed that the trust achieved the organisation KPI of a clinical protocol promoting patient privacy, dignity and respect, up to and including after the death of a patient.
- Porters transported deceased patients to the mortuary in a caring and respectful manner. The hospital used a special trolley called an X-Cube. The X-Cube frame was placed over the hospital bed and a cover placed over the framework which completely covered the bed. This meant that the patient was taken to the mortuary in a dignified manner.

Understanding and involvement of patients and those close to them

- The results of the National Bereavement Survey (VOICES) October 2014 to December 2014 showed that 82% of respondents felt that they were involved with decisions made about their loved ones. As a result of this response, the SPC team agreed at their annual meeting in April 2015 to improve the frequency with which it offered a written summary of the consultation to patients.
- We spoke with three patients and four relatives about the care they were receiving and information that they were provided. All we spoke with were highly complementary about the information that they had been provided with by the staff and felt that staff could not do enough for them.

Emotional support

- Where relatives were present at the time of death the ward staff would explain that the bereavement service would contact them the next working day. The bereavement service provided them with a hospital information folder 'Information for Relatives following Bereavement' which detailed the contact information for the bereavement service as well as other useful information.
- Ward, nursing and medical teams offered emotional support in addition to the palliative care team. The trust also had a chaplaincy service and a clinical psychologist, if required. Support for carers, family and friends were provided by the chaplaincy and bereavement services.
- The chaplaincy services within the trust provided support for patients and their relatives irrespective of their individual faith, or if they did not follow a faith.
- We spoke with four relatives and three patients during our inspection. All the people we spoke with told us they felt emotionally supported by all the staff involved in their care.

Are end of life care services responsive?

End of life care

Good

Overall we rated this service as good for responsiveness

The specialist palliative care team supported the provision of rapid discharge and rates of discharge within 24 hours were in line with the England average. For patients who were deemed to be nearing the end of their life the normal visiting times were waived when relatives visited the hospital and discounted parking fees were also available.

Most patients were seen by the hospital palliative care team within 24 hours. The trust had a rapid discharge service for discharge to a preferred place of care, however they did not routinely undertake patients' preferred place of care/death audits.

The service took account of individual needs and wishes and their cultural and spiritual needs. The national care of the dying audit had identified that the trust needed to ensure discussions with patients and /or their relatives happened about end of life care. This was appropriately documented during our inspection.

The specialist palliative care team had received no complaints from relatives regarding end of life care. The trust had started to analyse all complaints from January to December 2014 to ascertain if any related to end of life care.

Service planning and delivery to meet the needs of local people

- All the nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. A visitor told us they had been offered a side room for their relative but had declined.
- Nursing staff told us that where patients were nursed in a side room, relatives were able to stay in the room with them.
- Nursing staff told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends un-limited time with the patient.

Meeting people's individual needs

- Translation services were available 24 hours per day through a telephone service. Staff told us there were generally no delays in accessing this service when needed.
- We spoke with staff throughout the medical and surgical wards and all were knowledgeable about learning disabilities and what do if a patient admitted had a known learning disability. Each area had a link staff member to seek guidance and support from, there was also a named specialist nurse for learning disabilities.
- There was a specialist named nurse for dementia. Staff in the wards had received training in dementia and understood how to make a patient's experience of hospital with dementia better. For example where a person had dementia, a name card was placed on their tray table with their named care workers name for the day. We observed good examples of this being used.
- There was a multi-faith chapel available that held information relevant to people from different faiths and religions. There was a prayer space for Muslim prayer at the back; however we were told that on Fridays it was too small and there was not any separate space for women to pray on a Friday, which meant they had no Friday prayers. This meant there women were not able to attend prayers on Fridays. The washing facilities were also only available in a toilet on the corridor close to the chapel.
- Mortuary viewing facilities were appropriate and allowed relatives privacy. The room was appropriately decorated and staff were available to answer questions and signpost relatives to appropriate people if they had any questions or queries.

Access and flow

- The palliative care team members were visible on the wards. Nursing staff knew how to contact them. Referrals were made by telephone contact. Ward staff told us there were no delays for patients to be seen.
- The National Care of the Dying Audit identified that access to specialist care in the last hours of life was similar to the England average.
- The VOICES questionnaire indicated that 49% of relatives said there was a discussion with their loved one about where they would like to be cared for in their last days. The trust had a rapid discharge service for discharge to a preferred place of care; however they were not routinely undertaking patients' preferred place of care/death audits. We discussed this with the end of

life lead nurse for the trust who told us they were aware this information was not consistently documented as part of the patient's plan of care. They were not aware if this was part of the trust audit plan for 2015/16.
- An audit undertaken by the SPCT for 100 consecutive referrals during the period September to November 2014 identified that 74% of patients were first seen on the day of referral, with 24% seen the day after referral. Two people were first seen two days after referral. This demonstrated that SPCT response times were responsive and no patient waited more than two days for a first clinical assessment.

Learning from complaints and concerns

- Throughout the hospital, there was information for patients on how to raise concerns and complaints. Patients and relatives we spoke with knew how to raise any concerns and make complaints if they needed to.
- The hospital palliative care team had received no complaints from relatives regarding end of life care.
- We were told that the trust has started to analyse all complaints from January to December 2014 to ascertain if any related to end of life care. They told us that this would help them check whether any learning from complaints could be shared across the trust. The work on this had not yet been completed.
- Complaints featured on the agenda for the monthly palliative care team meetings but at all meetings there were no cases reported to discuss.

Are end of life care services well-led?

Good

Overall we rated this service good for being well-led

The leadership, governance and culture promoted the delivery of high quality person centred care. We saw several audits had been undertaken in order to evaluate the service, and there was evidence to show they were used to improve the care provided for people at the end of their life.

Across end of life services the culture and morale of staff was good. Staff were positive about their experience of working at the trust and were committed to delivering good and compassionate end of life care.

Information about patient experience was collected, reviewed and acted on.

Although there was not a formalised clinical strategy for end of life care, this was in the process of being developed.

The trust did not have a palliative care risk register, which meant that the SPC team may not always identify risks and ensure controls were put in place and reviewed to reduce the impact of risk.

Vision and strategy for this service.

- The trust clinical strategy for end of life care had not yet been re-written following the national withdrawal of the Liverpool Care Pathway. However we were told that this was in the process of being developed.
- We saw the SPCT Annual Report and Work Programme for 2014-2015 took into account national guidance and other documents such as NICE guidance with roles and responsibilities of the end of life care facilitators and the hospital palliative care team. We were told this information would be incorporated into the new strategy for end of life care at the trust.
- We also viewed evidence of strategic priorities being discussed at end of life care meetings and we saw that they were incorporated into the trust's action plans in relation to developing end of life care services.
- There is a named member of the trust board for care of the dying and a formal discussion and reporting process regarding care of the dying within the trust clinical and quality governance structure.
- Minutes of trust board meetings showed discussions of end of life care and its integrated care pathways across the trust.
- The trust had a non-executive director with responsibility for end of life care. This was recommendation following the review of the Liverpool Care Pathway in July 2013.

Governance, risk management and quality measurement

- Governance systems were in place to ensure learning and improvements were shared across the service.
- The trust did not have a palliative care risk register. This meant that adequate steps had not been taken to identify risks and ensure controls were in place and reviewed, to reduce the impact of risk. For example, risks had been identified by the team relating to syringe drivers and emergency bleeps.

End of life care

- There were systems in place to monitor and audit the quality of the palliative care service. These were discussed at monthly governance meetings. These internal audits included a care after death audit, DNA CPR audits and audits of the use of specific medicines used for patients at the end of life.
- Weekly clinical review meetings would be held where the specialist palliative care team would meet with allied health professionals and the lead chaplain to discuss patient care and any issues
- Staff understood how to raise and report incidents. Sharing of lessons learned was used to improve practice and quality across the service.

Leadership of service

- There was strong leadership and vision for the service, but, whilst improvements had clearly been made a strategy had not been developed. The team monitored its performance through their annual report and work programme. We saw a copy of the 2014-2015 programme.
- All the staff we spoke with were aware of the various support mechanisms available to deliver good end of life care and gave examples of the specialist palliative care team, chaplaincy, the mortuary and bereavement services and the porter service.
- Ward staff felt supported by the palliative care nurses who visited the wards every day and were approachable and accessible to provide advice.

Culture within the service

- Staff told us they enjoyed working at the trust. They felt there was good training opportunities and career progression.
- Throughout all areas delivering end of life care, staff consistently told us of their commitment to provide safe and caring services. Overall, we saw good morale amongst staff and staff spoke positively about the care they delivered.

Public and staff engagement

- In order to improve the services the trust provided to patients in their last days of life and their friends and/or relatives, questionnaires were handed out to recently bereaved friends and relatives to ask them a number of questions about their experience and that of their loved one.
- The team participated in activities on all trust sites during 'Dying Matters' week held in May to promote public awareness about dying, death and bereavement and planning for end of life.
- An extensive staff awareness campaign was undertaken by the team before it rolled out the new end of life care planning documentation across the trust.

Innovation, improvement and sustainability

- We saw staff had access to a palliative care resource folder in each clinical area. This provided staff with support and guidance when providing end of life care.
- The lead consultant in palliative care medicine had asked to be included in the trust wide mortality and morbidity meetings to discuss where deaths could be prevented. It could also highlight where people have died where their care could have been improved.

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

Worcestershire 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 304,490 outpatient appointments, of which 100,482 were new appointments and 176,604 were follow up's (27,404 appointments were not attended). Additional, during 2014/2015 the hospital conducted 201,062 radiology procedures including CT scans, MRI's, obstetric ultrasounds, general ultrasounds, nuclear medicine studies, plain x-rays, mammography's, angiographies, fluoroscopies and Dexa scans.

During our inspection we spoke with 25 patients and/or their relatives, 35 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.

Outpatient services provided by Worcestershire Acute Hospitals NHS Trust are located on two other hospital sites, those being Alexandra Hospital (AH) Kidderminster Hospital and Treatment Centre (KH)

Services at AH and KH are reported on in separate reports. However, services on all three hospital sites are run by one management team. As such they are 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 three reports.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the service as requires improvement. It was rated as inadequate for being well-led, requiring 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 & diagnostic Imaging

The premises were visibly clean however the environment was cramped and the seating arrangements were not sufficiently appropriate especially for patients attending the trauma and orthopaedic clinic following surgery to their lower limbs. 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 poor with some patients raising concerns that communication from nursing staff was poor. Further, 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.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall we rated this service as requires improvement.

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, 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. Additionally, whilst a chaperone process was in place, the presence of a chaperone was decided by individual treating medical practitioners; the application of this policy was therefore inconsistent.

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 pressure due to a shortage of radiographers; this meant that consultant radiographers who were employed by the service and used to report on images were also being used to support the radiographer rotas.

Outpatients and diagnostic imaging

Equipment used by the service was checked regularly and maintained by a third party as part of a private finance initiative (PFI). The seating arrangements within the outpatient department were noted to not be fit for purpose, especially for those patients attending the trauma and orthopaedic clinics as they were too low to the ground and did not have arms or supports meaning patients experienced difficulties both sitting and standing from the chairs.

Incidents

- There were two serious incidents and one never event reported in the outpatients/ophthalmology department between May 2014 and April 2015.
- We reviewed all incidents which were reported within the ophthalmology department, outpatients and radiology departments. The number of incidents reported within the outpatient department was exceptionally low; there had been ten incidents reported between the ophthalmology (6 incidents), outpatients (1 incident) and admissions office (2 incidents) between December 2014 and March 2015. 4 incidents were reported as minor harm, 1 classified as moderate harm and the remaining 5 incidents resulted in no harm.
- 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 six nurses who supported the outpatient clinics; they each said that they would not report issues such as the cramped environment issues within the clinic areas as they did not perceive them to be "Patient safety issues" and there was limited action that could be taken to resolve the matter. Nursing staff reported that the chairs in some clinics were not appropriate for some patients, especially for those who had recently undergo lower limb surgery; the chairs did not have arms so patients could not lower themselves safely into the chair. Staff were aware of the issue and had reported it to the OPD matron but considered that it was not necessary to report the issue as an incident. 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 221 incidents between March 2014 and March 2015; this had been an increase of 28 incidents when compared to the previous year.
- There was a discrepancy between the data provided on the quality dashboard for clinical support services which reported 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). Five of the ten incidents had occurred at Worcestershire Royal 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 practice which 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 had experienced aggressive or violent behaviour. However, staff reported that they would not routinely report clinic's which had over-run by a significant 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 respiratory clinic were able to describe a recent incident which involved faulty weighing scales in another part of the hospital; as a result of the incident, all weighing scales were checked to ensure they were working appropriately. 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

- For audiology, audits demonstrated that compliance with “Clean your hands” and “Bare below the elbows” policy was consistently 100% between July 2014 and March 2015. The number of cases audited however remained low with between two and three cases being audited monthly.
- Audits which measured performance and compliance against the trust policies for "Clean your Hands" and "Bare below the elbows" within the 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 the Five Moments for Hand Hygiene published by the World Health Organisation (WHO 2014).
- 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...
- Environmental audits were carried out of the Sorrell suite on 3 September 2014 and 8 December 2014 during which time the overall audit scores were 80% and 82% respectively.
- Toys within the children's outpatient department were cleaned with universal cleaning wipes by the reception team.
- An entry on the TACO divisional risk register dated 01/05/2010 reported that the carpet in the ophthalmology day case area was a potential infection control risk and had been rated as being a "Low" risk. The register had been updated on 30 June 2015 stating "To revisit possibility of obtaining funding for improvement to whole environment". Staff reported that the presence of the carpet presented an issue as it was difficult to maintain and to keep clean; additionally, presence of the carpet in the day case area was not in line with national best practice guidance.

Environment and equipment

- The outpatient department was divided into separate clinic areas; staff reported and we observed clinic waiting areas to be cramped due to the number of patients awaiting their appointment.
- 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.

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.
- Whilst there was a system in place for recording the serial numbers of FP10 prescription pads, we found that three FP10pads were unaccounted for. When we raised this with nursing staff they responded by suggesting that a consultant "May have taken them to a community

clinic". We raised our concerns with the hospital pharmacist and matron for outpatients who took immediate remedial action to resolve the issue and to locate the missing pads.

- 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

Records

- Staff reported, and we found that notes were generally readily available for clinic appointments as the hospital utilised an electronic patient record system. Three consultants told us that whilst the notes were available, there had been "Teething" problems with some notes being scanned into the section of patient notes; for example, there were specific incidents such as operation notes being filed under the wrong section of the patients notes; this resulted in clinicians having spent additional time during clinic appointments searching through the electronic file to locate the operation note.
- 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.
- We observed during our inspection of the dermatology clinic that when the reception desk was not staffed by personnel, a note was left on the desk which stated "Receptionist at lunch. Please take a seat and make a receptionist aware of your arrival on their return. If you need to hand a form in, please leave it at the desk and if you are in need of a follow-up, this will be sent in the post". This meant that when there was no staff member present, patients were required to leave information which potentially contained personal, confidential information unattended at an unstaffed desk.

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.
- The trust had a chaperone policy in place however it was reported by senior members of the nursing team that the use of chaperones was determined by personal consultant choice instead of it being the choice of the patient.
- Where children did not attend for a clinic appointment, there were arrangements in place for the trust safeguard lead to be copied into the letters which were generated and sent to the referring clinician, family and general practitioner.

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 reporting and minor incident investigation; the trust standard for completion of this training was 80%.
- 96% of staff had completed introductory training 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%.

Outpatients and diagnostic imaging

- 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 support staff 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 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.
- The radiology department had one radiation protection supervisor (RPS) for the whole site; their role was to ensure that the department was compliant with the Ionising Radiations Regulations 1999 in respect of work being carried out in an area which was subject to local rules. The current RPS had only recently been appointed and personally acknowledged that they were required to update their knowledge. The RPS reported that prior to their appointment, they had been allocated half a day each week to fulfil their duties as the RPS however due to shortages of radiographer support staff, they were required to work full time as a radiographer and was fulfilling the role of the RPS in their spare time.

Nursing, allied health care professionals and other staffing

- 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 assistants was high with an actual establishment of 11.99WTE against a budgeted establishment of 20.61 WTE.
- Two junior doctors raised concerns that the orthopaedic and fracture clinics were not always sufficiently supported by experienced nursing staff and so they were required to carry out some procedures including changing dressings. We reviewed incident reports dating from January to May 2015 which did not indicate that nursing levels had presented as an issue within the department.
- 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 post was 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 4.00 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 a vacancy 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.

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, neurophysiology and gastroenterology 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.
- The paediatric team offered next day appointments for children who were required to be seen urgently by a consultant paediatrician.

Outpatients and diagnostic imaging

- The radiology department offered walk-in services for patients referred by their General Practitioner. Additionally, GP's could send patients direct for a chest x-ray prior to referring patients to the 2 week wait lung cancer pathway. 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 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 dermatology clinic, patients were offered pain relief; we spoke with three 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 that 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%.

Outpatients and diagnostic imaging

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

- Radiology services offered 24 hours support to the clinical teams within the hospital. As a means of providing an effective service, some out of hours radiology reporting was outsourced to a third party to ensure that clinicians received timely reports to aid in making clinical decisions. The process of outsourcing images for external reporting was in the process of being audited by a senior radiologist as a means of internal quality assurance; the results of the audit were not available at the time of the inspection.
- 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.

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 by friends 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 not operating 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 well informed 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.

The outpatients department was cramped and clinics routinely overrun; there was no evidence that action was being taken to resolve these issues.

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.
- 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 304,490 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.

Outpatients and diagnostic imaging

- 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 average during 2013/2014 although it 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 Team in 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. One 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 trust in July 2015 confirmed that there had been 305 patients listed as "Urgent" who had waited for more than 18 weeks for an initial appointment; 46 patients on the inpatient waiting list had 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. Each of the 46 case notes were reviewed and action taken to ensure they had or were scheduled to receive the necessary care or treatment.
- Outpatient booking efficiency ranged 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.
- Laboratory turnaround times for a range of samples including histopathology for bowel screening samples, and MRSA screening were consistently being met. The turnaround time for GP requested urine microbiology, culture and sensitivity screening however was consistently below the 95%target between June2014 and March 2015.
- 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 with consultant 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 agency so 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 and 27 waiting between 14 and 17 weeks. There were no patients reported as waiting more than 18 weeks. 3 patients had been reported as having their clinic appointment cancelled on 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.
- In order to manage the utilisation of the ophthalmology theatre, a new "Clean room" was being built which would enable medical staff to administer intra-vitral injections to patients in a clean environment instead of relying on the main theatre; this room remained under construction at the time of the inspection.

Meeting people's individual needs

- We found that a toilet in the children's outpatient department was not sufficiently large enough to accommodate a patient in a wheelchair; this was because the door had been installed so that it opened into the toilet; this meant there was not enough room to manoeuvre inside the toilet and then close the door.
- Whilst the environment within the children's outpatient department was clean and well maintained, we noted, and patients reported that when attending for interventional procedures such as blood transfusions, the area they were treated in had no windows and so was considered by the patients that we spoke with to be a dull and under-stimulating environment.
- There was an outside play area for children to use whilst they waited for their clinic appointment however during the inspection the area had been temporarily closed to allow for overhead works to be carried out on the building.
- We received comments from nine patients who all reported that parking on the grounds of the hospital was difficult, especially when attending for morning clinic appointments.
- Staff reported and we observed that a number of outpatient clinic areas were of insufficient size and so were cramped, warm and congested with patients and visitors. This issue was particularly noticeable within the fracture clinic where a range of patients were waiting in wheelchairs; this caused significant congestion within the clinic waiting area; staff reported that patients were often required to wait along corridors if there was insufficient space.
- Children who attended the trauma and orthopaedic clinic were required to wait alongside adult patients as there was no dedicated, separate waiting area for children. Staff working in the clinic had liaised with the nursing staff from children's outpatients in order to develop a business case forward to have a separate waiting area developed however this remained at the infancy stage.

Learning from complaints and concerns

Outpatients and diagnostic imaging

- 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.
- The matron for outpatients informed us that the service received very few formal complaints 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 being 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 meetings 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, completion of nursing documentation and the requirement to replace chairs in outpatients. 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 carpet in the ophthalmology department was being managed locally by the matron however the risk had remained unresolved for a period of five years. Further, it was noted that issues such as the under-reporting of incidents in outpatients, which had been acknowledged by the local team as an issue, or the issue of chairs being unsuitable within outpatients, were not on the risk register; whilst staff had informal plans to resolve the issue to replace the chairs, there was no robust plan in place to mitigate the risk or to have the issue resolved in a timely way.
- The outpatient service had a Worcestershire Acute generic risk assessment dated 2015; one staff member had started to complete the risk assessments however had never received formal training on completing them. Whilst risks had been assessed, there had been no action plan or remedial actions put in place to mitigate the risks associated with the 10 areas of concern; this had been acknowledged by the individual who was working towards developing the action plans.
- Within radiology, governance process existed whereby matters associated with the radiology risk register were discussed, incidents were reviewed, 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.

Leadership and 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 and was 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 staff reported that they generally felt supported by their manager within outpatients. 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. Following the recent retirement of the radiology manager, the post was being covered by a consultant radiographer on an interim basis. The culture within the radiology department, specifically amongst the

radiographers was one of low morale with a reported lack of cohesive team working across the various imaging modalities. Radiographers reported feeling undervalued by the organisation as a whole. Nine 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 associated with 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

Outstanding practice

- There was an exceptional patient observation chart used within the critical care unit. This chart was regularly reviewed and updated with any new developments or patient safety, care quality and outcome measures. The detail within the chart meant few if any crucial measures or indicators were not recorded, regularly reviewed, and deterioration or improvements acted upon.
- The critical care unit had shown an outstanding example of responsiveness with obtaining and using noise monitoring devices. Patients need peace and quiet for their recovery in critical care, and this had been recognised by the provision of devices that reminded staff when noise levels were increasing to disruptive levels
- The pharmacy department operate an innovative seven day clinical service in the ED. This had shown a reduction in some direct admissions to hospital, patient's treatment had been optimised, patients had been counselled about their medicines to prevent readmission and a significant amount of patients (25%) benefitted from an intervention from the clinical pharmacist to prevent a future admission. The pharmacist told us that they often lectured at healthcare events and had other pharmacists visit the service to share the good practice. The service was planning to roll this practice out to other parts of the trust.
- We observed outstanding care in the early morning whilst visiting Avon 4 ward and found the staff approach to patients was extremely respectful, compassionate and caring. All patients had drinks and call bells to hand. The atmosphere on the ward at this early hour was relaxed and calm with appropriate low levels of lighting, and staff spoke with each other in low tones to ensure patients were not disturbed whilst asleep.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Improve the access and flow of patients in order to reduce delays from critical care for patients being admitted to wards; reduce the unacceptable number of discharges at night; reduce the risks of this situation not enabling patients to be admitted when they needed to be or discharged too early in their care; reduce occupancy to recommended levels; and improve outcomes for patients.
- Ensure all staff meet the trust wide mandatory training target of 95% compliance
- Review the HDUs to bring their data collection and provision of care and treatment up to all Faculty of Intensive Care Medicine Core Standards.
- Ensure there is a timely and appropriate response from the medical teams to the CCU requests for support, follow-up and patient discharge.
- Risk assessments must be completed and used effectively to prevent avoidable harm such as the development of pressure ulcers.
- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet the requirements of the service including the provision of daily ward rounds.
- Ensure that patient records are accurate, complete and fit for purpose, and ensure they are safe from removal or the sight of unauthorised people.
- Ensure patients nutrition and hydration status is fully assessed recorded and acted upon in a timely manner.
- Evaluate and improve their practice in response to the results from the hip fracture audit for 2014
- Ensure patients receive appropriate training and information about self-medication such as self-administration of heparin prior to discharge home.

Outstanding practice and areas for improvement

- Ensure that staff providing care or treatment to patients receive appropriate support, and training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- Take steps to ensure that all staff are included in lessons learnt from incidents and near misses, including lessons learned from mortality reviews, with effective ward based risk registers and safety dashboards being in place and understood by all staff.
- Ensure that suitably qualified staff in accordance with the agreed numbers set by the trust and taking into account national policy are employed to cover each shift.
- Review the environment within outpatients to ensure that the seating is fit for purpose
- Review the existing arrangements with regards to the management of referrals in to the organisation in order that the backlog of patients on an 18 week pathway are seen in accordance with national standards
- Develop a robust system to ensure children and young people who present with mental health needs are suitably risk assessed when admitted to the department to ensure care and support provided meets their needs
- Ensure all medicines are prescribed and stored in accordance with trust procedures.
- Ensure there are affective systems in place for the ongoing management of outlying patients
- Ensure that the risk matrix in MAU is completed to the frequency required by the trust policy
- Review consultant cover in the ED in line with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants workforce recommendations to provide consultant presence in the ED 16 hours a day, 7 days a week as a minimum
- Ensure there are the appropriate number of qualified paediatric staff in the ED to meet national guidelines
- Respond to complaints within agreed timeframes and summary data and meeting minutes should be explicit as to which location the complaint relates to and where performance times need to be improved

Action the hospital SHOULD take to improve

- Ensure that staff in critical care are supported with training and guidance to investigate and report upon serious incidents.
- Ensure that adherence to the Duty of Candour regulation should be recorded in incident reports in line with requirements.
- Record mortality and morbidity reviews in order to demonstrate lessons from any reviews are learned and these can be shared throughout the trust.
- Ensure trolleys for resuscitation equipment in critical care are secured in such a way to highlight to staff if they had been opened, used or tampered with between daily checks.
- Review and risk-assess the provision of the critical care Outreach team service which was not being provided for 24 hours a day.
- Review the cover and continuity of presence from specialist registrar doctors in the CCU to ensure this meets recommended safe levels at all times.
- Review the provision of care for CCU patients as this currently does not meet the National Institute for Health and Care Excellence (NICE) guidance 83 in relation to some parts of patient rehabilitation, including discharge advice and guidance and follow-up clinics.
- Review the role of the clinical nurse educator in the CCU to ensure adequate time and resources are given to this essential post in line with best practice and FICM Core Standards.
- Ensure patient notes in CCU have clear records of assessments and best interest decisions for patients who lack the mental capacity to make their own decisions.
- Revisit the use of patient diaries in order to use them more creatively to the benefit of patients and their loved ones.
- Review CCU access to a Regional Home Ventilation and weaning service in line with the Faculty of Intensive Care Medicine Core Standards.
- Ensure leaflets and information they provide contain the most up-to-date information for people to contact services.Information about getting leaflets in other formats should be included in all printed literature.

Outstanding practice and areas for improvement

- Review the use of care plans in Critical Care for patients living with a dementia in line with national guidance and best practice.
- Ensure critical care strategies and future plans are part of the overarching vision of the division in which it sat.
- Ensure that the critical care team are represented in all clinical governance meetings.
- Ensure high-level risks on the local risk register in the CCU are incorporated into the corporate risk register and have board oversight
- Address non-compliances identified by the 2014 National Emergency laparotomy audit-compliance including the provision of a sustained 24-hour Interventional radiology service.
- Ensure staff at ward level have access to information and agreed outcomes from governance meetings to continually improve their practice.
- Evaluate the effectiveness of the Patient Flow service to ensure it meets patient needs and improves access and flow of services.
- Review the management of medical outliers and devise a trust wide policy to improve their management.
- Develop an action plan to improve NNAP compliance.
- Ensure staff are aware of the trust's strategy and vision for the future.
- Improve the visibility of all senior staff in all of the areas of the maternity and gynaecology service.
- Ensure all staff in the maternity and gynaecology service understand their role and responsibilities regarding the Deprivation of Liberty Safeguards.
- Ensure cardiotocogragh (CTG) documentation is clear, in order to be assured that staff are following current local and national guidance.
- Review the system in the triage area on the delivery suite to develop a pathway to prioritise women attending by clinical need.
- Ensure that women are assessed in the emergency department before being transferred to the gynaecology ward.
- Ensure that antenatal screening KPI data can be reported.
- Develop a policy on restraint and / or supportive holding and provide training for staff to ensure they understand how to apply the policy.
- Consider developing/ adopting an early warning tool for neonates.
- Ensure that staffing records relating to medical staff accurately record who has worked each shift and that sickness absence is accurately recorded in order to monitor the shortfalls in shift and take necessary action to fill shifts to the required number.
- Approve the audit plan for children and young people and ensure audits completed in line with the plan with regular updates on audits outstanding with revised completion dates.
- Ensure that pain assessments for children are consistently completed.
- Review the dashboard for children and young people and update it to include all pertinent information.
- Develop a 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.
- Make available a communication tool for children who are unable to explain their needs and may require assistance from picture books for example..
- 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.
- Implement a risk register for end of life care services in order to ensure that risk is adequately assessed and monitored.

Outstanding practice and areas for improvement

- Resolve the issues relating to the faulty refrigerated storage units and inadequate water system in the mortuary.
- Develop an end of life strategy with well–defined objectives that are aligned to the 'five priorities for care of the dying person' as recommended by the Leadership Alliance (2014).
- Routinely audit the numbers of patients who achieve their preferred place of dying.
- Ensure all patients can reach their call bell, to facilitate alerting staff for help if needed.
- Ensure the ED door for entrance of patients brought in by ambulance is used appropriately.
- Ensure the child protection register is stored safely and securely to prevent theft, damage or misuse.
- Ensure that there is a systematic screening to identify patients with alcohol misuse to facilitate all patients who attend the ED for alcohol consumption receiving a brief intervention and signposting.
- Ensure all nursing and medical vacancies are recruited to.
- Ensure all appropriate patients have a drink within their reach.
- Continue to liaise with other organisations to improve the mental health service provisions.
- Ensure patients receive care and treatment in a timely way to enable the trust to consistently meet key national performance standards for E.Ds.
- Continue to engage with local organisations to improve patient flow to ensure that patient waiting for hospital beds in ED can be transferred in a timely manner to prevent breaches.
- Reduce the speciality referral time to less than 60 minutes to meet the trust target.
- Ensure that the whiteboard behind the reception in ED that displayed the waiting time is regularly updated to keep patients informed.
- Ensure delays in ambulance handover times are reduced to meet the trust target of 80% of patients admitted via an ambulance having handovers carried out within 15 minutes and 95% of patient handovers being carried out within 30 minutes of arrival by ambulance.
- Ensure the vision of the ED is understood by all staff.
- Ensure effective governance and performance management of ED to make significant improvements in the quality measures.
- Ensure audit action plans are always in place and provide assurance, evidence or progress updates to show how improvements had been achieved.
- Ensure all senior staff are visible enough for staff to recognise them and feel supported.
- Ensure the changes to manage overcrowding and patient safety in ED are sustainable.
- Review the audit process relating to the management of FP10 prescription pads to ensure that there is a robust audit trail for all pads used within the organisation.
- Ensure all patients have person centred care plans that reflect their current needs and provide clear guidance for staff to follow.
- Ensure all temporary staff have an effective ward induction.
- Ensure that any chemicals are stored appropriately, and 'out of bounds' areas are appropriately secured.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) HSCA 2008 (Regulated Activities) Regulations 2014 The care and treatment of service users must be appropriate, meet their needs in full and reflect their preferences Patients' discharge from Critical Care to the wards was often delayed and occurred at night

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 (1) (a) (b) (c) (f) 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 had not ensured systems or processes were established and operated effectively to review data and performance in HDU in line with national standards. Care records were not always in place and fit for purpose, and risk assessments were not always completed e.g. the risk assessment matrix in the MAU. Learning was not demonstrated from all audits e.g. the hip fracture audit,

This section is primarily information for the provider

Requirement notices

2014. 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 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (a)(b) (e) (i) (2)HSCA 2008 2008 (Regulated Activities) Regulations 2014 Care and treatment must be provided in a safe way for service users ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The trust had not ensured that all required risk assessments had always been completed and acted upon, and that there were effective systems in place to manage outlying patients needs and facilitate timely review, discharge and follow-up of all patients. Medicines were not always stored and administered safely and not all environments met patients needs.

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.

This section is primarily information for the provider

Requirement notices

The trust had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed to meet the requirements of the service in the ED and for out of hours medical staffing in surgery and medical care. The trust had not ensured all staff were supported by effective appraisal and completion of mandatory training

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulations 2014 (4) (a) HSCA 2008 (Regulated Activities) Regulations 2014 The nutritional and hydration needs of service users must be met. Patient's nutritional assessments were not always completed and acted upon and this was reported as contributory factors to the development of Grade 3 pressure ulcers.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Regulation 16 HSCA 2008 (Regulated Activities)Regulations 2014 The service should operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

The trust did not respond to complaints in a timely manner and in accordance with the trusts complaints policy.