Care Quality Commission

Sheffield Teaching Hospitals NHS Foundation Trust

Weston Park Hospital

Quality Report

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Date of inspection visit: 07 to 11 and 23 December 2015
Date of publication: 09/06/2016

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care (including older people's care)	Requires improvement
End of life care	Requires improvement
Outpatients and diagnostic imaging	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected Weston Park Hospital as part of the inspection of Sheffield Teaching Hospitals NHS Foundation Trust from 7 to 11 December 2015. We undertook an unannounced inspection on 23 December 2015. We carried out this inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

We did not inspect radiotherapy services during this inspection.

Overall, we rated Weston Park Hospital as requires improvement. We rated safe, effective and responsive as requires improvement. We rated well-led as good and caring as outstanding.

We rated outpatients and diagnostics as outstanding. Medical care and end of life care were rated as requires improvement.

Our key findings were as follows:

- The environment at Weston Park Hospital was in need of updating. A planned refurbishment programme had commenced and staff and patients had been involved in developing these plans. This would improve the environment for patients.
- There were no Methicillin Resistant Staphylococcus Aureus (MRSA) infections attributed to the medical wards in this service between March and September 2015. Two cases of Clostridium difficile (C.diff) reported by the trust between March and September 2015 were attributable to the medical wards.
- The trust implemented an infection control accreditation programme which set standards for infection prevention and control practices. All the areas we inspected were part of the trust infection control accreditation programme and there was evidence of audits meeting the required standards for accreditation to be maintained.
- There were appropriate levels of nursing in outpatient and diagnostic service. However, on the wards, nursing staffing levels were frequently below the planned level with many shifts having fewer registered nurses than required on duty.
- Medical cover at night was provided by the Hospital at Night team based at the nearby Royal Hallamshire Hospital.
- Patient's nutritional needs were assessed. The service had worked closely with dietitians and the hospital catering team to ensure that meals were served at a time that suited the patients. Audits identified that fluid balance charts were not compliant and an action plan was in place to address this.
- Patient's pain was assessed and pain relief provided promptly.
- The wards were not dementia friendly in layout or environment. No staff had been identified as dementia champions on the medical wards in accordance with the trust strategy.
- There were some mixed gender facilities for toileting and bathing.
- We were concerned about the use of the teenage and young adult unit for other patients who required an acute bed.
- There was no clear strategy for end of life care and trust guidelines had not been implemented at Weston Park Hospital.
- Patients preferred place of care was not monitored for patients at the end of life.
- We found excellent examples of multidisciplinary team (MDT) working in both radiology and OP services. MDT working underpinned service development and effective care delivery.
- We found that staff caring for patients and their families, treated them with compassion, kindness, dignity and respect.
- A microsystems quality improvement project was being piloted on Ward 3 and staff were optimistic this would bring positive changes.

We saw several areas of outstanding practice including:

- Within outpatients and diagnostic services, we saw numerous examples that showed staff respected and valued patients as individuals and empowered them as partners in their care.

Summary of findings

- The directorate hosted the 'Devices for Dignity (D4D) Healthcare Co-operative'. This is a national initiative to drive forward innovative products processes and services to help people with long-term conditions'. The Devices for Dignity (D4D) Healthcare Co-operative' had been recognised with a number of awards including 2012 Advancing Healthcare Awards and Allied Health Professionals and Healthcare Scientist and Leading Together on Health Award.
- The development of the Sheffield 3D imaging lab was unique to the NHS and provided improved quality of scans and detail of brain tumour growth. Images were processed quicker, in seconds rather up to an hour, saving time and money. The 3D lab was a finalist in the Yorkshire and Humber Medipex NHS Innovation awards.
- In addition to walk in services for general plain film imaging GP's can refer patients directly for CT, MRI, ultrasound, fluoroscopy and other specialised imaging examinations.
- There was a state of the art Medicines and Healthcare products Regulatory Agency (MHRA) Licenced Radiopharmacy, serving all of the trusts locations.
- Nuclear medicine staff were finalists in the Medipex NHS innovation awards 2014 after developing a new system for diagnosing debilitating digestive disorder that freed up the gamma camera, so reducing patient waiting times.
- Pet therapy had recently been introduced on Ward 3 and staff told us this was well received by patients.
- There was a multidisciplinary malignant spinal cord compression project group in the service to improve the care of patients with this serious condition. The service informed us that the project had been reviewed through audit, service evaluation, staff and patient experience surveys. The team were shortlisted in the Patient Safety Awards Cancer Care Category in 2015.
- The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.
- Art therapy had also been used as a way of communication on the teenage cancer unit for young people nearing the end of life.

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

Importantly, the trust must:

- Ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.
- Ensure proper systems are in place to ensure the safe management of medications.
- Ensure there is a clear strategy for the end of life care, which is implemented and monitored.
- Ensure that staff implement individualised, evidence based care for patients at the end of life.
- Person centred care and treatment must be appropriate, meet patient's needs and reflect their preferences.
- Ensure that DNACPR records are fully completed.

In addition the trust should:

- The hospital should improve the environment and the skills of staff to ensure that the needs of people living with dementia are met.
- The hospital should improve the completeness of patient records. In particular, the nursing care plans and review of patient risk.
- Level of compliance with mandatory training need to be improved, in particular, basic life support for adults and paediatrics and safeguarding children and vulnerable adults.
- The hospital should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.
- The hospital should undertake regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks.
- The trust should identify and monitor patients preferred place of care or death in order to meet the individual's needs and to improve or develop services.
- The trust should continue to implement IT systems to enable staff to access accurate and timely information.

Summary of findings

- The trust should review the Deprivation of Liberty Safeguards (DoLS) policy.
- The trust should monitor access to records in the outpatient departments.

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?
Medical care (including older people's care)	Requires improvement 	Overall, we rated this service as requires improvement. Nursing staffing levels were frequently below the planned level with many shifts having fewer registered nurses than planned on duty. We found evidence of patient records and documentation not being in line with national guidance, and not all staff were up to date with mandatory training. We also found there were gaps in documentation of checks of emergency equipment and had concern about the safety and storage of some medications and medical gases. The environment required improvement as some patients were not given access to same sex accommodation such as showering and toileting facilities, there was insufficient storage space and tired decor in some areas. There was a major refurbishment plan underway which would address this. The wards were not dementia friendly in layout or environment and there were no identified dementia champions Wards were visibly clean and equipment was available for staff to use. People's care and treatment was planned and delivered in line with current evidence based guidance and there was participation in local and national audits. Feedback from patients and carers was positive in relation to their experiences of the service and staff were proud of the service they provided. There was an open culture in the service with senior managers being visible and approachable for staff.
End of life care	Requires improvement 	Out of nine 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms we looked at, four were either incomplete or gave us concern. The draft guidelines for end of life care and the last days of life had not yet been implemented at the hospital. The Deprivation of Liberty Safeguards (DoLS) policy expired in October 2013. The flowchart to guide staff in DoLS decisions was also out of date. Patient choice around preferred place of care or death was not measured. There was no strategy in place for end of life care.

Summary of findings

The environment had limited facilities for patients at the end of life, such as side room availability and showers. There was a refurbishment programme which had commenced.
There were delays in 'Fast Track' discharges. There was limited monitoring of quality of care for end of life care.
However, we also found that lessons were learned and learning was shared after things had gone wrong. The specialist palliative care team of nurses and doctors were skilled and knowledgeable. All the clinical nurse specialists were non-medical prescribers. This meant they could prescribe medications for patients when they were needed
In the year from April 2014 to 2015, over 97% patients were seen within 24 hours of referral to the specialist palliative care team. The specialist palliative care team provided seven day clinical support to the hospital. We found evidence of compassionate and understanding care on all the wards at the hospital. Staff we spoke with understood the impact of end of life care on the patients and family well-being.
The teenage cancer unit had a bright informal atmosphere; patient's individual needs were met on the unit. There were positive examples of local leadership in the palliative care team, from both a nursing and medical perspective.

Outpatients and diagnostic imaging

Outstanding ☆

The services had a positive safety culture; there were clear management responsibilities and accountability for safety and governance. The services promoted continuous quality improvement. There were enough qualified, skilled and experienced staff to meet people's needs. Staff received good support; they told us their appraisals, and mandatory training was up to date. Radiology services provided well-established, highly regarded training programmes for medical staff at every stage of their five-year programme and for student radiographers from local universities.
All of the staff were passionate about their work and staff teams worked well together to provide an excellent experience for their patients. All of the patients and relatives we spoke with gave positive feedback about the staff and the services.

Summary of findings

	Staff were aware of the trust values; there was good staff engagement and an open culture. Staff participated in research activities and there were numerous examples of innovation and improvement.

Weston Park Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); End of life care; Outpatients and Diagnostic imaging

Detailed findings

Contents

Background to Weston Park Hospital

Weston Park Hospital (WPH) is part of the Sheffield Teaching Hospitals NHS Foundation Trust. It provides specialist, non-surgical oncology services for people from the local area as well as regionally from South Yorkshire, North Nottinghamshire and North Derbyshire and was one of the four national specialist hospitals that is dedicated to cancer care.

The service provided an assessment unit with two beds, two trollies and eight chairs, two adult inpatient wards and a five bedded teenage cancer unit for patients aged 16 to 25 years. There are 64 inpatient beds including the teenage cancer unit. The number of emergency and elective medical admissions from January to December 2014 was 4200. The service had also assessed on average 720 calls from patients each month since March 2015.

There are approximately 60,000 patient visits for radiotherapy and 20,000 patient visits for chemotherapy each year. There is a cancer clinical trials centre at WPH.

Imaging services (radiology) services provided at WPH include nuclear medicine, MRI, ultrasound and general x-ray plain film. The radiotherapy team mainly used the CT service based within the imaging department. The radiotherapy services mould room was situated within the x-ray department. We did not inspect radiotherapy services during this inspection.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis , Medical Director

Head of Hospital Inspections: Amanda Stanford, Head of Inspection

The team included CQC inspectors and a variety of specialists: including consultants, specialist nurses, student nurses, community nurses, therapists, medical directors, nurse directors and experts by experience.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

The inspection team inspected the following three core services at Weston Park Hospital:

- Medical care (including older people's care)
- End of life care
- Outpatients and diagnostics

Before the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), royal colleges and the local Healthwatch.

We held a listening event on 1 December 2015 at St Mary's Church and Conference Centre and attended focus groups in Sheffield for people with learning disabilities and older people to hear people's views about care and treatment received at the hospital. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Focus groups and drop-in sessions were held with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including physiotherapists and occupational therapists. We also spoke with staff individually as requested. We talked with patients, families and staff from all the ward areas and outpatient and diagnostic services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out an announced inspection on 7 to 11 December 2015 and an unannounced inspection on 23 December 2015.

Facts and data about Weston Park Hospital

The number of emergency and elective medical admissions from January to December 2014 was 4200. The service had also assessed on average 720 calls from patients each month since March 2015.

There are approximately 60,000 patient visits for radiotherapy and 20,000 patient visits for chemotherapy each year. There is a cancer clinical trials centre at WPH.

Between April 2014 and March 2015, there were 139 deaths at Weston Park Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of life care	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Requires improvement	Requires improvement	☆ Outstanding	Requires improvement	Good	Requires improvement

Notes

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

Medical care (including older people's care)

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

Information about the service

Weston Park Hospital was part of the Sheffield Teaching Hospitals NHS Foundation Trust. It provided specialist non-surgical oncology services for people from the local area as well as regionally from South Yorkshire, North Nottinghamshire and North Derbyshire and was one of the four national specialist hospitals that is dedicated to cancer care.

The service was managed by the Specialised Cancer Clinical Directorate within the Specialised Cancer, Medicine and Rehabilitation Care Group at the trust. The service provides a two bed, two trolleys and eight chair assessment unit, two adult inpatient wards and a five bedded teenage cancer unit for patients aged 16 to 25 years. We visited all these areas during our inspection.

There were 64 inpatient beds including the teenage cancer unit. The number of emergency and elective medical admissions from January to December 2014 was 4200. The service had also assessed on average 720 calls from patients each month since March 2015. Between April 2014 and March 2015, there had been 139 deaths at Weston Park Hospital.

We spoke with 11 patients, one relative and 18 members of staff. We observed care being delivered on the wards, looked at 14 patient records and six medication charts. We observed morning and evening medical handovers. We reviewed staff records and trust policies. We also reviewed performance information from and about the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences of using this service.

Medical care (including older people's care)

Summary of findings

Overall, we rated this service as requires improvement. We found evidence of patient records and documentation not being in line with national guidance and not all staff were up to date with mandatory training. We also found there were gaps in documentation of checks of emergency equipment and had concern about the safety and storage of some medications and medical gases. Nursing staffing levels were frequently below the planned level with many shifts having fewer registered nurses than required on duty.

The environment required improvement as some patients were not given access to same sex accommodation such as showering and toileting facilities, there was insufficient storage space and tired decor in some areas. There was a major refurbishment plan underway which would address this. The wards were not dementia friendly in layout or environment and there were no identified dementia champions.

However, we also found that wards were visibly clean and equipment was available for staff to use. People's care and treatment was planned and delivered in line with current evidence based guidance and there was participation in local and national audits.

Feedback from patients and carers was positive in relation to their experiences of the service and staff were proud of the service they provided.

There was an open culture in the service with senior managers being visible and approachable for staff.

Are medical care services safe?

Requires improvement

The safety of this service requires improvement. We found:

- Nursing staffing levels were frequently below the planned level with many shifts having fewer registered nurses than required on duty.
- We found evidence of patient records and documentation not being in accordance with national guidance.
- The trust target for compliance with mandatory training had not been achieved.
- There was concern about the storage, prescription and administration of some medicines and medical gases.

However, we also found:

- Wards were visibly clean and tidy.
- There was a good incident reporting culture and some evidence of learning from incidents.

Incidents

- Incidents were reported on an electronic system. Staff we spoke to were aware of how to report an incident and there was a good reporting culture.
- There were 240 incidents reported in the service from January to October 2015; 143 were classified as no harm to patients, 93 as low harm, three as moderate harm and one as severe harm.
- We reviewed the incident investigation report for the incident that had resulted in serious harm. This identified a number of issues relating to the assessment and prevention of falls and the appropriate use of bed rails. There was evidence in the ward meeting minutes that we reviewed, that improvements required in relation to this incident had been actioned and communicated to staff in the service.
- There was some evidence of learning from incidents in ward meeting minutes but there was a difference in the way this was communicated to staff; some minutes were extremely brief and it was possible to misinterpret or misunderstand. We also saw that staff received feedback from the matron and senior managers by this route.

Medical care (including older people's care)

- There were no never events reported in this service between January and October 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- A high number of reported incidents in the service related to medications, with drug related incidents accounting for 26% of all reported incidents. We saw actions had been put in place to improve this, which included staff using simulation training in November 2015.
- The service held quarterly mortality and morbidity meetings which were well attended by senior medical staff. Minutes from the meeting held in May 2015 showed that cases were discussed and other issues such as documentation, infection control and prescribing oxygen were covered.

Duty of Candour

- There was an understanding of the Duty of Candour at ward level; with some staff being able to articulate what this meant having had recent training. Staff were aware of being open and honest with patients. The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to moderate of significant harm.
- There was evidence in the governance committee meeting minutes that the Duty of Candour requirements had been exercised in a case where a patient had been harmed during treatment.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers (PUs), falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- The teenage cancer unit results from the NHS Safety Thermometer showed 100% harm free care from October 2014 to Oct 2015.
- There was some safety thermometer information on display on the wards showing infection rates. The trust told us that staff were involved in providing information for performance reports. The trust did not supply specific information to us relating to performance in harm free care in this service.

Cleanliness, infection control and hygiene

- The trust had in-house cleaning provision for this service. There were work schedules provided to the cleaning staff including checking the patient food storage areas in the kitchen and performing the daily Legionella flushing of taps and sinks. We checked the records for this and found these were mostly completed although the fridge in the kitchen on Ward 3 was not checked daily.
- The wards looked visibly clean but there was equipment stored in the corridors that made it look cluttered.
- There were no Methicillin Resistant Staphylococcus Aureus (MRSA) infections attributed to the medical wards in this service between March and September 2015. Two cases of Clostridium difficile (C.diff) reported by the trust between March and September 2015 were attributable to the medical wards in this service.
- Wards displayed infection control audit information that was visible to patients and visitors along with the hand hygiene procedure for the use of alcohol hand gel.
- However, there was little or no information displayed regarding the particular issues relating to the patients on the ward and the importance of infection prevention and control. Due to the nature of the patients' medical conditions and subsequent treatments many patients were neutropenic which means a much higher susceptibility to infection with more serious consequences. We were told by staff that side rooms/ cubicles were used for end of life care and isolation of patients who were known to have an infection.
- Most ward and sluice areas appeared clean and tidy, although there were cardboard boxes stored on the floor in some areas which prevented the floors being properly cleaned.
- Equipment in the wards areas was visibly clean and there were some labels in use indicating that the equipment was clean.
- We observed staff adhering to hand hygiene procedures and using personal protective equipment such as aprons and gloves appropriately including disposal.

- Information supplied to us by the trust showed that compliance with Level 1 infection prevention and control mandatory training was 98.1% which was above the trust target of 90%. At level 2 compliance was 92.6% which was also above the same trust target.
- The trust implemented an infection control accreditation programme which set standards for infection prevention and control practices. All the areas we inspected were part of the trust infection control accreditation programme and there was evidence of audits meeting the required standards for accreditation to be maintained.
- A Clostridium difficile review was carried out on Ward 2 in August 2014 following an increase in the number of cases which found a number of learning points. There was evidence in the quarterly audit programme that learning had been implemented and performance figures had shown an improvement in rates since then. The trust implemented regular quarterly audits relating to antibiotic prescribing practice. Information supplied by the trust from these audits showed that on both wards 2 and 3 in June 2015 there was poor compliance at 71% of doctors writing stop/review dates. However this was an improvement on the previous quarterly audit results. Compliance was 100% for allergy status and diagnosis recording on both wards.
- A documentation audit referred to in ward meeting minutes showed that the completion of cannulation care plans was not up to date or accurate which was a risk to patient safety and not in line with trust policy. A plan was in place to address this.

Environment and equipment

- Resuscitation equipment was available on all the ward areas we visited and stored in a tidy fashion. We checked the records and found that daily checks were mostly taking place although there were gaps on some days. For example on Ward 2 there were two days missed in November and seven days missed in October.
- The emergency hypo boxes for diabetic patients who had a hypoglycaemic attack did not all have tamper proof seals in place.
- We found sharps were stored in an unlocked room.
- There was a lack of storage space. We observed equipment and boxes being stored in the corridors on both wards we visited and on the floor in clinical rooms.
- Spill kits were available to staff on all ward areas we visited and qualified staff knew how to use these.
- Both wards 2 and 3 were in need of updating and redecorating. The service had a schedule for this work to be done over the next 18 months.
- Staff told us they were able to access equipment such as pressure relieving mattresses both in and out of hours without difficulty.
- Staff and patients told us there were insufficient toilets on the wards which meant that some patients needed to walk or be assisted for some distance from their beds to reach the toilet.
- Patients on the teenage cancer unit told us they liked the environment and they felt safe there.
- Adjacent to Ward 2 there was a brachytherapy suite with radioactive isolation facilities. This was where patients received specialist treatment involving the insertion of radioactive material directly into the affected area. A high dose of radiation is given to the tumour, but healthy tissue only gets a small amount of radiation. Closed circuit television (CCTV) was used here for observation purposes and we were informed by staff this was turned off for dignity purposes, for example if a patient required pressure area care. It was unclear if patients using this area were aware of the CCTV and had agreed to its use.

Medicines

- We looked at six sets of patient records regarding medication management. Patients were given their medicines in a timely way, as prescribed and records were completed appropriately.
- There was a ward based clinical pharmacy service during normal hours Monday to Friday. Staff told us there was usually no problem accessing medication out of hours if required, although there was no pharmacist on site at weekends. Nursing staff had to go to the adjacent location to obtain medications at the weekend which could take some time.
- We saw that controlled drugs were appropriately stored with access restricted to authorised staff and accurate records were maintained. Daily balance checks were performed in line with the trust policy. However, there were instances where patients own controlled drugs were not returned to them on discharge. There was a plan in place to address this.
- The monitoring of medicine fridge temperatures was incomplete. On ward 2 there were no records for November 2015, 12 records in October and nine records

in September. Daily monitoring of fridge temperatures should have been undertaken; medicines need to be stored at the correct temperature to ensure their effectiveness.

- Staff on all wards did not know how to operate the medication fridges. On ward 3 the thermometer had not been reset and the same minimum and maximum temperatures had been recorded every day since 3 October 2015. On seven occasions in November 2015, the temperature had fallen below the recommended range and no action had been taken.
- The safe and secure storage of intravenous fluids was a concern on all wards we visited. Doors to all medicine rooms were unlocked meaning that access to fluids was not restricted to authorised staff.
- On the assessment unit we found four bags of expired fluids in the medicines room, one of which expired in December 2014.
- On ward 3 we found four oxygen cylinders stored in a room with no appropriate signage on the door.
- We looked at the records for two people who were receiving oxygen and found that this was not prescribed in line with trust policy and national guidance.

Records

- Nursing documentation was completed using two systems. The introduction of an electronic records system was very recent and there were limitations to this. Hand written paper records were also kept which were multidisciplinary.
- Staff were not yet familiar with or confident in using the new electronic system.
- It was not possible for agency or bank nurses to use the electronic system yet. This meant that some nurses had to make entries for care they had not actually delivered. This is not in line with Nursing and Midwifery Council guidance.
- Intentional rounding (care rounding) charts were completed. This is a structured approach to patient care whereby a member of nursing staff checks patients at a set time to assess and manage their fundamental care needs. These charts were kept with the patient and completed every two hours. Medication charts and fluid balance charts were also kept with the patient.
- The Sheffield hospital early warning score records (SHEWS) were kept with the patient and completed. This enabled early recognition of a patient's worsening condition, by grading the severity of their condition and prompting staff to request a medical review at specific trigger points. We reviewed 14 patient records and found that all entries by doctors were timed, dated and signed in accordance with GMC guidance on record keeping.
- There were omissions in the nursing records. There were no individualised nursing care plans and entries made did not always relate to the nursing care guidelines.
- One patient had requested an air flow pressure relieving mattress and had sustained pressure related skin damage, but from the records it was not possible to tell if they had been assessed for a mattress or it had been provided. On asking staff it was confirmed that the patient was on an appropriate mattress.
- Most records we saw were stored in unlocked notes storage trolleys in the corridor of the main ward. It was possible for these to be accessed by unauthorised people. On the teenage cancer unit the medical notes were in a locked trolley.
- Information governance training was included as part of the trust's mandatory training programme. The trust compliance target was 90%. Information supplied by the trust showed this service was 95.7% compliant.

Safeguarding

- Information supplied to us by the trust showed that mandatory safeguarding vulnerable adults training compliance in the service was 96% at Level 1 and 94.1% at Level 2. The trust compliance target was 90%.
- Information supplied to us by the trust for this directorate showed that mandatory safeguarding children and young people training compliance was at 78.1% at Level 1; 47.3% at Level 2 with 48% of nursing staff having this level of training. At Level 3, 72.5% of staff who required this training were up to date with only 45% of this being nursing and midwifery staff. These are both below the trust compliance target of 90%. This is a risk particularly on the teenage cancer unit where there are vulnerable young people as patients and also a likely higher attendance of younger visitors to the ward areas. Staff from the wards rotated onto the teenage cancer unit.
- Staff we spoke to demonstrated knowledge about the safeguarding process and how to access information in the intranet.
- Safeguarding was a standing item on the governance committee agenda.

Medical care (including older people's care)

Mandatory training

- The trust target for mandatory training compliance was 90%. Data provided by the trust showed that overall training compliance in this directorate was 77.1%.
- The rates for some types of mandatory training were above the trust target of 90% such as Health and Safety training at 97.1% and Equality and Diversity training at 97.6%. However others were much lower, for example no nursing staff in the service including those who cover the teenage cancer unit had received paediatric basic life support training despite it being on the schedule for this group of staff. Only 73% of staff were up to date with fire safety training. Managers in the service were aware of the compliance rates and there had been improvements in the compliance rate leading up to our inspection.

Assessing and responding to patient risk

- The trust has adopted an early warning assessment tool called SHEWS. This was in use across the service. We looked at four charts and found they had been completed fully. Staff were able to explain the process and demonstrated a good understanding of how to escalate a deteriorating patient and we saw evidence of this in a patient record we reviewed.
- Information supplied to us by the trust showed that compliance for resuscitation and life support training was lower than the trust target of 90% with 52% of staff trained at level 1. This posed a risk to patient safety.
- There was a multidisciplinary malignant spinal cord compression project group in the service to improve the care of patients with this serious condition. All patients who were admitted to the service following a fall at home had neurological observations undertaken until they had been seen by a doctor.
- Whilst the Waterlow pressure ulcer risk assessment was recorded on admission in all the patient records we reviewed there were issues regarding the patient being reassessed on a regular basis in line with national guidance. This was identified by a documentation audit and a plan was in place to address this.
- Patients who used the telephone advice service initially spoke to a nurse practitioner and, if they were unable to respond effectively due to the patient's complexity, the call was passed to a doctor (this happened in approximately 2% of the calls taken). However concerns were raised about the lack of recording of these calls by the doctor. The service had identified this as a risk to patient care and safety. The September governance committee meeting highlighted the need for a risk assessment to be performed and a plan to be developed to improve this. We did not see any evidence of this at the time of our inspection.
- There were no doctors on site after 1am during the week or at weekends. An advanced nurse practitioner was available via bleep or a doctor based at the adjacent location would be called if required/in an emergency.
- The service carried out monthly audits regarding the use of the SHEWS. Completion compliance was good at 94%, however, only 20% of records showed evidence of escalation to a senior clinician when there was no improvement in the patient's condition. This was a risk to patient safety.

Nursing staffing

- The service used an electronic rostering system.
- Staff sickness was at 3.8% for nursing staff, 6.5% for support staff and 0.8% for medical staff across the service. This was less than the national average, but slightly above the trust target of 3.25%
- Staff turnover varied across staff groups with 10.2% for nursing staff, 6.8% for support staff and 25.5% for medical staff.
- The trust used a safer nursing care tool which incorporated a patient acuity and dependency tool. This information was taken to the daily morning meeting by the nurse in charge of the ward to discuss with senior managers.
- The planned and actual numbers of nursing staff on duty were displayed on the wards we visited.
- Information supplied to us by the trust showed that the planned number of qualified nurses on both day and night duty was less than 100% in August 2015. The lowest being at night time with 68%. The service had recently recruited new registered nurses to improve staffing levels.
- The information supplied to us showed that gaps in qualified nurses on duty were often filled with unqualified members of nursing staff particularly on night duty. We found this to be the case on the day of our inspection on Ward 3 where there was one less than planned registered nurse on duty and an additional health care support worker.
- Nursing rotas we reviewed showed only half the night shifts had the planned number of nurses on duty on

Ward 3 in October and November 2015. These rotas also showed there was the planned number of nurses on daytime duty on 57 of the 84 shifts in the six week period prior to our inspection. Gaps in qualified nurses had not been filled with unqualified members of staff on most occasions. This could pose a risk to patient safety.

- Staff on the ward we visited told us that there were shifts where the numbers of staff were insufficient, particularly when there were confused and agitated patients who required constant support.
- Staff told us they worked additional hours when required. They did not feel pressured by managers to do this but felt they had to if they could. Staff told us they did take time off in lieu of additional hours worked or were paid for this.
- Some staff told us they were able to provide good care but some staff felt they were over stretched and often missed breaks as a result.
- There were a number of newly qualified registered nurses on the wards who had worked there as students and had wanted to return. These nurses were working through a period of preceptorship and the ward manager organised the off duty to accommodate this as well as supernumerary status as much as possible.
- Data provided to us by the trust showed the use of agency or bank nurses at 7.5% across the service in March 2015.
- A senior staff meeting was held every morning at 08:50 in order for plans to be made for the day regarding bed availability and staffing levels.
- Some recently retired staff had been re-employed on zero hours' contracts in order to work as bank staff on the ward.
- The teenage cancer unit was staffed by two registered nurses with chemotherapy qualifications during the daytime and one registered nurse at night time. Overnight the staff from the adjacent ward supported staff with controlled drug and chemotherapy treatments. There was a buzzer system in use to summon assistance when required.

Medical staffing

- The medical staff skill mix in the service was similar to the national average for consultants and junior doctors.
- There was no on-site medical staff between 1am and 7am. Cover was provided by the hospital at night team based in the Royal Hallamshire Hospital. Junior doctors who were on call overnight needed to walk across to Weston Park Hospital if required. Between June 2014 and October 2015, seven emergency calls were made overnight from Weston Park.
- At the time of our inspection we were informed there was a shortage of swipe access cards to allow a shorter walk through a connecting tunnel, meaning a longer and less secure route for the doctor. However doctors we spoke to were happy with the system in place at night in terms of job co-ordination through the Hospital at Night service.
- The most senior doctor present overnight was a medical registrar. This doctor may not have the necessary skills and knowledge for the type patients in the service but had access to an on-call consultant oncologist if required.
- We observed a hospital at night handover in the morning and in the evening held at the Royal Hallamshire site. Patients from Weston Park were included in this handover if the junior or middle grade doctor had seen them overnight. The handover was not overseen by a consultant.
- The junior doctor returned to Weston Park Hospital for the consultant oncologist-led handover prior to the acute oncology ward round.
- Patients on the teenage cancer unit were covered by the on-call oncology team (solid tumour patients) or by the on-call haematology team (haematological malignancies).
- The service had identified a risk in the ability to attract and retain appropriately skilled and trained oncology staff. Workforce planning had been identified as a key area in the recently developed strategy.

Major incident awareness and training

- Staff we spoke to were aware of what the major incident contingency plans were and what would happen if this was to occur.
- Staff were able to tell us where the emergency kit bag was located.

Are medical care services effective?

Good

The effectiveness of this service was good. We found:

Medical care (including older people's care)

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- There was participation in relevant local and national audits.
- When people received care from the multi-disciplinary team this was coordinated and staff worked collaboratively to meet patient's needs.

However, we also found:

- There was a lack of understanding regarding the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff had access to policies and procedures and other evidence-based guidance via the trust intranet.
- There was a specific section of the trust intranet for cancer care services. Staff were able to show us how to access this at the time of our inspection.
- The nurse practitioners in the assessment unit were following the triage, rapid assessment and access guidelines recommended by the UK Oncology Nursing Society (UKONS).
- The service had cancer nursing care guidelines for nursing staff to use with reference to evidence based practice such as the Marsden Manual and the National Institute of Health and Care Excellence.
- The service also had access to trust guidelines and pathways in the treatment of deep vein thrombosis, pulmonary embolism, transient ischaemic attacks, chest pain, seizures and pneumothorax.
- The assessment unit was able to provide a rapid medical and nursing assessment, cannulation, intravenous fluids and other medications, diagnostic tests including phlebotomy, information and support as well as a senior medical review in one place within a few hours.
- We observed a process of assessment regarding the least invasive route for the delivery of chemotherapy.
- Mainstream services were part of an integrated and comprehensive trial and research programme and staff were aware of the participation in these.
- There was evidence in meeting minutes and on speaking to staff that regular audits were taking place in relation to documentation, antibiotic prescribing and infection control. The work under taken by multidisciplinary malignant spinal cord compression project group had been reviewed through audit, service evaluation, staff and patient experience surveys. The team were shortlisted in the Patient Safety Awards Cancer Care Category in 2015.

Pain relief

- The trust used a pain assessment tool as part of the early warning score clinical observation chart.
- Anticipatory medications were prescribed for patients who were deteriorating and near to the end of their lives.
- Patients on the teenage cancer unit told us that staff were very accessible and always came quickly to sort out pain relief.
- We observed the use of an oral assessment chart for patients.

Nutrition and hydration

- The trust had in house catering provision to this service. Meals arrived on the ward on a heated trolley and were served to patients by catering and ward staff and volunteers.
- The trust used an oral state assessment tool. This was particularly relevant in this setting due to the patients' medical conditions and the side effects of chemotherapy.
- The service had worked closely with dieticians and the hospital catering team to ensure that meals were served at a time that suited the patients with additional gravy or sauces to make them more palatable. Many patients required medication to reduce nausea and vomiting prior to meals and later meals times have allowed time for medication to be administered and take effect.
- Each ward had a nutrition link nurse and conducted audits. In September 2015, the nutrition and hydration audit showed only 60% compliance for the completion of MUST scores. Audit information is on the trust share point site for staff to access.
- A nutrition steering group had been established at the hospital in August 2015.
- The service was using the Hydration and Nutrition Assurance Toolkit (HaNAT) and audits were being conducted on the areas that we visited. At the time of our inspection no results were available.
- The trust patient feedback survey showed that 57% of the respondents did not feel there was always the help they needed to eat or drink between March 2014 and April 2015.

Medical care (including older people's care)

- Ward 3 had a nutrition volunteer who told us she assisted with giving out patients' meals and drinks and made sure that patients had what they needed.
- We saw that patients were supported by staff with menu choices. Menus were not available in other languages other than English or in other formats such as pictures.
- Patients were offered snacks and assisted to eat if required. Patients told us they were provided with food and water regularly.
- Protected meal times were used to allow patients time to eat adequately. The service encouraged relatives to support patient with eating and there was information about this on display.
- Whilst the malnutrition universal screening tool (MUST) score was recorded on admission for all patients we reviewed there were issues regarding this being updated on a regular basis in accordance with national guidelines. This was identified by a documentation audit and a plan was in place to address this.
- A documentation audit identified that the completion of fluid balance charts was not compliant. A plan was in place to address this.

Patient outcomes

- There were no current CQC outliers in this service; this indicated there had been no more deaths than expected for medical patients.
- The service has participated in the national lung cancer audit. In the 2014 audit results the service demonstrated 100% in cases being discussed at a multi-disciplinary meeting which is in line with best practice and NICE guideline. The results also showed slightly less than best practice in relation to patients being seen by a lung cancer nurse specialist at 79% with the recommendation being 80% and pathological diagnoses at 69% with the recommendation being 75%.
- There were quarterly mortality and morbidity meetings held for chemotherapy. These meetings also reviewed all cases of hospital admission for neutropenic sepsis; a potentially fatal complication of anticancer treatment (particularly chemotherapy). We reviewed the minutes of the meeting held in May 2015. The patients' notes were not available at this meeting for the medical team to review and cases had not been reviewed at the previous two meetings
- Information supplied to us from the trust shows this service had lengths of stay in line or above the national average with non-elective admissions being below the average.

Competent staff

- Information provided by the trust showed that staff were up to date with appraisals. The compliance rate set by the trust was 90% and the service had achieved 93.6%. Most staff we spoke with told us they had had a recent appraisal.
- There were specialist nursing staff working in the service for palliative care, lung and breast cancer, discharge planning, training and development and central line management.
- The service had a practice development nurse in post who had developed a competency package for nursing staff of all grades. There were also a series of study days for nursing staff working in the service to attend which were speciality specific.
- Information supplied to us by the trust showed that eight staff had been trained in the safe use of insulin and 12 staff in in-patient drug card use.
- Newly qualified nursing staff were subject to preceptorship over six months and received training for intravenous drug administration and also undertook a chemotherapy training programme.
- There were some opportunities for health care support workers in the service to develop new skills. There were Band 2 health care support workers in the service who could access end of life care training and training to assist patients with intravenous infusions in situ. There was also training on taking patient observations and what to do if these were outside normal parameters.
- We were told by staff that at night time there is one health care support worker on duty who has all the patient observations to do as well as providing drinks to patients and assisting patients to the toilet. Trained nursing staff were busy with medication administration and caring for the very unstable patients.
- Information supplied to us by the trust shows that in March 2015 68% of doctors in the directorate had had an appraisal.

Multidisciplinary working

Medical care (including older people's care)

- Staff we spoke to from the multidisciplinary team (MDT) told us that they had a good working relationship with each other. There was a MDT meeting held weekly on each of the wards we visited.
- We saw a patient receiving input from dieticians and speech and language therapy in relation to swallowing difficulties. The teenage cancer unit had good links with the palliative care team and Macmillan staff. Referrals to hospices were straightforward. There was also a clinical nurse specialist specifically for young cancer patients who facilitated transition of care into community based services**.**

Seven-day services

- The assessment unit was staffed Monday to Friday from 8am to 8pm. The service was still available to people outside these hours.Telephone calls were taken by ward staff who carried a bleep. Out of hours telephone calls are taken by a trained practitioner 24/7.
- Information supplied to us by the service showed that call rates were less overnight and could come from any patient in the South Yorkshire region.
- There was a daily acute oncology ward round on all wards preceded by a consultant led handover. The ward round reviewed all patients admitted within the previous 24 hours as well as any patient who was unstable. All other patients are reviewed by a middle grade doctor on a daily basis if not seen by their own consultant. Our review of the medical records supported this.
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- There was a pharmacy service available in the hospital to all the ward areas during the week but this was closed out of hours.
- The service does not offer 24 hour on site radiology services, which meant that in an emergency situation out of hours a patient would need to be transferred to the adjacent location.

Access to information

- Discharge paperwork was sent electronically to the patients' General Practitioner on discharge from the service.
- Weston Park Hospital medical notes did not leave the hospital. There was potential for a patient to have a number of sets of medical notes if they had seen other specialities on other Sheffield Teaching Hospital NHS Trust sites which could cause confusion. Records made during a patient's admission were photocopied and sent with the patient when they were transferred to another location.
- On Ward 3 there was a white board in the corridor that could be seen by visitors to the ward that contained patients' names. There was a risk of patient confidentiality being breached with this practice. The new electronic whiteboards to support the use of a newly introduced electronic bed management system did not have the patients' names permanently displayed.
- The cancer nursing guidelines were in need of updating. We spoke to the practice development nurse about this and a plan was in place to undertake this work.
- Some health care support workers did not feel they were always kept up to date with changes in patients' care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated an understanding of consent and the Mental Capacity Act or knew where to look for information if they were unsure of a situation. They also understood the relevance of this Act in relation to decision making for care and treatment.
- From the patient records we looked at it was not always possible to tell if a patient was in agreement or had consented to the delivery of the care and treatment. It was not clearly stated whether a patient was able to consent to specific care and treatment at the time it was given.
- One patient we spoke to had been asked to sign a consent form for a course of treatment but had not received all the information about the side effects of the drugs.
- Staff were aware of best interest decisions and how this was to be managed when required.
- Two qualified nursing staff we spoke to were less clear about the Deprivation of Liberty Safeguards and did not know under what circumstances this may be required.

Are medical care services caring?

Good

We rated this service as good for caring.

Medical care (including older people's care)

- Patients were supported well, treated with dignity and respects and they were involved in their care.
- Feedback from patients and their carers was positive about the way staff treated people.
- Patients were treated with compassion and kindness and were supported in decision making.
- The environment created difficulties in quality care provision which should be addressed with the planned refurbishment.

Compassionate care

- The NHS Friends and Family test (FFT) response rate for this service was 21.2% which is lower than the England average of 24.4%. The most recent results from this show that 97% and 100% of patients would recommend this service to their family or friends.
- Staff told us of a wedding that was arranged in the hospital at very short notice to facilitate the wishes of a terminally ill patient.
- Two of the eleven patients we spoke with commented on the impact of the environment on the delivery of dignified care. One patient told us they had to queue to for the bathroom and there were no showering facilities available. Another patient told us that privacy was compromised due to the layout of the ward.
- We saw that call bells were in reach of patients. A patient feedback survey showed that 79% of respondents felt that they received help within an acceptable time when using the call button.
- There were thank you cards on display on the wards we visited.
- One patient told us that the ward was noisy at night which had impacted on rest. This was also supported in the patient feedback information supplied by the trust.

Understanding and involvement of patients and those close to them

- Patients we spoke to were very happy with the care they had received indicating that good explanations had been given and they had felt involved with their care and treatment.
- We saw notice boards for patients and carers displayed information about support and care available from external agencies and charities.
- We observed a nurse practitioner on the unit taking a call that resulted in admission avoidance or GP attendance meaning that the patient was able to stay at home the patient was involved in this process.
- Patients on the teenage cancer unit told us they felt involved with their care planning.
- The hospital offered free car parking on site for visitors and patients which patients and relatives told us was appreciated although they reported long queues to get in on occasions. We observed queuing at the time of our inspection. The managers of the service are aware of this issue and had car parking attendants on site.
- The multidisciplinary malignant spinal cord compression project group project had been reviewed through audit, service evaluation, staff and patient experience surveys.

Emotional support

- Patients suffering hair loss were offered a NHS wig and given information and advice in a very compassionate way. One patient we spoke to told us she was impressed with the support she had received in relation to hair loss as a consequence of the chemotherapy treatment.
- The service employed specialist nurses for palliative care, lung and breast cancer and a nurse that facilitated complex discharges.
- The teenage cancer unit implemented open visiting and there were facilities available for visitors to stay overnight.
- A psychologist attended the weekly multi-disciplinary team meetings and also provided support to staff.
- There was information on display advising patients and relatives where they could get help, advice and support from. There were good links to the Cancer Support service.
- Volunteer staff were used to provide support to patients.
- Patients told us that staff on the wards were professional, polite and obliging.
- There was a multi-faith room in the hospital. Multi-faith chaplaincy support was available 24 hours a day.

Are medical care services responsive?

Requires improvement

We rated the responsiveness of this service as requires improvement. We found:

- The wards were not dementia friendly in layout or environment. No staff had been identified as dementia champions in accordance with the trust strategy.
- There were some mixed gender facilities for toileting and bathing.
- We were concerned about the use of the teenage and young adult unit for other patients who required an acute bed.

However we also found:

- Services met the specialist needs of patients in the locality and region.
- Access and flow through the service was well managed for patients.
- Services were planned and co-ordinated with other hospitals and referring agencies.

Service planning and delivery to meet the needs of local people

- Weston Park Hospital provided care to patients from across South Yorkshire, North Nottinghamshire and North Derbyshire.
- There was a patient telephone advice service for patients available at all times.
- The assessment unit experienced unpredictable demands. Management data demonstrated no pattern in the demand for the advice and support offered by staff on the assessment unit with wide variations in the volume of calls. Staff told us that some days it was very busy and difficult to cope with the volume of calls. Additional staff were on duty at busier times of the day.
- The service strategy included the involvement of charitable organisations such as Cancer Support and the Macmillan service.
- The teenage cancer unit had been upgraded and re-furbished in 2015 with Cancer Trust funding. The service now had all single en-suite rooms containing a television, gaming facilities and internet access. However at the time of our inspection there were three patients on the unit only one patient was in the age range of 16 to 25; the other two patients were 30 and 44 years old. We were told by staff that this happened if the other inpatient beds were full and there was a need to take an emergency admission.
- We were told by staff on the teenage cancer unit that it was rare for there to be patients under the age of 18 years. We were also told that on occasions the unit closed if there were no patients. We did not see any other information about this.
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- The environment required improvement as there was insufficient storage space and tired décor in some areas. The service was in the early stages of a major refurbishment.
- The plans for the refurbished ward areas included space for the care of bariatric patients.

Access and flow

- The service established an assessment unit in 2010 where all patients receiving chemotherapy could call for advice if they are unwell whilst on or immediately after treatment. This service received more than 700 calls per month in the six months prior to our inspection which were triaged by a nurse practitioner. This resulted in over 200 patient attendances to the assessment unit per month with other patients being given advice, referred to their GP or attending their local hospital.
- Trust data indicated that approximately 50% of these patients were subsequently admitted from the assessment unit to one of the wards. The main reasons for calls was chemotherapy treatment related symptoms such as infection, nausea, vomiting and diarrhoea.
- The assessment unit was open from 8am to 8pm Monday to Friday. The bed occupancy was high with the average attendance each day varying between 10 patients on Mondays to 7.5 patients on Fridays. The unit had capacity for 11 patients.
- We observed the nurse practitioner on the unit taking a call that resulted in admission avoidance or GP attendance meaning that the patient was able to stay at home.
- Information supplied to us from the trust showed that between January 2014 and December 2014 the average length of stay was 2.7 days for elective oncology patients which is higher than the national average for oncology patients of 1.5 days. This information also showed that between the same time frames the average length of stay for non-elective patients was 3.9 days which is below the national average of 6 days.

Medical care (including older people's care)

- A senior nursing staff meeting was held every morning at 8:50am in order for plans to be made for the day regarding bed availability and staffing levels.
- This service had a higher than national average rate of re-admissions for elective admissions.
- The patients on the teenage cancer unit were seen by the medical staff on duty on the main wards.
- Staff told us that delays sometimes occurred in discharging patients due to take home medications. There were a number of reasons given such as prescribing errors, complex regimes, patient education and dispensing issues. It was not clear what the service was doing to address this.
- Staff told us that delayed discharges occurred due to local community services provision not being readily available and difficulties in repatriating patients to their local district general hospital when their specialist treatment had been completed but the patient could not be discharged directly home.
- Information supplied to us by the trust showed that 4% of patients were subject to 3 ward moves during their inpatient stay. This may have been for clinical reasons or due to bed availability.
- Information supplied to us by the trust showed that some patients were moved from one ward to another after 10pm. This occurred on average 10.7 times per month between September 2014 and August 2015. Although some moves were for clinical reasons this practice is against trust policy and could cause distress to patients and disturb rest.

Meeting people's individual needs

- The wards were not dementia friendly in layout or environment. A Patient Led Assessment of the Care Environment (PLACE) undertaken in April 2015 showed a number of areas that were not compliant with the needs of people living with dementia such as signage for toilets, visible clocks and the type of flooring.
- The Butterfly scheme which provided a system of hospital care for people living with dementia was not operating in the service and no staff had been identified as dementia champions although the trust had a strategy to develop this.
- There was no learning disability specialist or liaison nurse in post. Staff told us there were cards available to help explain procedures in simple terms. On Ward 2 we observed a notice on the wall indicating a learning disability link nurse, but staff were not aware of who this was.
- Staff told us they would care for a patient with a learning disability in a side room.
- Staff we spoke to were aware of the "this is me" document which assisted them in understanding the needs of a patient with difficulties in communicating their needs.
- Staff told us that an interpreting service was available if required for patients who did not have English as their first language and they knew how to access this. On occasions patients' relatives translated but this did not happen for important medical or decision making information. Adaptations to the meal service had been made to meet the needs of oncology patients such as timing of meals and consistency/texture of the food served.
- There was a lack of handrails outside toilets and bathrooms to assist patients with mobility problems. There was a bumper handrail that ran along most of the walls in the ward corridor areas. This was also identified in the PLACE overview in April 2015.
- The nursing care plans for all the patients we reviewed were not individualised.
- On ward 2 there were mixed gender facilities for toileting and bathing.
- The teenage cancer unit was well equipped and designed to meet the particular needs of this age group.
- Medical staff we spoke to felt that the care and treatment was task orientated at times and not patient centred. Records showed the response to the referral for a patient requiring input from dieticians and speech and language therapists had taken place within 24 hours.
- On the ward we visited we observed patient information leaflets on display. Most of these leaflets were in date and for review in 2016.

Learning from complaints and concerns

- There were ten formal complaints made about the service from April to September 2015. There were no clear themes or trends identified in these complaints, however three were related to care and treatment and four were related to communication.

Medical care (including older people's care)

- Complaints relating to this service were discussed in the specialised cancer service governance committee meetings. There was no indication of delays in response times or unsatisfactory conclusions to these complaints.
- We reviewed ward meeting minutes and saw very limited evidence of complaints and shared learning after investigation into complaints.
- We also saw very limited evidence of concerns that had been raised in September about an abusive patient being passed to ward based staff. Advice from the trust security manager had been recorded in the governance committee meeting but no further communications were found in the notes we reviewed.
- Ward meeting minutes were on display in the staff rooms on the wards we visited. Staff told us they were aware of these.

Are medical care services well-led?

Good

We rated well-led as good for this service. We found:

- Staff members we spoke to told us the service was a good place to work and that they would recommend it to family members or friends.
- The service was well led locally and with good organisational, governance and risk management structures in place.
- The staff we spoke with said they felt well supported by the clinical lead and that they could raise any concerns with their line managers.
- There was a vision and strategy for the service that was well developed and well understood by most staff.
- The local management team was visible and the culture was seen as open and transparent.
- Staff were aware of the organisation's vision and way forward that included the PROUD philosophy developed by the Board at Sheffield NHS Foundation Trust.

Vision and strategy for this service

- The trust had a vision and a set of values and staff were able to tell us about this. There was also information about this on staff notice boards as well as patient/ visitor notice boards.
- The service was part of the Specialised Cancer Services Strategy for the next five years.
- The trust was also planning to develop collaborative working with key stakeholders and charities as part of the strategy.
- Staff were able to tell us about the microsystems approach that had been implemented by the trust for quality improvement. This was a bottom up quality improvement process that is designed to engage staff in making changes to improve efficiency and quality.

Governance, risk management and quality measurement

- The service held governance committee meetings on a quarterly basis. We reviewed minutes from these meetings and found that serious incidents, complaints and the risk register were some of the agenda items discussed. Not all the items on the risk register were discussed, despite some being past their review date in June 2015.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of the impact should it occur. We did not receive details of all the risks relating to this service.
- The wards participated in local trust audits such as documentation and infection control.
- Quality and safety information boards were on display on the wards we visited.
- The service participated in local and national audits such as the National lung cancer audit and performance management audits.

Leadership of service

- Staff told us that managers and senior staff were visible on the wards and they were approachable and supportive. Staff knew how to escalate problems if required.
- During our inspection we saw the matron and the practice development nurse supporting staff.
- The nursing leadership on the wards we visited was good and the ward managers had time allocated for office and managerial duties.
- Junior staff told us that the ward managers were supportive and communicated well.
- Staff were able to tell us about changes that were planned to the service.
- The manager of the hospital at night team had delegated greater responsibility to the support workers and they were managing their workload via an electronic task board.

- There were clear lines of accountability from the service leaders to the frontline staff.

Culture within the service

- Staff told us they were proud to work in the trust, in this service and of the job that they did.
- Staff demonstrated a commitment to provide a very high level of quality care to patients in the service and very prepared to work additional hours when required.
- Staff told us they felt supported to report incidents and to raise concerns to their line manager.
- Staff were able to articulate the PROUD values of the trust which were 'patient first, respectful, ownership, and deliver'.

Public engagement

- During our inspection we saw Friends and Family test results displayed on noticeboards.
- Patients had been involved in the refurbishment plans for the service.
- Information supplied to us by the trust showed patient satisfaction with the service was high with 97% giving an excellent or good rating (69% of patients giving an 'excellent' rating and 28% giving a 'good' rating.
- We reviewed patient feedback survey results and noted that 98% of patients who responded said the wards were very or fairly clean. 92% of patients said they always had confidence and trust in the doctors and the nursing staff. The response rate from this service to the patient feedback survey was high compared to other areas in the trust with 174 patients responding between April 2014 and March 2015.

Staff engagement

- We were told that staff were involved in the data supplied for the safety thermometer to make them aware of outcomes and measures but we have not been supplied with this information.
- Staff we spoke to felt that communication within the trust was good and they were able to give some examples of this.
- Monthly staff meetings took place on wards 2 and 3 and the minutes of these were shared between all staff. The quality of the minutes varied and it was unclear who had attended the meetings and who was responsible for any actions that were required following discussion at the meetings.
- Staff told us they felt well supported by their line managers. They indicated that this was needed due to the type of service they provided.
- Information from the staff Friends and Family test indicated that 89% of staff would recommend this service as a place to receive treatment and 69% of staff would recommend the hospital as a place to work.
- Staff had been involved in the refurbishment plans.

Innovation, improvement and sustainability

- The service was undergoing a major refurbishment at the time of our inspection. The wards areas and the assessment unit were all in need of updating and the environments required improvement due to the lack of storage space and tired décor. Staff told us they were looking forward to the new environments that were planned.
- The service strategy included a plan to work closely with other hospitals in the region to make best use of resources and improve patient experience.
- Pet therapy had recently been introduced on Ward 3 and staff told us this was well received by patients.
- The microsystems quality improvement project was being piloted on Ward 3 and staff were optimistic this would bring positive changes.
- There was a multidisciplinary malignant spinal cord compression project group in the service to improve the care of patients with this serious condition. The service informed us that the project had been reviewed through audit, service evaluation, staff and patient experience surveys. The team were shortlisted in the Patient Safety Awards Cancer Care Category in 2015, and staff in the service hope this work will continue.

End of life care

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

Information about the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services. End of life care was provided at Weston Park Hospital; the bereavement office and mortuary were based nearby at Royal Hallamshire hospital.

Weston Park Hospital was a dedicated cancer hospital which was built in the1950's. It provided cancer treatment services and end of life care for patients across the region, including Rotherham, Barnsley, Doncaster, Worksop and Chesterfield as well as Sheffield.

There was a cancer information and support centre which offered help and advice to patients and families. There was an eight-bedded assessment unit where patients who were receiving treatment, but experiencing side effects could be seen for advice and treatment.

There was a purpose-built Teenage Cancer Unit, for young people with cancer aged between the ages of 16 and 25. There were five single rooms with ensuite bathrooms. There were two adult in-patient wards where elective (planned) chemotherapy took place. Ward 2 had 30 beds and Ward 3 had 29 beds. Patients were also treated on the wards for emergency issues, such as sepsis and received care at the end of their lives.

The specialist palliative care team had both a clinical and educational role and worked seven days a week. It comprised of 4.6 whole time equivalent (WTE) consultants and 6 WTE specialist registrars, 8.6 WTE Clinical Nurse Specialists (including 1 WTE vacancy) and 1.6 WTE end of life care facilitators (this included a 0.6 WTE vacancy). The specialist palliative care team visited Weston Park hospital most days. Specialist palliative care is the total care of patients with progressive, advanced disease and their families. Care is provided by a multi-professional team who have undergone recognised specialist palliative care training.

There was a chaplaincy service, a chapel, and a family room shared with another ward. There was a bereavement office at Royal Hallamshire Hospital, where relatives collected death certificates and were given information.

As part of our inspection, we observed end of life care and treatment on wards. We looked at nine sets of patient care records, including medical notes, nursing notes and medicine charts. We spoke with 13 staff including ward nurses, doctors, a practice development sister, complementary therapists, allied health professionals and senior managers. We also spoke with one relative and two patients who were receiving care. Before our inspection, we reviewed performance information from, and about the trust.

End of life care

Summary of findings

We rated end of life care services as requires improvement because:

- Out of nine 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms we looked at, four were either incomplete or gave us concern.
- The draft guidelines for end of life care and the last days of life had not yet been implemented at the hospital. The Deprivation of Liberty Safeguards (DoLS) policy expired in October 2013. The flowchart to guide staff in DoLS decisions was also out of date.
- Patient choice around preferred place of care or death was not measured. There was no strategy in place for end of life care.
- The environment had limited facilities for patients at the end of life, such as side room availability and showers. There was a refurbishment programme which had commenced.
- There were significant delays in 'Fast Track' discharges.
- .There was limited monitoring of quality of care for end of life care.

However, we also found;

- We found that lessons were learned and learning was shared after things had gone wrong. The specialist palliative care team of nurses and doctors were skilled and knowledgeable. All the clinical nurse specialists were non-medical prescribers. This meant they could prescribe medications for patients when they were needed
- In the year from April 2014 to 2015, over 97% patients were seen within 24 hours of referral to the specialist palliative care team. The specialist palliative care team provided seven day clinical support to the hospital. We found evidence of compassionate and understanding care on all the wards at the hospital. Staff we spoke with understood the impact of end of life care on the patients and family well-being.
- The teenage cancer unit had a bright informal atmosphere; patient's individual needs were met on the unit. There were positive examples of local leadership in the palliative care team, from both a nursing and medical perspective.

End of life care

Are end of life care services safe?

Good

We rated safe in end of life care was good. We found;

- Learning was shared after things had gone wrong.
- Staff understood and there was evidence they had applied the requirements of the duty of candour.
- There was a skilled specialist palliative care team available seven days a week.
- An advanced nurse practitioner was available between 1am and 7 am to support patients and staff.
- Patients were prescribed anticipatory medications.
- The medical staffing levels were in line with the minimum requirement for the local population.

However we also found;

- Compliance with mandatory training for the specialist palliative care team was below the trust target.

Incidents

- Incidents were reported using an electronic reporting system. We saw that staff knew how to report incidents. During our inspection, we saw there had recently been a drug error. The incident had been reported on the electronic reporting system and the ward manager was undertaking an investigation.
- There was learning from incidents. Following a serious incident during 2015, learning from the incident was shared across the two inpatient wards. We saw the investigation report and action plan, which had been implemented.
- Information from the trust showed there had been a number of reported medication errors on ward 2 and 3 in the 12 months before our inspection. There had been 45 medication errors on ward 2 and 48 errors on ward 3, including errors involving intravenous drugs and controlled drugs. We saw actions had been put in place to prevent recurrence, which included staff using simulation training in November 2015.
- Minutes from the palliative care executive meeting of August 2015 showed there was a backlog of incidents waiting to be reviewed. A build-up of incidents awaiting review could result in a delay of learning from the incidents.

Duty of candour

- Duty of Candour is a legal duty on NHS trusts to inform and apologise to patients if there had been mistakes in their care which led to moderate or significant harm.
- Staff understood the requirements of the duty of candour and the need to talk to patients if an incident or mistake had occurred. They were aware of the need to be open and honest. Staff told us the matron or more senior staff were involved in meeting the duty of candour.
- We saw an example of the application of the duty of candour at Weston Park Hospital.

Cleanliness, infection control and hygiene

- Ward areas we visited looked clean and tidy.
- There was hand gel available on the wards. We observed staff adhering to hand hygiene procedures and using personal protective equipment such as aprons and gloves appropriately including disposal.
- There were no Methicillin Resistant Staphylococcus Aureus (MRSA) infections attributed to the medical wards in this service between March and September 2015. Two cases of Clostridium difficile (C.diff) reported by the trust between March and September 2015 were attributable to the medical wards in this service.
- There was a process for deep-cleaning the wards.

Environment and equipment

- The hospital was built over 60 years ago; the wards and public areas looked outdated and worn. There was a refurbishment programme which had commenced. The service had a schedule for this work to be done over the next 18 months. The teenage cancer unit was purpose built in 2002; it was informal and bright. There were kitchen and dining areas for patients and their families. The unit had been refurbished to meet the needs of the patients. Patients on the teenage cancer unit said they liked the environment and they felt safe there.
- McKinley syringe pumps were in use on the wards. (Syringe pumps are portable infusion devices, used in palliative care to deliver a continuous supply of medication over 24 hours). The pumps were obtained from the medical devices library at Royal Hallamshire hospital and were brought by a porter during working hours. Out of hours, the site manager obtained them for ward staff.
- The syringe pumps were maintained by clinical engineering staff. We were shown maintenance

schedules which indicated 89% of pumps were maintained within one month of the due date. This was against a target of 90% for high priority equipment such as syringe pumps.
- The teenage cancer unit had its own supply of these pumps, which meant there was no delay if they needed to use one.
- When patients died, a dedicated ambulance was used to transfer deceased patients from Weston Park to Royal Hallamshire.

Medicines

- Patients were prescribed anticipatory medications. The aim of anticipatory prescribing is to ensure in the last hours or days of life there was no delay in responding to a patient's symptoms.
- For patients at the end of life, current medication was assessed and non-essential medication discontinued.
- There was a ward based clinical pharmacy service during normal hours Monday to Friday. There was no pharmacist on site at weekends. If medications were needed from pharmacy on a weekend, staff had to go to Royal Hallamshire Hospital pharmacy. Ward staff told us they tried to obtain medicines and take home drugs for patients within normal hours, but situations arose outside of these times.
- The specialist palliative care team gave advice on medication to ward doctors and nurses.

Records

- An electronic records system had been recently introduced at the trust. Staff told us there had been some setbacks in its use which senior managers were aware of.
- There were both paper and electronic records in use across most areas of the hospital. We saw that paper records were stored securely, and the electronic boards on display were used in a way to maintain confidentiality.
- We saw there was a process to update records for patients at the end of life who were readmitted for treatment of symptoms.
- A Sheffield palliative care coordinating system project (SPaCCS) had been developed and was being piloted.

Mandatory training

- The specialist palliative care team had variable compliance with mandatory training. Of the 12 topics included in mandatory training, only two had been achieved to be near or above the trust target of 90%. Overall compliance was 79%.
- An electronic system was in use to monitor and manage mandatory training. Information was transferred from electronic staff records into the Personal Achievement and Learning Management System (PALMS).
- There were training leads and administrators who kept records up to date.

Assessing and responding to patient risk

- We saw risk assessments completed in medical and nursing records. These were commenced on admission and, for patients at the end of life, there was evidence that risk assessment continued throughout the patients stay in hospital. Examples of this included skin assessments for pressure ulcer risk, nutrition assessments and falls assessments.
- There was an airway resource trolley on ward 2. This contained equipment which could be used for patients who had a tracheostomy who had sudden breathing difficulty.
- An early warning tool, SHEWS (Sheffield hospitals early warning score) was used to monitor for patient deterioration.
- There was no on- site medical cover from 1am; this was when the doctor working a 'twilight' shift finished work. An advanced nurse practitioner was available via bleep or a doctor from the hospital at night team based at the adjacent location was called if required/in an emergency. Some staff felt there was a risk and delays to care if a patient deteriorated, however there was no evidence to support this.

Nursing staffing

- The specialist palliative care team had a clinical and educational role and the clinical nurse specialists worked seven days a week. There were 7.6 WTE (whole time equivalent) clinical nurse specialists (plus 1 WTE vacancy). A new team member was due to start working with the team in January 2016.
- The team had moved to seven day working without an increase in staffing. This meant the number of staff on during the week was reduced in order to cover weekends.

End of life care

- They covered three hospitals at the trust. The teams were based on the Macmillan palliative care unit at the Northern general hospital site and at Royal Hallamshire hospital.
- On a weekday, there were two nurses who each saw an average of 15- 20 patients.
- They told us they were just able to keep up to date with referrals but it was difficult with their current numbers of staff. They described this as "firefighting".
- The staff member who worked weekends worked on the Friday before the weekend so they were aware of the patients their colleagues had seen.
- There were two staff on duty on a weekday and one on a weekend based at Royal Hallamshire. If they needed to see patients at Weston Park hospital, they incorporated that into their day.
- There was funding for 1.6 WTE end of life care facilitators who worked across the trust and also provided training support to community nurses and care home staff. One permanent staff member worked two days a week and another was seconded into a three day post. There was a vacancy for a 0.6 WTE post.
- There were 73 end life care 'champions' or nominated link nurses across the trust. It was not known how many of these were at Weston Park hospital. Their role was to raise awareness of good end of life care and to promote best practice on the wards.
- Agency nurses were not used at Weston Park Hospital as staff needed to be able to administer chemotherapy treatments.

Medical staffing

- The palliative care doctors comprised of 4.6 WTE consultants and 6 WTE specialist registrars. They covered all areas of the trust. Information from the trust indicated there was a low vacancy rate of 0.2 WTE (less than 1%).
- There were 25 consultants who had patients on wards 2 and 3 at Weston Park hospital. Nursing staff told us there were a lot of ward rounds which they could not always participate in.
- The medical staffing levels were in line with the minimum requirement for the local population (Commissioning Guidance, National Council for Palliative Care 2012).
- Junior doctors told us they felt supported and the consultants were very 'hands on'. The on call rota could be busy for junior doctors, however consultants filled the gaps. This meant there was less need for temporary doctors.
- The core working hours of the palliative care doctors was 9am- 5pm Monday to

Friday. Some consultants finished at 6 pm on certain week days.

- There were no doctors working at Weston Park hospital overnight. One doctor worked from 9pm to 1 am on a twilight shift. Medical cover was provided by the hospital at night team based at the Royal Hallamshire Hospital.
- There was 24 hour cover from a palliative care consultant and registrar on an on –call basis. The on call duties included face to face medical care and telephone advice.
- The senior medical staff on call provided cover to wards in the trust, the local hospice and another hospice in Chesterfield.
- Senior doctors also supported some primary care (GP) and community services across Sheffield when specialist advice was needed.

Major incident awareness and training

- Staff we spoke to were aware of what the major incident contingency plans were and what would happen if this was to occur.
- Staff were able to tell us where the emergency kit bag was located.

Are end of life care services effective?

Requires improvement

We rated the effectiveness of end of life care services as requires improvement. We found;

- The trust draft guidance for end of life patients was not in use at the hospital. It was not clear which guidelines staff were following.
- Four out of nine (44%) of do not attempt cardiopulmonary resuscitation (DNACPR) forms we looked at were incomplete or gave us cause for concern.
- The Deprivation of Liberty Safeguards (DoLS) policy was due for review in October 2013. The flowchart to guide staff in DoLS decisions was also out of date.

End of life care

However we also found;

- A 10 point action plan had been developed in relation to the national care of the dying results; nine actions had been completed.
- There was a one year competency period for nurse who started working at the hospital; this gave staff time to develop skills and knowledge.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. They were supported to maintain and further develop their professional skills and experience.

Evidence-based care and treatment

- In response to the 2013 review of the Liverpool care pathway, the trust had produced guidance for staff. This was in use at two other hospital sites, but not Weston Park Hospital.
- We found the specialist palliative care team used evidence based care and treatment, however other staff were unaware of the draft evidence based guidelines which were in use in other parts of the trust. It was not clear which guidelines ward staff were following.
- There was no documentation related to the 'new' guidance in medical or nursing notes at Weston Park Hospital. Nursing and two medical staff told us they were aware of the guidelines, but had not had any training on their use. A senior ward nurse told us they had not yet seen the nursing care guidelines which had been launched two months previously. We could not ascertain which care guidelines were being used for end of life patients.

Generic standardised nursing care guidelines were available as a reference tool on the intranet; staff could print these to use as a guide.

- The hospital participated in the National Care of the Dying Audit in 2013. The results were published in 2014.
- In response to the performance results of the National Care of the Dying Audit, a project team developed an action plan with 10 recommendations. These included plans for a seven day face to face specialist palliative care service, an annual audit of care of the dying and the development of nursing guidance. Actions had been completed by May 2015 with the exception of one action regarding education and training in care of the dying for all staff that care for those patients. A training needs analysis was undertaken and discussed with the strategy group. The trust action plan showed further funding was obtained and a training plan was in development.

Pain relief

- The trust used a pain assessment tool as part of the early warning score clinical observation chart.
- Anticipatory medications were prescribed for patients who were deteriorating and near to the end of their lives.
- Symptom management guidance, including pain relief, had been produced by the specialist palliative care team. This was available on the trust intranet.
- There were key prescribing points for staff to follow related to pain relief and to ensure medicines were available when the patient needed them.
- Two patients told us their pain was well controlled.
- We did not see the effectiveness of pain relief had been audited.

Nutrition and hydration

- We saw special diets and food supplements were noted on white boards in ward kitchens, so support staff could ensure patients had prescribed supplements.
- Nutrition and hydration needs were included in nursing documentation. We saw evidence the HANAT (hydration and nutrition assessment tool) was in use.
- Staff told us they collected meals from the dining room at Royal Hallamshire Hospital for patients who wanted a meal outside of the standard meal times.

Patient outcomes

- The National Care of the Dying Audit (2014) results showed that five out of seven organisational KPIs and eight out of 10 clinical KPIs were not achieved. A trust wide action plan was put in place to address this.
- In the 2015 National Care of the Dying Audit, although the categories changed, this showed three out of eight organisational quality indicators were achieved. This meant there had not been significant organisational improvement.
- A number of audits had taken place to measure compliance with best practice. These included the documentation and communication of DNACPR to GPs when the patient was discharged.

End of life care

- An end of life communication audit had been undertaken (January to July 2014). The trust found a poor record of communication of relevant information to primary care (GPs) and a failure of patient care pathways to connect to each other.
- The hospital did not monitor compliance with patients preferred place of death. There were significantly higher cancer death rates in Sheffield than the England average. There were also significantly higher hospital death rates and lower care home and home death rates than England average.
- There was a plan for 2016 to collect and monitor information about patient outcomes. Topics included a service review of the use of ketamine in palliative medicine, a review of complaints and looking at why patients known to the palliative care service attended accident and emergency.
- The trust was developing an electronic system, a 'clinical information portal'. The aim was to link this to another electronic method, so that end of life patients could be identified if they were admitted to hospital. These meant the specialist palliative care team could be informed about their admission and see the patient quickly.

Competent staff

- Ward nurses had a one year competency framework to complete when they started at Weston Park Hospital. This gave them chance to develop in skills and confidence.
- The practice development sister was based at the hospital and trained all nurses in their induction to the area. Other staff training included the use of syringe pumps and chemotherapy drugs.
- Two staff nurses were currently studying for Master's degrees in palliative care.
- We saw 100% of staff on ward 2 were up to date with their annual appraisal.
- Ward managers and matrons told us there was no formal clinical supervision for them. The ward manager from the teenage cancer unit had support from the clinical psychologist. The manager told us it helped them gain skills to support other staff on the unit.
- Two junior doctors told us they had training at medical school on how to discuss end of life issues with patients, but had not had any while at the hospital.
- Two nurses told us they were not trained in advanced care planning; they said this was the role of the specialist palliative care team.
- There were clinical nurse specialists (CNSs) with a range of areas of expertise, for example a teenage cancer CNS who provided direct specialist nursing care and support; they also acted as key worker for young adults with cancer.
- There was a skilled and experienced nurse who was the end of life care facilitator. They were responsible for the training plan for different staff groups in the trust.
- They showed us the training schedule for 2016/ 2017. The programme included training for staff about care of the dying and the five priorities for care.
- End of life care training was given to apprentice staff and support workers in order to develop their skills in giving essential care.
- 'SAGE & THYME' ® training was part of the 2016 training plan. Consultants had been involved in delivering this training to staff for the last two years. The SAGE & THYME ® model was developed by South Manchester NHS Foundation Trust. Its purpose was as an aide-mémoire to train all grades of staff on how to listen and respond to patients or carers who were distressed or concerned.
- The specialist palliative care team of nurses and doctors were skilled and knowledgeable. They were experienced in providing support and training to other staff. Most of the team had worked at the trust for several years and they were an established team who had a good reputation throughout the trust.
- All of the nurses were non-medical prescribers. This meant they were trained to prescribe certain medicines for end of life patients.
- The specialist palliative care nurses commenced at band 6 and progressed to a band 7 senior post once they had fulfilled required competencies.
- The specialist palliative care nurses had group supervision with a psychologist. This meant they were able to reflect on and review their practice. They could identify training and development needs.
- The nurses had other roles which supported the learning in the team. For example, one specialist nurse was the 'link' for governance (the system in the NHS which looks at improving services).
- The specialist palliative care registrars met for half a day each week for education and training.

End of life care

- There were 73 care champions across the trust. They had an interest in improving care and support for people at the end of their life. They attended 'champions days' each year in order to share idea and learn from each other.

Multidisciplinary working

- We saw positive internal multidisciplinary team (MDT) working between all staff. This included including ward nurses and doctors, the specialist palliative care team, therapy staff, the bereavement officers, mortuary staff, pharmacists, psychologist's, porters and chaplains. Volunteer staff worked with professionals for the benefit of patients.
- The 'transfer of care' nurses supported ward nurses when arranging discharge or transfer from hospital.
- There was external MDT working with a CLIC Sargent charity social worker who worked on the Teenage Cancer Unit.
- There were also youth support workers who came into the unit to support young people and their families at end of life.
- Staff also liaised with the 'Intensive nursing at home' team and community staff who were involved in end of life care.
- The palliative care consultants were part of the NHS Sheffield end of life care planning and commissioning network and worked together with hospice staff for the benefit of patients.
- There was no use of a standard EPaCCS (electronic palliative care co-ordination system). This is a tool to allow professionals to share information about a person's care preferences across different organisations. A Sheffield Palliative Care Coordination System (SPaCCS) which was in development; when implemented, this would enable MDT working across organisations.

Seven-day services

- The clinical nurse specialists in the palliative care team worked across seven days a week from 9am – 5pm.
- There was a consultant and specialist registrar available 24 hours a day. They were based on the Macmillan unit at the Northern General hospital. They worked from a rota to cover out of hours.
- Junior doctors worked from 9am – 3pm on weekends and bank holidays.
- Onsite pharmacy services were not available at the weekends. If additional medications were needed, two nursing staff members went to the nearby Royal Hallamshire hospital pharmacy which had a 24 hour service.
- The service did not offer 24 hour on site radiology services, which meant that in an emergency situation out of hours, a patient would need to be transferred to the Royal Hallamshire Hospital which is also part of the Central Campus.
- Mortuary staff at Royal Hallamshire hospital provided 24 hour, year round cover for Weston Park hospital. The manager told us they were on call on a year round basis. They had been contacted several times for advice while on holiday. Out of hours, the duty manager would meet bereaved families at hospital reception and accompany them to the mortuary.

Access to information

- Weston Park was a regional cancer centre, so patients came from local areas and further afield.
- Staff told us out of area GPs and hospitals did not use the same systems, so patient information was shared by a variety of methods.
- There were different IT (Information technology) systems in use. Not all teams of staff could access information added by other teams. This meant that all the information needed for patient care could not always be shared in a timely way.
- Staff told us they copied information from one electronic records system to another so information could be viewed by hospice staff, community palliative care team, GPs, out of hours GPs and district nurses. However, they could not enter information onto the system.
- Complex care managers (who were involved with hospital discharge of patients with complex needs) used an electronic record system, which could be viewed by GPs and community out of hour's teams.
- Information from a system known as ICE (Integrated clinical environment) was used to write discharge information onto an electronic letter in the 'e- discharge' system. This was sent to GPs and printed out to give to community nurses when patients were discharged. This meant information about end of life care needs was passed to community teams.

End of life care

- Specialist palliative care consultants also used dictaphones in addition to writing in patient notes. This recorded information was typed by administrative staff and sent to GPs.
- A new system, the Sheffield Palliative Care Coordination System (SPaCCS) was in development.
- A further electronic system had been implemented shortly before our inspection. There was a period of transition, so both paper and electronic records were in use. Four staff told us this meant it took them much longer to record patient information in two places. Information from the trust showed work was being done to resolve these problems.
- We saw handover sheets on Ward 2 which identified patients at the end of life.
- We spoke with junior doctors about their medical handover; they told us all the junior doctors participated. The handover included all new admissions, what the focus of care was, which patients were not for resuscitation (DNACPR).

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care.
- We looked at nine DNACPR forms; four of them (44%) were either incomplete or gave us concern. For example, in one situation there had been no discussion with the patient. The notes said the patient "was unwell and on his own" at the time. We checked the notes and the patient had some confusion. There was no documentation about capacity and it was not clear from the records if the patient had any family or friends. The Resuscitation Council (UK) standards for recording decisions about cardiopulmonary resuscitation (CPR) 2015,states healthcare organisations should ensure "effective communication with and explanation of decisions about CPR to the patient, or clear documentation of reasons why that was impossible or inappropriate"
- In another situation, the patient had capacity but the DNACPR order was not discussed with them. The notes stated the reason was "they had a lot to take in". We saw discussions had taken place with family members.
- Two forms had not been signed by a senior doctor and had other information missing.
- One form had been signed by a junior doctor and had not been countersigned by a senior doctor until 11 days later. This meant junior doctors were making resuscitation decisions.
- We spoke with the Medical Director about DNACPR forms; they told us they were aware of issues related to a lack of countersignature by a consultant and a lack of documentation of capacity assessments.
- An audit undertaken in 2014 included the documentation and communication of DNACPR to GPs when the patient was discharged. This showed variable compliance with national standards. For example, 68% of forms included the patient's full name, date of birth and address. Other aspects of the audit showed 100% compliance, such as the initial decision of DNACPR being made by a doctor of F2 grade or above.
- The Deprivation of Liberty Safeguards (DoLS) policy was due for review in October 2013. The flowchart to guide staff in DoLS decisions was also out of date. We checked the hospital intranet for 'pending' policies and the DoLS policy was not included.
- Doctors completed capacity assessments and DoLS authorisation forms; the site matron completed these out of hours

Are end of life care services caring?

Good

Caring for patients at the end of life was good. We found;

- Compassionate, sensitive care was given to patients and people who were important to the patient.
- The trust was in the top 20% of trusts in England for,
  - Staff giving information about support groups and financial help
  - Staff telling the patient who to contact if they were worried after discharge.
- Patients told us staff understood their needs and information was communicated in a way they could understand.
- Spiritual and emotional support was available for patients.

Compassionate care

End of life care

- We found evidence of very compassionate, sensitive end of life care to patients at the hospital.
- We saw lots of thank you cards on the wards and the teenage cancer unit. There were messages from patients and family members which related to considerate respectful care.
- Staff told us there had been a recent wedding in the hospital for a patient at the end of life. Staff came in on their day off to decorate the conservatory. The hospital charity paid for the reception and the hire of wedding outfits.
- Bereavement office staff provided hot drinks for bereaved families while they were given the information they needed. The information included what official steps had to be taken after someone had died.
- Bereavement staff made appointments with the registrar so that families did not need to do this.
- Bereavement office staff had carried out a survey to find out the views of families. The survey was carried out in March 2015. The results were variable; almost half of the respondents said they were given a choice of times to go to the bereavement office; that meant the other half were not. Results showed 99% of people were met in a sympathetic and understanding manner and 100% said they had just the right amount of time and were informed of what to do.

Understanding and involvement of patients and those close to them

- The trust participated in the National Cancer Patient Experience Survey (2014). The trust was in the top 20% of trusts in England for;
  - Staff giving information about support groups and financial help
  - Taking part in cancer research being discussed with the patient
  - Staff telling the patient who to contact if they were worried after discharge.
- The trust was in the bottom 20% of trusts in England for patients being given enough privacy when discussing their condition or treatment..
- In Sheffield, 61% of families felt they were given enough information to provide care at home. This had fallen from 64% the year before. It was in line with the England average.
- The trust participated in the 'Dying Matters' week in 2015 where the public were invited to participate. The National Council for Palliative Care set up the Dying Matters group to help people talk more openly about dying, death and bereavement, and to make plans for the end of life.
- Patients told us staff understood their needs and information was communicated in a way they could understand.
- One patient told us they could not think of anything they would change about their care. They said they felt involved in decisions about their treatment.
- One relative told us they had been given free parking, and stay as long as they wanted to with their loved one.
- We were shown a leaflet with information for families and relevant others; it was called 'As the end of life approaches'. Part of the document was in the form of a relatives diary; it could be used to ask staff questions.
- There was a development of a questionnaire which was planned to be sent to bereaved relatives or carers. The questionnaire was expected to contain a set of questions about the preferred place of care. The questionnaire was due to start being sent out to relatives in January 2016.
- One of the new nursing care guidelines for use at end of life was 'Care of the family and relevant others'. There were guidelines within the 'guidance for the care of the person who may be in the last hours to days of life'. This included an overview of the conversation to have with the patient and relevant others when a patient was believed to be dying. The guidance suggested staff develop a care plan to include;

o What to expect as the patient neared the end of life

o What symptoms may occur

o The preferred place of death

o The needs of the family.

Emotional support

- Multi faith chaplaincy support was available 24 hours a day. The chapel was easy to find, it was accessible and welcoming.
- We saw chaplaincy leaflets which indicated there was emotional and spiritual support for patients and families.
- Staff could refer patients to the trust psychology service. We were told this helped patients cope with emotional difficulties.

End of life care

- Staff told us the psychology service was involved in bereavement support; there was a support group in the community each quarter.
- We spoke with a complementary therapist. They came to the wards three times a week and offered complementary therapies to patients. Therapies included massage, reflexology, reiki and 'healing' sessions. The sessions were tailored to patient's individual needs and preferences. They were free to patients; the cost was met by charitable funds.

Are end of life care services responsive?

Requires improvement

We rated the responsiveness of end of life care services as requires improvement We found;

- The hospital did not monitor if patient choice around preferred place of care or death was met. This meant because it was not identified, this information could not be used to improve or develop services.
- There were a limited number of side rooms. This meant if a more private area was wanted by an end of life patient and their family it might not be available.
- The environment had limited facilities for patients at the end of life, such as side room availability and showers. There was a refurbishment programme which had commenced.
- There were delays in 'Fast Track' discharges.

However, we also found;

- There was a clinical nurse specialist for teenagers and young adults.
- Patient's individual needs were met on the teenage cancer unit. Care was given in a way which took account of the needs of the patients. This included the environment, the approach of staff, and the way choice was offered.
- The specialist palliative care team provided seven day clinical support to the hospital. All the clinical nurse specialists were non-medical prescribers. This meant they could prescribe medications for patients when they were needed.

Service planning and delivery to meet the needs of local people

- Weston Park Hospital provided cancer treatment services and end of life care for patients across the region, including Rotherham, Barnsley, Doncaster, Worksop and Chesterfield as well as Sheffield.
- There was a cancer information and support centre which offered help and advice to patients and families. There was an assessment unit with two beds, two trollies and eight chairs where patients who were receiving treatment, but experiencing side effects could be seen for advice and treatment.
- There was a purpose-built Teenage Cancer Unit, for young people with cancer aged between the ages of 16 and 25 to meet the needs of young people with cancer.
- Trust-wide data from April 2014 to March 2015, showed there had been 2812 referrals to the specialist palliative care team. Of these 73% (2047) were cancer patients. The remaining 27% (765) were non-cancer patients.
- The number of referrals had increased from the year before; from April 2013 to March 2014 there had been 2524 referrals. Of these 78% were cancer referrals and 22% non-cancer referrals. This meant there had been an increase in the total number of referrals and an increase in the number of non-cancer patients seen by the team.
- Since the withdrawal of the Liverpool Care Pathway (LCP), there was no way to measure if patient choice around preferred place of care or death was met. This meant because it was not identified, this information could not be used to improve or develop services.The mortuary was for deceased patients from Royal Hallamshire hospital and Weston Park hospital. A dedicated ambulance was used to transfer deceased patients from Weston Park to Royal Hallamshire.
- The specialist palliative care team provided seven day clinical support to the hospital. All the clinical nurse specialists were non-medical prescribers.
- The environment had limited facilities for patients at the end of life, such as side room availability and showers. If patients or families requested a side room, staff tried to accommodate their wishes. This was not always possible due to rooms being used for infection prevention and control. The planned refurbishment would improve this.
- There was a room for family and friends to use and was available for wards 2 and 3.
- The chaplaincy team had 61% of the numbers recommended by NHS Chaplaincy guidelines (2014) for the size of the trust.

End of life care

Meeting people's individual needs

- The specialist palliative care nurses told us they prompted patients and their families to think about advanced care planning. There was no tool to prompt ward nurses to do the same. This meant opportunities for patients to talk with staff about their wishes might be missed.
- There was no individualised care pathway or care plan to help staff identify and care for end of life patients. Standardised nursing care guidelines were available as a reference tool on the intranet; staff could print these to use as a guide. We found this method relied on the knowledge and skill of individual nurses to recognise 'trigger points' so care could be initiated after they decided what care to give.
- We observed there was no place to record someone's preferred place of care or death. Two staff confirmed this to us, they said there was no way of knowing what someone's advance wishes might be. Trust guidance recommended a palliative care plan to include the patients preferred place of death. After our inspection, senior staff told us it was practice for this to be recorded in the notes.On the other inpatient wards, there were no patient showers in the bathrooms. This meant patients at the end of life had to wash at a sink or by their bed if they were unable to use the bath.
- There were a limited number of side rooms. The majority of beds were in six bedded bays. Staff told us side rooms were mostly used for infection control purposes.
- There was a relative's room which was basic and shared between two wards.
- The planned refurbishment included more ensuite side rooms and designated areas for families.
- There was a free bedside television and telephone service for patients.
- We found the ward environments were not designed to meet the needs of patients with dementia or a learning disability. The wards were a 'corridor' with bays and doors which led off it. There were no colours or other ways to distinguish one area from another. We were shown plans for building work and ward developments as part of the Weston Park transformation. We visited an area under construction; there were more single ensuite rooms. Areas were colour coded as part of a 'dementia friendly' scheme.
- The practiced development sister was designing a tool so patients and families could tell staff about their interests and needs, preferences, likes, and dislikes.
- There was leaflet with information for families and relevant others; it was called 'As the end of life approaches'. Seven pages contained information, the remainder of the document was in the form of a relatives diary; it could be used to ask staff questions.
- We saw patients individual needs were met on the teenage cancer unit. Care was given in a way which took account of the needs of the patients. This included the environment, the approach of staff, and the way choice was offered. We saw examples of how individual needs had been met for patients at the end of their life.
- Staff on the teenage cancer unit told us they were formalising a pathway so that deceased patients could be taken straight to the funeral director, rather than going to the mortuary at Royal Hallamshire Hospital. They had implemented this on several occasions to meet the wishes of the patients and their families. Staff told us families found some comfort from this.
- Patients and parents of the Teenage Cancer Unit were offered the option of transferring to the local 'Bluebell Wood' children's hospice for care in the last days of life. Adult patients were offered the option of transferring to St Luke's Hospice.
- In 2014, the chaplains carried out a carers and relatives satisfaction survey. The results showed 85% of the respondents said they had their spiritual needs met by the chaplains. The remainder said they did not have any spiritual needs or did not know about the service.

Access and flow

- Weston Park Hospital was a regional cancer centre and patients often were from outside of the local area. The transfer of care team and complex case managers were involved in discharging patients and transferring them back to hospitals in their own area.
- The trust was developing an electronic system, a 'clinical information portal'. The aim was to link this to another electronic record system, so that patients at the end of life could be identified if they were admitted to hospital. These meant the specialist palliative care team would be informed about their admission and see the patient quickly.
- There was a 'huddle' meeting each weekday morning. The matron and ward sisters met to discuss admissions,

the bed state and staff sickness. We were told the pharmacist, transfer of care nurse and complex care manger also attended, but this was not the case we observed. No medical staff were present.
- The duty matron was responsible liaising on a daily basis with the trust's clinical operations manager regarding the availability of beds.
- Senior staff tried to keep two beds on each ward per day in case of emergency admissions, but this was not always possible.
- We saw there were delays in 'Fast Track' discharges. A fast track discharge is one where a patient has a rapidly deteriorating condition which may be entering a terminal phase, that is to say, they may be dying. The trust had processes in place which included a referral to the 'Transfer of care' nursing team. They carried out a nursing assessment and requested ward doctors to compete the fast track tool. We saw this was done in a timely way. The fast track form was then faxed to the area where the patient lived. Sometimes there were delays subsequent to this.
- In February 2015, 66% of fast-tracked patients were discharged after three days; in March, this rose to 80%; in May 2015, 90% were discharged after three days.
- After our inspection the trust provided evidence that 46 % of fast track requests were approved by commissioners on the same day and a further (44%) the day after. It had been identified that some fast tracks had to be returned because the forms were completed incorrectly and work was being done to improve this.

Learning from complaints and concerns

- A senior nurse told us there had been no complaints on their ward in the last year.
- Monthly team meetings were held where concerns were discussed amongst all staff to ensure learning.

Are end of life care services well-led?

Requires improvement

We found end of life care services to require improvement for being well led. We found;

- There was no internal strategy in place for end of life care at the trust.
- There was limited monitoring of quality of care for end of life care.
- We could not ascertain how progress towards achieving the five-year plans leading up to 2017 was measured.
- In response to the 2013 review of the Liverpool Care Pathway, the trust withdrew the pathway and trained staff in the 'five priorities of care' as described in national guidance. Local guidance was not introduced until October 2015. Not all staff were aware of the guidance.
- The trust did not monitor if patients achieved their wish for preferred place of care or death. As this was not routinely identified, this information could not be used to improve or develop services.

However we also saw;

- There were positive examples of local leadership on wards from both a nursing and medical perspective. The palliative care consultants were visible and approachable. Ward staff told us the specialist palliative care team were also very supportive.
- Innovation funded by charity on the teenage cancer unit included a 'couples retreat' for patients at the end of life and their partners. They could spend time away from home and explore issues about coming to the end of life.
- Art therapy as a way of communication had also been used on the teenage cancer unit for young people nearing the end of life as an alternative or adjunct to talking to a psychologist.

Vision and strategy for this service

- There was no internal strategy in place for end of life care at the trust. We spoke with senior leaders who acknowledged this. An end of life strategy group were responsible for providing provided the vision and strategy for end of life services in hospital and community services. The group were in the process of developing a strategy for the service provided by the trust. We did not know when this would be out in place.
- We found the absence of a strategy had resulted in staff not knowing the vision for end of life care. We found front line staff were committed to caring for those approaching the end of their lives; however, staff could not tell us their role in achieving the strategy.

In response to the 2013 review of the Liverpool Care Pathway, the trust withdrew the pathway and trained staff

End of life care

in the 'five priorities of care' as described in national guidance. Local guidance was not introduced until October 2015. . Not all staff were aware of the guidance and it was not clear which guidelines ward staff were following.

- We saw a five year plan for specialist medicine from 2012- 2017. It included plans for end of life care as one of the six specialisms in the document.
- The document was written in 2012, and included an assessment of the trust position at the time, their aims over five years and how this was to be achieved. We understood this to be the 'vision' for the service.
- Within the five year plan, there was no written strategy with timescales to determine how different parts of the plan were to be achieved.
- We could not ascertain how progress towards achieving the plans for 2017 was measured.
- There was limited monitoring of quality of care for end of life care. The medical director agreed there was a need for more robust, strong data to support the general 'feeling' in the trust that the service was doing well.
- We saw that plans had changed since the five year plan was written. For example, the plan was for the specialist palliative care team to lead implementation of Advanced Care Planning and AMBER bundle across the Trust by 2017. This had changed following implementation of the AMBER care bundle on four wards at another hospital. The AMBER care bundle was not used at Weston Park Hospital.

Governance, risk management and quality measurement

- The ward areas held governance committee meetings on a quarterly basis. We reviewed minutes from these meetings and found that serious incidents, complaints and the risk register were some of the agenda items discussed.
- However, we found there was no real governance framework to support the delivery of the five year plan. There was limited monitoring of quality of care for end of life care.

The service participated in national audits, such as the care of the dying audit.

- There was a comprehensive audit programme for the specialist palliative care team for the coming year. This was to be used to monitor quality and plan where future action should be taken.
- We saw that staff were clear about their roles and responsibilities.
- The matron met with the medical director and deputy director of nursing every two weeks and with the chief nurse every quarter to discuss quality and safety issues.

Leadership of service

- The medical director was the lead director for end of life care. They told us there were several reasons for the lack of an end of life care strategy. This included awaiting publication of NICE guidance and a replacement national care pathway. They also told us department restructure and senior clinical developments were factors for not having a strategy.
- The medical director agreed there was a need for more robust, strong data to demonstrate the performance of the service. There was a comprehensive audit programme for the specialist palliative care team for the current and coming year. This was to be used to monitor quality and plan where future action should be taken.
- There were senior clinical leaders in each directorate, but it was not clear how knowledge and skills were shared across the directorates.
- We saw positive examples of local leadership on wards from both a nursing and medical perspective. We saw action had been taken to improve ward leadership.
- The palliative care consultants were visible and approachable. Junior doctors told us they received good direction and support from the consultants.
- Ward staff told us the specialist palliative care team were very supportive. Ward nurses knew them by name and were able to give us examples of their involvement in patient care.

Culture within the service

- We found an open and friendly staff culture at the hospital. Staff told us they had wanted to come and work at the hospital, they were aware of the 'PROUD' values. (Patients first, respectful, ownership, unity, deliver).
- Staff were open about reporting risks or incidents and there was a philosophy of learning from incidents and complaints.

End of life care

Public engagement

- The matron told us they made a 'word cloud' diagram for the patient board on wards 2 and 3. This was made of key words and phrases sent on cards and letters from patients and relatives. It showed which words had greater prominence such as 'Thank you', 'quality' and 'care'. We were told the information was used to shape the service.
- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying Audit for Hospitals (2013-2014)
- They did not participate in the survey of bereaved relatives as this coincided with the Christmas period at the time. The trust felt this might be a difficult time for families so withdrew from participating in the bereaved relatives' survey with view to carrying out a relative's survey at a more appropriate time.
- We saw the bereavement office staff carried out a survey in March 2015.
- In 2014, the chaplains carried out a carers and relatives satisfaction survey.

Staff engagement

- There was a suggestion box in the staff room on one of the wards, and we heard staff had been consulted about the plans for ward transformations. There had been MDT focus groups to discuss ideas with staff.
- Information from the staff Friends and Family test indicated that 89% of staff would recommend this service as a place to receive treatment and 69% of staff would recommend the hospital as a place to work.

Innovation, improvement and sustainability

- The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.
- Art therapy had also been used as a way of communication on the teenage cancer unit for young people nearing the end of life.

Outpatients and diagnostic imaging

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

Information about the service

Weston Park Hospital (WPH) is one of the five main sites of the Sheffield Teaching Hospitals NHS Foundation Trust (STHFT). Specialised cancer services at WPH Hospital provided outpatient (OP) services for patients from across South Yorkshire, North Nottinghamshire and North Derbyshire. There are approximately 60,000 patient visits for radiotherapy and 20,000 patient visits for chemotherapy each year. There is a cancer clinical trials centre at WPH.

Imaging services (radiology) were part of the medical imaging and medical physics (MIMP) directorate. This directorate was part of the Laboratory Medicine, Medical Imaging and Medical Physics, Obstetrics, Gynaecology and Neonatology (LEGION) Care Group. The MIMP directorate performed imaging investigations across all of the trust sites. There were approximately 500,000 attendances per year, and MIMP employed over 600 staff.

The MIMP services provided at WPH included nuclear medicine, MRI, ultrasound and general x-ray plain film. The radiotherapy team mainly used the CT service based within the imaging department. The radiotherapy services mould room was situated within the x-ray department. We did not inspect radiotherapy services during this inspection.

During our inspection of outpatient and diagnostic imaging services at WPH, we visited the oncology outpatient's department (OPD), oncology day case unit (DCU) and imaging services. We spoke with 11 members of staff in radiology and 10 members of staff in OP, including managers, nurses, medical staff and administration staff.

We also spoke with 12 patients and eight visitors/relatives. We reviewed five sets of patient records in WPH OP and 28 electronic patient records in MIMP. We looked at a range of other records such as policies, procedures and audits.

Outpatients and diagnostic imaging

Summary of findings

We rated the service as outstanding overall.

We rated the safe domain as good, with caring, responsive and well led being rated as outstanding. The effective domain was inspected but not rated. This was because we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic Imaging.

The services had a positive safety culture; there were clear management responsibilities and accountability for safety and governance. The services promoted continuous quality improvement.

There were enough qualified, skilled and experienced staff to meet people's needs. Staff received good support; they told us their appraisals, and mandatory training was up to date.

Radiology services provided well-established, highly regarded training programmes for medical staff at every stage of their five-year programme and for student radiographers from local universities.

All of the staff were passionate about their work and staff teams worked well together to provide an excellent experience for their patients. All of the patients and relatives we spoke with gave positive feedback about the staff and the services.

Staff were aware of the trust values; there was good staff engagement and an open culture. Staff participated in research activities and there were numerous examples of innovation and improvement.

Are outpatient and diagnostic imaging services safe?

Good

We judged the safety of this service to be good because staff planned and delivered care and treatment in a way that ensured people's health and safety, which protected them from harm. We found:

- Staff knew how to report incidents and could describe the requirements of the Duty of Candour. There was evidence of learning from incidents.
- People were cared for in a clean, hygienic environment. There were effective systems in place to reduce the risk and spread of infection. There was enough well-maintained equipment to ensure people received safe treatment.
- Appropriate arrangements were in place for obtaining, recording and handling medicines and there were arrangements in place to deal with foreseeable emergencies.
- Accurate and appropriate patient records were maintained, which were stored securely.
- The services had a positive safety culture and there were clear directorate management responsibilities and accountability for safety and governance.

However;

- We observed the OP waiting areas and clinic rooms were cramped and staff told us they needed more space. The trust had plans in place to refurbish and reconfigure these areas.
- Safety checklists within imaging services were not always completed as required. Internal audits had identified this issue and the service was working towards improving compliance rates.

Incidents

- There was evidence of learning from incidents; investigations took place and appropriate changes were implemented. Incident management and response was through the trusts online reporting system.
- Weston Park Hospital outpatients and diagnostic imaging had reported 215 incidents from September 2014 to August 2015. All of these had been categorised as either insignificant or minor.

Outpatients and diagnostic imaging

- There had been no 'never events' reported in the past 12 months; never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- The managers told us they encouraged staff to openly report incidents. Staff we spoke with across OP and radiology were aware and knew how to report incidents. They also confirmed they were actively encouraged to report incidents. Staff told us managers were trained to locally manage and investigate incidents within their own areas. The matron in oncology confirmed they reviewed all of the incidents; they said there were around 10 per week. They said the commonest incidents involved prescriptions for medicines.
- Staff received induction and training on how to report incidents. Learning from incidents was communicated through team meetings and monthly incident bulletins circulated to all staff. Staff we spoke with confirmed incidents and any lessons learnt were discussed at staff meetings.
- In radiology, section heads had 'their own incident dashboards'; these assisted them in monitoring incidents reported internally and externally. Incident dashboards also improved the timeliness of incident reviews and investigations. The directorate reported that monthly exception reports showed that 98% of incidents were closed within the trust's target of 35 days.
- The Radiation Safety Steering Group (RSSG) monitored the numbers of radiation incidents reported to the Care Quality Commission (CQC) under IR(ME)R regulations. The number of IR(ME)R reported incidents (exposures 'much greater than intended' and unjustified exposures) had increased over the previous 12 months. The clinical directors and directorate manager told us there had been an increase in externally reportable IR(ME)R incidents mainly due to a change in the 'interpretation of the legislation and in response to actions as determined by CQC'.
- This was confirmed in the RSSG annual report for April 2013 to March 2014 presented to the trust's Healthcare Governance Committee. The report stated, 'clarification had been sought from the CQC IR(ME)R inspectorate and the trusts reporting criteria amended accordingly'. The report also stated that these changes 'will result in a higher number of incidents being reported externally, but it was stressed that this is not as a result of an increased number of incidents'.
- The ionising radiation sub group report to the RSSG in July 2015 highlighted the on-going work to reduce the numbers of IR(ME)R incidents. This involved radiographers using the 'have you paused and checked' initiative. This initiative is a nationally recognised clinical imaging examination IR(ME)R operator safety checklist carried out before and after exposures.
- In radiology, the clinical, scientific and nursing directors together with the matron, directorate and governance managers attended directorate monthly clinical governance committee meetings. The committee routinely reviewed all incidents in order to identify trends. We saw from the June, July and September 2015 meeting minutes that incidents were reviewed and action notes recorded. Actions were monitored, and followed up appropriately at subsequent meetings.
- Managers, section heads and staff were aware of their responsibilities under the Duty of Candour (DoC) legislation. We reviewed the May 2015 radiology section heads meeting and saw DoC was discussed and recorded in the minutes. We also saw information leaflets for staff about the new DoC legislation; these leaflets had been issued in December 2014.

Cleanliness, infection control and hygiene

- The environment was visibly clean in all of the areas we visited. Hand sanitizer was readily available and we observed staff using this appropriately, we observed staff practising good hand hygiene before and after contact with each patient.
- Personal protective equipment (PPE) such as aprons and gloves was available and staff were observed using PPE correctly. Staff adhered to the 'bare below the elbow' policy.
- Clinical and domestic waste was disposed of correctly and sharps boxes were not overfilled. Appropriate containers for disposing of waste including clinical waste were available and in use across the imaging departments.
- Oncology OPD had an infection prevention link nurse.
- The outpatient and radiology departments carried out regular audits as part of the trust's infection prevention accreditation programme. This set the standards for infection prevention and control practice across all directorates. Compliance was assessed by monthly audits and quarterly compliance reports.
- These audits included aseptic technique, hand hygiene, cleaning and decontamination of equipment, care of

central venous catheters and standard precautions and monitored compliance with key trust policies. Between 1 October 2014 and 30 September 2015, WPH scored between 93% and 100% in these audits.

- The trust undertook an infection control accreditation programme. This programme sets standards for infection prevention and control practice. The aim was to optimise and assess infection prevention and control practices in clinical teams throughout the hospital in order to reduce infection rates. The July 2015 MIMP clinical governance minutes recorded that infection control accreditations were up to date. Infection control results reported in the September 2015 minutes showed the MIMP directorate achieved 99% compliance.
- The radiology waiting and examination rooms appeared clean, tidy and uncluttered. However, the sluice room situated within the main x-ray room was untidy, cluttered and domestic cleaning equipment was stored around and under the two sluice sinks. There was no cleaning schedule for this room. Clean domestic items such as cloths and mop heads were stored openly in this area. When we revisited this area, these issues had been addressed.
- Staff in radiology were responsible for maintaining the cleanliness of the radiology equipment in accordance with infection prevention and control (IPC) standards. Imaging and examination room cleaning schedules were available in all areas and were up to date.
- The curtains used to maintain the patients privacy during cannulation procedures within the MRI department clean utility area was fabric. There was no information to indicate when these curtains were cleaned. The oxygen masks and tubing ready for use were not stored within sealed wrapping. Staff replaced the fabric curtains with disposable ones before the end of the inspection.

Environment and equipment

- Staff had electrically tested equipment in the oncology OPD and day care unit; this meant patients were protected from harm. We found two pieces of equipment, which had not been electrically tested; staff removed these from use immediately as soon as we made them aware of the issue.
- There were arrangements in place to deal with foreseeable emergencies. We checked the emergency trolleys in oncology OPD and the day care unit; we found medications required, including oxygen, were all present and in date. Records confirmed staff carried out regular checks on the resuscitation equipment.
- The x-ray department was small and had one general x-ray (plain film) room in daily operation. A second plain film room was available should it be required. This room had a mobile x-ray unit rather fixed x-ray equipment and this room was not in use at the time of our visit. A dedicated ultrasound examination room was based within the department. Nuclear Medicine and MRI departments were situated elsewhere in the hospital.
- There were systems and processes in place to ensure the maintenance and servicing of radiology equipment. The directorate had an up to date inventory of all of the radiology equipment and the planned preventative maintenance (PPM) schedules.
- We were told by staff that a capital replacement scheme for equipment was developed and plans were in place for two additional MRI scanners and replacement of four CT scanners over the next two years.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff wore personal radiation dosimeters (dose meters) and these were monitored in accordance with legislation. A radiation dosimeter is a device that measures exposure to ionizing radiation.
- We saw that the majority of the equipment we looked at was routinely checked and labelled in date. Emergency resuscitation equipment was kept within the adjacent radiotherapy department for the radiology department and out patients for the MRI department, which was readily available for use. Radiology resuscitation equipment was checked regularly and checks were up to date.
- Radiation warning signs were displayed along with the use of illuminated do not enter signs within all modalities. Radiation local rules were displayed and described the duties to be undertaken by staff in accordance with the local rules. Local rules are written to enable work with ionising radiation to be carried out in accordance with the Ionising Radiations Regulations (IRR99). It is the primary responsibility of the Radiation Protection Supervisor (RPS) to supervise work and observe practices in order to ensure compliance with these regulations. All modalities had appointed and trained RPS's.

Outpatients and diagnostic imaging

- Radiation Protection Advisors (RPAs) attended the RSSG meetings and undertook annual risk assessment inspections of the radiology services at each of the MIMP directorate locations. The RPAs produced an annual report.
- The purpose of the inspections and reports was to evaluate compliance with legislative requirements associated with the radiation safety of patients, members of staff and the public. The findings from inspections were communicated to the trust Chief Executive and other responsible persons.
- We saw from the 2014 and 2015 inspection reports supplied by the trust that adequate standards of compliance were achieved. Where compliance fell short, requirements were issued and recommendations for action identified. The reports also contained follow up on previous requirements and recommendations.
- A shared disabled toilet facility was available within the radiology department and appeared clean and tidy, but this was not labelled to indicate shared use.
- The sluice room situated within the main x-ray room contained a metal unit with electrical labelling attached and electrical wiring connecting into the unit. The outer casing was not fitted correctly. We were told that the unit was to do with the air conditioning and was not working. There was no labelling to indicate that the unit had been safely decommissioned.
- The storeroom situated at the end of the x-ray department corridor close to the second x-ray and ultrasound room was used by the radiotherapy mould room staff for storage. This storeroom was cluttered and untidy. Items used for patient care were stored on the floor. The bags containing plaster used for making the moulds were split and plaster was spilt onto the shelving, the floor and stored items. We brought to the attention of one of the senior radiotherapists who rectified the issues. We observed patients clothing and personal items stored unsecured in a basket in the MRI clean utility area during the course of their procedure. Lockers were available in the changing MRI changing room area. Staff told us the keys for these lockers were missing and therefore they were not used.
- The MRI emergency anaphylaxis box was in date. This was stored on top of the clean utility area cupboards. The staff on duty at the time of our visit knew how to find it but there was no record to show the expiry date was checked regularly.

Medicines

- Appropriate arrangements were in place in relation to obtaining, recording and handling of medicines. Medicines were prescribed and given to people appropriately.
- Staff in oncology told us they were able to prescribe medicine for patients if they had none. They said medical and nursing staff wrote prescriptions for medicines and these were taken to the on-site pharmacy.
- The main x-ray department did not store controlled drugs. Other medicines used were stored correctly and were in date. The medicine key was not securely controlled and we discussed this with the manager, who immediately took action to secure the key.
- Staff checked the drug fridge temperatures in the x-ray department; records of these checks were up to date.

Records

- We reviewed five sets of patient records in oncology and found staff had completed these correctly and legibly in black ink. All entries were signed and dated by staff, where required. Documents within patient records were well organised, with tabs to help with correct filing of paperwork. We saw appropriate risk assessments were in place.
- Staff in oncology told us they completed a form and carried out dictation when they saw patients.
- In MIMP, we reviewed 28 electronic patient records (across the three hospital sites) specifically to check whether radiology safety checks for MRI, pregnancy and interventional WHO safety surgical checks had been completed. We found these were all completed.

Safeguarding

- People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse or harm and prevent it from happening.
- Mandatory and statutory training courses included adult and children safeguarding. Safeguarding training for all staff was completed at level 2 and senior staff, such as OP sisters, were trained to safeguarding level 3.
- The MIMP directorate did not routinely provide radiology for children; this was provided by a separate organisation.. A nominated safeguarding lead trained at level 3 provided in-house advice.

Outpatients and diagnostic imaging

- There was a radiation safety infrastructure in place which included the reporting of radiation incidents from local clinical teams and section heads into one of five radiation safety sub groups for; Ionising radiation (x-ray), non- ionising radiation (MRI and Ultrasound), radiotherapy (sealed sources), nuclear medicine (unsealed sources) and dental (x-ray).
- The purpose of the sub groups and RSSG was to ensure radiation safety issues requiring action by the trust were reported and acted upon appropriately in order to achieve on-going legislative compliance and ensure the safety of staff, public and patients.
- The minutes and action notes from the February and July 2015 RSSG meetings included radiation safety reports from each sub group. These reports were reviewed the meetings and any further actions recorded and followed up appropriately.

Mandatory training

- Staff we spoke with all confirmed they were up to date with their mandatory and statutory training. The trusts mandatory training and local supervisions were completed within the departments.
- Senior nursing staff in oncology told us mandatory training was 95-96% compliant against a target of 90%. Training in infection control was 100%. Records we reviewed confirmed this.
- The MIMP directorate report for appraisal and mandatory training compliance 15/12/2014 to 10/12/2015 showed all specialities at all locations were achieving good compliance. For example, 95% mandatory and statutory training course compliance.
- We spoke with a relatively new member of staff in radiology on rotation. They described to us their personal induction and development plan, which included performance reviews and appraisal.

Assessing and responding to patient risk

- The OP and radiology services assessed risks and responded appropriately in order to maintain patient safety. For example, there was an anaphylactic team on site who were available to respond to any patient that had an anaphylactic reaction during their treatment.
- In radiology, we looked at one patient electronic record on the Reporting Information System (RIS) to ensure pregnancy safety checks had been completed prior to exposures being undertaken. We saw a pregnancy check had been completed.
- We looked at four MRI safety checklists scanned into RIS and saw three checklists were signed by the radiographers but not dated and one checklist was not signed by the radiographer. The patients had signed all of the checklists we reviewed. The trusts policy stated that safety checklists should be signed and dated by the patient and by the radiographer undertaking the scan.
- The Sheffield Early Warning Scoring system was used to monitor the patient's condition prior to during and following radiology interventional procedures. Trust wide emergency teams were available to respond and support any medical emergencies.
- Hospital porters transferred patients from the wards and departments to the radiology departments. Patients assessed as requiring an escort by the ward staff were escorted to the department.

Nursing staffing

- There were sufficient qualified staff in the OP and radiology services to keep people safe.
- The trust reported that 'a workload based staffing tool was currently under development and STH was working in collaboration with external consultants to refine and test the methodology'.
- Staff in oncology used a staffing tool to assess patients against pre-determined criteria. They assigned each patient a level of dependency between one and four. The level of dependency determined the hours of care each patient required whilst in the department. Staff worked flexible shifts in the oncology day care unit. Staff told us they would stay late if patients' treatments took longer than expected. Staff could take time back if they did this.
- There were no vacancies in oncology OPD at the time of the inspection and specialist cancer services did not use any agency staff. Senior nursing staff told us there were no issues recruiting staff to specialist cancer services; they told us there was a waiting list of trust staff who wanted to transfer to the service.
- Nursing staff rotated between the oncology OPD and DCU. This rotation of staff had been in place for three years and enabled flexible working between the two areas.
- Nurse staffing had recently been increased within the DCU to manage the increase in workload and waiting times.

Outpatients and diagnostic imaging

- The oncology service had introduced allied health professional (AHP) led chemotherapy in a number of chemotherapy clinics.
- Sickness absence across the trust was 4.2% in May 2015 compared with the trust wide target of 4%. The position had improved from over 5% in January 2015.
- The MIMP directorate employed over 600 staff with expertise in clinical sciences and medical engineering, nuclear medicine, medical physics, nursing, administration, interventional radiology, multi imaging and diagnostics modalities for MRI, CT, fluoroscopy, cardiac, neurology and vascular angiography, breast screening, general X-ray and ultrasound.
- Radiation Protection Advisors (RPA's) and Radiation Protection Supervisors (RPS's) were employed within the MIMP directorate.
- The December 2015 MIMP staffing report showed the directorate was carrying around 26 whole time equivalent (WTE) vacancies across all specialities; recruitment to fill these vacancies was on going at the time of our visit. We found agency staff were used to maintain adequate staffing levels and skill mix within a number of radiology modalities.
- Staff from the other trust sites also rotated to WPH to maintain safe staffing levels. This included approximately 79 WTE radiographers, a team of around 22 qualified nurses and a number of clinical radiology support staff. Staff rotas included permanently based and rotational staff. There was sufficient qualified and unqualified radiography and scientific staff on duty to cover the capacity and demands of the service.

Medical staffing

- The trust had approved posts for three additional consultant oncologists and an associate specialist in oncology; these posts were due to be advertised in the near future.
- Medical staff in oncology worked across the trust sites and at neighbouring hospitals. At the time of the inspection, an analysis was being carried out to identify the medical staffing needs within the service. The long-term strategy was to provide more cross-cover, while maintaining safe staffing levels, which met the needs of the service.
- There were around 35 consultant radiologists employed by the MIMP directorate. They covered the range of specialisms and supported the multi-disciplinary teams (MDT).
- Arrangements for on call and out of hours cover were in place.
- The trust provided all facets of radiology training for doctors throughout the five-year training programme. Staff told us that a number of recent graduates had progressed into consultant radiologist posts.

Major incident awareness and training

- Major incident (MAJAX) training was part of the mandatory and statutory training programme for front line staff. The MIMP training report showed 95% of staff was compliant with their mandatory and statutory training and the OPD training report showed 98.3% of specialised cancer services staff had completed their mandatory training.
- To support the trust a MAJAX plan, the directorate had developed a range of guidelines for staff to follow in the event of a major incident. This information was accessible electronically to all staff on the MIMP shared drive and hard copies were retained within the departments.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected the effectiveness of services but this was not rated. We found;

- People's care and treatment reflected relevant research and guidance.
- The outcomes of people's care and treatment was routinely collected and monitored, including pain relief and comfort in patients receiving cancer treatments.
- Staff had the skills, knowledge and experience to deliver effective care and treatment, staff were aware of the mental capacity act and deprivation of liberty safeguards legislation.
- We found excellent examples of multidisciplinary working in both OPD and radiology services.

Evidence-based care and treatment

- People's care and treatment reflected relevant research and guidance. We visited the trial centre in oncology OPD and found research nurses worked in the clinics to

select patients for trials. Consultant oncologists led the trials. Staff told us many of the trials involved testing routine chemotherapy agents in different parts of the body.

- In specialised cancer services, evidence based guidelines had been developed and were used by the multi-professional team to ensure safe and effective patient care. These were available to staff in the anti-cancer therapy handbook. Therapy guidelines and protocols were also available to staff in this handbook.
- Staff in oncology audited the chemotherapy treatment timings. For example, records were kept of how scalp cooling prevented hair loss during treatment and of any complications relating to central line insertions.
- In radiology, we saw that policies and procedures within the directorate had been developed and referenced to NICE and Royal Colleges guidelines. These were available to all staff on the directorate's electronic shared drive.
- The MIMP directorate recognised the importance of innovation and the development of new techniques and treatments to improve patient care. For non-NICE guidance proposals, systems and processes were developed through the directorate clinical governance committee in conjunction with the trusts executive group for considering all these proposals. This was to ensure the proposals were appropriate, effective, and safe and the staff involved had the relevant expertise.
- The directorate provided examples of recent non-NICE approved proposals submitted for consideration in relation to ethanol ablation of neck nodes and fluoroscopically guided selective tubal cannulation.

Pain relief

- Staff told us they referred patients to the palliative care teams for advice with pain control. The palliative care team reviewed and assessed patients for pain and symptom management, including those patients receiving end of life care.
- The palliative care and WPH practice development teams had developed a pain teaching module, which included the principles of pain management and information about analgesics.
- A multidisciplinary team identified actions and reviewed outcomes relating to analgesia and patient comfort in oncology.

Patient outcomes

- Staff in oncology told us they used a patient outcome sheet. They said they had recently redesigned the form to capture more information. This redesign was carried out following an audit and now included information about waiting times. This showed staff were involved in activities to monitor and improve people's outcomes.
- The trust was performing around the national average for the results in the Royal College of Physicians Lung Cancer Audit with 100% of cases being discussed at MDT.
- Diagnostic reference levels (DRL's) were developed as an aid to optimisation in medical exposure. Trust policy was that radiation exposures doses should be audited on a regular basis.
- As part of the MIMP directorate's on-going quality monitoring of annual dose audits, a three yearly review of DRLs was undertaken. The audits carried out in 2014 and 2015 showed the results were good when compared against the new national levels in accordance with the relevant legislation. The audit reports included the detail of any actions required to aid optimisation.
- The MIMP directorate manager told us the service participated in the Imaging Services Accreditation Scheme (ISAS). They envisaged an application for accreditation would be submitted in the autumn of 2016. The manager also told us the audiology service had achieved accreditation for Quality in Physiological Services (IQIPS) scheme in October 2015.

Competent staff

- Staff had the appropriate skills, knowledge and experience to deliver safe effective care to patients. A staff training and competence assessment programme was in place, which included induction, preceptorship and equipment training. The practice development sister and clinical educator had developed the programme.
- In oncology OPD, nursing staff were trained to insert peripherally inserted central (PICC) lines; this meant patients did not have to wait for a doctor to carry out this procedure. Staff had competency checks to carry out this procedure.
- Staff in oncology told us they received one-to one training on any new initiatives.
- Chemotherapy training competencies were maintained for all middle and staff grade medical staff and

healthcare professionals, such as nurses and pharmacy staff. This applied to both permanent and locum staff and followed the requirements of the Royal College of Physicians.

- Staff in oncology told us 100% of staff appraisals were completed; we reviewed appraisal records, which confirmed this.
- The MIMP directorate employed a full time dedicated training and development manager responsible for the co-ordination and efficient management of the MIMP recruitment, training and development programmes.
- The directorate had a high staff retention rate and encouraged role extension. As a result, many of the areas benefited from having advanced practitioners such as nurse sedationists, advanced gastrointestinal (GI) radiographers, reporting radiographers, nurse specialists in nuclear medicine and nurse GI interventionist.
- We saw examples of a wide range of training and development competence programmes, which included CT vetting competencies, vascular angiography training pack, and initial competency assessment for band 5 radiographers. We observed examples of completed CT staff training records held electronically.
- The directorate provided well-established and highly regarded training programmes with Sheffield and other universities for medical staff training and development at every stage of their five year programme and for student radiographers.
- The directorate had an established faculty with many of the consultants at its core and representatives on the Royal College of Radiologists Education Board. Staff told us that the most recent Training and Accreditation Committee recently commended the directorate for its commitment and enthusiasm.
- The MIMP directorate provided examples of the records to show who was certificated within Nuclear Medicine to administer radioactive material; these were the Administration of Radioactive Substances Advisory Committee (ARSAC) license holders.
- The ARSAC electronic database managed by two research nurses provided monthly reviews of certificate holders, certificates held for each clinician for both diagnostic and therapeutics, serial numbers included on each certificate, which site each certificate covered for each clinician and the expiry date of each certificate.
- There were 15 qualified RPS within the directorate covering all modalities within MIMP locations. We saw evidence of their up to date training 2014 to 2015.The trust provided evidence of a competence update for one of the RPS in 2015.
- The MIMP directorate had six qualified advanced reporting radiographers. The reporting practices of all six were regularly audited. We observed an example of a completed audit and saw the practitioner had to achieve the required standard of report accuracy to prove competence to practice.
- We found 92% of staff across all of the MIMP directorate's modalities had completed appraisals. As part of induction, staff were provided with a supervisor/ mentor and a training portfolio. This included evidence of supervision as part of the trust continuing professional development (CPD) programme.
- Radiology staff we spoke with confirmed the positive training and development culture and opportunities to develop advancement in practice throughout the directorate.

Multidisciplinary working

- We found excellent examples of multidisciplinary team (MDT) working in both radiology and OP services. MDT working underpinned service development and effective care delivery.
- Staff in oncology told us there was good MDT working with other departments both internally and externally. These included psychotherapy, the cancer support centre, cancer charities, palliative care team, Macmillan nurses and local hospices.
- On-site specialist oncology allied health professionals were available on site from Monday to Friday. These included occupational therapy, dietetics, physiotherapy and pharmacists. Having a pharmacist available in clinic reduced the need to telephone pharmacy and resulted in less incorrect prescriptions.
- The OPD sister and counselling radiographer attended monthly meetings at the Cancer Information Support Centre. All new chemotherapy patients were told about this support centre.
- The chemotherapy service worked with the community to deliver appropriate therapies within polyclinics and were involved in a local project to deliver a better outreach chemotherapy service.

Outpatients and diagnostic imaging

- Radiologists were part of the multi-disciplinary teams and we saw examples of attendance rates for the breast and head and neck MDT meetings. The clinical director confirmed that radiologist attendance at MDT meetings was a priority.
- The directorate supported MDT working across the trust and has a well-established process to authorise non-medical staff to request radiology in compliance with legislation. Training and development was provided and the directorate retained a database of authorised users.

Seven-day services

- The oncology OPD was open five days a week from 8.30am to 5pm and the on-site pharmacy closed at 5pm. The oncology day care unit was open from 7.30am to 8pm.
- Nurse practitioners in oncology were available for advice seven days a week, including at night. Oncology patients we spoke with confirmed they could access advice whenever they needed it.
- The general x-ray department at WPH provided services during the core hours of 9am to 5pm Monday to Friday. On call cover was provided after these times and at the weekend from the Royal Hallamshire Hospital.
- The MIMP directorate provided seven-day services in MRI and core hours had extended within most modalities from 8am to 8pm. CT services were provided 24 hours a day and seven days a week at the Northern General Hospital and out of hours support to the Royal Hallamshire Hospital (provided by the resident on-call general radiographer who is trained to perform standard CT examination). For unusual and complex scans the CT on-call radiographer was contacted.

Access to information

- Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- The hospital did not monitor the availability of patient's records in the outpatients departments. During our inspection, we did not identify issues with access to records. Staff in OPD told us there was never a problem having access to their patients' records and information; they said patient records were always available. They told us they knew their patients well.
- The MIMP directorate used a Radiology Information System (RIS). The RIS is a dedicated computer system, which supports a range of functional requirements such as radiology operational workflow, business analysis and storage of patient data contributing to the electronic patient record across all modalities.
- RIS is combined with the Picture Archiving and Communications System (PACS) a nationally recognised system used to report and store patient images. Authorised user groups such as radiographers, radiologist and system administrators had individual user login and password authentication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training data submitted by the trust showed that staff in both OP and radiology were up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with were knowledgeable about the requirements of this legislation.
- The trust had policies and procedures in place for staff to follow to obtain consent from patients receiving diagnostic procedures. General x-ray procedures were performed using implied consent from the patient. The trusts written consent procedures were followed when performing more complex or interventional radiological procedures.
- Patients' identities were checked and confirmed against the original referral details on arrival in the department and prior to the procedure. Local guidance was in place for staff to follow if patients arriving in the department lacked capacity and where clear indications of consent and best interest decisions could not be determined.

Are outpatient and diagnostic imaging services caring?

Outstanding ☆

We judged the services outstanding for caring because people were respected and valued as individuals and were empowered as partners in their care. Staff caring for people and their families treated them with compassion, kindness, dignity and respect. We found:

- People experienced care, treatment and support that met their needs and protected their rights.

- People understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- People received emotional support to help them cope with their care, treatment and condition.
- We spoke with 12 patients and eight visitors and relatives; the feedback we received from all of the patients and their relatives or visitors we spoke with was outstanding.

Compassionate care

- People were treated them with compassion, kindness, dignity and respect. They experienced care, treatment and support that met their needs and protected their rights.
- We observed respectful interactions between staff and patients in both OPD and radiology. Staff showed a sensitive and supportive attitude; they were friendly, polite and courteous when caring for patients. We saw and heard staff introducing themselves to the patients and explaining the next steps in their treatment pathway.
- In the oncology day care unit the handover co-ordinator knew all of the patients individually. They had an oversight of all of the patients to be seen each day and individually allocated staff to each patient.
- Staff working in the oncology departments told us they were proud of the care patients received there. A survey showed that 88% of medical staff would recommend WPH for their family and friends to receive treatment.
- A Listening in Action survey carried out in in October in oncology OPD and DCU showed that patients felt well cared for. Patient feedback included “good communication and listening skills”, and “good patient explanation.”
- The friends and family test results for January 2015 to June 2015, showed 94% of outpatients who responded would recommend the service to their friends and family. This was better the national average.
- The radiotherapy team based at WPH held client information evenings, which attracted between 300 and 400 patients and carers a year.
- We spoke with 12 patients and eight visitors / relatives; the feedback we received from all of the patients and their relatives or visitors we spoke with was outstanding. Comments included “The staff are superb, they are very caring”, “They treat you with great respect and compassion”, “Everybody smiles, they are very cheery” and “They went through all the symptoms and told us what to expect.”
- The MIMP directorate reported they hosted the ‘Devices for Dignity (D4D) Healthcare Co-operative’. This is a national initiative to drive forward innovative products processes and services to help people with long-term conditions.

Understanding and involvement of patients and those close to them

- People’s individual preferences and needs were reflected in how their care was delivered.
- People who used the service were given appropriate information and support regarding their care or treatment. Written patient information leaflets about the service and cancer treatments delivered at WPH were readily available and provided to patients. This patient information was also available on the trust intranet. Staff told us they provided patients and their families with the information they needed, both verbally and in the written leaflets.
- People who used the service understood the care and treatment choices available to them. Patients were encouraged to ask questions about their treatments on any of their visits. Some patients looked around the department prior to their appointment, to provide reassurance.
- For example, we spoke with a support worker for a person who needed care. They told us, “They have gone over the information several times so they understand it better. They even showed them pictures.”
- Staff in the oncology trial centre told us patients were fully informed about any trials they may qualify to participate in and were given choice about whether to take part in a trial or not.
- In radiology, we saw a range of information leaflets available and provided to patients. For example, CT and MRI information leaflets were sent out in the post with the patient’s appointment times. These leaflets were also available in other languages and formats.

Emotional support

- Patients’ emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Outpatients and diagnostic imaging

- Patients received emotional and psychological support to help them cope with their care, treatment or condition. Volunteers, nursing staff and clinical nurse specialists provided comfort and support for patients and those close to them.
- Patients were counselled on their first treatment visit and given details of support centres, which provided help and emotional support. Staff were trained in counselling patients with cancer; their training included breaking bad news and communication challenges.
- Staff told us patients had an assigned nurse to deal with hair loss in patients and the service held 'look good, feel good' sessions.
- A hairdresser was available to support patients who experienced hair loss and teach them how to tie scarves. Staff told us, and we observed, 'cool caps' in use for patients. Cool caps help to prevent or minimise hair loss in patients undergoing cancer treatment.
- A breast care nurse supported patients with breast cancer with their body image. We saw from notices on display in OPD that chaperones were available for patients that wanted them.
- Staff in the oncology day care unit told us that holistic patient-centred care was a priority for them.
- We observed caring interactions between staff, patients and relatives. Staff reassured patients and relatives about the care and treatment they received.

Are outpatient and diagnostic imaging services responsive?

Outstanding ☆

We judged the responsiveness of these services to be outstanding because services were tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care. We found:

- Access and flow in the OPD and radiology departments was well managed, even though all of the departments were busy. We saw the nurse coordinator 'walking the floor.'
- Referral to treatment times (RTT) were being met and the 'did not attend' (DNA) rates were lower (better) than the national average.
- People's individual needs were being met; there were numerous leaflets and signs available. Staff used pictures for patients with additional needs such as learning disabilities. There were specialist oncology and research nurses within specialist cancer services.
- The services took account of complaints and comments to improve the service.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people. For example, staff delivered chemotherapy to patients at WPH on an outpatient basis, rather than being an inpatient; this improved patient experience and saved on resources.
- Oncology services were designed to meet patient's holistic needs and to provide relevant individual information and advice.
- The oncology OPD monitored the service's activity data and workload on a monthly basis. This ensured oncology clinics were planned to meet the needs of the patients using them.
- Space was limited in the oncology OP waiting areas and clinic rooms; staff we spoke with told us they needed more space. The trust had plans in place to refurbish and reconfigure these areas.
- The OPD had refurbished an office into a counselling room, providing an additional area for patients. Monies were awarded to the department from and 'essence of care' bid, which was submitted specifically for this purpose.
- Treatments were delivered in outreach hospitals whenever possible.
- Oral anticancer therapies were delivered to either the patient's home or a designated local pharmacy.
- The MIMP directorate performed radiology investigations for approximately 500,000 attendances per year. The directorate had a five year strategy developed for Medical Imaging and Medical Physics.
- Same day plain film X-ray services were provided for direct referrals from GPs and planned appointments for CT, MRI and ultrasound.
- Car parking was a significant problem for patients attending WPH; car park attendants managed the throughput of patients, visitors and staff. Several patients we spoke with said that car parking was the

only negative aspect of their experience of the service. The services ensured patients were kept informed of delay, and kept waiting times to a minimum where possible.

Access and flow

- Access and flow in the OPD and radiology departments was well established. We saw all of the departments were busy during our inspection, but patient flow was generally maintained.
- Referral to Treatment (RTT) within 18 weeks had been performing above the national average since September 2014. Staff in oncology OP told us medical records alerted the clinic if a patient was about to breach the 18 week target.
- The 'did not attend' (DNA) rates were lower (better) than the national average.
- Staff in oncology OPD told us they prioritised patients booked on hospital transport to avoid long waits.
- In oncology OPD, staff told us delays were common; however, staff kept patients informed and patients understood that some patients might need extra time with their appointments. Patient appointments were 20 minutes long, and 40 minutes for first appointments.
- The chemotherapy co-ordinator maintained a database of all new patients starting treatment. This information informed acuity by using complexity of treatment and nurse treatment times.
- We observed one clinic in oncology, which was running late. We saw staff alerted patients about the waiting times and staff kept them verbally informed with any updates.
- There was an escalation policy in OPD and pathology, which was used when patients had waited for more than 30 minutes. We reviewed this policy and observed that it was followed in the clinics.
- Work was underway to spread and embed technology for improved outpatient services such as call centre technology for making appointments, electronic referrals and electronic check in kiosks.
- At the time of the inspection, waiting time and late start data was not routinely collected across STH. Processes for routine collection of waiting time data was under discussion through the Outpatient Steering Group and with STH Information Services. This data would be used to measure performance and highlight improvement opportunities.
- Pathology laboratory services were all co-located on one site at the NGH, to ensure patients received their results as quickly as possible.
- Radiographers were in control of scheduling the arrival and departures times of inpatients to and from the x-ray department.
- No undue delays were observed at the time of our visit within radiology and staff told us in the event of any delays the patients were kept informed. Inpatient examinations were performed within 24 hours to assist reductions in length of stays.
- There had been no breaches of the six-week wait for radiology. Patient satisfaction surveys over the previous three years showed patients were satisfied with access and waiting times.
- The MIMP directorate monitored turnaround times and produced a radiology report. The report for March to August 2015 showed the directorate was reporting CT MRI and plain film reports within three days from the time of the scans. Sonographers reported ultrasound scans on the same day.
- The MIMP directorate waiting times and did not attend (DNA) report for December 2015 showed that the majority of patients appointments following referral were booked within two weeks. DNA rates were consistently low across all modalities.
- Shorter diagnostic waiting times are linked to treatment waiting times and are of benefit to patients getting quicker access to treatment. The 6-week diagnostic wait target introduced by the DH in 2008 was to ensure patients receive timely and appropriate treatment. The targets were being consistently met.

Meeting people's individual needs

- Services took account of different people's needs, including those in vulnerable circumstances, with disabilities or complex needs. There were numerous leaflets and signs available and staff used pictures for patients with additional needs such as learning disabilities. There were specialist oncology and research nurses within specialist cancer services.
- Translation services were available to request and these services were available through appointment bookings. Staff told us they were aware and knew what procedures to follow to secure the services of translators. Staff in oncology OPD told us they used telephone or face-to-face translation services for consultations that required them.

Outpatients and diagnostic imaging

- Patient choice for booking the location dates and times of appointments was provided. Patients with additional needs, such as those with dementia or a learning disability, were offered additional appointment time to ensure their needs could be accommodated and met.
- Patients we spoke with confirmed appointments were offered that suited their needs. Some patients confirmed that appointments were made within two weeks of their referral; others commented they did not have to wait a long time before they received their appointment.

Learning from complaints and concerns

- The provider took account of complaints and comments to improve the service. For example, following complaints from oncology patients about access to phlebotomy, changes had been introduced in September 2015. As a result, patient's care was not as fragmented, as trained staff nurses took blood samples from the patient's peripheral inserted central catheters (PICCs) prior to their clinic appointment.
- There were systems and processes in place to acknowledge, investigate and respond to complaints within a defined period. Managers discussed complaints to share findings and identify learning outcomes at departmental, governance and staff meetings.

Are outpatient and diagnostic imaging services well-led?

Outstanding ☆

We judged the well-led domain for this service to be outstanding because the leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. We found:

- Services had a clear vision and strategy which staff were aware of and passionate about.
- There was a well-established culture of continuous quality improvement, which was supported by robust governance, risk management and quality monitoring.
- Staff were happy and felt well-supported in all of the services we visited. There was evidence of good team working, both within and between teams, and a positive open culture.
- People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.
- There were numerous examples of innovation and improvement across all of the services inspected.

Vision and strategy for this service

- Services had a clear vision and strategy which staff were aware of and passionate about. Staff we spoke with were aware of the needs of their services and how the services planned to develop.
- Specialised cancer services had a five-year strategy for October 2015 to 2020, to develop the transformation strategy and operational plan. Teams of staff at different grades were working together to develop the aims of the strategy. The project included data reviews, a service improvement work stream and visits to other leading cancer centres.
- The MIMP directorate had a five year strategy developed that set out a range of developments in services and technologies to improve the quality of patient care and treatments. For example;
- growth in, and technological advancement of, cross sectional imaging
- introduction of new imaging technologies such as breast tomosynthesis
- The 3D imaging laboratory to become central to radiology workflows
- New PACS and RIS systems.

Governance, risk management and quality measurement

- There was a well-established culture of continuous quality improvement. This was supported and assured by robust governance, risk management and quality monitoring.
- The clinical, scientific and nursing directors together with the matron, directorate and governance managers attended the radiology directorate monthly clinical governance committee meetings. The committee routinely reviewed and monitored the directorates overall governance performance. It also routinely reviewed all incidents, complaints, claims and inquests in order to identify and monitor trends.
- The June, July and September 2015 meeting minutes included reviews with action notes recorded. Actions from previous reviews were followed up appropriately at subsequent meetings.

Outpatients and diagnostic imaging

- The Safety and Risk Management Board met monthly and included a range of managers attending from each clinical directorate. The MIMP governance manager attended these board meetings. We saw from the August, September and October 2015 minutes that patient safety alerts and safety reports were reviewed from a number of committees. The minutes included the learning from incidents, inquests, claims and complaints processes, health and safety, safety of medical devices and serious untoward incidents (SUI's).
- There was a radiation safety infrastructure in place which included the reporting of radiation incidents from local clinical teams and section heads into one of five radiation safety sub groups for; Ionising radiation (x-ray), Non- ionising radiation (MRI and Ultrasound), Radiotherapy (sealed sources), Nuclear Medicine (unsealed sources) and Dental (x-ray). RPAs and RPSs attended the radiation sub groups.
- All five safety sub groups reported to the Radiation Safety Steering Group (RSSG) who in turn reported to the trusts Healthcare Governance Committee and then onwards to the Board of Directors.
- The purpose of the sub groups and RSSG was to ensure radiation safety issues requiring action by the trust were reported and acted upon appropriately in order to achieve on-going legislative compliance and ensure the safety of staff, public and patients.
- The MIMP directorate employed Radiation Protection Advisors (RPA's) and Radiation Protection Supervisors (RPS's). Arrangements were in place to seek advice from the RPA's in accordance with the local rules. RPAs also supported procurement of radiology equipment, room planning, quality assurance incident investigations and governance, radiology local rules and local risk assessments.

Leadership of service

- A specialist team led specialised cancer services. This included a clinical director, chemotherapy lead clinician, deputy clinical director, radiotherapy lead clinician, nurse director, general manager, lead for physics and lead oncology pharmacist.
- A clinical director, supported by scientific, operations and nursing directors, led the MIMP (Medical Imaging and Medical Physics) directorate. All the directors together with a number of other senior managers and service heads managed medical imaging and medical physics services and an integrated staffing resource of clinical, scientific and technical experts across the directorate.
- The trust operated a system of devolved leadership and clinically led care groups and clinical directorates were responsible for managing the majority of services. There were nine care groups within the trust.
- The medical imaging and medical physics (MIMP) clinical directorate was fully integrated, bringing together the services of radiology and medical physics at the Royal Hallamshire Hospital (RHH), Northern General Hospital (NGH) and Weston Park Hospital (WPH).

Culture within the service

- Staff told us they were happy and felt supported in their roles. They also told us team working was good and they would be confident to ask questions.
- Staff in oncology OPD, DCU and radiology were aware of the trust's PROUD values; these had been incorporated into the appraisal process for all staff. PROUD was an acronym for:-
- Patient first
- Respectful
- Ownership
- Unity
- Deliver
- The internal reorganisation of the trusts medical imaging service was still in progress at the time of inspection. Senior managers envisaged this process was likely to continue for several months and it would take time for all the staff to adjust to the new ways of working.
- The majority of the staff we spoke with had a positive, optimistic and confident view about the recent changes introduced through the MIMP directorate and care group structure.
- Staff we spoke with reported that local leadership was positive and overall they were positive about the recent and future management of MIMP directorate. Teamwork across the directorate worked well.

Public engagement

Outpatients and diagnostic imaging

- Outpatients participated in the NHS England friends and family test (FFT).Following the 2014 quarter 1 FFT results; an engagement meeting was set up at WPH. Specialised cancer services analysed and took action on patient feedback on a regular basis.
- There had been a large donation by patients to improve the OPD, to make consulting rooms less clinical and to provide more information for patient support.
- Specialised cancer services carried out structured evaluations of patients' experiences to develop insights into their priorities and concerns and identify areas for care improvements.
- The radiotherapy team carried out a patient satisfaction survey every year. The feedback was positive and patients commented on the friendly, caring environment and staff and the calmness of the environment. The results were analysed by the team, shared with staff and an action plan was produced.
- In radiology, the service sought patient opinion through the MIMP patient survey. The 2014 and 2015 survey reports showed patients were very positive and satisfied with the services provided. Managers used patient feedback in business planning.
- The outcomes from these surveys were shared with the service heads. The service agreed on focused actions, to build on to further improve the quality of services provided to patients**.**

Staff engagement

- Staff in OPD told us that the trust's outpatient improvement programme and 'Listening into Action' groups were established within the directorate. Over 50 teams were undertaking improvement based work. Staff told us managers and senior staff asked for their ideas and solutions through local engagement.
- In radiology, there was a staff engagement lead; they were responsible for arranging engagement meetings and obtaining staff feedback, ideas and solutions. Listening in action groups were established within radiology.

Innovation, improvement and sustainability

- The directorate hosted the 'Devices for Dignity (D4D) Healthcare Co-operative'. This is a national initiative to drive forward innovative products processes and services to help people with long-term conditions'.
- The Devices for Dignity (D4D) Healthcare Co-operative' had been recognised with a number of awards including 2012 Advancing Healthcare Awards and Allied Health Professionals and Healthcare Scientist and Leading Together on Health Award.
- The development of the Sheffield 3D imaging lab is unique to the NHS and provides improved quality of scans and detail of brain tumour growth. Images could be processed quicker, in seconds rather up to an hour, saving time and money. The 3D lab was a finalist in the Yorkshire and Humber Medipex NHS Innovation awards.
- In addition to walk in services for general plain film imaging GP's can refer patients directly for CT, MRI, ultrasound, fluoroscopy and other specialised imaging examinations.
- There was a state of the art Medicines and Healthcare products Regulatory Agency (MHRA) Licenced Radiopharmacy, serving all of the trusts locations.
- Nuclear medicine staff were finalists in the Medipex NHS innovation awards 2014 after developing a new system for diagnosing debilitating digestive disorder that freed up the gamma camera, so reducing patient waiting times.

Outstanding practice and areas for improvement

Outstanding practice

Specialised cancer services provided a patient-centred holistic approach to patient care where the whole multidisciplinary team worked together to ensure the patient's experience of the service was the best that it could be.

The teenage cancer unit had a number of innovations which had been paid for out of charitable funds. These included a 'couples retreat' for end of life patients and their partners. They could spend time away from home and explore issues about coming to the end of life.

Areas for improvement

Action the hospital MUST take to improve

The hospital must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.

The hospital must have safe systems in place to ensure the safe management of medications

The trust must ensure there is a clear strategy for the end of life care which is implemented and monitored.

The trust must ensure that staff implement individualised, evidence based care for patients at the end of life.

The trust must ensure that DNACPR records are fully completed.

Action the hospital SHOULD take to improve

The hospital should improve the environment and the skills of staff to ensure that the needs of people living with dementia are met.

The hospital should improve the completeness of patient records. In particular the nursing care plans and review of patient risk.

Level of compliance with mandatory training need to be improved, in particular, basic life support for adults and paediatrics and safeguarding children and vulnerable adults.

The hospital should develop standard procedures for completing interventional radiology non-surgical safety checklists for all staff to follow.

The hospital should undertake regular audits of patient electronic records to ensure consistency in the completion of MRI safety checklist and pregnancy checks.

The trust should identify and monitor patients preferred place of care or death in order to meet individual's needs and to improve or develop services.

The trust should continue to implement IT systems to enable staff to access accurate and timely information.

The trust should review the Deprivation of Liberty Safeguards (DoLS) policy.

The trust should monitor access to records in the outpatient departments.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty. How the regulation was not being met: Nursing staffing levels were below the planned level with many shifts having fewer registered nurses than required on duty.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg. 12 (1) (g) There must be proper systems in place to ensure the safe management of medications. How the regulation was not being met: Intravenous fluids were not always stored safely and securely, oxygen was not prescribed, drug fridge temperatures were not always accurately monitored or maintained.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 Systems and processes must be established and operated effectively to: (a) assess, monitor and improve the quality and safety of services

This section is primarily information for the provider

Requirement notices

(c) Maintain securely and accurate, complete and contemporaneous record of care

How the regulation was not being met: There was no end of life care strategy. DNACPR records were not completed fully and accurately.