The Royal Wolverhampton NHS Trust

New Cross Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

We undertook this inspection 02 to 05 June 2015. It was an announced comprehensive inspection. This trust had been inspected in the first wave of the comprehensive programme November 2013.

Our rationale for undertaking this inspection was to rate the trust because the initial inspections did not receive a rating due to being in the early wave one pilot programme. In addition to this the trust had taken over some services from the dissolved Mid Staffordshire NHS Trust, which included Cannock Chase Hospital.

The trust had previously stated its intention to become a Foundation trust, but had had to postpone the application a number of times; allowing them to address current matters such as the integration of new services appropriately.

We recognise that we saw this hospital, and the trust is a state of change. Integrating services between New Cross Hospital and Cannock Chase Hospital. We also noted some significant building work on the hospital site, including a new Urgent and Emergency Care unit.

We inspected all core services on the New Cross site; this included Urgent and Emergency Care; Medical Care, Surgical Care, Critical care, Maternity Services, Children's Services, End of Life care, Outpatients and Diagnostic Imaging.

Overall we rated the New Cross Hospital as Requires Improvement.

We rated Urgent and Emergency Care and Surgical Services as Good, we rates all other services are Requires Improvement.

We rated the hospital as Good for Effective, caring and Responsive; we rated the hospital as Requires Improvement for Safe and well Led.

Our key findings were as follows:

- Good services were provided by Urgent and Emergency Care. Safe systems were in place and the hospital was responding to the increase in demand by expanding the unit. In the interim; processes and procedures were effective.
- Good Services were provided by Surgical Services; care was delivered within national guidance and the trust was largely meeting the 18 week referral to treatment target.
- We saw good compliance with hand hygiene and with the trusts 'bare below the elbows' policy. We saw staff in outpatients remind visitors to use hand gel. On the occasions we saw non-compliance, we raised this with the clinical manager and it was immediately dealt with.
- We saw largely good and compassionate care within the hospital. Staff were focused on patient care.
- We did see a number of examples in medical care services that did not demonstrate the high standards of patient care set in other parts of the trust. These isolated examples demonstrated poor patient care.
- We saw nurse staffing levels sufficient for the needs of the service including Urgent and Emergency Care and Critical Care and Children's Care and Outpatients. However in Medical Care we saw staffing a challenge to meet the requirements of each shift. Staffing in Surgical Care was on the trusts risk register, although we saw the trust had taken action to recruit more staff.
- There were mainly sufficient medical staff to care for patients. Children's services and radiology had vacancies and the trust were aware of these.
- We saw sufficient equipment across the trust to meet the needs of patients, although in medical care services there was a concern about sufficient monitoring equipment.
- We saw that the trust was meeting cancer access targets and the 18 week referral to treatment times in outpatients and in many of its surgical specialities.

We saw several areas of outstanding practice including:

Summary of findings

- The hospitals SimWard was being utilised to support staff competencies. Staff told us they were in the process of expanding the service externally to provide education and learning to other authorities.
- Doctors, nurses and therapists were provided with a stamp by the trust with their name and personal identification number. This enabled other staff to easily track who had completed the patient record when required.
- In surgical services, we saw that the trust recently instituted "In Charge" initiative was welcomed by patients and relatives. This was a badge worn by the person responsible for that shift on the ward.
- There were arrangements in place with Age Concern that certain patients funded by the local CCG could be called upon to transport suitable patients. There was a checklist in place for the driver who would ensure that the patient had all the necessary comforts in the home for example, food and a suitably heated home. The Age Concern drivers would stay with the patient in their home to ensure they are safe to be on their own.
- The "panel meeting" concept where senior trust staff provided high challenge and high support to wards managers after investigation of incidents. This meeting enabled staff to take the learnings from such events on board and ensure systems were put in pace to prevent reoccurrence.
- We saw that the mortuary staff were very passionate about delivering a high standard of care after death.

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

Action the hospital MUST take to improve

Medicine

- The trust must improve the attitude and approach of some of its staff to patients in their care.
- The trust must improve the level of detail in patient care records, reflecting individual preferences.
- The trust must review the amount of monitoring and supporting equipment on its wards.

Surgery

- The trust must make sure that the recruitment of additional staff that was being undertaken to resolve the transportation of blood is completed in a timely manner.

Critical Care

- The trust must ensure that regular checks are recorded regarding the cleaning of equipment.
- The trust must ensure that locally owned risks are identified and recorded on the risk register and have appropriate actions to mitigate them, with timely reviews and updates.
- The trust must ensure the medicine room is locked to reduce the risk of unauthorised people accessing medicines.
- The trust must ensure that intravenous medicines are stored correctly to reduce the risk of the administration of incorrect medicines.
- The trust must ensure that the microbiologist input is recorded within the patient records to support their care and welfare.

End of Life Care

- Controlled medication must be labelled, prescribed to a patient and packaging must not be tampered with.

OPD and Diagnostics

- The trust must ensure that when controlled drugs are removed from the medicines cupboard in radiology, this is clearly documented at the time of administration.
- The trust must insure that governance systems improve so that safety issues and shortfalls in risk assessments and protocols are highlighted and addressed.
- The trust must insure that there is clear ownership of responsibilities to ensure the radiology departments is working within best practice professional guidelines and IR(ME)R regulations

Summary of findings

Action the hospital SHOULD take to improve

Emergency Services

- The trust should improve staff understanding of the dementia care pathway for patients in the ED
- Medicine fridge temperature records in the ED should be recorded daily to ensure medicines were stored safely.
- Evidence of resuscitation status should be included in patient's records.
- ED staff take up of mandatory training should be improved.
- The trust should be clear about the use of the paediatric facilities in the ED
- The trust should improve public information about making a complaint in the ED

Medicine

- The trust should improve the attitude and approach of some of its staff to patients in their care.
- The trust should improve the level of detail in patient care records, reflecting individual preferences.
- The trust should review the amount of monitoring and supporting equipment on its wards.
- The trust should review arrangements for transferring patients to Cannock Chase Hospital late at night.

Surgery

- The trust should make sure that all staff is up to date with the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards so that patients are not put at unnecessary risk of staff not acting legally in their best interests.
- The trust should make sure that there are process in place to ensure formal "sign in" takes place in the anaesthetic room.
- The trust should make sure that a number of required policies and procedures identified from the national emergency laparotomy audit 2014 are put in place.
- The trust should make sure that patients with bowel cancer can access appropriate clinical nurse specialist.
- The trust should ensure there are resting seats available for vulnerable patients to avoid them to walk long intervals without resting.

Critical Care

- The trust should ensure there are procedures in place to record the checking of the resuscitation trolley.
- The trust should ensure that the trust's vision and strategy is cascaded to all staff.
- The trust should ensure that all policies and procedures are up to date and have been reviewed appropriately.

Maternity and Gynaecology

- The trust should improve the quality of record keeping in maternity.
- The trust should improve the checking of drugs and fridge temperatures where medicines are stored..
- The trust should ensure emergency equipment is readily available to use.

End of Life Care

- The trust might like to review staffing levels in particular on the oncology ward and surgical wards.
- The trust should develop clear guidance for staff on repositioning spinal cord compression and spinal cancer patients.
- Spinal cord compression and spinal cancer patients must be repositioned according to their assessment and trust policy. Staff should record incidents where appropriate.
- The hospital might like to improve on communication with families and better recording of their discussions with staff, ensuring discharge is consistently discussed and they are kept informed of patient's conditions.

OPD and Diagnostics

Summary of findings

- The trust should ensure that the renal unit complies with staffing requirements stipulated by the National Institute of Clinical Excellence.
- The trust should ensure that staff in radiology receives feedback in relation to shared learning and changes in practice resulting from incidents.
- The trust should ensure that call bells within radiology cubicles are fit for purpose and that there is clear signage outside x-ray rooms alerting patients not to enter and advising women to inform staff if they are pregnant.
- The trust should ensure that the procedure to check whether women are pregnant prior to receiving radiography tests is improved
- The trust should ensure that the nuclear medicine (imaging) service issues 'written instructions' to females who are breastfeeding and who have undergone a radio nuclide procedure.
- The trust should ensure that Local Diagnostic Reference Levels are available for the CT scanners (and other diagnostic procedures) and that CT radiographers have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended and how this should be reported.
- The trust should ensure that the clinical imaging protocols (operating procedures) are fit for purpose and that basic scan parameters are present that would allow an operator to follow and find operational information to be able to perform a scan safely and to check that recalled electronic settings within the scanning equipment is in concordance with the written protocol.
- The trust must ensure that the radiation risk assessments are fit for purpose and have enough specific detail for the radiation work undertaken in each area.
- The trust must ensure that there are Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.
- The trust should ensure that paediatric reports within radiography are produced promptly.
- The trust should ensure that appointment letters and patient information leaflets are available in languages other than English.
- The trust should ensure that there is a method of monitoring whether patients have been present in outpatients or radiology for long periods to ensure they have adequate food and drink.
- The trust should ensure that patient feedback is received and acted upon in radiology to improve service provision.
- The trust should ensure that radioactive medicinal products and waste are securely stored and accounted for at all times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	We found services provided by the ED overall were good. Safety systems were in place that supported incident reporting and learning from incidents, safeguarding children and adults and providing sufficient numbers of staff with the right skills to assess, treat and care for patients. Patient's care was planned and delivered in line with up to date guidelines and protocols. The ED checked its own performance regularly and took steps to improve on it if it was below standard or as a result of learning from incidents. There were good professional relationships between nurses and doctors and other specialist health and social care workers to support patients' needs and safe discharge. Staff were caring and responded compassionately to patients when they were in pain and were kind and warm towards patients and their relatives when they were upset and worried. Staff supported patient's dignity and privacy. The trust was responding to the increased need for emergency and urgent care services and working with local commissioners. The ED had not met national targets around seeing, treating and discharging patients within four hours but a new system had been put in place to help managers to improve the flow of patients through the ED and the wider hospital and avoid it becoming blocked at busy times. There were arrangements to make sure patients with particular needs were looked after such as children and people with mental poor health. Complaints were taken seriously, investigated and reported up to trust leaders. Staff learned from them. However, the complaints procedure was not readily available to patients in the ED. The ED was well supported by the rest of the trust, had strong local leadership and staff at all levels and roles worked as part of a team and enjoyed their jobs. There was an openness and willingness

Summary of findings

to learn from mistakes. Safety and quality was regularly reviewed and risk was managed. Staff and managers were also involved in planning the new emergency and urgent care centre.

Medical care

Requires improvement

Nurse recruitment within medical services was a known challenge for the trust. There were initiatives in place to recruit additional nurses but nursing staff shortages especially at night compromised patient safety. The trust policy, not to use agency nurses meant that shifts were frequently unfilled or the skill mix was inappropriate to meet patient's needs. Cardiology staff had particular concerns about how staffing was adversely affected when the day ward was open overnight which put cardiology patients at risk due to insufficient staff.

Incident reporting was established and was acted upon when needed; although staff felt staffing concerns were always adequately addressed.

Medical records were appropriately completed although nursing care records lacked detail and were not individualised. The safe hands system identified patients and staff location and was an excellent initiative to promote patient safety. The availability of appropriate equipment used to monitor patient's observations was insufficient and caused staff concern and put patients at potential risk.

Care was provided in accordance with evidence-based and best practice guidelines. Care was monitored to show compliance with standards and there were good outcomes for patients. Seven days working was established for the majority of staff and multidisciplinary working was evident to coordinate effective patient care. Staff had access to training and had received annual appraisals.

Patients said that staff were caring and friendly and felt that their dignity and privacy were respected. We observed mostly kind and compassionate care although found not all staff appeared caring or compassionate.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the patients. We saw patient focussed approaches to care and treatment.

Summary of findings

Staff were positive about the standard of care they provided and the support they received from their managers. There was a culture of audit and improvement within the medical services.
There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. However despite efforts to employ sufficient nursing staff this risk had not been fully addressed and this had not been appropriately addressed by senior managers.

Surgery

Good

Patient safety was monitored on a daily basis and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care.
The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. Surgical services performed in line with similar sized hospitals and with the England average for most safety and clinical performance measures. The results of the national emergency laparotomy audit 2014 identified a number of required policies and procedures were not yet in place. The National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist.
Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.
The majority of patients were admitted, transferred or discharged in timely manner. The surgical services achieved the 18 week referral to treatment standards for most specialties. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

Summary of findings

There was clearly visible leadership within the surgical services. Staff were positive about the culture and support available. The management team understood the key risks and challenges to the service and how to resolve these.

Critical care

Requires improvement

Critical care services required improvement to support safe care. There were significant risks posed by the infrastructure and environment of the integrated critical care unit (ICCU). Medical staffing was appropriate and there was good emergency cover. The storage of medicines in the integrated critical care unit (ICCU) required improvement to ensure secure storage facilities to reduce the possibility of misappropriation of medicines. We found intravenous medicines were mixed within the storage room visited which could lead to the misadministration of medicines to patients.
Staff told us they were encouraged to report any incidents which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The environment was visibly clean and most staff followed the trust policy on infection control.
The critical care service demonstrated good effective care. Patients received care and treatment according to national guidelines and there was good multidisciplinary team working to support patients. The service participated and provided data for the Intensive Care National Audit & Research Centre (ICNARC). This ensured that the practice was benchmarked against similar services. Policies and procedures were accessible to staff. However, we saw that some hard copies of policies were dated 2007 to 2014 with no evidence of review. Staff told us they were able to access up to date policies on the trust's intranet system.
Patient's pain was appropriately managed as was the nutrition and hydration of patients. Staff had access to training and had received annual appraisal. The critical care service had a consultant-led, seven-day service. Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Summary of findings

We observed good care within the ICCU. Staff cared for patients in a compassionate manner, with dignity and respect. They involved patients and, where appropriate, their relatives in the care. Emotional and spiritual support was also provided.
The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times. Patients had follow-up support from the outreach team.
Patients with a learning disability were provided with the necessary support. Staff also had access to translation services. Complaints were handled appropriately.
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We found that critical care services required improvement to be well-led. Most staff were not aware of the vision or strategy for the critical care service.
The ICCU held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. There were concerns about the impact on patient care and safety which were not identified on the risk register.
There was a culture of support and respect for each other, with staff willing to help each other. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.
Patients were engaged through survey feedback. The survey questionnaires showed that patients were happy with the care and treatment they had received.
Innovative ideas and approaches to care were encouraged and supported. There was positive awareness among staff of the expectations for patient care.

Maternity and gynaecology	**Good**		Overall we found the service was good although the domain of safe required improvement. There were many good examples of the maternity unit being safe including incident reporting

systems, audits concerning safe practice and compliance with best practice in relation to care and treatment plans. However emergency arrangements needed to improve.
Obstetric consultant cover was not adequate being below the required hours for the number of births undertaken annually.
Policies were based on National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecology (RCOG) guidelines. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice.
The birth to midwife ratio was 1:30. The named midwife model was in place and women told us they had a named midwife. Midwives provided one to one care in labour.
Patients told us that they felt well informed and were able to ask staff if they were not sure about something. We saw limited patient information leaflets available.
In March 2013 the maternity service at the Royal Wolverhampton NHS Trust achieved compliance with level two requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2012/13, scoring 46 out of 50.
There was an active maternity services liaison committee (MSLC), which met quarterly.

Services for children and young people

Good

Overall we found the service to be good.
We found that there was a reactive culture in the service which responded well after events had happened. They shared learning to prevent an event re-occurring and responded to issues which had been brought to their attention.
Similarly the Trust Development Agency (TDA) had completed a review of the paediatric ward earlier in the year, they identified 77 minor issues. We saw evidence during our inspection that all the issues had been dealt with and interventions put in place to prevent them re-occurring, but again the issues were such that proper governance and supervision should have identified.
We found that services were caring and staff were dedicated and knowledgeable.

Summary of findings

Services were based on recognised clinical pathways which meant patients received treatment based on the latest information and best practice guidance.
Patient care was individualised and designed to meet the physical and mental needs of each patient. The service responded to people's needs.
The service needed to improve to identify failings and prevent issues occurring in the first place.
We saw instances of unsafe practice in relation to services provided to children and young people both in the paediatric day-case unit and the fracture clinic. These were escalated and dealt with immediately, but the service failed to identify the risks themselves.

End of life care

Good

Out of the 94 incidents reported to the palliative team, we saw eight were in relation to low staffing levels. We noted some resulted in palliative patients not being attended to or observed as often as they required and "Care was compromised". Staff on surgical wards told us they would struggle to ensure end of life patients received the care that they needed. However, they told us that the palliative team were aware of their pressures and were very supportive.
The palliative team were not solely responsible for end of life patients but they supported the medical and nursing teams in providing specialist advice.
We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. Although improvement was needed to ensure that controlled medicines were safely and appropriately administered.
We reviewed medical and nursing paper care records and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and saw these were well completed.
The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

Summary of findings

The palliative care team had introduced a staff survey, the results identified how approachable, supportive and informative members of the team were.
The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life. Staff adopted practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) , staff returned jewellery in a small box, they were given the choice of the deceased being clothed in their own clothes rather than a disposable paper shroud and the hospital renamed the mortuary the Swan Suite for discrete communication in public areas. Literature on both hospital sites had been updated and rebranded such as: the advanced care plan, the 'practical information leaflet' and the feedback survey was redesigned to have the Swan logo.
The rationale for the Swan logo was to trigger a compassionate response and kind communication. All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.
We noted there was easy access to the palliative care team and they were responsive in supporting ward staff.
On both hospital sites the staff developed a 'Rapid Home to Die Care Bundle' which facilitated a rapid discharge. Staff told us they had used this bundle several times and were able to discharge a patient with a complex package of care within 24 hours.
For both hospital sites the palliative team had a clear vision for their service. The leadership,

Summary of findings

governance and culture promoted the delivery of high quality person centred care. The team displayed good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care. The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice.
We saw the culture was a positive energetic one.

Outpatients and diagnostic imaging

Requires improvement

Overall the services within outpatients and diagnostic imaging services required improvement. Most of our concerns related to imaging within safety, effective, responsive and well led.
Outpatients was broadly satisfactory.
Within radiology there were concerns with the safety of signage, out of date clinical items and the management of controlled drugs. Clinical imaging protocols and risk assessments were not fit for purpose.
Staffing levels within the renal unit did not comply with NHS England and British Renal Society guidelines. Appointment letters and patient leaflets were only available in English. There was no method of monitoring the length of stay of patients within outpatients to ensure they were provided with food and drink.
There was not a clear vision and strategy within the outpatients and radiology departments. There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.
Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to individual patient needs.

New Cross Hospital

Detailed findings

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

Detailed findings

Contents

Background to New Cross Hospital

The Royal Wolverhampton Hospital NHS Trust is one of the largest acute and community trusts in the West Midlands. New Cross Hospital has more than 800 beds including 42 intensive care beds. This included 14 general beds, 14 cardiac beds and 14 neonatal intensive care beds. New Cross Hospital provides secondary and tertiary services, maternity, accident and emergency, critical care and outpatient services.

The trust employed over 8,000 with 6,700 staff providing a comprehensive range of services across New Cross Hospital.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

Team Leader: Tim Cooper, Head of hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

There were three experts by experience who were part of the team, they had experience of using services and caring for a person who used services.

Detailed findings

How we carried out this inspection

We analysed the information we held about the service, which included national data submissions and information which people had shared with us. In addition to this we reviewed the information the lead inspector had of the service.

We visited the service as part of an announced inspection. The trust had 12 weeks' notice of our inspection start date.

We spoke with patients and visitors and previous users of the service via listening events and specialist groups. We also spoke with staff both clinical and non-clinical staff. We also spoke the executive team about their roles and responsibilities strength and weaknesses of the trust. We spoke to staff individually and in focus groups arranged in advance and one arranged for the same day, as the demand to speak with the inspection team was high.

To reach out ratings we also reviewed documents in use at the time of the inspection and documents sent to us both pre and post the inspection, plus our observations of staff practice.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

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

We carried out an unannounced inspections between the dates of 08 to 19 June 2015.

Facts and data about New Cross Hospital

The Royal Wolverhampton Hospital NHS Trust is one of the largest acute and community trusts in the West Midlands. New Cross Hospital has more than 800 beds including 42 intensive care beds. New Cross Hospital provides secondary and tertiary services, maternity, accident and emergency, critical care and outpatient services.

The trust employed over 8,000 with 6,700 staff providing a comprehensive range of services across New Cross Hospital.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The Royal Wolverhampton NHS Trust is one of the Acute Trusts in the region. They provide a comprehensive range of district acute and specialist services for the people of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire.

Wolverhampton is a multi-ethnic, multinational city and one of the most deprived local authorities. The deprivation is worse than the England average.

Emergency Department (ED) attendances across the trust from March 2014 to February 2015 were 153,315.

According to Trust Board performance report of April 2015, the ED continued to see increasing numbers of patients with attendances at year end 6.75% higher than last year. This equated to an additional 7,915 attendances at New Cross Hospital only and the total increase in attendances for 2014/15 (including Walk in Centres) was 10,735 (6.92%).

The emergency department includes a paediatric area. The ED was responsible for seeing and treating on average 75 children during a day.

The trust was in the process of completing construction of a new emergency and urgent care facility on the New Cross Hospital site at the time of our inspection and had taken over running the minor injuries unit at Cannock Chase Hospital in March 2015.

During our inspection, we spoke to approximately 50 people using the service and twenty staff in a variety of roles in the ED.

Summary of findings

We found services provided by the ED overall were good.

Safety systems were in place that supported incident reporting and learning from incidents, safeguarding children and adults and providing sufficient numbers of staff with the right skills to assess, treat and care for patients.

Patient's care was planned and delivered in line with up to date guidelines and protocols. The ED checked its own performance regularly and took steps to improve on it if it was below standard or as a result of learning from incidents. There were good professional relationships between nurses and doctors and other specialist health and social care workers to support patients' needs and safe discharge.

Staff were caring and responded compassionately to patients when they were in pain and were kind and warm towards patients and their relatives when they were upset and worried. Staff supported patient's dignity and privacy.

The trust was responding to the increased need for emergency and urgent care services and working with local commissioners. The ED had not met national targets around seeing, treating and discharging patients within four hours but a new system had been put in place to help managers to improve the flow of patients through the ED and the wider hospital and avoid it

Urgent and emergency services

becoming blocked at busy times. There were arrangements to make sure patients with particular needs were looked after such as children and people with mental poor health.

Complaints were taken seriously, investigated and reported up to trust leaders. Staff learned from them. However, the complaints procedure was not readily available to patients in the ED.

The ED was well supported by the rest of the trust, had strong local leadership and staff at all levels and roles worked as part of a team and enjoyed their jobs. There was an openness and willingness to learn from mistakes. Safety and quality was regularly reviewed and risk was managed. Staff and managers were also involved in planning the new emergency and urgent care centre.

Are urgent and emergency services safe?

Requires improvement

We found safety in the ED to require improvement.

There was an appropriate system in place to tell people when something had gone wrong with their care and openness and transparency about safety was encouraged. Incidents and errors were reported and investigated and lessons were learned and shared in order to improve safety.

There were processes in place to prevent infection and staff were generally compliant with them. Further improvements needed to be made around some aspects of infection control.

The trust had already recognised that improvement was needed in the completion of patient's documentation and we found some inconsistencies in the quality of records.

We found there were robust systems in place within ED, supported trust wide, for safeguarding children and babies. However systems for safeguarding vulnerable adults were not so visible although staff did understand their responsibility to respond to concerns.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe and there was a system in place to respond to staff shortages quickly without resorting to agency staff use. The ED was dependent on locum doctors and some nursing staff believed this had a negative impact on implementing a senior rapid assessment of patients.

The trust had already acknowledged that uptake of mandatory training by ED staff was poor.

There were systems in place to triage and prioritise patients quickly according to their condition and to monitor and manage the flow of patients around the ED for maximum safety in busy periods.

Nursing staff had the skills and experience to carry out their roles including treating children. There was a strong consultant presence in the ED including over weekends.

The trust had good systems in place to respond to emergencies and major situations and the role for the ED was well prepared and visible.

Urgent and emergency services

Incidents

- The ED department reported seven serious incidents requiring investigation to the NHS's Strategic Executive Information System (STEIS) between 1 April 2014 and 31 March 2015. These were two delayed diagnosis; two failures to act on test results; one attempted suicide; one critical care transfer and one grade 3 pressure ulcer.
- We asked to see the root cause analysis (RCA) for one of these incidents and noted that it had been carried out effectively and included an action plan for improvement.
- We noted a staff room notice board set out to keep ED staff informed of current RCA results and lessons learned. These included at the time of our visit a medication error and Methicillin-resistant Staphylococcus aureus (MRSA) as well as trust wide incidents shared learning.
- The trust had a policy and procedure for carrying out its legal duty to be open and candid with people where avoidable harm had occurred while they were receiving care and treatment and the system was well embedded within the Governance of the department.
- We tracked a sample of three recent such incidents through the electronic system that managed them, with an ED complaints officer. We noted that the process facilitated the trust's compliance with legal requirements in a timely way. We saw that RCA's included identified shortfalls in care, for example a grade 3 pressure ulcer analysis showed gaps in a care round on the ED and the Waterlow assessment score not recorded daily while the patient was in the Acute Medical Unit (AMU).
- These incidents were reported to ED Governance meetings and posted within the department for learning. We saw and heard evidence of this and noted, for example, that a new pathway to ensure that up to date poisons advice and guidance had been followed. This had been developed in ED as a result of an unexpected death from overdose.

Cleanliness, infection control and hygiene

- The trust had 51 toxin positive cases against a target of 38 for the whole year from March 2014 to March 2015.
- We noted infection control audit for the ED carried out by the trust in February 2015 found only 67% compliance for commode cleansing and a 50% compliance for the urinary catheter audit.
- The trust had policies for infection control and prevention and large bill board signs featuring the character 'Hans Klean' were displayed around the hospital to educate patients and visitors.
- We saw appropriate cubicles that were allocated for use for isolation when necessary including Ebola readiness.
- We noted that staff including consultants complied with the policy for being bare below the elbows and we saw most staff using gloves and aprons when they were treating patients.
- Hand washing facilities were provided at the point of care and most doctors and consultants that we observed used these before and after treating a patient.
- We did not observe much general hand cleansing as staff moved between different areas of the department or in and out of the main doors. However the hand hygiene audit for the ED carried out by the trust in February 2015 found 95% compliance among staff.
- The Trust Development Authority (TDA) carried out an infection control audit of the trust in February 2015 and found shortfalls against standards. The ED clinical lead told us that the ED had showed improvement since February to an average of 70% compliance.
- There was no clear invitation on display at the entrance to ED for people to cleanse their hands. The Hans Klean cartoon was obscured to incomers when the automatic entrance doors were opened by leavers which, was very frequently.
- We noted that there were bottles of hand cleanser on the reception desk at each of the three windows but we observed that patients did not use them. We heard one receptionist ask one patient to do so.
- We noted that the sharps audit for the ED carried out by the trust in February 2015 found 99% compliance.

Environment and equipment

- The trust had recognised that the current accommodation was too small to meet the demands placed upon it. They were building a new urgent and emergency care centre on site and anticipated it would open in November 2015.
- We noted that a temporary extension had been added to the existing ED footprint to provide eight further majors cubicles. This was spacious, bright and airy.

- The ED risk register identified a frequent lack of resources (capacity and staff) in the resuscitation area. During our visits this area was not busy so we could not make a judgement by observation about this.
- There was a clinical decisions unit (CDU) adjacent to the ED and this had seven cubicles with 24 hour access. The intention wasto have flexibility to provide a mix of trollies, chairs and beds according to patient's need. . We noted there were chairs in use for most patients but two were in beds.
- There was a separate paediatrics area with a waiting area separate to the main ED waiting area accessed by security pass. There were four dedicated paediatric examination cubicles and one resuscitation space. Staff told us that the short passage way connecting the adult minor's area to the paediatric area was a relatively recent modification to reduce the isolation of the paediatric services.
- We noted that this facility was not always used to treat children and we heard conflicting accounts about its use from staff and the trust including one senior nurse who told us it was too isolated from the rest of the department.
- We saw children; including a baby being treated in the adult's major's part of the ED during our visit.
- We saw appropriate resuscitation equipment around the ED and noted from records that it was checked regularly.
- The lighting was poor in the main reception area giving a gloomy atmosphere and further disabling people with visual impairment. By the end of our visit at 10pm on 4 June 2015 only nine of the twenty light bulbs in the ceiling fittings were working. We raised this with the trust before we left. We had assurances that this was going to be addressed promptly.
- We noted that the TV monitor used to inform patients of current waiting times was not working throughout our visit. We saw engineers in the department attempting to fix it on the morning of 4 June 2015 but reception staff later told us they had been unsuccessful.
- Nursing and clinical staff we spoke with raised no issues about shortages of equipment.
- We noted there were no pressure relieving mattresses on the trollies in the ED. A senior nurse told us that patients assessed as being at risk from pressure damage were turned 'regularly' by staff and if they were on a trolley for more than eight hours they were placed on a hospital bed.
- The trust subsequently told us there was one specific pressure reliving trolley mattress available in the ED. The remaining mattresses had variable pressure reliving properties ranging from medium to high risk.

Medicines

- The trust reported in March 2015 one medication error causing harm and this was in the ED.
- The Chief Pharmacist agreed that shared learning from medicine incidents needed to be strengthened which was a priority for the new trust level Medication Safety Group.
- An automated medicine control system was available to the ED which meant that nurses could control, dispense and manage medicines. A nurse explained that it was very easy to use and improved the time taken to obtain medicines to administer to patients.
- We found arrangements were not being followed to check the medicine refrigerator temperatures regularly. The pharmacy department had identified that medicine refrigerator monitoring across the trust was inconsistent.
- Fridge temperature records in the ED were not always recorded daily. However, the available records documented that the temperatures were within the safe storage range for medicines. We advised the ward manager who agreed that the records should be recorded daily to ensure medicines were stored safely.

Records

- The trust had a Health Records Policy and it carried out an audit of compliance for each quarter during 2014/15.
- The trust had recognised that the ED had achieved between only 26% to 56% compliance with this policy across a number of relevant questions asked by internal auditors.
- Action plans were put in place to improve this and report back to Governance by May 2015.
- We found a variable standard of documentation completion during our visit to the ED.
- We saw that sepsis documentation and also DNACPR in the resuscitation area had been completed fully for patients.
- However there was no evidence of resuscitation status having been discussed in at least five of the ten sets of records we looked at in the rest of majors. We noted that some entries including assessment scores had not been timed.

- Nursing assessments throughout ED were generally fully completed with, for example early warning scores, Waterlow and mobility assessments and hourly comfort rounds recorded.

Safeguarding

- The trust had policies and procedures that linked with the local authorities for the protection and safeguarding of children and vulnerable adults.
- Training in safeguarding children at level 1 and level 2 had a high compliance rate among all staff roles including consultants (over 86% and mostly 100% for trusts target at April 2015) from data provided to us by the trust.
- We were unable to assess from the data provided what compliance rates were for level 3 safeguarding children training as recommend by the Royal College of Nursing standards for an ED. The clinical lead told us that safeguarding children at level 3 stood at 73% across the department although doctors covered this as part of junior doctors training and consultants were up to date (with compliance)
- Safeguarding adults training at level 1 was 85% for medical staff and 100% for untrained nurses and clerical and administration staff at April 2015.
- We noted bruising on the arms of a frail elderly patient who arrived by ambulance waiting in the corridor for a cubicle to become available in the majors area of the ED. The nurse on duty to care for 'corridor patients' showed us that this had been noted in the assessment document that they had just completed of the patient. They told us they would mention it to the examining doctor who would make a judgement about whether the bruising was reasonable or untoward.
- However we didn't see any indication of a systematic prompt for considering a safeguarding referral and making a record of the decision on patients notes.
- Nurse managers in ED we spoke with were very clear about their safeguarding responsibilities and they were very positive about the support they received from the trust safeguarding team. 'We have a safeguarding specialist in domestic violence that does liaison with different agencies. There is also a learning disabilities team and we try to get them involved quickly. Safeguarding have merged teams now, all staff have been give explanatory leaflets. We do daily checks for child protection – we identify children who are at risk on the child protection register'.
- The ED saw between 70 and 80 children each day and had the highest rate of referral to children's social care services in the trust.
- We spoke with a paediatric nurse on duty in ED who showed us how staff access comprehensive information on safeguarding through the trusts intranet. They told us that doctors and nurses were trained to ask if a child had a social worker or was a cared for child but confirmed there were no specific prompts for this in the clerking proforma.

Mandatory training

- The ED clinical lead acknowledged that mandatory training in the ED was poor.
- For example for a trust target rate of 100%' infection prevention was at 90%; consultant compliance for moving and handling training was 0%; safeguarding children at level 3 stood at 73% across the department although doctors covered this as part of junior doctors training; consultants were up to date.
- We noted figures for April 2015 posted on the staff room notice board. These confirmed that compliance with safeguarding children training at level 3 for qualified nurses and junior doctors was 'red' risk rated. Safeguarding children training at level 2 was 'amber' risk rated for junior doctors as was basic life support at level 3 for qualified nurses. Compliance with moving and handling people was red risk rated for qualified nurses.

Assessing and responding to patient risk

- Between January 2013 to October 2014, there were a low number of ambulance handovers delayed over 30 minutes (in comparison to other trusts) in the winter period. However the ambulance time to initial assessment was worse than the England average at between five and ten minutes.
- Generally time to treatment was close to and just above the England average at 50 to 60 minutes.
- Between October 2013 and October 2014 the time to treatment for ED patients was generally just below the England average at 50 to 60 minutes, but peaked to match that average in January 2014, April 2014 and October 2014.
- Time to initial assessment and management of patients who arrived by ambulance for the same period varied. It was the same as the England average in the first quarter

of 2014 at about five minutes, then rose to a peak of eight minutes in the second quarter of 2014 and fell again to track the England average during the third quarter of 2014.

- All patients whose care and treatment journey we tracked were seen promptly by junior doctors but we saw no evidence in records of rapid assessment and treatment (RAT) by consultants. We noted within the draft RAT standard operating procedure that clinical staff had been identified to triage and treat patients. These were a support nurse, a triage nurse, a junior doctor and a senior doctor,
- Although there was a room with two cubicles set aside for this assessment we did not see them being used. Senior staff referred to 'roving rapid assessment; meaning that patients were assessed when they entered a cubicle for treatment, when we asked about this.
- Senior nurses told us that 'everyone was doing their own thing [with regard to RAT] because they were used to working at different places and there was no one consistent approach to RAT.
- However, as we did not see the ED during an extremely busy period, therefore we were unable to make a judgement about what this meant in practice.
- Streaming/triage arrangements were in place from the main waiting area of the ED. We observed patients being triaged and streamed into treatment according to priority in the minor or major's area.
- We also noted some patients being taken to the minor's area directly from the ambulance handover triage.
- Local leaders told us the ED responded to an incident of a deteriorating patient last year by establishing a system of rotation of patients within the major's area when it was busy. They said that there was some resistance to this practice from nurses and it was not yet consistent.
- A triage duty nurse was responsible for making sure that patients in cubicles were sicker than those in the corridor.
- We observed this system in practice as the department became busy on the Thursday evening that we visited and it appeared to be effective. We noted that patients who needed less close monitoring than others were sent to the majors number two area which was a short distance away from the hub of the ED.
- We noted there was an early warning tool in place to identify when a patient's condition was deteriorating.
- The department had escalation procedures in place and medical staff we spoke with understood the early warning score system and how to escalate.
- However we found no standardised or documented response to changes in the early warning score. 'Track and Trigger' protocol was not implemented in the ED.
- We noted figures for April 2015 posted on the staff room notice board that compliance with paediatric basic life support training for junior doctors was 'red' risk rated, as was basic life support at level 3 for qualified nurses.

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Nursing staffing

- We observed an effective bed handover in the ED from a senior sister to the nurse in charge of the shift.
- Local leaders told us that the ED employed 110 nursing staff and they used an electronic rostering system.
- We viewed the daily workbook and noted that nurses were allocated to areas within the department.
- On the afternoon of one day of our visits we noted that 13 qualified nurses were on duty for the late shift, three were on duty for the middle shift of 10am to 10pm and one was on from 12pm to 12am.
- Nurses were supported by five health care assistants on the late shift and one working 10am to 10pm.
- One qualified nurse was rostered to care for up to six patients should they be waiting in the corridor because the majors stream was busy. The clinical lead told us this number could be increased if necessary within the shift allocation up to nine patients and thereafter staff would be 'pulled in to work'.
- Within the majors one stream one registered nurse was allocated to three cubicles and a staff nurse was working on 'trolley triage'
- We noted when we visited the paediatrics area at 8pm that a senior nurse from the adults minors area was 'looking after it' while the rostered nurse was on a break.
- The senior nurse told us she was 'mainly on minors' but was a paediatrics' nurse with advanced paediatric life support training. We were told the senior sister on duty that night also had advanced paediatric life support training.
- The trust told us that although the paediatric area is open 7 days a week, 24 hours a day, the qualified nursing cover is from 0945hrs – 2200hrs with the nurse allocated to the minor injuries area covering paediatrics from 2200hrs until 0945hrs.

Urgent and emergency services

- The trust said that although it strived to have a paediatric nurse on shift each day, staffing levels at the time of our inspection and number of paediatric nurses available to the roster meant this was not always possible.
- The ED could not always allocate the paediatric nurse who was on shift, to the paediatric area, they may be allocated to the resus area. Therefore, they did not have a paediatric nurse on duty within the ED 24/7 at that time but local leaders expressed this as the ideal. However nursing staff attended from the paediatric ward and the Paediatric Assessment Unit (PAU) when needed. In addition to this the PAU and children's ward staff undertake a three month rotation in ED to maintain and upgrade skills. We noted the minor's stream was led by emergency nurse practitioners supported by junior doctors and an associate specialist.
- The clinical director told us the ED used only nurse bank staff and not agency nurses. There was a system of processes, checks and balances in place for monitoring the number of hours worked by nursing staff who requested bank shifts for safety. Local senior leaders expressed confidence in it.
- Senior nurses told us that despite the bank sometimes they found it difficult to fill shifts. On one day of our visit they reported that they were short of one nurse. Our observations were that there appeared to be sufficient staff on duty to meet the needs of the patients at that time.

Medical staffing

- There was a named consultant paediatrician for the ED three days per week.
- The ED clinical lead told us one of the strengths of the department was having consultants working on the floor and not in offices, this prevented unnecessary admissions. The current difficulty was recruitment.
- The establishment was up to 12 consultants. There were six whole time equivalent adult consultants; two paediatric emergency medicine consultants and four locums each with over six months service at the trust.
- Some local nursing leaders told us there were a lot of locum consultant shifts and locums did not always feel committed to the department, 'this is one of the reasons why the Rapid Assessment and Treatment (RAT) isn't working'.
- Junior doctors confirmed that consultants were on site until 2 am and back at 8 am on week days, and from 9am to 6pm, 10 am to 10pm or 6pm to 2 am on Saturday and Sunday, depending on their shift. During weekends, consultants are on call between 2 am and 9 am. "they are on call in between and paediatrics consultants will always come down".
- Capacity managers told us they had good discharge rates at weekends as there was a high consultant presence at weekends.
- ED consultants told us that New Cross Hospital ED was much better staffed with consultants than other hospitals they had worked in within the region.

Major incident awareness and training

- We noted that there were highly visible arrangements for major incidents and public emergencies (MAJAX) in place throughout the department. The 'silver command' control room was based in the ED.
- Staff regularly checked equipment, and pathways, action cards and specific information were available to them on the ED intranet pages. Staff we spoke with understood these arrangements
- Receptionist staff told us security arrangements were in place to lock down the ED if necessary from a panic button at the desk. They told us security staff responded to support them when they needed it.
- All staff and patients carried a security tag for safety. This allowed a software system to track them in most parts of the hospital and create an alert in a security situation.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We found services in the ED were effective.

People's care was planned and delivered in line with current evidence based guidelines and protocols were improved as necessary when a poor outcome had occurred or from national and local audit results.

Urgent and emergency services

Standardised systems were in place to triage and assess people's needs and their care and treatment was regularly reviewed and updated. Assessment was supported by a mental health crisis team based in the ED.

Staff were qualified and had the skills they needed to carry out their roles including minor surgery and the emergency treatment of children and people with complex acute medical conditions. There were systems in place to support and develop staff.

There were positive professional relationships between nurses and doctors and good multidisciplinary working. Patient flow managers worked within the integrated health and social care team alongside social workers.

Staff had easy access to the information they needed to care for and treat patients effectively and patient consent was embedded in staff practice.

Evidence-based care and treatment

- The ED had clinical guidelines and protocols easily available to staff on its intranet webpage. They included paediatric and CDU pathways. Staff showed us how to access these.
- The ED had a consultant lead for audit and had participated in a number of national, local and NICE audits during 2014.
- Audits in progress within the ED at the time of our inspection were College of Emergency Medicine (CEM) Asthma (children) Audit; CEM Mental Health; CEM Fitting Child; Audit of CG112 on Sedation in Children in the ED.
- Local audits were also undertaken for example Safe Sedation in ED: Compliance with trust and joint Royal College of Anaesthetists (RCOA)/CEM) guidelines was also in progress.
- The sepsis audit for 2014/15 in which the trust had participated showed poor results at that time. The consultant lead told us that action had been taken to improve safety. A new paper flow chart and pathway had been introduced to guide staff. A newly employed member to the team was able to show us where it was and talk us through it.
- Staff told us sepsis was now addressed early to avoid intensive care unit admission, 'we were slow in recognising sepsis, now we can prioritise patients.'
- A re audit subsequently carried out by the trust showed improvement in most areas of care and treatment, for example the administration of antibiotics had improved. Against a standard of 50% in 1 hour, only 16% had been achieved in 2013/14 and for 2014/15 this had improved to 38%. Against the standard of 100% before leaving, 80% was achieved 2013/14 increased now to 92% in 2014/15.
- We observed in the management of sepsis for a patient that the sepsis documentation was completed with early administration of antibiotics provided.
- We noted the stroke pathway was particularly effective, with stroke consultants responding rapidly to the ED and enabling treatment to begin quickly.
- The renal colic pathway had been improved and consultants told us this had resulted in sending the patients more likely to actually have stones for diagnostic scans.
- We observed patient hand over to the triage nurse from ambulance crew. The ED used a standardised triage system which included the patient's medical history, analgesia and discussion to establish pain score and observations were recorded. This data was put into the ED software system and was available to any staff treating the patient.

Pain relief

- We noted that pain was assessed in children by using the smiley face system. Staff told us this was the same system used by the paediatric department in the hospital to ensure consistency. Teenagers were asked to rate pain on a scale of 1 to 10.
- We noted the results of the recent nursing documentation audit reported a compliance rate of 95% for pain scores.

Nutrition and hydration

- A senior nurse told us that the department had recently trialled a trolley service for patients refreshments and has now ordered a beverage trolley. Nurses conduct hourly comfort rounds and will obtain food if required.
- A senior nurse told us that each day between 8am and 4pm, a ward assistant went around the ED
- However, during our evening visit of 4 June 2015 we did not observe any patient being offered food or drink. We did see some patients given food and drink in the major's area when they asked for it.

Patient outcomes

- In-hospital mortality figures for May 2013 to April 2014 showed conditions associated with mental health to be a risk factor for this trust. Staff told us crisis team was based in the hospital from 8am until 10pm and the aim was to see mental health patients in ED within 1 hour during these times.
- The ED responded to learning from an incident involving an overdose by developing a pathway to reduce error in relation to toxic substances. We observed this in use during our visit.
- We noted local audits were undertaken in the ED. For example we saw that recent nursing documentation audit had been carried out by a Band 6 nurse. They told us this showed improvement in recording of standard assessments and observations from the previous audit.
- The ED had participated in a number of national audits during 2014/15 and we noted it had an audit plan.
- The number of unplanned readmittance to the ED within seven days of being discharged was consistently just higher than the England average of about 7.5% during 2014/15. However it peaked to 9% in July 2014 and in January 2015.
- We asked consultants how the ED re attendance rate was being addressed by the trust. They told us that analyses had been undertaken but no particular factors had been so far identified.
- There was a system in place to ensure all potential admissions to wards from the ED were seen by a consultant in order to try to reduce admissions.
- The number of patients who left the ED without being seen was lower than the England average of 3% between October 2014 and February 2015.

Competent staff

- The ED had four Band 7 nurses and 25 Band 6 nurses.
- There were six whole time equivalent Band 6 RSCN (children's nurses) on its establishment and the paediatrics nurses in the hospital did a rotation through the ED.
- We noted a paediatric trained nurse on duty when we visited including in the evening and overnight, however local leaders told us that it was not always possible to roster paediatric trained nurses on duty in the ED.
- The ED had two associate specialists in emergency medicine.
- Consultants worked alongside nurses and this included an acute medicine specialist and a paediatric specialist.
- The ED carried out its own minor surgical procedures and this helped to reduce demand for

orthopaedic work and speeded up the patient journey. For example hand and finger injuries.

- The clinical lead acknowledged that annual appraisal rates in the ED were poor against the target of 100%. Nursing staff had achieved only 70% compliance. There had been a 'big push' with medical staff and that stood at about 90% compliance.
- Band 7 nurses had their own teams of nurses for supervision and appraisal. Junior doctors said they received good supervision and support from seniors and consultants.
- There was a Band 7 and 8 nursing, midwifery and health visitor forum in place within the trust to provide opportunities for supporting and mentoring these managers. We noted that the April 2015 meeting had no representation from the ED.

Multidisciplinary working

- We noted effective integration with the rest of the hospital. For example we observed one patient presented to ED with headache and weakness, they were received by an ED consultant and had a scan within ten minutes. They were then received by a stroke consultant and Thrombolysis (treatment to prevent blood clotting) was started in the ED within 20 minutes.
- Senior nurses told us the ED had a good grasp of the availability of beds and resources to best plan for patient treatment.
- Senior nurses told us they had a good and effective relationship with the mental health team.
- There was an acute medicine consultant working within the ED whose role was to expedite and avoid admissions.
- Patient flow managers worked within the integrated health and social care team alongside social workers. They told us this provided them with 'opportunities for creative thinking around the discharge of patients'.

Seven-day services

- ED staff told us that speciality consultants, registrars and specialist nurses provided a consistent, responsive service 24 hours a day and seven days a week.
- Senior nurses told us there was good senior medical cover out of hours and at weekends.

- The paediatrics area of the ED was available seven days a week.

Access to information

- Staff had access to patient's information and treatment activity through an electronic system.
- We noted there were also paper records completed. We found notes made by one consultant in the minor's stream were not legible and a junior doctor attending confirmed this. The information had been handed over and discussed verbally between them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff demonstrated to us the trust web site safeguarding adult pages provided clear and easy to access information about MCA and DoLS.
- We noted that a formal consent process was embedded within procedures throughout the ED for example, for minor operation such as abscess incision.

Are urgent and emergency services caring?

Good

We found services in the ED were caring.

Every patient or relative we spoke with was very positive about the way staff in all roles had responded to them. Staff responded compassionately to people when they were in pain and were kind and warm towards people when they were upset and worried.

People's privacy and dignity was respected including when they had to wait on trollies in the corridor or when they challenged the service by their behaviour.

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

Compassionate care

- We observed throughout the ED that patients were given appropriate privacy with curtains, screens and blankets. For example we saw staff preserve the privacy and dignity of one very drunk patient in resuscitation during clean up and examination.
- We saw and heard many positive examples of staff at all levels and roles treating patients and their relatives with kindness across the two days of our visit throughout the ED. We also sat in the main waiting area for 40 minutes during one afternoon observing staff interactions with patients.
- We noted reception staff were friendly and took time with and were focussed on patients when they arrived. We saw a senior local leader physically comfort a patient who arrived in a state of fear and anxiety.
- We tracked a patient with a hand injury through their treatment pathway and they told us that staff were very careful not to cause them further pain when they examined and dressed the wound.
- We noted that staff were patient and supportive of a person who presented with mental ill health while ensuring their challenging behaviour did not have an impact on others.
- We saw children being treated with warmth and interest and spoken to at a level that matched their understanding.
- We also noted however that initial contact with their patients varied in quality among some triage nurses. Some staff greeted some patients warmly when they called them into the consulting rooms and invited them to sit down. But other patients were not warmly greeted, given eye contact or invited to sit. Staff resumed their own seat in front of the computer monitor after opening the door and expected the patient to know what to do, including to close the door behind them.
- We heard a consultant sensitively discussing end of life care with a family.

- The Care Quality Commission patient survey found patients experience of using the ED in 2014 was 'about the same' as most other trusts that took part in the survey.
- Low response rates were common for Friends and Family test (FFT) in ED's. However the response rate for the ED at New Cross Hospital in the friends and family test in March 2015 was higher than the England average (22.9%) at 26.3%.
- Data shared with us by the trust showed there had been an almost consistent decline in the number of respondents recommending the ED service from 94% in

December 2013 to 84% in November 2014 with a sharp drop to less than 81% in September 2014. There was no analysis to investigate this apparent decline in satisfaction.

- During our visit we noted a large notice publicising the FFT which was slightly obscured at the entrance to the ED from the main corridor. There was a pile of FFT response cards beside each receptionist's window.
- We saw one receptionist prompt a patient to complete a card by handing it to them when they booked in. Otherwise we saw no patients pick up a card. We looked in the comment card box on two successive days of our visit and noted there was only one card in it.
- Data that we saw posted on the staff room notice board showed the April 2015 FFT results as 83% recommending the service and 9% not recommending it out of a total response of 1,471 (attendance figures for April 2015 indicated that approximately 2300 people used the ED each week).

Understanding and involvement of patients and those close to them

- Relatives of patients we spoke with told us they were satisfied with the care provided by the ED.
- We saw relatives being involved in discharge plans of patients and compassionate discussion between a consultant and relatives about end of life care for a patient with dementia.

Emotional support

- Local leaders told us ED patients received emotional support from the nursing and medical team whilst they were in the ED. If there were other requirements the ED had access to the trust bereavement service, chaplaincy service, PALS, psychiatric services, social workers, safeguarding services and alcohol / drug liaison service.

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

Good

We found services in the ED were responsive.

The trust was responding to the increased need for emergency and urgent care services and working with local commissioners to include primary health care access.

Social care was integrated with health care to improve patient flow from the ED through the hospital and collaborate in appropriate discharge arrangements for patients with complex ongoing needs.

Paediatric emergency services were provided on site but there was a lack of clarity about the use made of the separate accommodation and facilities that were available for treating children. There were facilities for specialist eye treatment, end of life care and for people experiencing significant mental ill health. Systems to identify and support patients with dementia through the ED were not well embedded.

The trust had not met the national target of treating, admitting discharging 95% of patients within four hours of attendance at the ED for the six months October 2014 to March 2015. A new system had been put in place to better support capacity managers to improve the flow of patients through the ED and the wider hospital.

The ED had good systems in place to handle concerns and complaints and to learn from them. Access to the complaint procedure was not very visible to patients in the department however.

Service planning and delivery to meet the needs of local people

- The trust was in the process of building a new urgent and emergency care centre on the New Cross Hospital site. This was to include primary health care and an urgent care centre.
- . The health and social care manager was part of the emergency services group which included the ED.
- Patient flow managers told us that a capacity team member and a social worker reviewed each delayed transfer of care to make a daily plan towards discharging the patient.
- There was a step down to a nursing home arrangement in place and this could be funded for a patient for up to six weeks.
- The trust provided a walk in centre in a different part of Wolverhampton and this referred patients to the ED at New Cross Hospital if they needed treatment it could not provide.

- Patients referred by their GP were admitted directly to the Acute Medical Unit and by passed the ED.
- There was a specialist eye treatment service with its own consulting room within the ED.

Meeting people's individual needs

- The ED risk register identified as a 'yellow' risk a need for more paediatric resources in the unit 'to enable meeting CQC and OFSTED guidelines'.
- We found that ED had a paediatric area including waiting area, treatment rooms and resuscitation. It did not have its own reception.
- We observed that it was used some times and not others during our visits and on one afternoon we saw a child and a baby being treated in the adult's major's area.
- We found staff had conflicting perceptions about the paediatrics ED area. ED leaders told us it was used and staffed constantly. Some senior nurses told us it was not often used because it felt isolated from the hub of ED and children were often treated in the minor's area instead.
- When we asked senior nurses later about a child and a baby being treated in the adult's majors area they assumed at first we were mistaken and then said it 'probably' happened because they needed close monitoring.
- The trust told us that paediatric trained staff were not always on duty 24/7 in the ED although that was the intention. Also if rostered to the ED they were not always available to the paediatrics area.
- The paediatrics waiting area was also used by parents with children while they waited for their own care within the minors ED. It was secure from the main ED waiting room and provided toys.
- The mental health liaison team was based on site and available from 8am to 10pm, seven days a week and provided a service to the ED and wards. Out of hours the mental health team were contactable through Penn Hospital. The crisis team was based in the health and social care team office .
- We noted there was a 'quiet' room designated for patients who presented in a state of high anxiety or distress while they waited for mental health assessment. The room was designed to be a safe environment physically and included a panic strip.
- Senior nurses told us there was good domestic violence support to the ED and staff awareness was high.
- There was a private viewing room for families of patients who had died and this was set up in keeping with the trust's approach to end of life care.
- Staff confirmed they had access to a language line service.
- The ED was very well served with a good quality information displayed on the walls explaining the function of each part of the service. All of this information was written in English only. We noted on a number of visits to the ED waiting area over three days that people from a broad range of ethnic origin and nationality reflecting the current population of Wolverhampton, were accessing the service.
- The trust had a learning disabilities specialist team on site and ED staff reported they received good support from this team when they needed it.
- For one patient with dementia whose care pathway we tracked to the Acute Medical Unit (AMU), we noted that the dementia bundle had not been completed in ED. We asked the nurse on duty in the AMU at the time about this but they had not noticed its absence.
- Local leaders told us that dementia awareness nurses in the trust ran study days. Nurses assess through triage whether a patient may have dementia but there was no system for identifying these patients immediately to staff throughout their treatment and care pathway.

Access and flow

- The Care Quality Commission A&E survey of October 2014 found in response to the question 'overall, how long did your visit to the A&E Department last? Patients of New Cross Hospital ED reported better experience than other trusts.
- When we visited the ED on the evening of 4 June 2014 at 8pm there were five ambulance crews waiting to transfer patients into the major's area and there were no available cubicles at that time. There was a duty triage nurse managing the patient flow through cubicles in major's area one and two and the minor's area if applicable.
- The trust had an electronic system in place to monitor and analyse the flow of patients through the ED department and the wider hospital. This data could be accessed by staff throughout the department and in the capacity management team situated in a different part of the hospital.
- Between April 2014 and March 2015 there had been delays in the handover of patients to the ED from

ambulance staff of between 30 and 60 minutes each month. For ten months there had been greater than forty delays with a peak in January 2015 of 103 and a drop in February to 11 delays. The number returned to over 40 in March 2015.

- For the same period there had been delays in the handover of patients to the ED from ambulance staff of over 60 minutes during six months peaking at 13 in November 2014, 21 in December 2014 and 29 in January 2015. Other months were below four, which was broadly in line with the national average.

We reviewed documents from the trust which demonstrated a 3-4% increase in the number of ambulance attendance comparing January to June 2014 and 2015

- The trust had not met the national target of treating, admitting discharging 95% of patients within four hours of attendance for the six months October 2014 to March 2015. April to June 2015 we saw the trust met the target for April and missed the target by one and two percent for the following two months.
- There were no trolleys waits (patients waiting over 12 hours from decision to admit to admission) from April 2014 to March 2015. Senior staff told us that only on one recent occasion (January 2015) the CDU had been used for the overflow of E D medical patients.
- We noted by 8.15pm on our visit of the evening of 4 June 2015 there had been eight breaches of the national four hour target.
- The on-screen trust analysis in the ED showed the reasons for the breaches were: unwell, overdose ANC (clinical need) first assessment, admission avoidance, three clinical needs, one for change of condition and psychiatric liaison.
- Staff told us there were 56 patients in the ED at that time. We observed the ED was starting to use the corridor at that point, two patients were there. Throughout the evening until 10pm we saw no more than three patients waiting in the corridor at any one time.
- There was a duty triage nurse reviewing and controlling the flow of patients from the corridor where they were assessed by a staff nurse and into cubicles to be seen by doctors as soon as a cubicle became free. This kept the waiting time in the corridor to a minimum.
- The number of patients leaving the ED without being seen was almost consistently below the England average from October 2014 and January 2015 at between 2% and 3% with a decrease to about1% in February 2015.
- The number of ED attendances resulting in an admission had risen by just over 2% from 2013/14 but remained well below (5%) the England average (that remained broadly the same for 2013/14 and 2014/15).
- We followed the journey of five patients on the evening of 4 June 2015. They had presented to the ED earlier that day.
- We found their records showed that they waited on average 30 minutes for a junior medical assessment. Three patients were admitted to the AMU, two of which were discharged from there later in the day.
- Three patients admitted that day waited on average over three hours to see a consultant.
- There was a patient flow manager on duty in the hospital 24hours a day and seven days each week. Patient flow was managed from a control room in a different part of the hospital. As part of an integrated health and social care team, the office space was shared with social workers.
- We spent some time with a patient flow manager, who was a clinician, on duty on the evening of 4 June 2015. They worked closely with the ED shift flow manager to prevent blockage in ED.
- We observed a new interactive tele tracking bed management system in action. Staff told us that this had been in place for five weeks and the paper system would be phased out. At the time of our visit the two systems were running together to provide real time information on bed state and capacity within the whole hospital.
- A software bracelet system was in place. Worn by every patient, it meant their care and treatment journey could be tracked from admission through to discharge. When the bracelet was removed into a box on discharge this triggered and tracked a series of actions, including cleaning, that led to the bed being free for a waiting patient in ED.
- The trust planned to make this real time information available on screen to all wards and this meant that the whole hospital was engaged with keeping the ED flowing.
- A number of capacity meetings were held each day attended by the chief operating officer, to assess the

flow situation and we observed one. Staff told us that at weekends a meeting was held at 12 noon and included consultants, the sister in charge of ED, the on call duty manager, a member of the executive team and a capacity manager.

Learning from complaints and concerns

- The ED had a dedicated complaints officer working within the governance team. We tracked three recent complaints and noted there was a time targeted procedure for responding to them and this was tracked by an electronic system with prompts.
- We looked at an agenda for the May 2015 Governance meeting and noted that five complaints were tabled for discussion.
- Lessons learned from one complaint that was also reported as an incident led to the development of a new overdose pathway in the ED. We saw this used in practice in the ED major's area.
- We observed in the control room during our evening visit, the senior matron pro-actively dealing by phone with a concern raised by a relative about an inpatient. The patient flow manager told us that they would take any complaint or concern that came in overnight and escalate it to the on call matron if they could not resolve it.
- We noted on the shared learning notice board in the ED staff room four complaints that had been received during April 2015, the department's response and the lessons learned.
- We did not see any conspicuous invitation around the ED for patients to share their concerns about the service or raise a complaint through the procedure.

Are urgent and emergency services well-led?

Good

We found the ED was well led.

There was clear vision and values driven by quality and safety that staff understood. Staff and managers were also focussed on and involved in planning the new emergency and urgent care centre.

Safety and quality was regularly reviewed and risk was managed by good governance arrangements.

The ED was well supported by the rest of the trust, had strong local leadership and there were good professional relationships. Staff at all levels and roles worked as part of a team and enjoyed their jobs. There was a culture of openness and willingness to learn from mistakes.

An interactive patient tracking system was being embedded at the time of our inspection and this innovation engaged the whole hospital system in addressing the challenges faced by the increasing public demands being made on the ED.

Vision and strategy for this service

- The trust was constructing a new emergency and urgent care centre on site at New Cross Hospital. All staff we spoke with were aware of the plans and said they had been consulted about its design and purpose.
- We found staff were very focused on and enthusiastic about the prospect of improved service delivery through the new facility.
- The acute medicine consultant told us the trust had good plans for integration with acute medicine and the ED to maximise ambulatory care in the new emergency and urgent care centre.
- The trust took responsibility for providing services at the minor injuries unit in Cannock Chase Hospital from 1 March 2015. It was unclear to staff we spoke with at New Cross how these two services would work together.

Governance, risk management and quality measurement

- The ED held a monthly Governance meeting where incidents, complaints, Duty of Candour issues, staffing levels and clinical audit outcomes were reviewed and discussed.
- We found that although clinical audit action plans had resulted in improvements in practice for example over sepsis, staff 'on the shop floor' did not always seem aware of this.
- Junior nursing staff were involved in undertaking local audits such as nursing documentation quality.
- We found that three of the ten ED consultants took responsibility for all head injury care including inpatients and some post neurosurgical rehabilitation and review clinic follow-up. They told us that no arrangements were in place to avoid consultants being taken out of the ED to carry out these duties.

- There was a system of checks and balances on the number of bank (overtime) shifts that staff could undertake.
- The ED department appeared to cope well with the 75% increase in ambulance attendance for the first six months of 2015. The trust had not met the four hour wait target five times but had done so for April. The percentage of people who had been seen and treated within the four hour target ranged from 90-94% for the five months it did not meet the target.

Leadership of service

- The ED directorate was led by a clinical director, group manager and a matron. The emergency department was part of the emergency services group which also included an integrated health and social care team. This team included five 24 hours patient flow managers working together with social workers
- The ED was led by a charge nurse, a unit manager and four senior sisters. The unit manager's post was vacant at the time of our inspection and it was being recruited to.
- Departmental leaders said the ED had good support from the executive and senior leaders.
- Leadership at a local level seemed effective and staff said they felt supported. Nursing and medical staff told us they enjoyed their work. We observed good professional relationships between staff in all roles.
- Junior nursing staff told us they felt 'part of the team', for example they were included in newsletters and email about departmental issues and involved in team building exercises such as a Go Karting event. They said all staff were approachable and listened to them.

Culture within the service

- The ED had an open culture which enabled learning from error. We observed that nursing and medical staff worked well together in effective team work and respected each other. Junior and trainee staff said they received support from seniors. Staff attended focus groups during our visit and told us about the open and supportive culture.

Public engagement

- We noted the Friends and Family Test cards in the ED main waiting area were not being taken up by patients and staff were not promoting their use.

Staff engagement

- Although the response rate was low for the trust overall, the ED services staff score for the 'Chatback' was just above trust target (70%+ agreement), representing an improvement from 2014.
- The ED team was nominated for a trust award for outstanding teamwork. Staff confirmed that they had opportunities to become involved with the new emergency and urgent care centre development project through project groups. One Band 7 nurse had been seconded to the project.

Innovation, improvement and sustainability

- A new interactive tele tracking bed management system had been put in place five weeks before our visit. It provided real time information on bed state and capacity within the whole hospital. The information would be available on screen to all wards and this meant that the whole hospital was engaged with keeping the ED flowing.

Medical care (including older people's care)

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

Information about the service

The Royal Wolverhampton NHS Trust had between July 2013 and June 2014, the Royal Wolverhampton NHS Trust received 48,737 medical admissions.

Medicine specialities included elderly care, diabetes, respiratory medicine, renal medicine, gastroenterology, haematology and oncology. The Trust had an acute medical unit (AMU) which incorporated a 48 bedded ward and an acute ambulatory unit. In this report we will also report on cardiology which was managed by the trust within a separate division. The Royal Wolverhampton NHS Trust provided medical care on three hospital sites: New Cross Hospital, Cannock Chase Hospital and West Park Hospitals. Cannock Chase Hospital and West Park Hospitals are reported on in separate reports.

Both stroke thrombolysis and primary percutaneous coronary intervention were delivered 24 hours a day, seven days a week at New Cross Hospital.

During our inspection, we visited fifteen medical wards including: A7 and A8 (elderly care), B7 (general medical ward), B12 (stroke ward), B14 (cardiology day and overnight ward and catheter laboratory), C21 (acute medical unit), C22 (dementia ward), C18 and C19 (respiratory), C15 and C16 (diabetes), C24 and C25 (renal), C41 (gastroenterology). The oncology/haematology wards Deanesly Ward and Clinical Haematology Unit (B11) were inspected by the end of life team and will be reported within the end of life section of the report.

The CQC inspection of medical services was undertaken announced between 2 and 5 of June 2015, we also visited unannounced on 15 June 2015. We spoke with over 110 members of staff, including nurses, doctors, therapists, healthcare assistants and housekeepers. We spoke with 54 patients and 13 relatives. We reviewed 55 care records and observed interactions between staff and patients. We attended nursing and medical handovers and multidisciplinary team meetings. We held focus groups which were also attended by staff working within medicine.

Medical care (including older people's care)

Summary of findings

Nurse recruitment within medical services was a known challenge for the trust. There were initiatives in place to recruit additional nurses but nursing staff shortages especially at night compromised patient safety. The trust policy, not to use agency nurses meant that shifts were frequently unfilled or the skill mix was inappropriate to meet patient's needs. Cardiology staff had particular concerns about how staffing was adversely affected when the day ward was open overnight which put cardiology patients at risk due to insufficient staff.

Incident reporting was established and was acted upon when needed; although staff felt staffing concerns were always adequately addressed.

Medical records were appropriately completed although nursing care records lacked detail and were not individualised. The safe hands system identified patients and staff location and was an excellent initiative to promote patient safety. The availability of appropriate equipment used to monitor patient's observations was insufficient and caused staff concern and put patients at potential risk.

Care was provided in accordance with evidence-based and best practice guidelines. Care was monitored to show compliance with standards and there were good outcomes for patients. Seven days working was established for the majority of staff and multidisciplinary working was evident to coordinate effective patient care. Staff had access to training and had received annual appraisals.

Patients said that staff were caring and friendly and felt that their dignity and privacy were respected. We observed mostly kind and compassionate care although found not all staff appeared caring or compassionate.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the patients. We saw patient focussed approaches to care and treatment.

Staff were positive about the standard of care they provided and the support they received from their managers. There was a culture of audit and improvement within the medical services.

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. However despite efforts to employ sufficient nursing staff this risk had not been fully addressed and this had not been appropriately addressed by senior managers.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

We judged that this domain was inadequate people were not adequately protected from avoidable harm. Nurse recruitment within medical services was identified as a challenge for the trust. There were initiatives in place to recruit additional nurses including overseas nurse recruitment. However we found continuing nursing staff shortages especially at night which compromised patient safety. The trust policy was to use agency for specialist provision such as patients requiring mental health support. Where that provision was not required bank staff were used, but this was not always the case and impacted negatively when shifts were unfilled and the skill mix was inappropriate to meet patient's need. Cardiology staff had particular concerns about nurse staffing and particularly how patient safety was adversely affected when the day ward was open overnight with no additional staff available. Incident reporting was established and acted upon when needed. However there was a need to ensure that all incidents including staffing concerns were appropriately reported as some staff felt this was discouraged.

The performance of medical services had a good track record of patient safety. However with on-going shortages of nurses there was a risk this would not continue resulting in increasing risks to patients. When things went wrong there were appropriate systems in place to review or investigate and when needed lessons learnt and acted upon.

The ward and patients areas were mostly tidy although three fire exits were obstructed on one ward. Adjustments were made by the trust to address this. Infection control policies and procedures were followed. Staff had required mandatory training and this was monitored to ensure it was sustained.

Nursing care records lacked detail and did not reflect patient's preferences, all their needs and were not individualised. The safe hands system identified patients and staff location and was an excellent initiative to promote patient safety. Equipment in working order was not sufficient on some wards to monitor patients' observations to ensure there was timely action should a patient's condition deteriorate.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There were zero never events registered for medical care services from 1 April 2014 to 31 March 2015.
- The trust had an established electronic system for reporting incidents and near misses. Between 1 April 2014 to 31 March 2015 there were 107 serious incidents which required investigation, 48 grade 3 pressure ulcers, 30 slips, eight confidential information leaks, six episodes of clostridium difficile and hospital-acquired infections and three episodes of MRSA bacteraemias. Each incident submitted was reviewed and graded by a senior nurse and the investigation was proportionate to the grading and any harm to the patient involved.
- Staff we spoke with were aware of, and had access to, the incident reporting system. This allowed them to report incidents, including 'near misses', in which patient safety may have been compromised. Staff confirmed they received feedback from incidents they had reported.
- Two nurses working on the cardiology ward told us that they had been discouraged from reporting staffing concerns. We also spoke with another nurse who told us that they had reported their staffing concerns but remained concerned that the risks were on-going. The risks were present on the directorate risk register, which meant it was still under regular review.
- The trust investigated every serious incident through a root cause analysis (RCA) process. We looked at a selection of RCAs, which involved pressure ulcers, falls and incidence of infections, and saw that required actions were being addressed. For example junior doctors, told us that following confidential information leaks their induction training had included information on maintaining confidential information and they had been instructed not to put patient names on handover sheets.
- Incidents were reviewed by medical and senior nursing staff depending upon the nature of the incident. Incidents were discussed at the monthly directorate clinical governance meetings. Staff told us that the ward manager would ensure that any learning from incidents was shared with them.
- Mortality and morbidity meetings were mostly held monthly for each directorate i.e. renal, diabetes, elderly

care, cardiology, respiratory, stroke and acute medicine. During the meetings attendees reviewed the notes for patients who had died in the hospital within the previous month and when needed actions were taken and shared to improve practice. We saw noticeboards and bulletins that identified learning needed on the Ward C21. Staff on other wards also told us that the ward manager would ensure that any learning was shared.

Safety thermometer

- The NHS safety thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter-associated urinary tract infections (CAUTIs), venous thromboembolism (VTE) and falls. Safety information including some of the information from the safety thermometer was displayed at the entrance to each ward so that staff and visitors to the ward were aware of the performance in the ward or department. This included information about infections, new pressure ulcers and falls.
- For medical services between December 2013 and December 2014 the rates of all grades of pressure ulcers were fairly consistent throughout the year changing from one to three instances each month.
- The number of falls within medical services was generally low. Staff identified patients at high risk of falling and when needed actions were taken to reduce this risk such as one to one care or a staff member to remain within that bay/ area at all times.
- The trust used a management tool which contained information about each ward or unit's performance against agreed targets. It included: staffing information in relation to breaches in staffing levels, incidence of infections, and incidence of pressure ulcers, slips, trips and falls, patient feedback and risks such as late patient observations (reported as less than 5% of late observation) and medication errors.

Cleanliness, infection control and hygiene

- We saw that care environments were clean and well maintained. All wards we visited were clean and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and marked as ready for use with 'I am clean' labels.
- We found when we visited C21 (Acute Medical Unit) during our unannounced inspection that a used blood syringe was left by the blood gas machine. The nurse in charge addressed this whilst we were there and confirmed that medical staff would be reminded this was poor practice.
- Staff followed the trust's infection control policy. We observed that staff were 'bare below the elbow'. Staff had access to personal protective equipment that included aprons and gloves.
- Staff compliance with hand hygiene was checked by a senior nurse as part of their 'five moments' audit when hand washing by five staff members was checked monthly. Nursing staff told us that all had an annual practical assessment of the effectiveness of their hand washing. We saw records that confirmed that compliance with this assessment was reviewed as part of staff mandatory training.
- The trust used 'Safe Hands' this system had a location device on staff name badges and on devices worn by patients to show their location on a ward. Senior nurses told us that the 'Safe Hands' system enabled them to track and check that staff used hand gels appropriately before and after patient contact.
- The trust had a target that 95% of staff should receive infection control training and receive an assessment of their hand washing annually. Within the medical services division 92% of clinical staff had infection prevention training and a hand washing assessment.
- Instructions and advice on infection control were displayed at the ward entrances for patients and visitors..
- There were three cases of MRSA bacteraemias recorded across medical wards/ units between April 2014 to March 2015. MRSA is a type of bacterial infection that is resistant to a number of widely used antibiotics.
- We reviewed the records for three reported MRSA bacteraemias in the trust. We found that detailed root cause analysis (RCAs) investigations were completed and when needed lessons were learnt.
- We saw and staff confirmed that side rooms were used, where possible, as isolation rooms for patients identified as having an increased infection control risk (for example patients with MRSA). We saw there was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms could also be used to protect patients with low immunity.

Medical care (including older people's care)

Environment and equipment

- Generally we found the majority of wards were tidy and well maintained. We found on ward A7 that furniture and equipment were blocking three fire doors.
- We observed a desk and chair with files and a stack of visitor chairs in front of two fire exits and two hoists, a stack of chairs, intravenous stands, blood pressure machines and other equipment obstructing another fire exit. We escalated our concerns to the senior manager in charge of the hospital who told us that this would be addressed. However, the trust sought the advice of an independent fire services officer. It was agreed as appropriate to have a one person desk and chair that was clearly labelled 'to be moved in the event of a fire alarm'. This was confirmed with the trust following the inspection.
- The trust used the 'safe hands system'. Staff name badges had a location device and patients also wore a device that identified their location on a ward and movement between wards. The safe hands system could identify when staff attended to patients and highlighted if they had not been checked upon for some time. The safe hands system was able to identify and record when staff used hand gels or washed their hands before and after patient contact. We found the safe hands system to be an excellent initiative to promote patient safety.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place. The trust had a central equipment bank for pressure-relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- The trust required that all resuscitation equipment was checked and ready for use. Resuscitation equipment on the wards we visited had been recorded as checked regularly; equipment was in date, appropriately packaged and ready for use.
- We observed that all but two of the call bells we checked were accessible to patients so they could summon staff when they needed to.
- All medical wards had a good supply of manual handling equipment such as hoists, slings, sliding sheets and condition-specific equipment such as nebulisers and syringe drivers, which were well maintained.
- Staff of the majority of wards did not raise any concerns about the sufficiency and availability of equipment. However on C21 (AMU), B14 (cardiology) and B12 (the stroke unit) staff told us that despite ongoing replacement of equipment there was sometimes a shortage of equipment such as monitor leads and infusion stands as equipment went with the patient when they moved to another ward. One nurse told us that there could be a delay obtaining equipment which was required for seriously ill patients. One staff member on B14 told us that they had 10 and not the required 12 electronic units (Vital Pac) to monitor patient's observations and frequently some of the units required repair. When we visited the ward unannounced we found that just three units were available with another three having broken screens and could not be used. This meant that equipment provided to identify an early warning about patients whose condition was deteriorating was not available. However, the trust was aware of this issue and was taking steps to resolve it.
- Nurses on B12 said that they did not have enough blood pressure machines. They told us that three beds had blood pressure machines which could not be moved away from the beds. They had just one portable blood pressure machine for the remaining 22 patients.
- Nurses also told us that they also had to share an electrocardiogram machine (ECG machine) used to monitor patients' electrical activity of the heart with the trans ischaemic clinic. This meant that essential equipment was not on the ward.
- Nursing staff told us that they had a central store for equipment such as intravenous infusion pumps. Nursing staff told us that there was a shortage of these pumps which were used to control the flow of intravenous infusions which frequently contained medicines such as antibiotics

Medicines

- We found the medical wards we visited had appropriate storage facilities for medicines.
- Before our inspection a need to ensure that all medicines refrigerator were locked was identified. We found during our inspection that all medicines refrigerator were locked with the exception of the medicines refrigerator on C24. We also found that medicines refrigerator temperatures were regularly recorded and checked, recorded and adjusted as appropriate.
- Patients across most medical wards were prescribed and administered medication as per their prescription charts. We observed that when medicines were not

administered the reason for this was usually recorded. On wards C15 and C16 we found nursing staff had recorded 'no stock' or were 'out of stock'. This meant that patients did not have the medicines they were prescribed. We found three omissions on medication charts on ward C16 where patients had not received a diabetic medication and pain relief. One patient that we spoke to told us they had been waiting two days for newly prescribed medication.

- On C16 and C17 we checked the 'Hypo Kit' and glucagon kit which were used in an emergency situation for patients with a low blood sugar. We found that all medicines were available and in date.
- We observed that staff wore red plastic tabards when they were administering medicines which identified they should not be disturbed. We saw that this was good practice and protected patients from potential harm.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient. Regular checks of controlled drug balances were recorded.
- To take out (TTO) medicines were ordered when patients were deemed medically fit for discharge. Staff said they told us that sometimes there may be a delay obtaining patient's TTOs and whenever possible they asked the doctors to prescribe TTO medicines the day before the patient's anticipated discharge, although this was not always possible.

Records

- Medical wards used a combination of paper and electronic records. Medical records for that hospital admission were in paper files which were then included in the patients electronic records. We found that medical records were legible, dated and with the name of the doctor who had completed the record.
- Nursing records were also in paper and computer format. Nurses wrote a summary of the patient's condition and day in the medical notes. Patient's daily care charts such as records of change of position and food and drinks provided were in paper format. Patient observations were recorded within the electronic records.
- Care plans lacked detail and did not reflect patient's preferences or all their needs as they were all a standard template and all read the same. Care records did not detail washing and dressing needs, including oral care needs or their dietary needs. For example we looked at care records of three patients who preferred non British food. There was no record of what they preferred to eat. We noted that two patients had been eating and drinking only minimal amounts but their care records did not provide staff with information about their preferences to assist in tempting them to eat and drink. One of these patients told us that they were given chicken and rice but they did not like chicken. We shared our findings with the ward manager who told us that they would discuss our findings with the staff.
- We looked at eight patients who required/ or were receiving oral care. We found that care records for two patients did not identify a need for oral care although their mouths were dirty and coated. We found that the other six records patients were receiving oral care. However there were no instructions in care records we looked at that identified the frequency that oral care should be provided or an evaluation of the effectiveness of the care provided. We shared our findings with senior staff who agreed that the records did not fully identify patients care needs or the effectiveness of the care provided. Following our inspection the trust confirmed that additional input was sought and delivered which involved members of the multidisciplinary team to support these patients.
- We found the fluids patients had received was mostly recorded. However we found that they were not completed in the three of the five records we looked at on ward C15 and two of the four records we looked at on A7.
- Risk assessments such as pressure ulcer risk and nutritional risk were included in both paper and electronic records. We found that this system provided duplicated information and in some case essential information was not recorded for example we found that nutrition risk assessments were either not undertaken or reviewed at the required frequency on ward C16 for three of the five patient records we looked at.
- The trust used an admission assessment booklet which detailed observations and assessments patients had received. We found that there was no confirmation that the venous thromboembolism (VTE) assessment had been completed in eight of the nine assessment booklets we looked at. Also there was no record of a nutritional risk assessment in two booklets. We

discussed this with the sister in the acute admissions unit. We were able to later confirm that VTE assessment had been undertaken but not documented. However the nutritional risk assessments had not been undertaken. There was a need to review the use and completion of this booklet.

- The trust provided all medical, nursing and therapy staff working within medical services with a stamp with their name and confirmation of their personal identification number. This enabled other staff to easily track who had completed the record when required. We saw this as a good practice initiative.

Safeguarding

- Staff were able to describe situations in which they would raise a safeguarding concern, and how they would escalate any concerns. We saw and staff told us about examples that appropriate actions were taken to protect patients from abuse.
- Staff received safeguarding training at induction and at regular intervals and this was well-attended. Figures provided by the trust showed that 100% of staff on the majority of wards had attended safeguarding adults training. Achieving a compliance rate of 99.5% against a trust target of 75%.

Mandatory training

- Mandatory training included for example: fire safety, infection control, basic life support, moving and handling, conflict resolution training and information governance. In addition clinical staff also had an annual hand hygiene assessment and a blood transfusion assessment, trained nurses had intravenous administration training. Qualified and unqualified nurses had level one nutrition training and doctors and nurses had oxygen administration training and route cause analysis training.
- Training records we looked at on the wards confirmed that most wards were achieving almost 100% compliance. If compliance was lower ward sisters were able to explain the reason for this such as, long term sick leave or maternity leave or that training had been arranged. For instance Bullying and Harassment training trust target was 95% actual achievement was 99.4%. Hand hygiene assessment trust target was 75% actual achievement 92.8%.
- Nurses and healthcare assistants across medical services told us that ward managers ensured they completed all their mandatory training.

Assessing and responding to patient risk

- Medical services used an electronic patient observation recording system. The technology enabled quick and reliable recording of observations and automated early warning score calculation at the bedside. If a patient's deterioration was detected, an urgent alert was generated to enable appropriate escalations to be made to duty clinicians and hospital-wide teams. We saw the technology allowed for a quick response
- Nursing staff told us that, should a medical assessment be required for a deteriorating patient, attendance to the ward was swift and assessments were thorough.
- All patients diagnosed to be 'FAST' positive strokes were assessed by a stroke registrar and stroke nurse immediately on arrival at the hospital. FAST is a process of recognising the most common signs and symptoms of a stroke. F= face, A= arms, S= speech and T= time to call 999.
- Patients' individual risk assessments were completed weekly or more frequently dependant on identified risks. However we found that one patient's risk assessments on C16 did not reflect the increased risk of poor diet and fluid intake or other system to mitigate this risk. We escalated our concern to the ward manager who reviewed the patient and agreed that staff should have taken additional actions. The ward manager completed an incident report to identify the increased risk and failure to provide appropriate care, the patient was also referred the patient to a dietician.
- We observed nursing handovers on a number of wards, both during the day and at night time. We saw nursing handover sheets that contained information about care needs, past medical history and plans for discharge. There was a thorough discussion of each patient, which included information about their progress and potential concerns.
- Patient handovers took place at the beginning of every shift change. We observed handovers on five wards. We saw that handovers were given to all staff coming on duty by the nurse in charge of the previous shift. On AMU the handover took place between individual nurses handing over to the nurse that would care for those patients on the next shift.

- We found that nurses routinely attended ward rounds, making communication of nursing and medical information efficient and enabling nursing and medical staff to respond to patients' needs in a timely manner.

Nursing staffing

- The safer nursing care staffing tool was completed daily by the senior nursing staff for medical wards. The rotas were managed by the trust's electronic rostering system.Senior nurse managers told us that nursing vacancies was an on-going challenge. The head of nursing for division two told us that throughout the division (which also included emergency care), there were 27 (WTE) nurse vacancies. A recruitment drive was on-going which had included recruitment from overseas but in line with national data nurse vacancies were difficult to fill. Following the inspection the trust confirmed that 6.1 (WTE) had been recruited and were awaiting start dates.
- Wards managers told us that they had difficulties ensuring that their wards were fully staffed. Ward managers told us that they frequently had to replace a trained nurse with an untrained as they had insufficient trained nurses.
- The ward manager for B7 told us that they had vacancies for up to four full time nurses (3.7 whole time equivalents), B12's ward manger told us that they had two qualified nurse vacancies, one of which was a new post for a practice development nurse and an additional qualified nurse was on maternity leave. The wards managers on wards C15 and C16 also confirmed that nurse staffing was an ongoing challenge. Between C15 and C16 there had 7.85 WTE nurse vacancies. In addition there were several junior and overseas nurses who needed support and supervision to ensure patients received safe and appropriate care.
- A staff nurse on ward C16 told us, they are "frantic some days" and went off duty late due to poor staffing levels. They told us that they had a lot of newly qualified nurses who work autonomously and did not have proper supervision from senior staff which was unsafe. They said, "There have been no accidents so far but it is just a matter of time". Staff told us and we noted from incidents that on some days they did not have breaks on 12 hour shifts which staff told us was unsafe.
- Nursing staff working on B21 the cardiology ward told us about their concerns around staffing. The cardiology ward had 12 cardiac beds where the patients' needs were of a higher dependence and 25 other cardiology beds. Nursing staff told us that the higher dependency beds were staffed on a 1:3 ratio and the remainder of the beds on a 1:7 ratio. The cardiology ward had 12 beds for patients with higher dependency needs and 25 other cardiology beds. There was one shift coordinator over all 37 beds. The shift coordinator on night duty also was in charge of the separate cardiology day ward which may mean they were in charge of up to 51 patients. This did not appear to be sufficient.
- Nursing staff on B14 also told us that frequently the cardiology day ward was used overnight in response to bed pressures. Nursing staff told us that when the cardiac day ward was used overnight they were expected to provide staff to cover this ward within their usual night staff. When we visited the cardiology ward during our unannounced inspection we found that there was one shift coordinator who was supernumerary, five band five nurses and one band two. The band five nurse and band two health care assistants went to work on the cardiac day ward. This meant that three band five nurses were allocated to the nine higher acuity patients and left two band five nurses to support the remaining 25 patients. This ward admitted patients twenty-four hours a day who are acutely ill and required emergency treatment for a heart attack and initially required one to one care of a qualified nurse. Nursing staff told us that staffing arrangements were unsafe.
- When we visited unannounced we observed that the cardiology day ward was in open overnight. We found that staff had been moved from B14 which meant that B14 was short staffed. Whilst we were on the ward a patient rang their bell because they were worried about the wellbeing of another confused patient. We had to go and find staff in another bay to ask them to come to assist the patient as there were no staff either in the bay or nearby. Following the inspection the trust sent us documents to demonstrate that they had undertaken a review of staffing this area in November 2014. The staffing ratio was in line with the trust review and risk assessment. However the experience of the nursing staff and some patients was still not satisfactory.
- Nurses working on Deansley ward told us they felt staffing levels at night were insufficient. They told us that there were insufficient staff on duty to provide care for spinal patients who required specialist lifting by up to five nurses. A failure to provide sufficient nurses meant that patients were at increased risk of unsafe

movement or could not be safely moved and put them at increased risk of pressure ulcer development. Staff told us they had not recorded this as an incident. Following the inspection the trust informed us that there was a procedure for moving staff to the ward when they needed assistance.

- We found during our announced inspection that the wards mainly had the required number and grade of nursing staff on duty. Ward managers told us that night staffing was problematic and frequently they had to replace qualified nurses with untrained nurses particularly on night duty although there were still nurses in charge of ward/ units.
- When we visited unannounced we found that six of the ten wards we visited were short staffed with at least nine qualified nurses short between the wards we visited (late evening and on the night shift).
- The trust ward performance dashboard (March 2015) identified a 'red flag' for breaches of agreed staffing levels for the following wards, with number of breaches identified in brackets: AMU (3), A7(2), A8(3), W3(2), C15(2),C16(3), C41(4), C24(5), C25(2), C17(5), C18(4). Wards C17 and C35 staffing concerns were highlighted by a 'red flag' for actual staffing against planned: C17 (21 shifts), C35 (22 shifts). The ward dashboards highlighted the impact of staffing which identified 'a red flag' more than 5% late patient observations for: AMU, C15, C16, C17, C24, and C17. Increased patient harm was identified for AMU (avoidable pressure damage), A8 (avoidable pressure damage, falls with harm), C15 (avoidable pressure damage, falls with harm), and C25 (avoidable pressure damage). We saw that staffing shortfalls had resulted in patient harm.
- We observed during our announced inspection that planned and actual staffing levels were displayed on all wards with the exception of B14 (cardiology). However when we visited unannounced we found that planned and actual staffing were not displayed on three of the ten wards (B12, B14, C25) we visited.
- When shifts could not be fully staffed from their own staff working their contracted hours, staff could work additional hours on the hospital bank. There was a policy that agency nurses were not used within the trust. This meant that if cover could not be provided by bank staff following escalation to hospital management, staff would be reallocated from other areas if available.
- Ward managers were supernumerary and not counted in the daily staffing rota, although they sometimes had to form part of the core staffing to cover short notice vacancies due to staff sickness.

Medical staffing

- The proportions of consultants across medical services were slightly higher than the national average. Of the overall Medical staff establishment in the trust there were 36% consultants compared to 33% in England; 5% middle career doctors within the trust compared to 6% in England; 38% registrars within the trust compared to 39% in England; 21% junior doctors within the trust compared to 22% in England.
- There had been a reorganisation of the medical bed base and consultants providing cover for medical patients. The reorganisation had separated medical wards into directorates around medical specialisms such as: rehabilitation, acute medicine, renal, diabetes, elderly care, and gastroenterology and respiratory. Consultants and junior doctors we spoke with were positive about these changes.
- Nursing staff reported excellent medical cover across all wards, with minimal delays when requested to assess patients whose condition had deteriorated.
- Junior doctors covered weekends and had access to consultants and medical registrars as required. Junior doctors confirmed that consultants would come into the hospital when on-call. One doctor confirmed said, "Consultants expect to be called". Another doctor said, "We are well staffed at night and we are supported. On-calls (shifts) really aren't as bad as other hospitals".
- There was minimal requirement for medical locum use.

Major incident awareness and training

- The trust had an 'Emergency Preparedness and Resilience Strategy' (EPRS). This strategy provided an agreed framework to prepare for all emergencies and ensure business continuity plans were in place. The policy which emergencies and disruptions to services such as: period severe bed pressure, extreme weather conditions, an outbreak of an infectious disease, industrial action or a major transport accident.
- Staff we spoke with had mixed understanding and awareness of the procedures for managing major incidents and winter pressures on bed capacity. The ward sister on C21 showed us the major incident folder which had action cards, call and contact details and

debrief documents as well as basic information about major incidents. Some staff told us that they were aware that an annual practice for actions in a major incident took place. One staff member (a healthcare assistant) told us that they had been asked if there was a major incident if they would be willing to come in. However other staff did not know what the system was. One staff nurse in AMU thought the sister would tell people what needed to be done, they couldn't remember seeing anything about major incidents nor having had any training in actions that were required.

- Emergency plans and evacuation procedures were in place and on display on noticeboards. Staff were trained in how to respond to fire and evacuation procedures.
- Staff told us that there was a bed management system that aimed to ensure that patients' needs were met when there was an increased demand for beds. The lead consultant told us that previously medical services had used winter pressures wards.

Are medical care services effective?

Good

The trust showed that care was provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patients' care.

Policies and procedures were accessible to staff and they were able to guide us to the relevant information. Care was monitored to show compliance with standards and there were good outcomes for patients.

There were mainly suitable arrangements for ensuring that patients received timely pain relief. Patients were assessed for their nutritional and hydration needs and mostly referred to a dietician when required. However there was a need to ensure that patient's diet and fluid intake was appropriate and this was recorded.

Multidisciplinary working was evident to coordinate patient care. Staff had access to training and had received annual appraisals.

Evidence-based care and treatment

- All medical services delivered evidence-based practice and followed recognised and approved national guidance across the medical directorate. When speaking with nursing staff we found they had a good knowledge of guidelines, best practice and where to find guidance.
- There were care pathways based on NICE guidance for stroke patients, heart failure, diabetes and respiratory conditions. The hospital contributed to national audits. We saw that action plans were in place if required to improve performance.
- Medical services were encouraged to take part in both national and local audit to review and improve practice. We saw several examples of this which included: dietetic involvement with patients who were at high risk of low nutrition; improvements in stroke care and an audit of weekend prescriptions for insulin and renal treatment. The audits identified when further actions needed. We also found that an audit had identified that a larger audit with a larger number of patients should be undertaken to provide assurances of effective treatment.

Pain relief

- All but two patients told us they received the pain relief they needed. We looked at these patients records and found both had their pain relief regularly reviewed by medical staff. However we did observe that there had been a delay obtaining topical (gel that is applied to the skin) pain relief.
- Patients were administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels. We saw staff were quick to identify patients in pain, for example on AMU and cardiology. We saw on B12 that patients were assessed for pain at every medicine administration round.
- We saw nurses ask patients if they were in pain and when needed ensure that pain relief was administered.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patients' nutrition and hydration when applicable. We observed that fluid balance charts were completed on the majority of wards. However we found on A7 and C16 they were not fully completed to reflect the amount of fluid given and daily fluid totals used to monitor patients' hydration status.
- Patients had access to a cold drink by their bedside.

Medical care (including older people's care)

- A patient on C16 told us at when we visited the ward at 8pm that, "I can speak up for myself but the majority of patients can't and they have not had a hot drink since 2pm"; We asked a nurse if patients had received a drink. The nurse told us that the shift had been very busy and agreed that patients had not had a hot drink. Patients who do not receive adequate drinks were at increased risk of dehydration.
- Patients said they were given choices of food and snacks. However, they had mixed views regarding the quality and suitability of the food available. The majority of patients told us that the food was of excellent quality and that they had a choice.
- Two patients we spoke with on C15 said that they did not like the English food and preferred meals that met their cultural preferences. There was a need to ensure that patients were consistently offered a choice of meal available.
- Patients on diabetic wards C15 and C16 told us that snacks were available outside meal times.
- Nursing staff said they monitored patients' nutritional state and would make a referral to the dietician when needed. We saw evidence of a referral to the dietician in some of the records we read. However we noted that one patient on C15 did not have a recent nutritional assessment completed, had no accurate weight recorded despite being in hospital for almost four weeks and had not been referred to a dietician. We highlighted this to the ward manager, when we visited the following day we saw that appropriate actions had been undertaken.
- The wards had introduced protected meal times when visiting was not allowed. This was to allow patients time to have their meals undisturbed.
- There were 'red trays' to identify patients who needed support with eating and 'yellow jugs' for patients who needed assistance with drinking. We observed one patient with a red tray being helped by staff. When we asked two members of staff on the ward what the red tray system meant, they were able to tell us.

Patient outcomes

- The Standard Hospital Mortality Indicator (SHMI) produced by the Health and Social Care Information Centre (HSCIC) for July 2013 to June 2014 was banded "as expected". Royal Wolverhampton Hospitals Trust had the 20th lowest SHMI value in England for this period (out of a total of 137 acute trusts).
- The trust had demonstrated on-going improvements in stroke resulting in a score level B (level A is the highest achievement and level E is the lowest) in the Sentinel Stroke National Audit Programme (SSNAP) in September 2014.
- Physiotherapists told us about improvements identified in response to the SSNAP for the care received by stroke patients, such as identified patient care goals. Audit results we looked at also confirmed this.
- **The Myocardial Ischaemia National Audit Project** (MINAP) audit for 2013/14 showed that the trust performed better than the national average in two out of three areas that data was submitted for. For example; the audit 2013/2014 demonstrated that the trust performed better than the national average for people with ST segment elevation myocardial infarction (nSTEMI – a form of heart attack) being seen by a cardiologist, with a record of 100% against the national average of 94% and 87% of patients were referred for or had angiography (heart procedure involving widening of the arteries) against the national average of 79%. Patients who were admitted to cardiac unit or ward within the trust scored worse at 22.5% against a national target of 55%.
- The trust performance in the National Diabetes Inpatient Audit (NaDIA) was mixed compared with the England average. Ten of the 22 indicators were better with 11 indicators worse than the England average and no data was available for one indicator. Examples where improvement was needed included medicine errors, including insulin errors, patients seen by the MDT within 24 hours of admission to hospital and foot risk assessments within 24 hours, after 24 hours and during a patient's stay. However indicators such as visits by the specialist diabetes team, staff awareness of diabetes and patients' overall satisfaction were better than the England average. An action in response to the audit identified a need to change the prescription sheet to reduce medicine including insulin errors. We observed during our inspection that identified changes had been made to the prescription sheets.
- The trust had a dementia care strategy and advocated 'person centred dementia care'. The strategy included a person centred assessment which included completion of the 'About Me' booklet.

- The reach out care bundle developed on the specialist dementia ward for patients and their carers living with dementia, had shown positive results for patients and demonstrated within the first 12 months of implementation:

1. Reduction in complaints (1 compared to 3.4) and increase in compliments
2. Reduced number of falls and no multiple falls
3. 75% reduction in acquired infections
4. 50% of patients had either gained weight or weight had remained the same
5. Increasing percentage discharged back to previous residency
6. Consistency low use of anti-psychotic medicines
7. Improved staff job satisfaction with 50% lower mean stress assessment scores than and lowered staff sickness absence (2.8% compared with overall trust level of 4.8%).

- We saw a diabetes audit which assessed the care given to 25 diabetic patients. It identified that: 22 out of the 25 patients had been reviewed by a diabetes consultant at least three times weekly, 24 out of 25 patients had been reviewed by a doctor daily, 23 out of 25 patients had a VTE assessment within 24 hours of their admission and 25 out of 25 had their observations recorded. This audit identified why required standards were not met and where further improvements were needed.

- Junior doctors working on the C22 and A8 told us about actions taken to highlight patients who were at increased risk of falls and included stickers in patients notes which identified an increased risk and prompting doctors to review patients medicines The trust's emergency standardised readmissions rates were generally worse within medical services than the England average, with the exception of general medicine which performed better than the England average.
- Respiratory medicine had developed a 'Respiratory Network Group' for monitoring and improving respiratory medicines both within the hospital and local community. The Respiratory Network group had shown improvements in reduction in length of stay, high patient satisfaction and an embedded structure for monitoring and improving performance of integrated respiratory services.
- The trust participated in the Joint Group on GI Endoscopy (JAG) and received five year certification which confirmed that satisfactory standards were in place on 29 June 2010.

Competent staff

- We observed clinical practice, attended staff handovers and MDT meetings and saw that staff working across medical services were competent and knowledgeable within their chosen wards.
- Competency assessments were in place to show that staff had been assessed and were proficient within their respective specialist wards. For instance the stroke ward had a competency assessment for nurses to assess patients who might be having a stroke. However the nurse in charge told us that staff shortages on the stroke ward had meant that it was difficult for nurses to gain experience alongside an experienced staff nurse to gain this competence. However, staff did have the opportunity to gain this competence in the emergency department.
- Respiratory, cardiac, stroke and renal specialist nurses worked within their designated specialist wards and provided support and advice to staff and patients.
- New nursing staff received induction training and were supernumerary for at least one week. We spoke with a nurse who had transferred from another ward in the hospital. They confirmed that they had been supernumerary both when they had first come to work at the hospital and were now supernumerary for a further week since moving to their new ward (C21 AMU).
- As part of the trust's dementia strategy there was a plan that all staff should receive dementia awareness training. Information provided by the trust showed that this training had commenced at the time of our inspection although uptake within medical wards had been minimal.
- Staff told us that they could access their own education and training via the trust's intranet. The education programme identified both mandatory and development training that was available. Staff were able to book on to the training courses to develop their knowledge and skills.
- Junior medical staff told that us on A7 and A8, weekly teaching sessions were held for staff to help them look after patients living with dementia.
- On B14 (cardiology) 28 out of 52 (56%) registered nurses had a post registration qualification in cardiology.

- Junior doctors we spoke with said they felt supported by consultants and nursing staff. Junior doctors working within elderly care told us that the consultant provided them with good teaching in medicine and dementia care. They confirmed that they had plenty of opportunities to perform audits and research. They also said that they had dedicated time each week to attend teaching sessions.
- On AMU we spoke with two nurses from overseas who had recently moved to the UK to work at the hospital. The nurses told us that they felt well supported in settling in and that they were getting all the training that was needed. We also spoke with a student nurse who told us that they had good learning outcomes from their time on the ward and was well supported by senior nurses to make sure that these outcomes were achieved.
- Information provided by the trust identified that the trust target for staff appraisal was 75% with actual achievement of 85.5%. Information we looked at on the wards identified that the majority of staff had received an appraisal.
- All staff we spoke with confirmed they had an annual appraisal. Staff told us that as part of their appraisal they discussed their development and any training needed. Ward managers received monthly information about staff who required a forthcoming appraisal in the next two months

Multidisciplinary working

- Therapy services, such as respiratory and musculoskeletal physiotherapists, occupational therapists and the mobility team were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.
- Speech and language therapists were part of the multi-disciplinary team. One speech language therapist told us that they felt there were insufficient speech and language therapists available for stroke patients. They told us that there had been long term sickness within the team of (two) speech and language therapists. Nursing staff told us that they would undertake an initial swallowing assessment and when needed would make a referral to a speech and language therapist. The SSNAP survey which reviewed stroke services had identified an improvement was needed for speech and language therapy for patients who had a stroke.
- On the stroke unit (B12) staff told us that twice weekly multi-disciplinary team meetings (MDT) took place. We attended a MDT meeting and observed that stroke consultants and junior doctors, nurses, a speech and language therapist, an occupational therapist and discharge coordinator attended the meeting. The meeting discussed the patient's progress referral to other services such as psychologist and plans for further treatment and discharge.
- Speech and language therapists and dieticians attended the medical wards as required.
- Patients were also referred to clinical psychologists if necessary. We saw evidence of this in the records we saw on the B12.
- On the elderly care and dementia wards (A7, A8 and C22) staff told us and we observed that MDT meetings took place.
- On respiratory ward there were fortnightly MDT meetings to discuss chronic respiratory patients. They also undertook daily ward huddles.The MDT consisted of community matrons, respiratory nurses, physiotherapists and both respiratory and palliative care consultants.
- A respiratory consultant reviewed respiratory patients on the AMU, seven days a week from 09:00 until 11:45, helping to provide specialist opinion for acute respiratory problems and facilitating discharge and evidence-based management for others with appropriate follow-up.
- Staff told us that there were twice weekly MDT meetings within cardiology.
- Staff on other wards told us and we also observed that daily MDT 'huddles' took place with involvement of other professionals, such as physiotherapist and social workers. Doctors told us that following a reorganisation of social services social workers did not attend as frequently as previously. We observed these huddles taking place on several wards we visited.
- On B12 we observed that appropriate arrangements were made to transfer stroke patients to West Park Hospital to continue their stroke rehabilitation. We also observed arrangements to transfer patients from the care of the elderly wards to West Park Hospital.
- We observed on the stroke unit that when required arrangements were made for patients to be reviewed by a psychiatrist.

Seven-day services

Medical care (including older people's care)

- The medical lead for medicine told us that there was seven day consultant cover within medical services and were working towards having two ward rounds a day, seven days a week.
- Consultant cover over the weekends was provided on a rota within each directorate such as diabetes, renal, respiratory, elderly care and stroke. This ensured that consultant/ senior doctor ward rounds took place seven days a week. This provided continuous patient review and staff told us they felt supported to manage patient care effectively.
- Therapy services, such as respiratory and musculoskeletal and stroke physiotherapists, occupational therapists and the mobility team were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.
- Speech and language therapists and dieticians were available five days a week.
- The hospital pharmacy was open seven days a week, although for reduced hours at the weekend. Urgent medicines could also be accessed by senior on-call staff.

Access to information

- On most of the wards we visited, nursing notes were kept close to patients and were accessible at all times. "Skinny" medical notes which related to the current admission only were kept on the wards securely within notes trolleys.
- All medical wards used a large electronic screen detailing number of beds patient details, admission and estimated discharge date and listed healthcare professionals involved in the patients care. This information was accessible to all medical wards and provided staff with instant information as to the location and condition of each patient.
- Nursing staff told us that, when patients were transferred between wards, staff teams received a handover about their medical condition. We saw that ongoing care information was shared appropriately in a timely way.
- Discharge summaries were given to GPs to inform them of a patient's medical condition and the treatment they had received before discharge.
- The trust used an electronic system to record patient's observations and provide early warning of possible deterioration. We saw this being used by the nursing staff. It was seen as vital to ensuring patient safety on the wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant the trust had ensured that decisions about the care and treatment arrangements for a person without capacity did not amount to a deprivation of their liberty.
- Patients were asked for their consent to procedures appropriately and correctly. We saw examples where staff had acted in accordance with the MCA when patients did not have capacity to consent.
- When patients did not have capacity to consent, staff said they would apply for best interest decisions in deciding the treatment and care they required.
- Ward staff were clear about their roles and responsibilities regarding the MCA.
- The records, when applicable, showed clear evidence of informed consent that identified the possible risks and benefits of care.

Are medical care services caring?

Requires improvement

Overall patients we spoke with were positive about the care they received from staff. A number of patients commented that staff were caring and friendly and that they felt they were being looked after. Patients felt that their dignity and privacy were respected and we observed this on the wards. We observed mostly kind and compassionate care on all the wards we visited.

However on three different wards we observed staff interactions with patients that were neither caring nor compassionate. We saw these did not meet the standards set by other members of staff.

The Friends and Family Test (FFT) was used and the results displayed on most wards. The trust response rate to the FFT was worse than the England average.

Compassionate care

- All of the wards we visited monitored responses from the NHS Friends and Family Test (FFT) and the number of compliments received.

- The trust used the FFT. This was a single question survey which asked patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The response rate varied between 11% and 50%. The average FFT response rate for the Trust was 23%, which was worse than the England average of 30%.
- Patients across all medical wards were satisfied with the quality of service they received and all 53 patients and relatives we talked with told us they had no complaints.
- We observed many examples of caring and compassionate care on the medical wards we visited. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- However on C16 we observed two health care assistants were abrupt and uncaring they did not explain what they were doing when they moved a patient and 'tutted' when the patient asked them to make them more comfortable. We shared our observations with the deputy ward manager who told us that the staff concerned were very caring but they would discuss our observations with them.
- On C15 a patient told us that some patients had not had a drink. We asked a qualified nurse about this, they told us they had not been working in that bay and said they had been very busy. We also highlighted that a patient was walking around the bay without footwear. The same nurse said they were not working in that bay. We highlighted to the nurse as a trust employee all patients were under their care and this was neither caring nor promoted the patient's dignity. A second nurse who was working in that bay confirmed the patient without footwear had been regularly encouraged to wear them.
- Also on a separate occasion we observed a different member of staff state loudly that a (named) patient had asked to go the toilet. They went on to say this was before they had provided care to another patient. The patient then quietly explained the reason why they no longer needed to go to the toilet. The staff member then from across from the other side of the bay said: "What, you have wet your pad?". It was evident that the elderly patient was embarrassed by this exchange. However we then observed a student nurse come over to the patient and quietly reassure them that everything was ok and they would take them to the bathroom to make them more comfortable. All the patients in that bay had earlier told us that staff were lovely and caring. We shared our observations with the ward manager who told us that the staff concerned were very caring but they would discuss our observations with them.
- During our unannounced inspection we visited C19. We observed a staff nurse administering medicine to patients. They were very loud, abrupt in their manner and did not appear either friendly or empathetic. However, the family of other patient said they were one of the best members of staff and was really friendly and helpful.
- The patients and relatives we spoke with were pleased with the care provided. They told us doctors, nurses and healthcare assistants were caring, compassionate, and responded quickly to their needs. One family told us that not all nurses had being caring when another family member had been a recent patient. They told us that they had raised their concerns with senior staff and it was being investigated. However they made positive comments about caring staff on ward A7.
- We observed doctors conducting ward rounds and saw that doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- On B12 and C15 we observed physiotherapist assisting patients with mobility, walking at the patients' pace and waiting whilst the patient rested along the ward corridor when mobilising as part of their programme of therapy. They acted in a caring manner and maintained the patients' dignity throughout. It was obvious from the interaction and the way the patients responded that this level of care was normal.
- Patients told us they felt that the nurses and doctors "Really do care". Another commented "Nothing is too much trouble".

Understanding and involvement of patients and those close to them

- All the patients we spoke with told us they felt generally involved in aspects of their care and treatment.
- We observed interactions between doctors and patients, we saw how issues were explained and patients had opportunity to discuss what they were being told. Consent was always obtained prior to any interventions taking place. They asked patients if they had any questions and gave them time to reply.
- There was evidence of when a patient's family had been involved in their relative's care and discharge plans. For

example, discussions with family members were documented in patients' notes on the stroke ward. These discussions detailed information about the care and support patients would require when discharged from hospital.

Emotional support

- Patients had access to further support from clinical nurse specialists. For example, diabetes nurse specialist were available to support patients with diabetes, clinical nurse specialists provided advice for and support for stroke patients and dementia outreach nurses provided support and advice for patients and their relatives living with dementia.
- We observed that on the stroke unit patients were offered counselling services to give them additional emotional support.
- The hospital chaplains visited the wards on a regular basis. A multifaith room was available in the hospital for patients or relatives to access.

Are medical care services responsive?

Good

The trust has several initiatives to prevent admissions to hospital and facilitate patients timely discharge from hospital as soon as they are well enough or able to leave. This meant that patients could rest and recover at home or in a place they were comfortable sooner and had less time in hospital.

The trust worked together with partners and commissioners at a strategic level to respond to the needs of the population, patients and winter pressures. Different departments worked together to provide better environments for patients with complex needs.

There were initiatives and facilities on wards to meet the need of individual patients. Patients were encouraged to identify goals and targets and their needs assessed so that the right level of care could be provided. We saw patient focussed approaches to care and treatment.

Service planning and delivery to meet the needs of local people

- The trust provided primary percutaneous coronary intervention primary (PCI), an emergency treatment for patients who were having an acute ST-segment-elevation myocardial infarction (STEMI), 24 hours a day, seven days a week.
- The trust provided emergency treatment, 24 hours a day, seven days a week for stroke patients.
- The trust had implemented the 'SWAN' pathway which included advanced care planning for patients at the end of their life.
- Respiratory medicine had a 'Respiratory Network group' which had developed the Respiratory Action Network for the benefit of Wolverhampton (RAINBOW) group. The RAINBOW group oversaw the integration of community, acute trust and palliative care services for people with Chronic Obstructive Pulmonary Disease (COPD).

Access and flow

- National standards state that 90% of referred patients should start consultant-led treatment within 18 weeks of referral. Between November 2013 and November 2014 the trust met this standard for medical services. Gastroenterology, geriatric medicine and rheumatology achieved 100% figures for patients who were admitted. This was above the England average.
- The trust did not meet the target for the two week cancer wait, 62 day wait for first treatment and 62 day wait for screening between January and March 2015.
- The trust's emergency standardised readmissions rates were generally worse within medical services than the England average, with the exception of general medicine which performed better than the England average.
- There were occasions when there were insufficient beds for medical patients which required medical patients to be accommodated on a non-medical ward; this is sometimes called a medical outlier. Consultants and junior doctors told us that each directorate (or specialism), had a duty rota which included named doctors on call for the division. The division had 'paired wards' the 'paired wards' had named consultants who they were able to contact if they had medical patients who needed to be seen. We saw during the inspection that this system worked well and patients on outlier wards mainly received timely assessment, care and treatment. However we did find one patient on C41 who

had previously been on a surgical ward and had not been seen for several days. The patient's records identified that an incident report had been made to ensure any shortfalls were identified and addressed.

- A specialist respiratory nurse completed the discharge bundles for patients with COPD and asthma and coordinated the early supportive discharge for respiratory patients.
- On C21 (AMU) staff told us that there was no cut off time for transfer of patients to wards. They told us that they continued throughout the night to move patients out from AMU if beds became available. The only exceptions were –
  - Dementia patients in general weren't moved after 8.30pm so as to reduce their anxiety.
  - If AMU was particularly quiet, and plenty of beds were available then patients were not moved until morning.
- Information provided by the trust identified that the average number of bed moves for each medical patient stay between April 2014 to March 2015 was 1.5.
- The average length of stay for the majority of elective and non-elective medicine patients was higher than the England average. This meant that patients were staying in hospital longer than in other hospitals around the country.
- Patients discharge dates were discussed at daily ward rounds and MDT meetings. This was to ensure those patients who were medically fit could be prioritised to leave the hospital.
- Prior to discharge patients' needs were assessed so that the correct level of care could be put in place at home or a care setting. On the stroke ward an occupational therapist discussed the outcome of a home visit during the MDT meeting. This was to assess the patient's ability to undertake tasks within their home. Staff then made appropriate discharge arrangements with care agencies or families.
- During the handover on C15 we observed that staff identified those patients who were fit for discharge and their discharge plan and arrangements were discussed.
- Medical and nursing staff told us that most delays in discharges were because patients were waiting for care packages to be in place if returning to their own home, or for a rehabilitation or care home place to be available.
- Staff told us they felt that there was good communication and work between hospital staff and social care providers. We saw evidence in medical notes of working with local authorities, care homes, and GPs in discharge planning.
- We noted that significant numbers of patients were transferred to Cannock Chase hospital late at night to assist with flow.

Meeting people's individual needs

- There was an interpretation service available for patients and their families who did not have English as their first language. Staff told us that although they had used this service the hospital had a multi-cultural staff and they were able to get a member of staff to translate. We spoke with one patient and their family who told us they had been offered access to an interpreter on several occasions.
- We saw a wide range of information available to patients and their families on large notice boards and leaflet racks on the wards and visitor waiting areas. The notice boards were clearly visible and accessible for patient and families. All the information we saw was written in English and so was not easily accessible for some patients who did not have English as their first language.
- Patients over the age of 75 were routinely screened for signs of dementia. This enabled staff to put in place the right level of care and escalate any issues. If there were signs of dementia it would be escalated to medical staff to undertake further assessment. We saw examples of completed screening questionnaires and escalation in patients' records.
- Staff told us that patients living with dementia, learning disabilities and mental health problems were provided with one to one support where needed on wards. Some wards also operated supervised bays where patients who needed it could have continual support and supervision which we observed during our inspection. Staff told us that when people living with dementia were confused or agitated they could request 'one to one' care for this person. Staff said mostly this would be arranged.
- The trust had a dementia outreach service which provided specialist multi- disciplinary care and follow up for patients living with dementia and their relatives. The leaflet highlighted the dementia outreach service and gave contact details for outreach staff.

Medical care (including older people's care)

- We saw that patients who were living with a cognitive impairment had a 'About Me' document in their nursing notes. This enabled staff to better understand their communication requirements and social background to improve their experience of the hospital environment.
- People told us before our inspection that only one pillow was available for patients on AMU. When we visited AMU the availability of pillows was assessed. Staff confirmed that patients had one pillow and said this was because the head of the bed could be raised. Staff told us that if requested additional pillows would be made available. We spoke with four patients on AMU all said they usually slept with more than one pillow and felt that more than one pillow should be available but were not aware they could ask for additional pillows.
- Relatives contacted us during the inspection and told us that patients on A7 (elderly care) were allocated just one pillow as the bed head could be raised. They told us when they asked staff for additional pillows they were told that just one pillow was allocated. The relative told us in response to this they had brought in two pillows from home for their relative and put the patients name on it. Staff told them that the pillows may go missing. They told us when they visited their relative the following day they had just two pillows and the hospital pillow had been removed. The relative felt that this local cause of action for just one pillow was not appropriate for frail and elderly patients.
- For people with diabetes there was an 'Emergency Nurse Service'. This service was a nurse-led telephone service that provided help and guidance to patients and negated the need to attend hospital.
- The services offered by a lead respiratory consultant and their team included a chronic respiratory multi-disciplinary team (MDT) meeting, respiratory HOT clinics (clinics for fast access to respiratory consultants to prevent admission), respiratory consultant review within AMU and community clinics to ensure that people received timely review and both evidence based and effective early treatment.
- Between 1 November 2014 ad 30 April 2015 235 primary PCIs were performed within the trust. Most effective results are achieved if patients receive treatment within 90 minutes, this is called 'door to balloon time'. Data provided by the trust show this standard was met in four of the six months between November 2014 and April 2015. The average 'door to balloon' over this time period was 79 minutes.

Learning from complaints and concerns

- Information available to patients and visitors about how to raise concerns or complaints was displayed on notice boards and leaflets available throughout the medical wards.
- Nursing staff told us they knew how to deal with concerns and complaints. Most staff we spoke with wanted to try and deal with concerns quickly and immediately. If this could not be resolved patients would be signposted to patient advice and liaison service (PALS).
- One relative we spoke with before our inspection said they had previously raised concerns with ward staff on a medical ward but had found that improvements were not made. They told us when they raised their concerns with PALS they would only accept their concerns in writing. They told us that in response to their concerns that the consultant and matron were both responsive and they had met with them to discuss further.
- Nursing staff told us that feedback from patients was shared in a variety of ways including staff noticeboards, emails, and team/ward meetings and in person.
- Nursing staff told us that they had meetings with patients and their families to resolve complaints or deal with concerns. Nursing staff gave us examples of changes to practice on wards as a result of complaints. For example, a member of staff told us about a change in filling out property lists after a patient complained that their property had gone missing.

Are medical care services well-led?

Requires improvement

We rated well led as requires improvement. The leadership were sighted on the staffing issues, but the actions undertaken had not been effective. This in turn had had a negative impact on safety and caring due to overworked staff.

Staff felt well supported by their immediate managers. Staff were positive about the standard of care they provided and of that their achievements were recognised. There was a culture of audit and improvement within the medical services.

Medical care (including older people's care)

There were suitable arrangements to identify and manage risks, and to monitor the quality of the service provided. However despite efforts to employ sufficient nursing staff this risk had not been appropriately addressed by senior managers.

The trust's vision was well embedded within medical services. Staff demonstrated commitment to its vision and values. However evidence of staff shortages compromised this vision.

Vision and strategy for this service

- Staff were aware and understood the vision and values of the trust and how their role and behaviours that would achieve these values.
- Senior Sisiters told us that they discussed the trusts values during ward meetings, handovers, and recruitment interviews and staff appraisals.
- Ward managers told us about strategies to aid nurse recruitment which included ongoing advertisements for nurses, nurse recruitment days, sharing the benefits of working for medical services within the trust. Ward managers told us that wards which had most difficult recruiting nurses and had a high vacancy rate agreement would be made by the head of nursing for an enhanced bank nurse rate for that ward.
- The trust had a dementia strategy which was in place for all services including medical services. This strategy identified: high quality person centred care that meets the needs and expectation of patients and their carers. Staff caring for people living with dementia were passionate about providing high quality care for people living with dementia and their carers.
- Staff working within the stroke unit told us that the vision for their service was to extend the service and provide specialist stroke services 24 hours a day, seven days a week for other local hospitals. At the time of our inspection there was a regional stroke review being undertaken and one of the options was to provide emergency stroke treatment for patients from Walsall Manor Hospital, however, no agreement had been reached.Senior managers for the division told us the vision for acute medical services was for twice daily senior doctor ward rounds, seven days a week.
- Doctors working within respiratory medicine told us that their vision for their future included: Closer working with community services and improving the hospital-community interface and seven day working.

Governance, risk management and quality measurement

- Monthly ward reviews were completed and monitored by senior managers. These included ward hygiene, staff hand washing and compliance with staff training and appraisals.
- There were weekly core team meetings within the directorate which discussed the day to day management and performance of the directorate.
- There were monthly governance meetings for each directorate within medical services. We looked at minutes and found that, incidents and complaints were discussed and actions identified to reduce further the risks during the meetings. We also saw that lessons were shared between the directorates.
- Risks that affected the delivery of safe care were clearly identified on the division's risk register. Ward managers told us that they could add risks to the risk register at any time. The risks were then assessed by the directorate management team and when needed escalated onto the division and trust risks registers. This ensured that senior trust managers were aware of significant and ongoing risks. The risk logs included actions that were required to reduce risk and were reviewed at each risk meeting. However on the risk register they identified low staffing levels on several medical wards however a blanket decision not to use agency staff remained in place. We did not find there had been a suitable response to this ongoing risk. We found that some ward managers were concerned that they were not able to always meet required staffing levels, despite efforts by the trust to recruit additional nursing staff. Two ward mangers told us that were particularly concerned about night time nurse vacancies. The ward managers told us that if they were unable fill qualified nurse shifts they would put an additional untrained staff member on duty to cover. Ward managers also highlighted their concerns about the blanket decision not to use agency staff.
- We found when we visited at night that a capacity manager was on duty with a senior manager on call from home. There was a band six nurse on duty on cardiology but for the remainder of the wards we visited the most senior staff on duty were band five staff nurses. When we finished our unannounced visit we struggled

to identify a senior staff member on site. We did feedback our concerns over the telephone but were unable to show a senior manager our concerns about potential risks.
- The senior manager we spoke with however did assure us that actions would be taken to remove furniture and equipment that was blocking the fire exits.
- A root cause analysis investigation was undertaken following each serious incident, the investigations undertaken were detailed identified actions to reduce the risk of further similar incidents in the future.

Leadership of service

- General medicine, acute medicine, elderly care, stroke, diabetes, renal, respiratory and gastroenterology were part of division two. The division had a divisional medical director, deputy chief operating officer and head of nursing. Cardiology were part of division one which had the same senior management structure. The divisional management team reported to the trust board.
- A management structure was in place and understood by all staff if that was the case
- Modern matrons provided leadership to the specialties.
- The leadership drove continuous improvement and staff were accountable for delivering change.
- Ward managers were all supernumerary (additional to nurses on shift) and mainly worked Monday to Friday.
- We observed during both our announced and unannounced inspection that staff who were in-charge of the shift wore a badge that identified: "In charge" to assist patients and relatives and staff from other wards to identify the most senior person on the ward should they need to speak to them.
- Nurses told us that matrons were visible and supportive and felt able to raise concerns and were listened to.
- Two ward managers told us that they were relatively new in post. They told us that their matron had been supportive. One ward manager told us that they had been concerned about the ward skill mix with junior and inexperienced nurses. They told us that the matron had agreed and had facilitated the transfer from other more established wards to ensure that more experienced staff were available.

Culture within the service

- Staff told us that the hospital was a friendly place and they liked coming to work.
- Staff in several areas we visited commented that they were "A good team". They told us that they would recommend the hospital to their friends and family for care and treatment.
- Staff commented that patients come first.
- Staff were encouraged to complete incident forms or raise concerns. Staff felt that these concerns were usually adequately addressed and were appropriately responded to by senior managers. However some staff on cardiology told us they had been discouraged from reporting their staffing concerns.
- All the managers told us that they were proud of their team and their commitment to high quality patient care.
- Medical staff told us that there was "A culture of audit and improvement" within the trust.

Public engagement

- There were walkabouts undertaken by the executive team during which patients were spoken to about their experiences of care within medical services. Some but not all of the nurses we spoke with were aware that visits had been undertaken.
- There were patient group involvement for the stroke or cardio patients. For example there was a Stroke User Group which met regularly at West Park Rehabilitation Hospital.

Staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with staff.
- Managers were visible on the medical wards. Staff spoke positively about ward managers and matrons and the support they provided.

Innovation, improvement and sustainability

- There were appropriate systems in place to review service delivery and when needed ensure that lessons were learnt and appropriate actions taken. As a consequence of medication incidents, nursing staff involved have to complete additional training and assessment.
- Medicine services had a trust cost improvement programme. We had mixed comments from staff about the cost improvement plan. Some staff were concerned that when shifts were unfilled the decision not to use agency was an inappropriate cost saving. Staff also said

they thought that a lack of basic equipment was the result of an effort to save money. However the trust refuted these, pointing out that staffing and equipment had never been part of a cost improvement programme.

Surgery

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

Information about the service

The Royal Wolverhampton Hospitals NHS Trust at New Cross Hospital offers emergency and elective surgical procedures on an inpatient basis as well as day case surgery. Surgical specialities include general surgery, cancer surgery, trauma and orthopaedics and urology.

There are seven surgical wards (one of which is gynaecology which is being reported in the maternity and gynaecology section), a surgical assessment unit and one Admission / Day Case Unit. There are 19 theatres. Wards that were visited as part of this inspection included trauma and orthopaedics, urology, surgical assessment unit, general surgery, cardiac surgery and ear, nose and throat.

We spoke with 20 patients, 10 relatives, and 30 members of staff. These included nursing staff, healthcare support workers, ward clerks, junior and senior doctors, pharmacists, physiotherapists, operational support staff, and managers. We observed care and treatment and looked at 10 care records including medication charts and pain management records. We reviewed other documentation from stakeholders, including performance information provided by the trust.

Summary of findings

Patient safety was monitored on a daily basis and incidents were investigated to assist learning and improve care. Patients received care in safe, clean and suitably maintained premises. Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients' needs and staff assessed and responded to patients' risks. Staff received mandatory training in order to provide safe and effective care.

The surgical services provided care and treatment that followed national clinical guidelines and staff used care pathways effectively. Surgical services performed in line with similar sized hospitals and with the England average for most safety and clinical performance measures. The results of the national emergency laparotomy audit 2014 identified a number of required policies and procedures were not yet in place. The National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Patients spoke positively about their care and treatment. They were treated with dignity and compassion.

The majority of patients were admitted, transferred or discharged in timely manner. The surgical services

achieved the 18 week referral to treatment standards for most specialties. The majority of patients whose operation was cancelled for non-medical reasons were treated within 28 days.

There was clearly visible leadership within the surgical services. Staff were positive about the culture and support available. The management team understood the key risks and challenges to the service and how to resolve these.

Are surgery services safe?

Good

There were good systems and processes in place to prevent avoidable harm. Patient safety was monitored on a daily basis. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff told us they were fully supported when they did so. However, we found there was no systematic approach to sharing the learning of incidents across all wards.

Medicines were stored safely and given to patients in a timely manner. The staffing levels and skill mix was sufficient to keep people safe at all times.

There were plans in place to respond to emergencies and major situations.

Incidents

- Surgical services reported no never events since 2011.
- Staff across all areas we visited told us they were encouraged and supported to report incidents. Matrons and ward managers described the processes they used to investigate incidents and how they used investigation findings of incidents to inform their quality assurance processes. For example, when a pressure grade 3 or 4 ulcer is recorded on a ward, staff are called in to a "panel meeting" at which they are asked to present their findings and the panel comprising of the director of nursing and matrons from other areas provide challenge. Staff told us that these meetings whilst highly challenging and highly supportive, enabled them to take the learnings from such events on board and ensure they put in systems in place to prevent such events.
- Nurses, healthcare support workers, and doctors were able to describe changes which were made as a result of incidents. For example, a recent incident of C difficile resulted in increase in a dedicated domestic staff on a ward and changes to the cleaning regimen.
- Staff on individual wards and in theatres told us they received feedback from incidents they reported and that learning points from incidents were shared at staff team meetings.
- Although there was evidence of learning from incidents, learning from incidents which took place on individual

wards was not consistently shared across the hospital. Most of the staff we spoke with were not aware of learning points resulting from incidents which had been made in other areas of the trust.

- Morbidity and mortality meetings were used across surgical specialities to review incidents and unexpected death in order to identify learning and improve services. Senior and junior doctors told us that monthly mortality and morbidity meetings were used to discuss complications and learning points where patient care could have been better.
- Within the surgical division there were a total of 45 incidents reported to the Strategic Executive Information System (STEIS) for the year April 2014 to March 2014. These incidents were, for example, pressure ulcers, slips/trips/falls and delayed diagnosis. We saw that these were discussed in the division's governance meetings and learning was shared with staff in ward or unit meetings.

Duty of Candour

- The Duty of Candour legislation requires an organisation to disclose and investigate mistakes and, where mistakes are substantiated, to offer an apology if the patient experienced a defined level of harm or was at risk of harm. The principles aim to improve openness and transparency in the National Health Service (NHS).
- Staff we spoke with understood their responsibilities with regard to the new Duty of Candour legislation. Staff in almost all areas we visited told us incidents involving potential mistakes in patients' care or treatment were investigated and findings were shared with patients, and where appropriate, their relatives. They also described the need for patients involved in incidents to be given an apology.

Safety thermometer

- The NHS safety thermometer is a monthly snapshot audit of the prevalence of avoidable harms including new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism (VTE), and falls. Patients, visitors and staff could access safety thermometer information at the entrance to each of the wards we visited. This included information about falls with harm, new venous thromboembolism (VTE), catheter use with urinary tract infections, and new pressure ulcers.
- Safety thermometer data showed that, for the surgical specialities, the rate of falls and urinary tract infections was better (lower) than the English average.
- The prevalence of pressure ulcers was better (lower) than the English average.
- Nursing and healthcare support staff we spoke with were able to tell us how they used skin care bundles and why, and how they could access support from the tissue viability nurse.

Cleanliness, infection control and hygiene

- The ward areas and theatres we visited looked clean. Overall standards of cleanliness in theatres and in the wards we visited were good.
- We saw that staff across all three areas wore clean uniforms, with arms bare below the elbow and that personal protective equipment (PPE) was available for use by staff. Hand washing and sharps disposal was undertaken as per established protocols.
- Cleaning schedules were displayed on the surgical wards we visited and cleaning tasks were clearly identified. Clinical equipment, such as IV pumps, was cleaned by nursing staff.
- Hand hygiene gel was available at the entrance to every ward, along corridors and at the bottom of each patient's bed. We observed good hand hygiene practices on all wards.
- Hand hygiene audits were completed at ward level and monitored at divisional level. Overall, they showed good compliance with hand hygiene standards.
- Each surgical ward had an infection control lead who took responsibility for infection control issues on the ward and who could provide advice and support in relation to infection control.
- Patients and relatives we spoke with had no concerns about the cleanliness of the wards and told us cleaners were regularly seen on the wards.

Environment and equipment

- Equipment was regularly checked.
- Resuscitation equipment checks in all areas we looked at were completed daily. Appropriate resuscitation equipment was available in all the areas we visited.
- Staff said they were able to access equipment that was needed to deliver care safely to patients.
- The trust had ensured all surgical patients had access to patient mattresses that if required could be converted to a pressure relieving mattress.

- We found there was attention paid to patient safety including the availability of pressure prevention aids
- We visited theatre suites and found they were fit for purpose. Maintenance records showed the trust reviewed the safety and suitability of its theatres. Recovery areas were well planned and there were separate recovery areas for adults and children.
- During our inspection, we were provided information by a whistle-blower regarding lack of staff and availability of equipment in Nucleus theatre. This was investigated by the inspectors who found that the Nucleus theatre did not have its own blood fridge and if a particular type of blood was required, staff would need to go to the intensive care unit for that type of blood. This was about 11 minutes away from Nucleus Theatre. Without the necessary complement of staff to do that run, it could adversely affect patient outcome. We highlighted this to the trust who investigated these concerns and undertook formal risk assessment of the current situation. The outcome of this risk assessment was that it was the staffing required for the transportation of blood from the blood fridge to Nucleus Theatres that was the issue and not the location of the blood fridge. As a result, the recruitment of additional staff that was being undertaken would help resolve the matter. The trust had taken action to resolve this.

Medicines

- Medicines were stored safely. The temperature of medication fridges was monitored.
- Patients we spoke with told us they were given good explanations of their medicines and usually understood why they had been prescribed.

Records

- Nursing records were held at the end of patients' beds and at the nursing station. Medical records accompanied patients to and from theatre.
- Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- The paper patient records we looked at were generally legible and well maintained.
- Surgical safety checklists (based on the World Health Organisations WHO checklist) should be used at each stage of the surgical pathway – from when a patient is transferred to theatre until return to the ward. In the patient records we saw, WHO patient safety checklists were always completed.
- However, during one observation undertaken in theatres, we observed there was no formal "sign in" in the anaesthetic room. There was no introduction by the anaesthetist and no "pause" to discuss issues covered by the surgical safety checklists. There were delays whilst additional anaesthetic help was arranged by the anaesthetist. However, there was no explanation given to the surgeon or the theatre team. During the same observation, a full formal "time out" was taken and this was well embedded.
- We looked at 15 patient records in the recovery area for theatres. We found that documentation intended to alert staff to patients who were deteriorating was available.
- In all other areas we visited, patients had clearly documented treatment plans written by doctors and nursing care plans were in place. There were records of care from physiotherapists, dieticians, and pharmacists. Patient records on surgical wards were usually complete.
- We saw evidence of risk assessments completed for each patient when they were admitted onto a ward. For example falls risk assessments were undertaken to alert staff to potential falls risks. There was a system to identify patients who were at risk of developing a pressure ulcer which provided prompts on the actions to be taken to manage the risks.

Safeguarding

- Training records shared with us by the wards we visited for its surgical divisions, showed a high take up (over 90%) of safeguarding training by nursing staff. Nursing staff told us they had safeguarding training and were aware of safeguarding procedures and protocols. They were able to describe situations where they would raise a safeguarding concern.
- Nurses who had raised safeguarding concerns explained how they had done so and how such concerns were investigated and addressed.
- Staff on all the wards we visited could identify a safeguarding lead to whom they could go for advice and support.

- There had been no reported safeguarding incidents relating to surgery at the hospital during the past 12 months.

Mandatory training

- There was an induction programme for all new staff. We spoke with six new staff on various surgical wards and they were complimentary about the trust's induction programme. They told us they felt well supported when they started working in the trust. They were able to describe induction arrangements and what was included in their induction.
- We saw the training figures for nursing staff for mandatory and statutory training for the surgical division. This included fire, infection control, moving and handling and code of confidentiality. All these were over the 90% trust target. Nurses and healthcare support workers we spoke with told us they had completed their mandatory training and could describe what was included in the training. Theatre and ward managers told us they monitored attendance at mandatory training and their staff were up to date.

Assessing and responding to patient risk

- Staff were aware of how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues. There was daily involvement by the ward and theatre managers and the matron to address these risks. For example, all wards had a daily written safety briefing that took place during nursing handover to identify patients at risk of harm. These safety briefings included review of staffing, bed capacity issues, risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, risk of falls and infection control risks.
- If a patient's health deteriorated, staff in theatres were supported with anaesthetist input and on wards were able to contact the surgeon or in urgent situations the critical care outreach team.
- Staff used a surgical safety checklist based on the internationally recognised WHO checklist to ensure required pre- and post-operative safety checks were undertaken. The trust conducted an audit of compliance with its WHO surgical safety checklist in April 2015 and found overall compliance with required standards was at 100%.

Nursing staffing

- Staffing levels on the trauma and orthopaedic wards had been recorded on the trust risk register. At the time of our inspection, there were 16 vacancies across two wards (A5 and A6). The trust had taken appropriate actions to mitigate this risk by recruiting more nurses and healthcare assistants. The trust had recently recruited five nurses who were going to start in July 2015. There was a commitment by the trust to fill all 14 vacancies with the right candidates. Until then, there were plans in place to ensure the ward was safely staffed. We spoke with staff on the wards who told us that the orthopaedic wards were improving and the appointment of a new ward manager and matron had a positive impact on the wards.
- At the time of the inspection, the ENT department had been running with vacancy levels of 30%. Though the department was safely staffed with bank staff, the service had recently recruited three additional staff and would be in post by July 2015
- On the surgical admissions unit they had a handover each morning to discuss the day ahead and their planned admissions. They had the required staffing levels in place. We spoke with seven nursing staff who told us there were enough staff on the ward. We cross checked this information with 4 randomly selected sets of weekly rotas that also confirmed staff numbers on the ward.
- The day unit staff told us they had the correct number of staff as per their allocation.
- The nursing staff on surgical wards told us they were working at their allocated numbers.
- The staffing levels for theatres to include anaesthetics and recovery were meeting the Association of Perioperative Practice (AFPP) guidelines. They had recruited from overseas to fill vacancies and the staff from overseas we spoke with told us they were well supported through training and induction.

Surgical staffing

- This trust had slightly more consultants at 44% compared to the England average of 40%. They had 7% middle grade doctors compared to England average of 11%. For the registrar group they were slightly less at 34% compared to England average of 37%. They also had slightly more junior doctors at 14% compared to the England average of 13%.
- There was a daily safety and staffing briefing in theatres.

- We were shown copies of the duty rotas for out of hours cover. This showed junior doctors, middle grade and consultants were on call.
- There was 24-hour consultant on call cover for the surgical wards, seven days a week. Nursing staff told us there was no difficulty in getting support from a consultant. They said consultants were easily contactable and responsive.
- Junior doctors were part of the 'hospital at night team' that stayed on site for emergencies. We were told they could contact senior staff for support if required.

Major incident awareness and training

- There was a trust major incident plan and staff were able to tell us their role in it. They said they had major incident exercises to practice and ensure their familiarity with the plan.
- Emergency plans and evacuation procedures were in place.
- Staff told us about the hospital's business continuity plans and said these had been used to manage demand for services over the winter.

Are surgery services effective?

Good

The surgical services provided effective care and treatment that followed national clinical guidelines and staff used care pathways effectively. The services participated in national and local clinical audits.

Improvements in general health and condition-specific indicators after procedures were slightly better than the England average. The results of the national emergency laparotomy audit 2014 identified a number of required policies and procedures were not yet in place.

The trust had overall good results in the National Lung Cancer Audit 2014 and most of the results of the National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist where the trust performed worse than the England average.

The majority of patients had a positive outcome following their care and treatment. Patients received pain relief suitable to them in a timely manner.

Patients received care and treatment by trained, competent staff that worked well as part of a multidisciplinary team. Staff sought consent from patients before delivering care and treatment. Most staff understood the legal requirements of the Mental Capacity Act 2005 and deprivation of liberties safeguards.

Evidence-based care and treatment

- Surgical services adhered to National Institute for Health and Clinical Excellence (NICE) guidelines for the treatment of patients.
- Staff told us NICE guidelines were discussed at clinical governance meetings and we saw this in the minutes and records of these meetings.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) recommendations.
- The use of national guidelines and the enhanced recovery programme was used, where relevant.
- Regular clinical governance meetings were held to discuss changes to guidance and the impact of changes on services.
- The trust participated in relevant national clinical audits for surgical procedures. There was also evidence of a trust-wide audit and ward based audit programmes which were used to monitor the quality of care.
- Results of audits were disseminated and this was noted in the clinical governance meetings minutes we saw. Ward staff told us they received feedback from audits done on their wards.

Pain relief

- In the national inpatient survey published in April 2015, which included 361 respondents, the trust scored 8.0/10 for pain management. The trust scored 'about the same' in this area as similar trusts nationally.
- In theatres, there was a system in place whereby an intravenous morphine prescription was sometimes used by anaesthetists so that the patient relief was provided immediately.
- There was a dedicated pain team that could be accessed for support in controlling patients' pain. Staff told us the pain team was easily accessible and could be contacted for support when required.
- A system of assessing pain called the 'Abbey Scale' was used to assess pain in patients who could not

communicate well. Staff told us they usually used this scale with patients who have learning disabilities and who are unable to verbalise how much pain relief they require.
- We inspected 10 patient records which showed patients were given pain relief and, once patients were given pain relief, they were usually asked later whether the pain relief was sufficient to control their pain.
- All patients we spoke with reported that their pain was well-controlled and staff provided them with pain relief promptly when requested.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the wards.
- A malnutrition screening tool (MUST) was used to identify patients who were at risk of malnutrition. Patients identified as being at risk were referred to a dietician and we saw care plans were in place to address special requirements. Fluid balance charts were used to monitor patients' hydration status.
- We observed that patients usually had access to drinks which were within their reach although there were few exceptions.
- The patients told us they were given meal choices and most rated the quality of food as adequate. In the national inpatient survey published in April 2015, the trust scored 5.5/10 for describing the hospital food as good. The trust scored 8.8/10 for having been offered a choice of food and 7.3/10 for being given enough help from staff to eat their meals, if they needed this. The trust scored 'about the same' in all these area as similar trusts nationally.
- We observed meal times and found patients who needed assistance were identified to staff and were being provided with necessary assistance.

Patient outcomes

- The hospital's overall mortality rates were lower than expected and there were no mortality outliers (outside the expected range) for this service.
- The Hip Fracture Audit 2014 highlighted that 79% of patients with a hip fracture received surgery within 48 hours; this was better than (above) the England average, as was the trust's score for patients receiving a preoperative assessment by a geriatrician. According to the survey, the percentage of hip fracture patients developing pressure ulcers post-surgery was worse than the national average. Data showed the length of stay of patients with hip fracture was lower (better) than the England average.
- The surgical division took part in national audits, for example, the elective surgery Patient Reported Outcome measures (PROM) programme, national hip fracture database and national joint registry.
- PROM scores for improvements in general health and condition-specific indicators after procedures were slightly better than the England average.
- Results from the national emergency laparotomy audit 2014 were varied and identified a number of required policies and procedures were not yet in place.
- The trust had overall good results in the National Lung Cancer Audit 2014. The results of the National Bowel Cancer Audit 2014 showed overall good results in all areas. The exception was the number of patients seen by a clinical nurse specialist where the trust performed worse than the England average. There were action plans to address these gaps.
- Standardised relative risk readmissions for non-elective surgery at New Cross Hospital compared favourably with national comparators. However, data showed urology elective readmissions were significantly higher than the national average.

Competent staff

- The nursing and medical staff we spoke with were positive about on-the-job learning and development opportunities and told us they were supported well by their line management.
- Medical staff told us there was good access to clinical supervisors within the trust.
- Junior doctors told us there was good support and teaching from senior house officers.
- Nursing staff told us they received annual appraisals and regular supervision.
- All nursing staff on band 6 on the orthopaedic wards had been on a specific orthopaedic training programme designed to uplift the skills of the nursing staff and give them the necessary confidence to care for this group of patients.
- The trust had a procedure it was following to achieve revalidation for medical staff.

- Approximately in 2013, the trust ensured that all surgeons received a full five days training programme offered by the Association of Perioperative Practice. This ensured all surgeons were compliant with sign out briefs and debriefs in theatres.
- The trust had ensured staff were trained on the use of high risk medical devices. It was now undertaking a similar programme for medium risk medical devices. The results of these were submitted to the board on a regular basis.
- The directorate had two healthcare assistants dedicated to check equipment and label them appropriately.

Multidisciplinary working

- There was evidence of multidisciplinary team working on all the wards we visited. Staff on wards confirmed that the multi-disciplinary approach was part of the culture of the trust.
- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these.
- We inspected ten patient records that showed care and treatment was provided by a variety of healthcare professionals including nurses, doctors, pharmacists, physiotherapists, dieticians, social workers and others.
- Staff on orthopaedic wards told us that the physiotherapy teams worked very well with ward staff in an integrated manner and this had a positive impact on patient care. Staff described physiotherapy staff as "effective and passionate" about the care they provided.
- Patient records showed patients were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.

Seven-day services

- Staff told us there were consultant led seven-day services. Patient records we looked at showed surgical patients on surgical wards were reviewed during the week and at weekends.
- Staff told us access to medical advice at night came from the hospital at-night team, although junior doctors could contact consultants if they needed to. Staff told us the hospital at night team provided advice and assistance when needed.
- Physiotherapy was available seven days a week for orthopaedic patients. Reduced physiotherapy was available on weekends for patients who needed it.
- Radiology on call services were available at all times, including weekends. Staff could access CT scans, MRIs, ultrasounds and emergency plain films. Services were consultant led.

Access to information

- Patient records were stored in hard copy. When patients were transferred between wards, all their nursing and medical records were transferred with them. Staff told us they always provided a verbal handover as well as the written records.
- Staff told us about the handovers between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information. For example, the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory.
- Nursing staff told us when patients were transferred between wards they received a handover.
- We found patient discharge summaries were not always sent immediately when the patient was discharged from hospital. This posed a risk that patients might not have received the care they needed when they returned home.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately and correctly. Where patients did not have capacity to consent, formal best interest decisions were taken in deciding treatment and care patients required.
- Where patients were confused or there was a question about their capacity to consent, mental capacity assessments were undertaken by medical staff to determine whether they could make decisions relating to their care and treatment.
- However, we found a few ward staff were not clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They were unable to summarise the key points of the MCA and the implications of the MCA on their work.

Surgery

Are surgery services caring?

Good

Staff were caring and compassionate and treated patients with dignity and respect. The results of the NHS Friends and Family test were better than the England average. Privacy and dignity were maintained. We spoke with 20 patients and most spoke positively about their care and the way they were treated by staff. Patients spoke positively about the staff who looked after them. There was emotional support for vulnerable patients.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. Patients told us they had no concerns about how staff maintained their privacy and dignity. For example, we observed staff closing curtains when providing personal care and interacting patiently and respectfully with very confused patients.
- We found privacy and dignity maintained at all times.
- Many of the patients we spoke with felt staff treated them with compassion and empathy. They generally felt well cared for and told us staff were responsive to their needs.
- We did not observe any breaches of single sex accommodation. Staff told us a breach of single sex accommodation was rare and would be reported as an incident.
- Each ward had details about their friends and family test results. For example, on ward A12 for April 2015 they had a response rate of 41% and of these they had a positive score of 95.2%. On ward A14 they had a response of 48% and of these 96.4% were positive.
- Patients on the day surgical unit told us the staff were “great” and “very helpful”.
- We observed a ward round and saw that doctors introduced themselves appropriately and that curtains were drawn to maintain patient dignity.

Understanding and involvement of patients and those close to them

- Patients told us they were kept updated with their condition by doctors and nurses. One patient said “they keep changing what is happening to me”.
- We spoke with patients who had undergone surgery. They told us they had been given details about the operation and what to expect post operation.
- Patients told us they were pleased with their pre-operative assessment. They said they were given sufficient verbal and written information about their procedures and their questions were satisfactorily answered.
- Most of the patients and relatives we spoke with said they felt involved in their care. They said they were given opportunities to speak with the consultant looking after them and to ask questions.
- Staff in all the areas we visited were able to describe specific arrangements for involving patients with special needs and their families, in planning and providing care and treatment.

Emotional support

- Clinical nurse specialists were employed throughout the trust to provide support and advice to patients undergoing various types of procedures. We saw and spoke with a number of clinical nurse specialists on the surgical wards we visited.
- Almost all the patients we spoke with praised staff for their responsiveness, friendliness and emotional support.

Are surgery services responsive?

Good

Services were planned and delivered to meet the needs of local people. There were systems in place to support vulnerable patients. Concerns were addressed at a local level before the issues resulted in a complaint. The majority of patients were admitted, transferred or discharged in a timely manner. The surgical services achieved the 18 week referral to treatment standards for most specialties.

Service planning and delivery to meet the needs of local people

- The Hip Fracture Audit 2014 highlighted that 79% of patients with a hip fracture received surgery within 48 hours; this was better than (above) the England average, as was the trust’s score for patients receiving a preoperative assessment by a geriatrician

- Recognising the needs of the aging population, the trust had recently agreed a business case to recruit an orthogeriatrician across both sites. This post was going to be advertised shortly.
- There was a surgical waiting list initiative in place on Saturdays. The trust undertook two lists every Saturday.
- To meet the needs of local people, there were plans in place to increase beds for the centralised head and neck emergencies, and these will be accommodated on the Surgical Assessment Unit (SAU). Staff told us that these plans would only be implemented subject to the trust recruiting appropriate nursing cover.
- The trust told us they were planning to reconfigure some more of their services. This is where a specific service is moved to one location rather than being at both hospitals. Senior staff told us that prior to any discussions being made they would consult with staff and the public.

Access and flow

- Patients could be admitted for surgical treatments through a number of routes, such as pre-planned day surgery, via accident and emergency or via GP referral.
- Patients admitted via accident and emergency or GP referral were directed to the surgical assessment unit. The unit also had three assessment rooms and a seated area for up to eight patients that were waiting to be assessed by staff.
- During the inspection, we did not highlight any concerns relating to the admission, transfer or discharge of patients from the surgical wards and theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Patient records showed discharge planning took place at an early stage and there was multidisciplinary input (e.g. from physiotherapists and social workers). Staff completed a discharge checklist, which covered areas such as medication and communication with the patient and other healthcare professionals to ensure patients were discharged in a planned and organised manner.
- The trust had recently appointed a "flow co-ordinator" who was responsible to ensure patients were effectively discharged to nursing homes. Staff told us that this had improved discharge arrangements.
- There was a discharge lounge that operated between 0800-2200. We observed arrangements were in place for patients to be given food and drink if there were delays in their transport or medicine to take home.
- Surgical doctors told us they were issued with a daily list of surgical patients across the hospital's wards and they made sure surgical outlier patients were seen daily.
- There was sufficient bed space in the theatres to ensure patients could be appropriately cared for pre and post-operation. There was a designated area in recovery for critically ill patients that required stabilising prior to transfer to the intensive care unit (ICU).
- Bed occupancy of the trust was significantly higher than the national average. 85% occupancy level is the accepted level at which bed occupancy can start to affect the quality of care afforded to patients and the systematic running of a hospital. The trust's bed occupancy rate of 90.2% between April-June 2014 was higher than the England average of 88%.
- The trust was not meeting the 18-week referral-to-treatment time (RTT) target of 90%. The specific specialities meeting the targets were urology, oral surgery, plastic surgery and cardiothoracic surgery. Overall, since April 2013 to April 2015, the trust met the standard set by NHS England only once. It performed better than the England average six months out of the 25. It performed the same as the England average five months out of the 25. Fourteen months out of 25, it performed worse than the England average. The specific specialities not achieving the target included general surgery, trauma and orthopaedics, ophthalmology and ENT. The plan to ensure these specialities met the 18-week RTT target of 90%, was to add additional patients to the operating lists to avoid cancellation. This had not yet started.
- NHS England data showed that between April 2011 and March 2015 the trust performed better than the England average for the number of patients whose operations were cancelled and were not treated within the 28 days. For the period April 2011 and March 2015, for those patients whose operation had been cancelled, staff arranged a new date with the patient on the day of cancellation. The trust honoured the new date given and the operation was never cancelled again.

Meeting people's individual needs

- There were arrangements in place to respond to the needs of patients with special needs and staff in all the areas we visited were aware of these. Staff told us there was a specialist learning disabilities nurse whom they could access for advice and support.
- Patient information leaflets about different conditions and surgical procedures were available in the hospital and on the wards we visited. Leaflets were only available in English.
- The theatre recovery areas had designated paediatric recovery bays. These were separate to adult recovery area and were quiet.
- Staff could access appropriate equipment such as specialist commodes, beds or chairs to support the moving and handling of bariatric patients (patients with obesity) admitted to the surgical wards and theatres.
- The ward manager on the ENT wards told us patients were provided with a choice of meals. The result was patient satisfaction with the service increased. Patients provided positive comments to the nursing staff about the care and their well-being.
- There were arrangements in place with Age Concern that certain patients funded by the local CCG could be called upon to transport suitable patients. There was a checklist in place for the driver who would ensure that the patient had all the necessary comforts in the home for example, food and a suitably heated home. The Age Concern drivers would stay with the patient in their home to ensure they are safe to be on their own.
- We observed there were no resting seats between wards C1 to C19 and from C24 to C37. These were long intervals for people with mobility issues to walk without resting.

Learning from complaints and concerns

- The service had a proactive approach to handling complaints. They addressed concerns at a local level before they became a complaint. Staff told us that this proactive approach helped reduce the number of complaints and gave them opportunities to learn from these complaints.
- We were told how one ward invited someone who had received poor care on the ward to come and share their experience at a staff meeting. The ward sister told us this helped staff receive feedback and encouraged reflective practice. Nursing staff we spoke with also welcomed this initiative.
- Information related to complaints was reviewed at ward level and staff told us they received feedback about complaints at team meetings. Staff were able to give us examples of complaints and changes which were made in response.
- Information boards on many of the wards we visited showed information about key concerns raised by patients and relatives and the ward's response. This took the form of "you said, we did" posters.

Are surgery services well-led?

Good

The trust had a vision and strategy in place. Senior staff in the surgical service had outlined a service business plan on how they would contribute to this overall vision. Staff in all areas knew and understood the vision and objectives. The focus on patient safety was highlighted as a central

The organisation had audit processes to monitor performance against objectives.

The service proactively engaged and involved staff and ensured that voices of all staff were heard.

Vision and strategy for this service

- The trust had a vision and strategy in place. Senior staff in the surgical service were aware of this vision and had outlined a service business plan that incorporated how they would contribute to this overall trust vision.
- The service business plan incorporated the trust's overall strategy and had specific performance targets and action plans relating to safety, quality and patient outcomes. These included plans for improving compliance with national clinical audits and developing care pathways and improvements in patient admission processes.
- The trust vision and objectives had been cascaded to staff across the wards and theatre areas we inspected and staff had a good understanding of these.

Governance, risk management and quality measurement

- There was a clinical governance system in place that allowed risks to be escalated to divisional and trust board level through various committees and steering groups. There were action plans in place to address the identified risks.
- During the inspection, we looked at the surgical divisional risk register and saw that key risks had been identified and assessed. This risk also appeared in the trust wide risk register. The risk register was reviewed at routine clinical governance meetings.
- In each area we inspected, there were regular staff meetings to discuss day-to-day issues and to share information on incidents and audit results.
- There were audit and monitoring of key processes across the wards and theatre areas to monitor performance against objectives. Information relating to performance against key quality, safety and performance objectives was monitored and cascaded to wards and theatre managers. For example, cancellation of operations were analysed and reported at monthly clinical governance meeting.

Leadership of service

· Staff told us they felt supported by and listened to by their immediate line managers, divisional management and the executive board.

· Staff we spoke with knew who the chief executive and nursing director were. Nursing staff said they felt well supported by the nursing director and all said they could approach the leadership with any concerns.

· Senior nursing staff told us they felt they were being listened to by the executive team and there was a real focus on patient safety.

· Staff also told us about the executive walk around and how they had taken part in these and fed back any issues they might have had.

· All staff spoke highly of their immediate line managers and felt well supported by them

Culture within the service

· A number of staff we spoke with said they had worked for this trust for considerable number of years and all said it was a good place to work**.**

· Staff told us they would feel comfortable in reporting any concerns to their line manager or a senior member of staff. Staff were also aware of the trust's whistle blowing policy and raising concerns policy and where to find them. Concerns were investigated and lessons from these were acted upon.

· Staff told us there was an open culture that was not about blame. They were encouraged to report incidents as it was seen as by the trust as important learning.

Public and staff engagement

- Theatres and ward-based staff told us they routinely engaged with patients and their relatives to gain feedback from them. Information on the number of incidents, complaints and general information for the general public was displayed on notice boards in the ward and theatre areas we inspected.
- The trust's proactive approach to complaints had resulted in a positive outcome with a reduction in complaints.

Innovation, improvement and sustainability

· The trust had recently instituted the "In Charge" initiative. This was a badge worn by the person responsible for that shift on the ward. Patients and relatives we spoke with welcomed this initiative.

· The cardiothoracic department recently introduced an innovative system to drain chests after cardiac operations. Staff told us this innovation sets a new standard in thoracic drainage therapy and had reduced patient length of stay in hospital.

· Recently (November 2014) the orthopaedics wards had a high number of incidents relating to patient safety and poor patient experience. The matron who was in charge of the service took plans to reduce the ward by six beds to senior managers and thus improve the service. This plan was agreed and put in action in December 2014. The matron restructured the wards to meet the needs of patients. For example, there was an improvement in the mandatory training programme for nursing staff from 60% in December 2014 to 90% in April 2015. During the inspection in June, we observed the improvements had begun and there were indicators the matron was using to continually monitor and improve.

Critical care

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

Information about the service

The critical care service at the Royal Wolverhampton Hospital NHS Trust is provided at New Cross hospital. The service has a total of 28 beds allocated to adults. The hospital undertook approximately 800 elective operations a year and a further 100- 200 urgent surgical operations a year. Critical care included areas where patients received more intensive monitoring and treatment for life threatening conditions. The hospital provided special expertise and facilities to support vital functions using the skills of medical, nursing staff and other members of the multi-disciplinary team. Patients receiving coronary care were also treated within the critical care service. The unit included an outreach service.

As part of our inspection we visited the integrated critical care unit. We spoke with six patients, four relatives and 22 staff. These included nursing staff, junior and senior doctors, a pharmacists, domestic staff, therapists and managers. We observed the care and the treatment patients were receiving and viewed 11 records. We reviewed performance information about the service.

Summary of findings

Critical care services required improvement to support safe care. There were significant risks posed by the infrastructure and environment of the integrated critical care unit (ICCU). Medical staffing was appropriate and there was good emergency cover. The storage of medicines in the integrated critical care unit (ICCU) required improvement to ensure secure storage facilities to reduce the possibility of misappropriation of medicines. We found intravenous medicines were mixed within the storage room visited which could lead to the misadministration of medicines to patients.

Staff told us they were encouraged to report any incidents which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The environment was visibly clean and most staff followed the trust policy on infection control.

The critical care service demonstrated good effective care. Patients received care and treatment according to national guidelines and there was good multidisciplinary team working to support patients. The service participated and provided data for the Intensive Care National Audit & Research Centre (ICNARC). This ensured that the practice was benchmarked against similar services. Policies and procedures were

accessible to staff. However, we saw that some hard copies of policies were dated 2007 to 2014 with no evidence of review. Staff told us they were able to access up to date policies on the trust's intranet system.

Patient's pain was appropriately managed as was the nutrition and hydration of patients. Staff had access to training and had received annual appraisal. The critical care service had a consultant-led, seven-day service. Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

We observed good care within the ICCU. Staff cared for patients in a compassionate manner, with dignity and respect. They involved patients and, where appropriate, their relatives in the care. Emotional and spiritual support was also provided.

The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times. Patients had follow-up support from the outreach team.

Patients with a learning disability were provided with the necessary support. Staff also had access to translation services. Complaints were handled appropriately.

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We found that critical care services required improvement to be well-led. Most staff were not aware of the vision or strategy for the critical care service.

The ICCU held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. There were concerns about the impact on patient care and safety which were not identified on the risk register.

There was a culture of support and respect for each other, with staff willing to help each other. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.

Patients were engaged through survey feedback. The survey questionnaires showed that patients were happy with the care and treatment they had received.

Innovative ideas and approaches to care were encouraged and supported. There was positive awareness among staff of the expectations for patient care.

Critical care

Are critical care services safe?

Requires improvement

Critical care services required better procedures to support safe care.

The service did not have clear procedures for the disposal of used blood bags or the cleaning of equipment which we found to be dusty and dirty. We found intravenous medicines had been mixed up in the storage area which meant there was a risk of patients receiving incorrect care. The storage of medicines was not secure and action was required to reduce the possibility of misappropriation of medicines.

Critical care staff told us they were encouraged to report any incidents which were discussed at weekly meetings. There was consistent feedback and learning from incidents reported. The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The environment was visibly clean and most staff followed the trust policy on infection control. Medical staffing was appropriate and there was good emergency cover.

The hospital's critical care safety checklist was fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical handovers were well structured within the unit whereby they discussed the patient's well-being.

Incidents

- There have been no "never events" reported in critical care between April 2014 and March 2015. A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures are implemented.
- During April 2014 and March 2015 three serious incidents were reported in critical care which required investigation. Two were related to unexpected deaths and the other to a grade three pressure ulcer. A further 35 incidents were reported through the National Reporting and Learning System (NRLS) for critical care of which 27 were classed as "no harm", six as low harm and two as moderate harm. We were shown a copy of the action plans that had been recently developed and saw how the learning was shared across the department through team meetings.
- We saw that there had been 21 recorded incidents within the unit in April 2015. We saw the majority of these related to medicine errors with no effect to the patient. The records identified the action taken for example; additional medicine administration training.
- The integrated crucial care unit (ICCU) used an electronic system to record incidents and staff said they knew how to report incidents. Staff were able to describe the types of incidents they would report for example, challenging behaviour.

Duty of Candour

- The responsibilities of Duty of Candour was already embedded into the running of the ICCU.
- Staff understood their responsibilities with regard to the new Duty of Candour legislation. The Duty of Candour legislation requires an organisation to disclose and investigate mistakes and offer an apology if the mistake resulted in a severe or moderate level of harm. Staff described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not.
- Staff were able to describe the process to follow which involved a conversation with a patient explaining what had happened and how they would provide assurance this would not occur again.

Safety thermometer

- The NHS Safety Thermometer information was displayed on the ICCU. The NHS Safety Thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included for example; new pressure ulcers, catheter-related urinary tract infections (UTI's), venous thromboembolism (VTE), and falls.

Cleanliness, infection control and hygiene

- We observed, during our visit, used blood bags stored in the sluice room. We saw these on 04 June 2015 and on our return visit on 05 June 2015. This meant the blood bags had been left unattended for at least 36 hours. We asked senior staff to address the matter and we observed the appropriate disposal of the blood bags.
- We found that during our visit on 04 June 2015 the utility room which held cleaning materials was unlocked. This was brought to the attention of senior staff. We were informed that this room would be locked when not in

use and remain open when in use by the domestic staff working in the area. During our revisit on 05 June 2015 we saw this matter had been addressed and a secure entry system had been installed.

- Cleaning of the unit was carried out by permanent members of staff specifically allocated to the ICCU. However, on our visit to the unit we did not see a cleaning schedule in place which meant that staff could not ensure that the standard of cleanliness was being maintained. However, the trust informed us that a cleaning schedule was displayed in the main noticeboard within the clinical area. They told us there were also additional cleaning books and duties by the nurse's bed station.
- Staff had received training on infection prevention and control at induction and during mandatory training. The records showed that 89% of non-clinical staff and 97% of clinical staff had received their infection control training.
- Staff were aware of the trust policy on infection control. The 'bare arms below the elbow' policy was adhered to. There were hand-washing facilities and protective personal equipment, such as gloves and aprons, available. We observed that not all staff used gloves and aprons and did not always change these between attending to patients. This was brought to the attention of the senior sister during our inspection.
- We saw good procedures in place for a patient diagnosed with campylobacter (a group of germs (bacteria) that are a common cause of food poisoning). We observed staff adhering to infection control processes. The records identified daily microbiological review. However, we saw the door of another patient diagnosed with an infection being propped open. This meant there may be an elevated risk of infection to people who used the service. This was brought to the attention of senior staff. Staff however could articulate the rationale for the propping open of doors whereby the infection was not airborn and effective risk assessments had been undertaken to reach this decision.
- There were effective arrangements for the safe disposal of sharps, including the dating of when the sharps box began to be used. All sharps boxes we inspected had their lids closed and were not overfilled.
- There were information leaflets and posters on display in the relatives' room and on notice boards about how visitors could help prevent and control infection when visiting the ICCU.
- The unit contributed their patient data and outcomes to the Intensive Care National Audit and Research Centre (ICNARC) which was evaluated against similar departments nationally. The ICNARC data for 2013/14 showed that the trust had two infected patients; one with methicillin-resistant staphylococcus aureus (MRSA) and the other with vancomycin-resistant enterococci (VRE). VRE is a bacteria which is resistant to many antibiotics.
- We checked the store room and found a renal filtration machine and a nasogastric (NG) feed pump which were dirty**.** NG intubation is a medical process involving the insertion of a plastic tube through the nose, past the throat and down into the stomach. We also found a dirty and taped up TV/Video remote control.
- We saw two "continuous positive airway pressure" masks which were out of date. The masks are used as a sleep aid for people with sleep apnoea. These were disposed of by senior staff.
- We were unable to identify which equipment had been cleaned as they did not display the "I am clean" stickers. We saw clean/decontaminations stickers were available but not used.

Environment and equipment

- The units environment was bright and spacious and in good decorative order. There was adequate space between each bed area.
- There was a specific room that was used by relatives to stay in, and there was also a sofa bed within it for relatives to use.
- There were regular safety checks of medical equipment used in the ICCU, signed by the individual undertaking the checks.
- The resuscitation team checked their equipment each day which included; the defibrillators and the "bleep" to ensure they were working properly. We saw the records which showed these equipment's checks were undertaken daily.
- We saw the cardiac arrest trolley audit for 2015 and found the records identified inconsistencies in the daily

checking within ICCU. This was confirmed in the records viewed. The trust had introduced a new resuscitation booklet but we found there was no structure within the unit regarding the completion of the booklet.
- The unit had three resuscitation air bags. During our inspection we found that one of the bags was out of date. Senior staff removed the bag to ensure that it would not be used.
- One of the safety checks included fire safety arrangements, we saw that the fire doors into theatres from the unit were broken and remained open. This had been a problem since October 2013. It had been reported and repaired numerous times but a final solution had not been found. The fire risk is acknowledged on the directorate risk register which incorporated actions with regard to the fire door. During our inspection we raised the issue and engineers were present on 05 June 2015.
- We saw that all safety alerts were reviewed by the matron. Any alerts identified for the unit were placed in the staff folder and noticeboard and included in handovers. This was confirmed by staff spoken with.
- All equipment used by the unit were managed by the technicians. We saw they were able to track equipment on the trust's intranet site using a tag system. Some staff said that occasionally new equipment was introduced without an implementation plan or training. This meant there was a risk of patients being attended by staff who may not have knowledge of the equipment being used.

Medicines

- Within the storage cupboards we saw that intravenous (IV) fluids for saline and potassium were mixed up. We saw out of date medicines identified for "training" were stored with medicines which were in daily use. There was a risk of staff accessing and administrating incorrect medicines to patients. These were brought to the attention of senior staff who arranged for the storage of medicines to be reviewed and re-stored.
- Controlled drugs were safely and securely stored. We looked at the controlled drugs book for each area and found that the records accurately reflected the supply. The process for reviewing and recording controlled drugs was in line with the Royal Pharmaceutical Society guidelines.
- The medicine records of 11 people we looked at during our inspection were found to accurately reflect the prescribed and administered medicines for those patients.
- The medicines and stock records were accurate.
- The area used to store medicines in the ICCU was not locked and there was a risk of unauthorised people accessing medicines. This was brought to the attention of senior staff.
- Fridge temperatures were monitored daily; this ensured medicines were maintained at the recommended temperature and the checks were signed by the individual undertaking these checks.
- Senior staff told us the fridge which stored blood was not working and had been out of action for six weeks. Staff said they utilised blood which was stored and situated 10 minutes from the ICCU. In an emergency, staff said they had access to blood within the adjacent theatre fridge. We saw evidence requesting the fridge to be serviced and the purchase order for new software in relation to the fridge.
- There were arrangements for the effective access to medicines out of hours. The ICCU had its own allocated pharmacist who visited the unit daily and reviewed all medical prescriptions to ensure sufficient stocks were available. Doctors told us that their input as part of the multidisciplinary team worked very well.
- We saw the medicines were audited by the pharmacists who did not identify any issues or concerns.

Records

- We reviewed 11 records of patients using the service. Medical and nursing records were in paper form and followed the same format which meant information could be found easily. The unit also used the electronic VitalPAC observation system. The system replaced paper based observation systems and manual Early Warning Score (EWS) calculations with easy-to-use touch screen technology.
- Records were completed and stored in accordance with trust policies.
- Records were designed in a way that allowed essential information, for example, allergies and medical history to be documented and easily viewed. The records contained treatment details and care plans.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example for falls, pressure ulcers and nutrition screening.

- The wards had care plans to identify what care should be given to patients. This meant that staff had access to information on how to care for a patient.
- Vital signs were well documented along with cardiac and respiratory indicators. Observations were clearly recorded.

Safeguarding

- Most staff were able to explain safeguarding arrangements and said they would raise any queries with the senior sister on duty. Staff were able to describe when they might be required to report issues to protect the safety of vulnerable patients.
- The training records within the service identified that 100% of medical and nursing staff had attended their safeguarding training.

Mandatory training

- The consultants said they ran an in-house cardiac advance life support course which was well supported by staff.
- Resuscitation officers provided training in basic life support, intermediate life support, advance trauma life support and care of the critically ill patient. They told us this was mandatory training for staff working in the unit.
- We saw that 83% of staff had completed their basic life support training as of April 2015. Staff told us they had a couple of link nurses who monitored the training and identified staff who needed to attend. The training was made up of two parts which included face to face training and a practical assessment. Anaesthetists completed two sessions on life support training which covered both adults and paediatrics.
- The unit had a training plan for all nursing staff to ensure they met their mandatory training targets. Data provided for April 2015 showed that the unit had an overall rate of 97%. For example; pressure ulcer and manual handling was at 96% and infection prevention at 98%.

Assessing and responding to patient risk

- The national early warning score escalation process for the management of acutely unwell adult patients was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- Patients were monitored using recognised observational tools. The frequency of observations was dependant on the acuity of the patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patients' condition. This meant deteriorating patients would be identified and action taken and escalated to the appropriate team without delay.
- The resuscitation team were a part of the cardiac arrest team and covered the "bleep." Each morning there was a team handover run by the registrar to review all cardiac arrests attended to.
- Risk assessments for patients for pressure ulcers and VTE were completed on admission and prophylactic therapy initiated for VTE prevention.
- Staff from the Critical care outreach team told us they operated from 08:00-21:00hrs. However, the trust informed us they were able to provide an outreach nursing team throughout the organisation 24 hours a day seven days a week. At night an anaesthetist was usually available, but not in every instance.

Nursing staffing

- The consultants said they had good staff and the retention of cardiac nurses was excellent.
- We saw the staffing rosters and found that staff worked on a rotational basis of days and nights. All level 3 patients were nursed one-to-one, and level 2 patients were one nurse to two patients.
- The business manager of critical care told us they had adequate staff to meet the patient's needs. Where there were shortfalls in staffing levels, they were covered by bank (overtime) staff. The unit did not use agency nurses.
- The matron had the responsibility to ensure there was always adequate staff with the right skills. The rosters seen demonstrated adequate staffing levels. On the day of our inspection there were enough staff on duty.
- We saw the staff sickness levels within ICCU from January 2015 to May 2015 which averaged 7%. We saw this had increased from 6% for the whole of 2014. Staff said there had been some restructuring within the unit during December 2014 and January 2015 which had impacted on staff morale. We saw the sickness level figures showed a steady decrease each month from February 2015.

Medical staffing

Critical care

- Care in the ICCU was consultant-led. The medical staffing included an anaesthetist, consultants and fellow surgeons. They provided cover seven days a week 8am to 8 pm and were available on-call at other times.
- The consultants said that the majority of their middle grade doctors came from overseas. This often caused difficulties with retention as the doctors were predominantly on short term contracts. For example, they informed us that in September 2015 four of their middle grade doctors would be leaving the trust. They also said that communication and training could, on occasions, be challenging.
- We saw the consultants' work patterns ensured continuity of care.
- There were vacancies within ICCU for a consultant intensivist and an anaesthetist. The consultants said they were actively recruiting for these posts.

Major incident awareness and training

- Staff were aware of the procedure for managing major incidents, winter pressure and fire safety incidents.
- We saw a plan located within the staff office regarding evacuation procedures.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds.
- There were emergency battery back-up supplies and this ensured that vital medicines and life support systems would continue in the event of an electrical power cut or a disruption to the supply of medical gases.
- There were clear procedures instructing staffs what to do, for example, in the event of a fire. This meant that staff working in the unit were clear of their responsibility in the event of a major incident.

Are critical care services effective?

Good

The service demonstrated that care was provided in accordance with evidence-based national guidelines. National guidelines and pathways were used extensively, so that best practice was used to manage patient's care. Policies and procedures were accessible for staff on the trust's intranet system. However, we saw that some policies relating to critical care were dated 2007 to 2014 with no evidence of review. Care was monitored to demonstrate compliance with standards.

Patient's pain was appropriately managed as was the nutrition and hydration of patients. Multidisciplinary working was evident to coordinate patient care. Overall, staff had access to training and had received annual appraisal. The critical care service had a consultant-led, seven-day service.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Evidence-based care and treatment

- The critical care unit used a combination of National Institute for Health and Care Excellence (NICE) and Intensive Care Society and Faculty of Intensive Care Medicine guidelines to determine the treatment they provided. This included the guidance for rehabilitation after critical illness. Patients had a rehabilitation assessment completed within 24 hours of admission to critical care.
- Policies were accessible for staff and were developed in line with national guidelines such as the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) guidelines for managing patients with a subarachnoid haemorrhage and managing patients with a tracheostomy.
- The unit complied with the NICE Interventional Procedure guidance for the Trans Catheter Aortic Valve Implantation (TAVI). The consultants said they had a TAVI standby list but very rarely received these patients.
- The ICCU used the Ramsey sedation score based on the Intensive Care Society guidelines. This meant that they effectively managed pain, anxiety and sleep as part of the sedation therapy regime.
- Nationally recognised care bundles were followed. These included care bundles to reduce the risk of ventilator acquired infections and central line infections and complications.
- We saw staff utilised the delirium assessment tool in accordance with NICE guidance. This ensured that staff were able to evaluate patients and assess the risks.

- The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC). The ICNARC data supports critically ill patients by providing information/feedback about the quality of care provided.
- We saw the resuscitation team's trolley annual audit for March 2015. Staff said the audit was incorporated in their key performance indicator. The audit showed they were 100% compliant with the seal, 96% complaint regarding the equipment check and 98% for the expiry date. We saw evidence to asure the appropriate reporting of broken equipment. We saw procedures in place to performance manage bank nurses not aware of how to use the equipment. We saw that additional training had been completed to address this.
- The unit covered all non-invasive ventilation (NIV) treatment. NIV is the management of patients with chronic obstructive pulmonary disease admitted to hospital with acute respiratory failure.

Pain relief

- In ICCU staff followed the unit's protocol on pain control for ventilated patients. Patients were assessed pre-operatively for their preferred pain relief.
- Patients' pain scores were regularly assessed and documented using the pain scale found within the medical early warning score (MEWS) system. Records showed that pain relief was administered promptly and patients' pain reassessed after they had received the pain control medicines.
- Most staff said they had received appropriate training in the use of medical devices to assist with pain control, such as syringe drivers. This ensured that they were used safely and effectively.
- Patients told us that they had received pain control medicines when needed.

Nutrition and hydration

- The unit used the malnutrition universal screening tool (MUST) to assess the nutritional needs of patients. We inspected 11 records and found the assessment tool had been appropriately recorded and utilised.
- In the ICCU, staff followed the protocol for hydration and nutrition for ventilated patients and enteral tube nutrition was initiated. Staff told us there was support and guidance available to support patients' needs.
- The audit data showed that 304 patients (38%) were given nutritional support during 2013/14.

Patient outcomes

- The unit displayed their outcome data on a notice board at the entrance to their unit.
- The cardiothoracic surgical governance meeting reviewed the mortality and morbidity cases within the trust. We looked at six cases; five of which were closed and one which required action to be taken. This was identified in the meeting minutes.
- The cardiothoracic surgical governance meeting also reviewed readmissions. We saw that two cases had been discussed which reviewed the reasoning for readmission and the outcome.
- The resuscitation team collated the number of arrest calls to patients. For example, between January 2014 and March 2015 they had attended 148 arrest calls of which 67 were actual arrests.
- The critical care outreach team had collected a considerable amount of data on the quality of the service. For example, the data identified that the number of ward cardiac arrests had declined over the past year. We saw this trend was continuing and the data from August 2014 to February 2015 showed a decrease from 25 to 13 ward cardiac arrests.
- The annual audit for the ICCU showed a continuous downward trend in the overall Standardised Mortality Ratio (SMR) as measured by the Acute Physiology and Chronic Health Evaluation Classification System (APACHE II). For example; in 2013/14 the overall mortality rates were 18% compared to 21% for 2012/13.
- ICNARC data was displayed in the unit so that patients, their relatives/carers and staff could see the quality of care on the unit.

Competent staff

- Staff confirmed they had received annual appraisals. These processes covered training and development needs and practices. We saw that 100% of staff had received their appraisals.
- The unit had professional development nurses (PDN) attached to the service. They said they monitored all training which we saw was up to date.
- There was an induction programme for all new staff. Data provided for April 2015 showed that 100% of staff had attended their induction. New members of staff said

they had been supported when joining the hospital. They had completed a trust wide induction programme. When on the ward they were given the opportunity to understand processes and procedures.

- All new staff undertook competency tests to ensure they had the necessary skills to carry out their role. The PDN said the trust had bought the rights to the Manchester competencies framework which they utilised. We saw they had created workbooks, which were target based, for staff to complete. Examples of areas covered included anaesthetics and care of deteriorating patients. We reviewed the record of a new staff member which had been completed and signed by senior staff.
- Consultants said the nurses they had on the unit were very good and competent in their role. They said they would like to develop the nurse practitioner role so that they became specialised nurses who could prescribe and insert arterial lines for example.
- The trust had launched a new bereavement service called "The Swan Campaign". The trust provided training exercises for staff to enable them to deal with the emotional circumstances when a patient passed way and support both the patient and relatives appropriately. Staff said they had attended training which they found to be beneficial.
- The physiotherapists provided in-house training to staff. They told us this was not ICCU specific with the exception of the critical care on-call role. We saw competencies in place for the on-call role.
- The outreach team told us they had recently begun to complete the National Outreach Forum (NOrF) competencies for the critical care outreach services framework document. They told us this was a work in progress and would in due course evaluate the data collected.
- The professional development nurse said they facilitated courses for staff progression. Staff told us they had attended the Acute Life threatening Events—Recognition and Treatment (ALERT) course. The course is designed to teach healthcare staff to anticipate, recognise, and improve the quality of care for critically ill patients.
- In the ICCU, 58% of the nursing staff had achieved a post-registration award in critical care nursing.

Multidisciplinary working

- There was a multidisciplinary team who supported patients and staff in the unit. For example, there was a dedicated critical care pharmacist who provided advice and support to clinical staff in the unit.
- The unit was well-supported by physiotherapists who were available five days a week with an on-call service at the weekend. The physiotherapists had their own morning round. We observed a morning round and saw physiotherapists discussing with the patients their needs before sharing the outcomes with the nursing staff.
- Doctors undertook daily ward rounds which had input from nursing, microbiology, pharmacy and physiotherapy. Input from dieticians and speech and language therapists were sought if needed. We were given an example of a recent patient in ICCU who required expert dietician input and how this was accessed.
- The unit had an outreach team that was fully integrated and provided valuable support in the care of the critically ill patients. The outreach team reviewed any patient who staff felt would benefit from their intervention or whose condition was causing concern. The team also followed up all patients discharged from the ICCU.
- There was a specialist nurse for organ donations based at the ICCU. The unit had good links with the organ donation team. There was support available for potential donors and their families.
- The microbiologist visited the unit daily. However, most of the records read did not identify any guidance from the microbiologist regarding the prevention, diagnosis or controlling of infections. This meant that staff may not have the necessary information to attend to the care and welfare of patients.

Seven-day services

- There was consultant cover for patients in the unit during the day from 8am to 8pm and an on-call service out of hours.
- Consultants carried out daily ward rounds and were available for advice and support at other times.
- There was an outreach team that provided support seven days a week from 8am to 9pm for the management of critically ill patients in the hospital.

- At the weekends, support was available on site from the multidisciplinary team, including microbiology and pharmacy. The unit also had access to a radiologist via the on-call system at weekends.
- The physiotherapists assessed patient's needs Monday to Friday. They provided an on-call service at the weekend.

Access to information

- Staff told us they had good access to patient related information and records whenever required. The bank staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us when patients were transferred between wards staff received a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Whenever possible, patients were appropriately asked for their consent to treatment and procedures. Staff were able to provide examples of patients who did not have the capacity to consent to treatment. The Mental Capacity Act 2005 was adhered to appropriately.
- The senior sister told us that, during our inspection, there was no one who was receiving care under the Deprivation of Liberty safeguards (DoLs). Staff we spoke with were aware of Mental Capacity Act 2005 and DoLs and could show how this related to the patients they cared for.
- The records, where applicable, showed clear evidence of informed consent which identified the possible risks and benefits of surgery.
- Patients confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to.
- Staff confirmed they had received training from the Deprivation of Liberty Safeguards (DoLS) nurse. This was confirmed in the training records seen.
- We saw the DoLS forms were available at the nurse's station and a DoLS flow chart was on display in the nurse's room.

Are critical care services caring?

Good

We observed good care within the critical care service. Patients we spoke with gave us examples of the care they had received in the unit. Staff built up trusting relationships with patients and their relatives by working in an open, honest and supportive way. Patients and relatives were given good emotional support, and throughout our inspection, we saw patients being treated with compassion, dignity and respect. Staff provided good care, by understanding what was significant to patients and making arrangements to ensure patients retained what was special in their lives.

Patients said they were kept informed and felt involved in the treatment received.

Compassionate care

- We observed staff caring for patients in a kind, compassionate and professional manner. We saw that patients were treated with the utmost respect and dignity throughout their treatment. Nurses were attentive and were always in close proximity to patients. When they provided care to patients, they always introduced themselves and spoke in a gentle and kind way. However, we saw some staff entering patients side rooms without knocking and introducing themselves.
- We observed staff dealing with a patient with agitated behaviour with compassion and empathy.
- We attended a ward round. However, we observed that doctors did not introduce themselves to patients when carrying out ward rounds although curtains were drawn to maintain patient dignity and confidentiality.
- We observed good interaction between patients and their consultant during our visit. We saw the consultant explained everything to the patient and provided guidance when required to.
- We observed the receptionist speaking to families in a polite way when they visited their relative. One relative said they were "very happy and well informed."
- Patients spoke positively about the care provided by staff. One patient said staff were "helpful and friendly." Another said the care was "fantastic."
- We saw the results of the critical care survey. Examples of the feedback were: "really impressed" and "everyone is "kind, informative and supportive."

Critical care

Understanding and involvement of patients and those close to them

- We observed staff explaining procedures to patients to help them to understand and be involved in decisions concerning their treatment. Patients told us they were given appropriate information in a way they could understand, and this helped them to be able to make decisions.
- Families said they had been involved in decisions about their relative's care and treatment. We spoke with a family member who told us they had been kept well-informed about the condition of their relative.
- The hospital had an interpreter policy which provided guidelines to staff in the use of interpreters.
- Many patients who attended the ICCU often had little memory of their stay. Patients' treatments were recorded in patient diaries which were completed by nursing staff and families to improve patient memories of their stay. Patients had access to these diaries after they left the unit. If a patient passed away, the dairies were made available to relatives as part of the bereavement process.
- The trust had launched a new bereavement service called The Swan Campaign. We saw a swan box which contained various prayer books, sincere condolence cards and the ability to take photographs of relative's hands. Staff said that friends and families had told them they found this service really helpful during their bereavement.

Emotional support

- The trust had a dedicated bereavement service. Bereavement support was offered through the ICCU 24 hours a day, seven days a week. Staff provided support and guidance to the family.
- Access to specialist nurses was available to support the emotional needs of patients and families. We spoke to a relative and they told us how members of staff spent considerable time with them to help them with their loss.
- Patients from ICCU could access the multi-faith chaplaincy services for support, including clergy and equivalents from other faith groups. Information on how to access chaplaincy services was available through staff. Staff told us they regularly interacted with the trust's palliative (end of life care) team, who provided support and advice during bereavement.
- Staff were passionate and driven to provide good care to patients. For example, we saw staff spending time talking to a patient who was confused and distressed. We also saw staff being supportive to a relative of a patient within the unit.

Are critical care services responsive?

Good

The critical care services were responsive to the needs of patients. Patients were admitted to and discharged from the unit at appropriate times. Patients that were discharged had follow-up support from the outreach team.

Patients with a learning disability were provided with the necessary support, including the services of a learning disability nurse who shared their expertise with members of staff in the unit. Staff also had access to translation services. Complaints were handled appropriately.

Service planning and delivery to meet the needs of local people

- The critical care unit provided a service for patients undergoing elective and emergency cardiac and general surgery.
- The consultant surgeons said they undertook approximately 800 elective operations a year and a further 100/200 urgent surgical operations a year. They said that all patients identified as level 3 patients did not go to recovery but were transferred straight to the ICCU ward. Hospitals classify patients according to their needs from level 0 to level 3. This helps them to provide the best possible care and tailor their services to meet patient's requirements. Most patients who require critical care services are categorised as either level 2 or 3.
- Planning the delivery of the service was co-ordinated at bed meetings held during the day.
- The unit had 28 critical care beds. Between 2013 and 2014, figures showed that the bed occupancy for adult critical care beds across the trust was similar to the national average.
- The ICCU had a specialist nurse organ donation service attached to the unit. We saw the audit data regarding

organ donation for 2013/14 which showed that 34 patients had been referred to the transplant co-ordinator of which 10 granted permission and 24 declined.
- Patients who were discharged from the unit were aware of their discharge plans and had appropriate records and information given to them or to those receiving them into their care.
- All professionals involved with a patient during their admission to the unit contributed to the plan for their discharge.
- The critical care outreach team was involved in discharge planning and visited patients after discharge from the ICCU to offer continued support. We saw the outreach figures which showed they achieved 100% in their critical care follow up.

Meeting people's individual needs

- The unit had processes to support people with a learning disability and staff knew how to access these. For example, there was a learning disability nurse who provided support to staff in the unit.
- The unit had flexible visiting hours that allowed relatives to come in when they wanted to. However, relatives were informed that, during certain hours, patients would be provided with intensive support and relatives would be requested to leave the unit. We spoke to two relatives who told us they were well-informed of when they would be asked to leave so that doctors and nurses could continue to provide the necessary care to the patient. They told us they did not mind this because once the care was completed, the nurse would invite them back to visit the patient.
- The unit had access to translation services. Staff could contact the NHS interpretation service by telephone, or request interpreters to visit the unit. However, because relatives were present most of the time, staff were able to use relatives to help patients understand the care being provided.
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- Written information was available in multiple languages. Literature we saw explained the different formats and languages in which information could be accessed.
- Safety goals and risk assessments were documented, acted upon and evaluated, for example for moving and handling and pain assessments.
- A chaplaincy team was based at the hospital to provide support for patients' spiritual and religious needs.

Access and flow

- The consultants said that access to the wards could be a problem but the hospital had an effective pre-planning bed arrangement process which addressed these issues.
- The consultants said that some "bed blocking" occasionally occurred if a patient had an intra-aortic balloon pump as they had to be admitted to the cardiac section of the ICCU coronary care section.
- The consultants said they accepted level 3 patients from other hospitals who required a stent. A stent is a small mesh tube that's used to treat narrow or weak arteries. The consultants told us the trust's policy was that these patients were returned to their original hospital as soon as possible and this process worked very well.
- Consultants said the return to theatre rate was 10% which was higher than the national average. They said they were more proactive and took patients back earlier which they felt was good and aided patient recovery.
- Patients were admitted to the unit within the standard four hours from the decision to admit.
- The ICNARC data showed the length of stay on the ICCU was similar to the national average. The unit saw 803 patients for 2013/14 of which for example; 173 patients (22%) stayed for 24 hours, 94 patients (12%) stayed for 48 hours.
- Most discharges from the unit occurred during the day between 8am and 10pm, which followed national guidelines. Staff said they did not discharge patients out of hours which was confirmed by the consultants spoken with.
- Patients who were discharged to other wards had follow-up visits by the critical care outreach team within four hours of discharge or when required.
- We saw the audit data which reviewed patient readmissions within the unit. For example in 2013/14 six patients were re-admitted within 24 hours, post ICCU discharge and all six were discharged from hospital. Two patients were re-admitted within 48 hours, post ICCU discharge and both died in the ICCU. We saw the readmission rate was lower than 2012/13 which was 28 patients.
- There were zero non-clinical transfers out of the unit between April 1st 2014 to March 31st 2015.

Learning from complaints and concerns

- Complaints were handled in line with the trust's complaints policy. If a patient or relative wanted to

make an informal complaint, they would be directed to a senior staff member. Staff would direct patients or relatives to the Patient Advice and Liaison Service (PALS) team if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained.
- Information on how to make a complaint was available for patients and carers.
- Outcomes and actions from complaints were disseminated to staff through formal and informal meetings. We were told that there had been no complaints received in the past six months.

Are critical care services well-led?

Requires improvement

We found that critical care services required improvement to be well-led.

Most staff were not aware of the vision or strategy for the critical care service Staff however, were able to access the trust's mission statement and philosophy of care on the critical care intranet site.

The service held monthly clinical governance meetings and senior nurses' meetings where quality issues such as complaints, incidents, a audits and actions were discussed. Governance processes had a focus on risk and quality and we saw reviews of the provision of the service. Although there was evidence of department risks which were highlighted on the directorate risk register; some concerns highlighted by staff were in the process of being assessed. There were clear actions around the risks accepted. However, there was a disconnect between the risks identified at unit level and those identified and understood by senior management. There were concerns about the impact on patient care and safety which were not identified on the risk register. We found that interim plans to manage and mitigate risks were not addressed at local level.

There was good local leadership on the critical care unit. Within the service there was a culture of support and respect for each other, with staff willing to help each other when they were short staffed. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service. Staff told us they felt there was effective and supportive team working across professional groups in the critical care service.

Patients were engaged through survey feedback. The survey questionnaires showed that patients were happy with the care and treatment they had received.

Innovative ideas and approaches to care were encouraged and supported. There was positive awareness among staff of the expectations for patient care.

Vision and strategy for this service

- The business manager and the clinical consultants demonstrated a clear vision for the future of the service. There was a sense of purpose and passion to deliver the vision. Staff we spoke with were clearly passionate about the critical care unit and how it supported the wider hospital and trust.
- Some staff said the trust's visions and values were the six "C's" which are the enduring values and behaviours that underpin compassion in practice. However, most staff said they did not know what the vision and values of the trust were.
- Staff said they did not know what the aims of the unit were and were unable to describe the trust's strategy for ICCU.

Governance, risk management and quality measurement

- The unit had regular joint steering group meetings which included nurses, and consultants. We saw these involved small working groups to resolve problems, for example; a review of the delirium policy.
- The unit had a risk register and we saw the risks identified in critical care. However, we saw written evidence of a broken fire door between the unit and the cardiac theatres dating back to 17 October 2013 which was not identified on the risk register. Staff said that this was a longstanding intermittent problem. From 24 May 2015 to 03 June 2015 the fire doors had been broken for 16 days. During our visit on 04 June 2015 we observed the fire doors to be broken and open. This was brought to the attention of the senior staff and escalated to senior management. On our return visit on 05 June 2015 we observed that the fire doors had been mended.

- When asked about the risks detailed on the risk register for ICCU, the senior sister in charge appeared unaware of what was on the risk register or how to mitigate the risk identified.
- We saw the health and safety audit for June 2014. This looked at actions and progress for the unit which included risk assessments and associated hazards regarding work equipment.
- We saw the senior sister meeting minutes and the cardiothoracic surgical governance meeting minutes for April 2015. Areas identified included incidents and the actions taken, staffing levels and training. The outreach team also attended the meetings and fed back to the team.
- The unit had a quality dashboard for the service and this showed performances against quality and performance targets. Members of staff told us that these were discussed at team meetings.
- The resuscitation team said there was good governance and interaction with the education team.
- Staff said the monthly morbidity and mortality meetings provided them with the opportunity to discuss unexpected deaths.
- We found that the policies relating to critical care were out of date and found no evidence of review. For example; the critical care procedure policy was dated 2012 and the pulmonary artery catheter policy was dated 2008. This meant that the information provided to staff may not be up to date and could affect the care and welfare of patients who used the service.
- Local leadership were either not aware of the risks or were not acting on them appropriately.

Leadership of service

- The unit was led by senior sisters and consultant clinical leads.
- Staff told us the team operated collaboratively. They told us the leadership was visible within the unit.
- Staff were aware of the head of nursing within the hospital whom they said was visible and approachable.
- The general and cardiac section within the unit each had a senior sister who provided day-to-day leadership to members of staff on the unit. Staff told us the senior sisters were visible and approachable.
- Some staff said the leadership and communication from the trust was good. They said they were aware of the chief executive officer and felt the trust listened to them.

Culture within the service

- Staff told us that the senior sisters and medical staff were visible and approachable on the unit.
- Staff we spoke with worked well together as a team and said they were proud to work for the trust.
- Staff spoke positively about the lessons learnt from reporting incidents and raising concerns.
- All staff spoke with pride about their work, including those who were working in difficult circumstances

Public and staff engagement

- During our inspection we saw a number of cards and letters from patients and their relatives thanking staff for the care they had received in ICCU.
- The unit undertook a relative's satisfaction survey, used patient diaries and obtained feedback from patient and their families. We looked at 17 returned surveys and found that all were positive. Comments included "thank you for saving a very special person" and "staff are dedicated, knowledgeable and informative."
- Staff recommended the trust as a place to work or receive treatment. Staff told us there was good communication between senior management and staff.

Innovation, improvement and sustainability

- Staff told us the unit had created an environment where all members of staff were recognised and rewarded regarding the improvements to quality and innovation. Staff said they had received thank you letters and e-mails for the good work they had done. Staff said they were also thanked by the team leaders for the day.
- The trust had created a "Sim Ward." The aim of the SimWard was to improve patient safety through curriculum based simulation. The ICCU said they found the SimWard invaluable as an educational aid for staff and allowed all learners to develop their skills through real time participation. Staff said they used the SimWard as part of their competencies and were fully debriefed on their performance.

Maternity and gynaecology

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

Information about the service

Between July 2013 and June 2014, 4,034 babies were born at the Royal Wolverhampton NHS Trust.

Consultant led obstetrics services were transferred from Stafford hospital January 2015.

Services offered included a Midwifery Led Unit (MLU) and a consultant-led delivery suite including an induction of labour unit and triage area, antenatal clinics, a foetal medicine unit, a maternity assessment unit, and an antenatal and postnatal inpatient ward. Women could also choose to have a home birth supported by community midwives.

There were ten delivery rooms, a high dependency room, a two room bereavement suites, six triage beds with two assessment couches, and a ten bed induction of labour unit located on delivery suite. The MLU has five rooms, the ante-natal and postnatal ward has 36 beds, which are interchangeable according to activity. The majority of the time there are 8-10 antenatal beds and 26-28 postnatal beds.

Specialist services were available for example, diabetic care, substance misuse and mental health support.

Community midwifery was part of the Royal Wolverhampton NHS Trust's maternity services. Working in partnership with GPs, health visitors, family nurses, children's centres and lifestyle services they promoted well-being during pregnancy and in the early days following a baby's birth. Six teams of community midwives provided antenatal care, parent education classes, home births and postnatal care in Children's Centres, GP surgeries and in women's homes.

The gynaecology service offered inpatient services, day care and emergency assessment facilities. Outpatient services included colposcopy, hysteroscopy, fertility management, treatment for miscarriage and pre-operative assessment. The gynaecology ward had 26 beds and can increase to 30 beds to respond to increased capacity.

A team of gynaecologists specialised in specific problems and were supported by a specialist gynaecology oncology nurse, general nurses and health care assistants

We visited all the wards and departments relevant to the service. We spoke with 34 maternity patients, 14 midwives and support workers individually and 28 midwives in two focus groups. We spoke with 18 gynaecological patients, four nurses, one student nurse and two support staff who care for gynaecological patients. We met and spoke with seven medical staff that worked across both the maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

Overall we found the service required improvement but the domains of, effective, caring and responsive, were good.

There were many good examples of the maternity unit being safe including incident reporting systems, audits concerning safe practice and compliance with best practice in relation to care and treatment plans. However emergency arrangements needed to improve.

Obstetric consultant cover was not adequate being below the required hours for the number of births undertaken annually.

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

The birth to midwife ratio was 1:30. The named midwife model was in place and women told us they had a named midwife. Midwives provided one to one care in labour.

Patients told us that they felt well informed and were able to ask staff if they were not sure about something. We saw limited patient information leaflets available.

In March 2013 the maternity service at the Royal Wolverhampton NHS Trust achieved compliance with level two requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Clinical Risk Management Standards 2012/13, scoring 46 out of 50.

There was an active maternity services liaison committee (MSLC), which met quarterly.

Are maternity and gynaecology services safe?

Requires improvement

Arrangements for emergencies needed to improve as this put patients a risk of poor outcomes. We were not assured that the maternity team was supported by the **critical outreach team at night time**

Consultant obstetric cover on the delivery suite was on average 60 resident hours per week at the time of the inspection. A 98 hour labour ward consultant presence is required for 4,000 – 5,000 deliveries.

The most senior qualified member of staff on duty had the responsibility to ensure that all resuscitation equipment was checked as per policy. We noted equipment needed in an emergency was not readily available to be used. Controlled drugs and fridge temperature checks were not undertaken as per trust policy.

Records were not maintained in a neat order and we found email addresses of another patient in one set of records.

The midwife to birth ratio was 1:30 in December 2014, this is in line with the national average. The named midwife model was in place and women told us they had a named midwife. Women received one to one care in labour and women expressed their satisfaction with this. However we did see some issues with staffing numbers and difficulty in achieving skill mix. The planned staffing levels were displayed at the entrance to each maternity ward, however it was not displayed on the gynaecology ward.

There were no never events reported in 2014. We saw that a robust process of investigation would take place if a never event occurred including a root cause analysis (RCA), establishment of lessons learned, an action plan and dissemination of learning points.

All areas of the hospitals were visibly clean and well maintained. However, we saw that equipment was not consistently labelled with tags to indicate that it had been cleaned.

We noted that the battery was low on the VitalPAC and were told' it happens all the time'. We saw that labels on intravenous cannulas which were not dated which could put patients at risk of infection.

Maternity and gynaecology

- 26 serious incidents were reported to the NHS strategic executive information system (STEIS) by maternity services between April 2014 and March 2015. There were eight unexpected admissions to the neonatal unit (NNU), seven intrauterine deaths, two intrapartum deaths, one unplanned maternal admission to the intensive care unit (ITU) and six unspecified incidents.
- We reviewed action taken regarding a recent maternal death in the maternity unit during our visit. We saw that an RCA had been undertaken and that a multidisciplinary risk meeting had taken place to review the RCA. We saw that a table top review was planned and that lessons learned had been identified in the early stages of this investigation. Duty of candour had been observed; relatives had been offered explanations, apologies and been invited to the review meetings.
- There were 23 stillbirths reported in the trust between January and September 2014, with a further six babies stillborn between October 2014 and April 2015. We saw a robust approach to the investigation of these deaths and the subsequent review undertaken to identify suboptimal practice and trends. We saw evidence that an action plan had been drawn up and reviewed. Actions included the introduction of NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth which recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour.
- Ten cases were identified where there had been suboptimal care that might have made a difference. Four of the women involved were smokers or had just given up smoking. They had not been referred for smoke cessation support in line with trust policy. Community midwives were issued with carbon monoxide monitors and they were recording CO levels on all women and referring them for smoking cessation support if indicated.
- We saw that the trust recognised their data around reporting episodes of reduced fetal movements was flawed. Between November 2013 and October 2014, there were 1000 episodes of reduced fetal movements recorded. However, the trust was unable to identify whether this was single episodes or repeated episodes. The impact of this was that it was difficult to accurately estimate the numbers of women who would require an ultrasound scan following an episode of reduced fetal movements, which was the recommended course of action.
- Posters were distributed to GP surgeries and children's centres to inform women about fetal movements and when to seek advice.

Women who required induction of labour for post maturity were no longer cared for on the Midwife Led Unit (MLU). Such women had previously been able to have their baby on the MLU and, following an incident of a misinterpretation of the cardiotocograph (CTG) monitoring of the baby's heart rate on the Maternity Ward prior to transfer to MLU, this pathway is no longer available.. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour.

- Staff told us that they were able to raise concerns and were confident that their concerns would be listened to.
- Escalation of risk was identified through a computer based incident reporting system (Datix). Royal College of Obstetrics and Gynaecology (RCOG) trigger list was used to guide the inputting of Datix forms. This meant that incidents were identified, investigated and that necessary learning could take place.
- We saw from the Maternity Trend Analysis Report for Quarter 4 (Jan – Mar 2015) that there were 172 incidents reported.
- 153 incidents were reported regarding patient care. This included Intrapartum incidents, staffing, issues with the patient journey, treatment and procedure and medication errors.
- Intrapartum incidents included complications at birth and babies born before admission (BBA) to hospital. We saw that there was some under reporting of some types of incidents. For example there were six cases of shoulder dystocia recorded on the maternity information management system but only three Datix forms were submitted. Nine babies were born before admission to hospital and only two Datix forms were submitted. The risk manager emailed ward managers to ask them to remind staff to complete Datix forms for shoulder dystocia and BBAs.
- Patient care related incidents included treatment and procedure. The most significant change was an increase

from 3 incidents in the previous quarter to 10 in the Quarter 4 in delay to treat. This included delay in suturing after birth, delay in screening and a delayed elective caesarean section due to on-going building works.

- Patient care related incidents included 14 medication errors, the main incident was medication not given or delayed (seven). We saw that in response to medication being given late or delayed, a 2pm drug round was reintroduced and a laminated sign left for women who were not by their bedside informing them to let the staff know they wanted medicine once they returned to their bed.
- We saw that incidents are reviewed at the weekly risk meeting which are minuted and attended by the senior management team. Following every reported serious incident, a full investigation would be undertaken. This would include a RCA review and a report would be developed. We saw examples of RCA reports from both obstetrics and gynaecology completed and presented.
- We saw that learning from incidents took place and was disseminated to staff. A safety brief was introduced at handover in all clinical areas to ensure direct and timely feedback. Each area had as risk management folder and an information board. We saw a risk management board specifically for junior doctors to ensure they had access to learning from incidents. Information was also distributed to all staff via email.
- Feedback was given on an individual basis and we saw evidence of a management plan that was developed in response to concerns over a doctor's management of a patient on the labour ward.

Gynaecology

- Staff on the gynaecology ward told us of a change in practice that arose following and incident of a retained vaginal pack. Yellow wrist bands were used to indicate when a woman had a vaginal pack in situ. This was removed once the pack was removed.
- There had been two never events in the gynaecology unit since 2012, one retained drain and one retained pack post operatively. The risk of never events was on the Directorate risk register and the risk was being managed. A modified WHO checklist was in place and audited for procedures that took place outside of theatre, for example hysteroscopy.
- We looked at the minutes of the Obstetrics & Gynaecology Governance Risk meetings from October, November and December 2014 and January 2015 and saw that there were 93 gynaecology related incidents reported. We saw that these were reviewed at each meeting and actions had been taken.
- We looked at one set of minutes from January 2015 that showed that two Datix reports were made against gynaecology by external directorates. The facilities department reported poor disposal of a needle injuring a domestic. Nursing and Quality reported an incidence of hospital acquired venous thromboembolism (VTE).
- We saw that an RCA had been undertaken in response the hospital acquired VTE and that lessons learned had been identified and staff reminded of the importance of risk assessment.

Safety Thermometer

- We asked to see the maternity safety thermometer as it was not displayed. The trust was not yet using the maternity safety thermometer. The NHS Patient Safety Thermometer was used and information was inputed into the on-line Kite site. The maternity safety thermometer allows maternity teams to take a temperature check on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. The maternity safety thermometer measures harm from **perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby** and **psychological safety**. It also records babies with an **Apgar of less than seven at five minutes** and/or those who are **admitted to a neonatal unit.** We saw that on the whole harm free care was provided on the gynaecology ward. There had been one pressure ulcer in April, which was the first one in three years.

Cleanliness, infection control and hygiene

- All areas of the maternity and gynaecology units were visibly clean and well maintained. We saw environmental audits for all areas. Areas in the

maternity unit achieved 100% in the audit. Ward D7 (Gynaecology) scored 66%. We did not see an action plan to address the shortfalls identified at the time of the Inspection however this has subsequently been provided to the CQC.'.

- Sluice areas were clean and had appropriate disposal facilities, including disposal of placentae.
- We observed some elements of compliance with the trust infection control policy. Staff were seen using hand gel and protective clothing and the bare below the elbow policy for all staff was adhered to. We saw that cleaned equipment was labelled with tags to indicate that it had been cleaned. However this was not consistently applied. For example, we saw that two out of five pieces of equipment had been labelled on the induction suite.
- We looked at the birthing pools on all wards and found them to be well maintained. Staff we spoke with knew the pool cleaning procedure.

Environment and equipment

- The most senior qualified member of staff on duty had the responsibility to ensure that all resuscitation equipment was checked as per policy. We observed that the emergency trolley on the maternity ward lacked two defibrillator pads; staff told us they would access emergency equipment in a neighbouring ward.
- It is It is the responsibility of the coordinator of each clinical area to ensure that resuscitation equipment is readily available and regularly maintained. The rescusitaire (emergency equipment that is used to resuscitate babies) was stored in a cupboard on the MLU to preserve the home from home environment. This was not readily accessible because it was not plugged in and ready for use. In the case of a baby not breathing at birth, staff used basic equipment in the birthing rooms and the rescusitaire had to be obtained, plugged in and set up for use. This could put babies at risk in the first few minutes of life. A rescusitaire has a stop clock that is used in the management of resuscitation of the newborn along with an overhead heater. Accurate measurement of time is important in the assessment of a baby's progress during resuscitation. Maintaining heat is a vital component of the management of a baby requiring resuscitation.
- Midwives had access to the equipment they needed to confirm the health and well-being of mothers and babies. We saw that equipment such as fetal monitoring machines, vital sign observation monitors and rescusitaire had been maintained and stickers applied to confirm that checks were up to date.
- Telemetry CTG machines were available for women whose babies needed monitoring in labour but did not want to be restricted to the bed. Monitoring with a CTG machineinvolves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. Telemetry CTG machines operate by Wi-Fi and enable the woman to be mobile.
- Staff were able to tell us about the procedure to evacuate a mother from the birth pool in the case of an emergency.
- We saw that VitalPAC was used to ensure intravenous therapy safety. VitalPAC is **a clinical monitoring system that** monitors and analyses patients' vital signs and enables staff to automatically summon timely and appropriate help when a patient deteriorates. This removes the need for paper based monitoring charts.
- We noted that the battery was low on the VitalPAC and were told' it happens all the time'. We saw that labels on intravenous cannulas which were not dated but labelled with messages such as 'review Friday'. We were told that nurses enter reminders into the notes which prompted the them to check the cannulas.
- It was noted that the directional signage was generally poor across the site and that the maternity and gynaecology unit was difficult to find. This could be a challenge for people who use the services particularly when trying to finding the maternity unit when a mother was in labour.

Medicines

- We saw that medication was stored in locked cupboards within clinical rooms. Controlled drugs were checked twice a day in most areas. We found that the controlled drugs had not been checked as per trust policy four times in six months on the gynaecology ward and that they had not been checked 39 times on the MLU since 1st March 2015.

- We saw that the drug fridge on the gynaecology ward had not been checked 57 times in six months. We asked the manager about this and were told that it was not checked at weekends, although the ward was open on weekends, and this accounted for the deficit.
- We saw that VTE scores were recorded in patient's records and monitored. Prophylactic treatment was prescribed and administered in accordance with the trust guidelines.
- We saw that the nurse undertaking the drug round was identified by wearing a red tabard. This indicated that she was not to be disturbed during the medicine round to allow her to concentrate on the administration of medicines.
- We observed respectful, clear explanation of medicines being given to a patient with assurance that the medicine could be changed from a tablet as the patient had difficulty swallowing.
- We were made aware of delays with medicines due to charts being in pharmacy. This also affected patients waiting for take home medicines. One patient told us her medication was delayed by two days because "The pharmacy computer was broken". We were told that there were plans for an automated medicine control system to be installed on the ward which would mean that nurses could control, dispense and manage medicines.
- Midwives may supply and administer substances specified in medicines legislation under midwives exemptions for use in their professional practice. We found an inconsistency in the arrangements for midwives to dispense medicines. We were told that community midwives at Cannock had medicine packs dispensed by the pharmacy for them to supply and administer. This was good practice and ensured the available medicines had been checked for safe administration. However, Wolverhampton based community midwives obtained medicines for home birth from the labour ward stock. This meant it would be difficult to track and check what medicines had been taken; this increased the potential for a medicine error.

Records

- We saw that records were mostly kept secure and away from public view. We did observe that the records trolley was left open at the time of our inspection and unattended on the maternity ward.
- Records were not maintained in a neat order and were difficult to navigate. We saw that loose leaves were contained in many of the records we looked at. Sections were not clear and we found email addresses of another patient in one set of records.
- On the maternity unit we saw the individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born.
- We reviewed eight sets of maternity records and two sets of gynae records and noted that risk assessments was recorded in all records. VTE status was missing in two sets of records.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse and reflected safeguarding legislation and local policy.
- Data for training was held by each ward manager. Training rates for Safeguarding was recorded between 88% and 98%
- All ward staff followed the trust's safeguarding policy and reporting procedure. Staff reported that they get good support from the safeguarding midwife who visits each Monday to review safeguarding issues and was available by telephone throughout the rest of the week. The safeguarding midwives also met women who had working agreements or other plans in place to ensure that they understood their circumstances.
- A flag showed on maternity service information system for any woman who had a safeguarding concern. Records were also kept in in the patient records and a note was made in the special features of the handheld maternity records.
- If a woman presented herself for treatment who was not known to the service, staff informed the local safeguarding board who then made enquiries with the social services department in the patient's home area.
- We were told that the trust was developing a policy on Child Sexual Exploitation.

- Community midwives told us that on occasions they did not have adequate time for safeguarding activities, which meant that they wrote reports and made referrals in their own time.
- We were told about and saw evidence of support being put into the community to minimise the risk of safeguarding issues being missed. A risk was identified that safeguarding could be missed due to shortage of staff in the community. This could impact on safeguarding due to lack of continuity. A named midwife was allocated to higher risk clinics to monitor and act on safeguarding issues. We saw that all women are asked about domestic abuse in line with NICE guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded. Staff knew how to make referrals to other agencies in cases of disclosure.
- A safeguarding case supervision policy was in date. Community midwives had group supervision offered three times a quarter and it was mandatory to attend one session a quarter. The named midwife for safeguarding held quarterly group supervision sessions for midwives working in the hospital and it was mandatory to attend two sessions a year. Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2010).
- There was an abduction policy. We observed that CCTV was in operation. We saw that babies were tagged once they were admitted to the postnatal ward. We were told that babies were not tagged from birth on the delivery suite due to on-going work with the fire protection system that was interfering with the baby tagging system. Baby tagging would commence on delivery suite once this work was completed.
- We saw that due to on-going building work, some access doors to delivery suite were not locked or swipe activated. We also observed that codes to security key pads were written on the door frames to some rooms.
- Community midwives based at Cannock shared an office with administrative staff. They told us that this caused concern when they needed to make telephone calls about child protection or to refer women to the hospital as they did not have the facility to speak in private when discussing confidential information. We were told that alternative accommodation was due to be provided from July 2015.

Mandatory training

- Mandatory training covered subject matters including maternal and neonatal resuscitation, electronic fetal monitoring, and management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- The lead midwife for education and development was responsible for mandatory training and other learning within the directorate.
- Mandatory training was provided over two days and covered subject matters including; maternal and neonatal resuscitation, electronic fetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia and cord prolapse. The unit had the use of the SIM Lab five times a year. The Simulation Lab offers staff the opportunity to practice emergency situations in a safe and supported environment. Staff told us that they did not have adequate access to the SIM Lab and this could mean that some staff could not access the training.
- Data for training was held by each ward manager. Overall completion of mandatory training was high. Infection control was recorded for each ward and varied between 93% and 96% and basic life support was 100%, except the MLU that was 86%.
- CTG machines were used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. CTG training compliance for delivery suite in February 2015 was recorded as 70%. This had been 80% in January and the drop in compliance was put down to the transfer of midwives from County Hospital who had yet to undertake the training.
- Mandatory training for nurses on the gynaecology ward was recorded and RAG rated on a ward performance monitoring form. We saw that the form was predominantly green for April 2014 – March 2015 with the exception of blood transfusion competency and training (88%).

Assessing and responding to patient risk

- **Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman.**

We asked about the response time for emergency teams in view of the location of the maternity unit in relation to the rest of the hospital. We were told that there was always an anaesthetist on the labour ward. We reviewed an RCA that demonstrated that on call anaesthetists could be divided between administering anaesthetics in theatre, inserting epidurals as well as caring for HDU patients. It also demonstrated that the anaesthetist on call for ICCU was not always available as in this case the doctor was stabilising a patient in the accident and emergency department. Whilst the on call anaethetist was called in and reviewed the patient this instance, there is a risk that patients could be put at risk due to the anaesthetic workload.

- **We were told that the critical outreach team supported midwives with the care and management of critically ill women. I**t was noted that there was no outreach team available within the Trust on this occasion due to sickness, however there is normally a Critical Care Outreach Team available at night time. Midwives had needed to transfer a collapsed woman to intensive care and following this no Datix had been submitted or escalation initiated. The decision was made to call the emergency services and the transfer continued with three paramedics and a midwife.
- Women that had problems in pregnancy were reviewed on the fetal assessment unit (FAU). From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery' guidelines. The checklists we looked at showed that all the stages were completed correctly.
- The senior midwives on duty provided cardiotocograph (CTG) review known as 'fresh eyes'. This was recommended by NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters.
- We reviewed 10 patient records and saw that there were detailed risk assessments and plans of care in place.

Midwifery staffing

- A recent Birthrate Plus® assessment had been carried out at the trust for April 2015. The use of Birthrate Plus® (a midwifery workforce planning tool) had been recommended in recent Department of Health maternity policy; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority.
- Birthrate Plus® assessment demonstrated that 135.8 WTE midwives were required for activity. Calculations based on an increase of 750 birth per year showed that 171.5 WTE midwives would be needed.
- The midwife-to-birth ratio is currently 1:30 (one midwife to 30 births). Midwives told us that they were able to provide one to one care in labour.
- Managers and staff told us that staffing was much better than it had been. However the trust expected increased capacity as data demonstrated that women who would have booked at the County Hospital were choosing to book at RWT. There was active recruitment taking place and the trust anticipated recruiting six newly qualified midwives in September 2015.
- Nursing and midwifery staff were very flexible and worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to senior staff.

The planned staffing levels were displayed at the entrance to each maternity ward.

- Delivery suite, triage and the induction suite required 11 midwives on the early shift, and 10 on the late and night shifts. On the day of our visit, we saw that there were eight midwives on duty for the morning shift and seven midwives on the late and night shifts respectively. Staff told us that this was a normal occurrence. They felt that it would be safer if triage and the induction suite were staffed separately; particularly as they told us that the emergency buzzers could not be heard on delivery suite and there was often only one midwife in each area. The

trust confirmed that emergency buzzers on both the Induction Unit and the Maternity Triage Unit are set to be heard on Delivery Suite. The panel on delivery suite also indicates the area that requires attention.

- Community Midwives told us that their workload had increased since the dissolution of the former Stafford Hospital. This included increased safeguarding concerns. Workloads had also increased since community midwives began undertaking examination of the newborn and recording of CO2 levels for all women.
- Team leaders were not having management time which was impacting on their capacity to undertake management activities such as coordination, appraisals and sickness management.
- Staffing requirements for the postnatal wards was five midwives on the early shift, four on the late shift and three on the night shift. This was adhered to at the time of our visit.
- The vacancy rate was 4.0 WTE at the time of our inspection and recruitment was in process. We saw that the sickness rate was 5.2% and maternity leave rate was 2.5%.
- The maternity and gynaecology wards did not use agency staff and had its own bank of staff. This was made up of existing staff who undertook extra work to cover shortfalls. Staff told us that they 'liked to help colleagues out', worked on 'goodwill' and that they were tired.
- Staff expressed concern that the skill mix was sometimes difficult due to the combination of grades on duty.
- The rotation of midwives to all areas on the maternity unit has made the escalation policy more robust because midwives were confident to work in all areas.
- We saw that the Band 7 delivery suite coordinator was supernumerary and we were told that in times of increased activity, they may have to look after labouring women. This could impact on the safety of labouring women as the co-ordinator needs to have an overview of activity at all times in order to manage the ward safely
- The trust expected staff shortages in the forthcoming summer months. We saw an action plan to support the community throughout this time until on-going recruitment was completed. This included community midwives not working shifts on the MLU and other staff helping with postnatal clinics at the weekends to release community midwives.
- We saw that maternity support workers (MCAs) were on duty in all areas to provide additional support according to their training and designated responsibilities.

Nursing staffing (Gynaecology)

- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse for eight patients. We did not see a safe staffing board that displayed planned and actual staff on duty on the gynaecology ward.
- We were told that although the gynaecology ward had 26 beds an additional four beds could be used. The ward was only staffed for 26 beds and this put the staff under pressure. We saw documentary evidence from risk meetings that this had been an issue for the service over the winter months and had been escalated to Divisional managers.
- We looked at six months off duty and saw that the rota was organised around workload which meant more staff were on duty on days when there were theatre lists. The monthly template for night staffing was amber. We were told that if three registered nurses were on duty, one was always moved. We saw that bank usage was high for unqualified staff on night duty and staff told us that this was because the pressure of work was higher in the day and that health care assistants (HCAs) were therefore allocated to day duty. The ward manager told us that she would like more HCAs.
- There was a clinical nurse specialist for gynae-oncology and an advance nurse practitioner who undertook colposcopy and hysteroscopy examinations.

Medical staffing

- The trust employed 29 whole time equivalent medical staff in the maternity services. There was a higher level of consultant cover than the national average 48%:34%; fewer registrars than the England average 37%:51: medical staffing mix was similar to the England average.
- Consultant obstetric cover on the delivery suite was on average 60 resident hours per week at the time of the

inspection. The consultant staff stayed on the delivery suite every day from 08.30 until 17.00 Mon – Fri and 08.30 until 13.00 on Saturdays. There was a consultant on call at all other times.

- A 98 hour labour ward consultant presence is required for 4,000 – 5,000 deliveries. We saw that consultant cover on labour ward had been on the directorate risk register since 2013. Documentary evidence on the risk register demonstrated that in March 2015 there was an approval in principal for a business case for additional resource to recruit two consultants.
- There was a separate on-call rota for gynaecology consultants. This meant that two consultants covered the service and that women were seen in a more timely way. At any time two registrars covered the gynaecology ward and delivery suite; we were told that delays were experienced for gynaecology patients due to their workload.
- We noted that it could be difficult to arrange for an obstetric review to take place. We reviewed an RCA that described how the on call obstetric team was busy on delivery suite all night and the obstetric registrar called in the afternoon to review the woman had been in clinic and also on-call for gynaecology emergencies. The impact of this put patients at risk because they are not assessed and treated in a timely manner.
- There was 24 hour senior anaesthetic cover for labour ward.
- Handovers were carried out four times during each day. We observed the formal 8.30am handover which included discussion on inpatients and overnight deliveries.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- We were told that the gynaecology ward was 'twinned' with a medical consultant who managed the medical outliers. This meant that patients were seen by the right doctors and that doctors treating gynaecology patients were not taken away from their duties.

Are maternity and gynaecology services effective?

Good

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

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

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

Patients we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24 hour period.

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

We saw good examples of multi-disciplinary team (MDT) working the maternity service. Staff worked collaboratively as part of the multidisciplinary team to serve the interests of women in the hospital and community settings.

Some issues were identified with relationships between medical and nursing staff on the gynaecology ward that could be prohibitive to safe and effective patient care.

Women were provided with information which helped them to understand their treatment and care before consenting to this. Patients told us that they felt 'safe and secure' with their care and treatment.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home birth service.

Evidence-based care and treatment

Maternity

- Policies were based on NICE/Royal College guidelines; the best clinical outcomes were promoted.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of

care in labour). These standards set out guidance in respect to; the organisation, safe staffing levels, staff roles and education, training and professional development. In addition to the facilities and equipment to support the service.

- Staff had access to guidance, policies and procedures via the trust intranet.
- We saw that there was a good process for screening for fetal abnormality. High risk women were invited into the clinic for counselling and on-going treatment
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital-based care.
- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included for example; having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw that a 'fresh eyes' approach was used to peer review electronic recordings of the baby's heart rate. This involves a second person assessing the baby's heart rate against certain criteria to confirm that the baby is coping with labour.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff were supporting women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Audits

- We saw an audit of the Modified Early Obstetric Warning System (MEOWS).. The audit recommended that the chart was reviewed and updated. The updated chart and guideline should be re-launched as part of 'Campaign of the Month' to help improve compliance. We saw the action plan had been put in place to achieve these recommendations.
- The trust provided us with further audits on the uptake of rubella screening, CTGs, caesarean section, induction of labour, babies born before arrival (BBA) and group and save and we saw the same robust approach to audit and the implementation of findings.
- The trust actively participated in national audits such as the National Screening Committee antenatal and newborn screening audit.
- The Morecombe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw documentary evidence that the trust had monitored its performance against the recommendations of the report and that action plan was in place to address any shortfalls identified.
- We saw that the trust used a mandatory audit system called Symbiotixs and included a catheter bundle, C.Diff bundle, documentation, falls, medication, nutrition and hydration, pressure ulcers, patient experience and transfer and discharge. All were reviewed monthly and discussed at the Gynaecology Care Meeting.

Gynaecology

- Minor gynaecological surgery was undertaken on the day unit. The expectation was that the patient went home on the day of the procedure. Patients told us they had received good care and they had been informed about their discharge home.

- There was evidence from information reviewed and from discussion with staff that the service adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4. We found that the documentation completion of both forms followed a robust process.

Pain relief

- Patients we spoke with in maternity and gynaecology felt that their pain and analgesia administration had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including Tens machines and Entonox. Epidurals were available 24 hour a day.
- Birth pools were available on the MLU and delivery suite so women could use water emersion for pain relief in labour.

Facilities

- We observed an effective outpatients/specialist clinic service with good facilities and pleasant patient waiting areas. Privacy and dignity was maintained with quiet areas available for consultations.

Nutrition and hydration

- An infant feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the important health benefits known to exist for both the mother and her baby. Their policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how they will feed their baby.
- The trust had been awarded and maintained UNICEF Baby Friendly Initiative (BFI) stage three accreditation, which is the highest level of the BFI accreditation process.
- We saw that the initiation of breast feeding rate was 65.6% in April 2015 which was below the national average of 75%. Women told us that they received support to feed their babies.
- In relation for food and drink, women were able to choose from a varied menu, which also met their cultural needs. The support staff told us that it can be difficult to communicate with patients about food and that an interpreter would be helpful. The same staff told us that if people do not finish their food, they record this, offer an alternative and inform the nurses.
- We saw that patients were helped with drinks on the gynaecology. They had three different options of drinks.
- Patients told us that food was available outside of set meal times if they did not feel like eating at set meal times.

Patient outcomes

- The maternity dashboard was the tool for recording activity and outcomes. We looked at the dashboard for March 2015 and saw that six items were rag rated red. These were the number of bookings, the numbers of mothers delivered, the caesarean section rate, the number of unexpected term admissions to the NNU, the number of formal complaints and the number of red incidents.
- Eleven indicators were rag rated amber. These included induction of labour rate, transfer of women from the MLU to delivery suite, weekly consultant hours on delivery suite, midwifery staff sickens, the supervisor of midwives to midwife ratio, booking achieved by 12+6 weeks, third and fourth degree tears, smoking rates at delivery, initiation of breastfeeding rates, and early neonatal deaths.
- Information on the maternity dashboard demonstrated the following outcomes in March 2015:
- There had been one maternal death in Quarter 4 (January- March 2015). This was recorded on the dashboard under the categories of STEIS and Red.
- We saw that the induction of labour rate was 29%, which is higher than the national average of 25%.
- The instrumental delivery rate was 8.9% in April 2015, which is below the national average of 12.9%. Of these, 4% were Ventouse and 3.4% were forceps deliveries.
- The rate of third and fourth degree tears was 3.7% which is above the trusts target of below 3%. A third-degree laceration is a tear in the vaginal tissue, perineal skin, and perineal muscles that extends into the anal sphincter (the muscle that surrounds your anus). A fourth-degree tear goes through the anal sphincter and the tissue underneath it.

- There were four babies admitted to NNU in February 2015 three of whom required intubation at birth and one required level 3 care but was not intubated at birth.
- The Caesarean section rate had increased (worse) from the previous year being 27% for 2014. For the first six months of 2015 the rate was 28%. The national average was 26%.
- The number of normal deliveries had increased (better) from the previous year being 61% for 2014. For the first six months of 2015 the rate was 62%

Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology assessment unit. A team of staff supported patients in investigative procedures, giving advice as necessary.

Competent staff

- Community midwives had been trained in Newborn and Infant Physical Examination (NIPE) and carried out this examination within 72 hours of birth. However, very few midwives on the ward were trained and this impacted on women waiting for a paediatrician to examine the baby before discharge home.
- All newly qualified midwives undertook an 18 month preceptorship period prior to obtaining Band 6.
- Appraisal rates for staff were provided for us and these demonstrated that between 86% and 100% of midwives, 100% of the nurses on the gynaecology units and 100% of medical staff had been appraised.
- We saw that there were 55 live sign off mentors who are able to confirm a student midwife's competence. Additionally there were 39 midwives who were mentors but not sign off mentors. This meant that students had adequate support to achieve the competencies required to qualify as registered midwives.
- The function of statutory supervision of midwives to ensure that safe and high quality midwifery care was provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- There were varying reports of the ratio of supervisors of midwives (SoMs). The NMC Midwives Rules and Standards (2012) requires a ratio of one SoM for 15 midwives. We saw that the midwifery report dated 1st June 2014 stated that the SoM to midwives ratio was 1:11 with 15 established SoMs and two new qualified SoMs awaiting appointment by the LSA and that this 'has the trust in a strong position'. The maternity dashboard recorded the SoM ratio as 1:17 and we were told that, at the time of our visit, the ratio was 1:19 due to retirement which was higher than the ratio of 1:15 required by the NMC. We were unable from our observations to confirm that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.

Multidisciplinary working

- We saw good examples of multi-disciplinary team (MDT) working in the hospital in both the specialised antenatal clinics and on the delivery suite. Community staff told us they had support from health visitors, GP's and social services.
- We observed staff and medical handovers where patient care was discussed and discharges planned.
- Communication with community maternity team was efficient. In the community we were told of effective multidisciplinary team work between Health Visitors, GP's and social care. The gynaecology wards and departments ensured patients discharge arrangements were appropriate.
- Medical staff reported that the relationship between them and the nurses on the gynaecology ward could be improved. They told us there was 'no verbal communication between nurses and juniors' and that 'it feels like a nurse led ward and not a consultant led ward'. Instructions, via post it notes on patient records, were left in a tray for junior doctors to action. This was unsafe as the post it could become detached from the records. We were told of pressure from nurses to discharge patients, in one instance against the instructions of the consultant.

Seven-day services

- Access to medical support was available seven days a week.
- There was a consultant on the delivery suite Monday to Friday between 08.30 and 17.00. At the weekend, a consultant was present between 08.30 and 13.00. There were always two consultants on call out of hours to cover obstetrics and gynaecology.
- The lead anaesthetic consultant for obstetrics was available for 10 sessions during weekdays, with on call cover out of hours. There was other senior anaesthetic cover for labour ward 24 hours a day.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- There was a live board for bed management on the gynaecology ward that assisted with keeping up to date with patient information and patient flow.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 10 sets of notes and saw that the process for obtaining consent was thorough and robust. Women told us that they had provided written consent for surgical procedures.
- Women told us that the doctors made the decision to induce labour and that they gave verbal consent for induction of labour.
- Staff on the gynaecology ward had a good understanding of consent when capacity was diminished. We were told and saw that there were three types of consent and that next of kin or another appropriate person could assist with the consent process.
- We saw that the procedure of consent was readdressed before going to theatre which was good practice.

Are maternity and gynaecology services caring?

Good

Feedback from people who used the service and those who were close to them was positive about the way staff treated people. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.

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

Staff responded compassionately when people needed help and supported them to meet their personal needs and those of their babies. People's privacy and confidentiality was respected. We observed nurses being gentle and caring with patients.

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

Compassionate care

- Maternity Services were added to the Friends and Family Test (FFT) in October 2013. The data was collected on a prepaid postcard or by text message. The November 2014 FFT achieved the following results:
- How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? The trust did not submit a score for this question: the national average was 95.5%.
- How likely are you to recommend our delivery suite/ birthing unit to friends and family if they needed similar care or treatment? A score of 100% was achieved which is above the national average of 97%.
- How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment? A score of 91% was achieved compared to the national average of 93%.

- How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? A score of 98% was achieved compared to the national average of 97%.
- We observed caring and compassionate interactions between staff and patients.
- We observed patients being cared for during 'comfort rounds'. Comfort rounds included changing beds, offering pressure area care and enquiring about fluids and food requirements.
- We saw that thank you cards were displayed in ward areas; an indication of appreciation from patients.
- Patients on the gynaecology wards told us that the staff were 'absolutely wonderful' and that 'nothing was too much trouble, if anyone called, they were there'.
- One patient told us of the kind, patient way in which staff cared for an elderly patient with dementia.
- The trust results were within the national averages for the CQC Midwifery survey 2013.

Understanding and involvement of patients and those close to them

- Patients told us that they felt well informed and able to ask staff if they were not sure about something.
- One woman who had her baby on the MLU told us that she had a good experience, the midwife was 'always there and was very supportive'. Her partner felt involved throughout the birth. Another woman told us that her husband 'was very involved' and that the midwife and he were 'having good chats'.

Emotional support

- Patients reported continuous one to one support during in labour.
- Women told us that they received support and reassurance from the midwives when their babies were transferred to the neonatal unit after birth.
- Midwives observed women for anxiety and depression levels. They made referrals as necessary to the mental health team.
- A specialist mental health midwife and obstetrician offered support to women. The team had links to the mental health team for on-going support and continuity. This meant that women with mental health conditions were seen in a 'one stop shop' style clinic where their needs were assessed and treatment plans developed.

Are maternity and gynaecology services responsive?

Good

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

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

There were arrangements in place to support people with particular needs.

Translation services could be arranged as required.

The complaints were investigated and responded to when raised.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly.
- We saw limited information leaflets and posters in use across the maternity service. However, the oncology gynaecology ward displayed a wealth of Macmillan (not trust) information leaflets for women with gynaecology related cancer.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and where necessary doctors. The Red Book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- There were arrangements in place that recognised women and babies with additional care needs and for referring them to specialist services. For example, there

was an on-site Neonatal Unit (NNU). We were told about and were shown the ward that would become the transitional care ward for babies that needed close observation but did not need admission to the NNU.

- Women had a choice regarding the management of miscarriage. Women could choose medical or surgical termination or expectant management and await the natural expulsion. For ectopic pregnancies the choice was either medical or surgical. Information leaflet were available to help women in making their choice in addition to discussion with staff.

Access and flow

Maternity

- The trust reported that the maternity unit had no closures between July 2013 and December 2014.
- We were told about and saw written documentation which confirmed women were supported to make a choice as to the place to give birth. This decision was made at 34 weeks and information was provided to assist in making their choice. We saw that there were specific risk factors, which needed to be considered and would lead midwives to advise a hospital birth, rather than home or the MLU.
- A Fetal Assessment Unit (FAU) provided care to women with concerns such as such as reduced fetal movements. The Maternity Triage Unit was run by midwives attached to labour ward and were allocated to the unit on a daily basis. Medical cover was provided by the on call medical team for obstetrics.
- The labour ward, triage and induction suite were managed and staffed as one unit. The triage area of six beds was situated on the same floor as the delivery suite and was staffed by midwives who were allocated to the unit on a daily basis Medical cover was provided by the on call medical team for obstetrics. We saw documentary evidence that births took place on this unit but were unable to confirm that this was due to flow through delivery suite.
- Women could be referred by community midwives, GPs or they could self-refer. Women told us that at times they had to wait for review because doctors were busy on labour ward.
- The 10 bed induction suite was also situated on the same floor as delivery suite and staffed by midwives who were allocated to the unit on a daily basis.
- Midwives were competent in examination of the newborn. However, the community midwives undertook this examination once the baby was transferred home. Women and babies with high risk needs had to be seen by a doctor which could result in them not being discharged in a timely manner.
- We were provided with documentary evidence of an increase in births following dissolution of the former Stafford Hospital. Between April 2014 and October 2014, the number of women choosing to have their babies at RWT ranged from 18 (August) to 32 (May). There was an increase to 95 women in January 2015. The trust had planned for approximately 700 more births however an estimated 850 women had chosen to give birth at RWT. The impact of this will be evident to the service in September.
- We saw evidence that 304 women had birthed at RWT in April 2014 compared to 355 in April 2015.
- Staff told us that the service was 'pressurised' and that woman were required 'to move around' the wards to free up beds. We spoke with one patient who had her baby at 06.30 that morning. It was not possible to transfer her to the ward due to capacity. She asked to have a bed so she could sleep and was taken to the pool room on labour ward where two delivery beds were stored. She remained in this room until 16.00 hours when she was transferred to the MLU. During this time, she had waited for a doctor to check her baby. She had also waited for medicines to be administered to her. Her parents had visited and had to sit on the emergency bed in the room on labour ward as there were not any chairs. We observed that the patient transported her own luggage to the MLU.
- The neonatal unit was a Level 3 unit that takes babies from outside of the trust and partnered with Walsall who transferred babies under 28 weeks gestation to the RWT. This could impact upon flow through the maternity unit and could result in women being transferred to other units if their babies required admission to a neonatal unit at birth.

Maternity and gynaecology

- Bed occupancy for maternity for Q2 2014/15 was 98.1% compared to the England average of 59.9%. This indicated that women were having longer stays in hospital in comparison to the other trusts.
- In May 2015, the trust introduced an enhanced recovery plan as part of the elective caesarean section pathway. This meant that, following preparation, women would be discharged home to the care of community midwives within 24 hours of caesarean birth.
- We were not clear about the function and use of the 'departure lounge'. We were told it was used for women awaiting discharge from the ward and the HoM told us that it was used for women waiting to go to theatre for caesarean section. However, we did not see it used in either of these ways on our visit and it remained empty despite problems with flow.

Gynaecology

- The Early Pregnancy Assessment Unit (EPAU) was open from 08.00 until 18.00 weekdays and 08.00 – 13.30 on Saturdays. It was staffed by a nursing assistant and two nurse sonographers who normally saw patients within 24 hours. Referrals were accepted from midwives, GPs, nurse practitioners and A&E.
- Women with suspected gynaecological cancers were cared for by a three specialist doctors (Gynaecology Oncologists) supported by a specialist nurse who followed women through their treatment journey.
- We were told that medical outliers on the gynaecology wards had been a challenge since July 2014 but this had resolved in the past few weeks. We saw that this matter was on the Directorate risk register and that 50 operations were cancelled since December 2015 as beds were not available.
- A discharge nurse was allocated to the gynaecology ward. We saw the use of a checklist to ensure safe discharge from hospital. The expected date of discharge was noted on live patient management system 48 hours prior to discharge. This enabled relatives to be informed, social care referrals to be made and take home medicines to be ordered. We saw that there were two delayed discharges on the day of our inspection.

Meeting people's individual needs

- Women with complex requests or needs were said to be discussed with the supervisor of midwife and a plan was then developed. We saw evidence of detailed recordings where a woman had made specific requests around the birth of their baby, which were outside of normal expectations that midwives would have.
- The trust ran a number of specialist clinics to support women with complex needs through their pregnancy. These included fetal medicine, diabetes and vulnerable women.
- A number of midwives had chosen to specialise in a specific area of practice. Many of the midwives worked with specialists to provide a link between community maternity services. Having undertaken additional training they gave additional advice and support to midwives and parents in areas such as female genital mutilation (FGM) diabetes, substance and alcohol misuse, antenatal and newborn screening, mental health, bereavement support, infant feeding and child protection.
- Partners could visit between 10 am and 10 pm. However, facilities for partners to stay overnight varied across the maternity unit. They were able to stay on the MLU. Partners were not encouraged to stay on the delivery suite or the maternity ward.
- We saw that there was a translation service both face to face or via telephone.
- The MLU promoted a 'home from home' experience, where partners could stay overnight, for low risk women who wished to have the comforts of a home birth with the added reassurance of being in a hospital. They offered a birthing pool facility, home furnishings and specialist equipment such as beans bags, mattresses and birthing balls to promote the comfort of women in labour.
- We found that women who had experienced still birth were cared for in a suite that was situated away from the main delivery suite so they and their partners could remain private and avoid areas where women had just given birth.
- The trust offered a bereavement service for parents. Two individual rooms were available with cold cots which meant the babies could stay longer with parents. This area was accessed by a lift that was situated opposite the rooms. This meant that parents did not have to

access the bereavement rooms through areas where women had babies with them. A self-contained bereavement suite was being refurbished at the time of our visit.

- A dedicated bereavement midwife had been nominated by the Stillbirth and Neonatal Death Society as bereavement midwife of the year. She was the Swan champion for maternity and ensured that the Swan symbol was used to identify women who had suffered a loss.
- We spoke with a patient waiting for a bed in the gynaecology waiting room that had restricted mobility and hearing loss. She told us that she was worried and anxious about being on the ward. She had been waiting to be seen for four hours since 7am. We asked if she would like the television on to help with the wait and she nodded. We asked a nurse to do this. We asked the staff what measures had been put in place to communicate with the patient and were told that a signer had been arranged and was usually punctual. We spoke with the patient later that morning who, although satisfied that after speaking with the doctor accompanied by the signer, did not have a communication plan in place for her post-operative stay and this was making her feel anxious.
- The same patient indicated to us by writing that she needed the toilet. She confirmed that she had not been shown the facilities. We asked the staff to assist her.
- We were told by a patient that she had requested a bath and was told by the staff on the gynaecology ward that there was not a bath on the ward due to hygiene reasons. We saw that there was a bath on the ward.
- Another patient told us that she had called her mother from her mobile phone in the night because she was unable to reach her call bell. This was close to hand at the time of our visit.

Learning from complaints and concerns

- We saw a Patient Advice and Liaison Service (PALS) information leaflet for patients informing them of how to raise concerns of make complaints.
- Initially complaints were managed locally and we were told that many complaints were resolved at this stage. If formal complaints were made, PALS forwarded the complaint to directorate managers who investigated the complaint, including asking staff to review the letter of complaint. A response letter was composed that was reviewed by the divisional manager for factual accuracy and signed off by the Chief Executive.
- We were told by a patient that she had made a complaint about her care in 2013 and that it was still not resolved. We were unable to corroborate this at the time of our visit.
- We discussed learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint. Themes arising from complaints were attitude and communication. In response to this, the supervisors of midwives led a training day based on the '6Cs'; the Chief Nursing Officer's vision for care in the NHS.
- The maternity dashboard showed that there was one complaint made in April 2015.

Are maternity and gynaecology services well-led?

Good

Overall we saw that the service was well led. The governance arrangements facilitated discussion and review of quality and safety matters, with dissemination of learning. There was oversight of quality and safety at the trust board meetings.

However we saw that leadership capacity was insufficient. The Head of Midwifery was also covering the Head of Nursing role and a matron was acting head of midwifery (HoM). We were told that the acting HoM was doing two jobs and had 'no decision making power'. Staff felt that this created a lack of direct control and that the HoM did not have direct sight on all the issues. Staff were confused as to the accountability of the current model.

There was an active maternity services liaison committee (MSLC), which met quarterly.

Vision and strategy for this service

- We were told the maternity strategy was to develop expertise in maternal and fetal medicine by offering for women with complex health conditions such as congenital heart disease, renal disease, hypertension and haemoglobinopathies.
- Staff were aware of the trust vision and values when asked about this.

Governance and risk management

- We saw that robust clinical governance and risk management arrangements were in place.
- We saw evidence that separate obstetric risk management meetings and gynaecology risk management meetings were held weekly and that new incidents were reviewed. These meetings were attended by clinical risk managers, obstetric and gynaecology consultant leads for risk and clinical nurse and midwifery managers.
- Perinatal case reviews were held to review intrauterine deaths, stillbirths and neonatal deaths. These meetings were attended by paediatricians as well as obstetric and midwifery staff to provide a full and robust review and make recommendations.
- All incident reporting forms were reviewed by the Head of Midwifery, the Deputy Head of Midwifery, clinical matrons and ward managers. Staff told us they recieved feedback if they had completed an incident reportng form.
- We saw evidence of a robust approach to investigations. Root Cause Analysis was undertaken in line with the NPSA format. We were told that when necessary parents were involved in all reviews because of the duty of candour.
- Staff told us that they recieved feedback in various ways. Specific issues were taken up with the individual. A Quality and Risk newsletter was available electornically and in hardcopy.
- We asked what was on the trust risk register and we were told and saw evidence that midwifery staffing and the on-going building works were on the register.
- There were care group meetings for each area including gynaecology that were held monthly. We saw that risk and audits were included in the agenda of these meetings.
- We were told that a management and a supervisory investigation took place after an incident and 'run alongside each other'. This is not in line with the requirements of Rule 10 of the Midwives Rules and Standards, 2012 and the recommendations of the Local Supervising Authority which both advocate sharing of investigations. Undertaking two investigations is not recommended as the impact could be onerous on the person being investigated, it is confusing for parents and supervisory investigations have not always been shared with the Trust with is contrary to the duty of candour and prevents learning from incidents.
- The contact Supervisor of Midwives met bi-monthly with the chief nurse to discuss supervisory issues.
- The projected numbers of births exceeded what was expected following the disillusion of the former Stafford Hospital. The trust estimated 700 more women may choose to have their babies at RWT and data showed this was more likely to be nearer 850 extra women and that impact would be keenly felt in the late summer. The HoM told us that the trust had collaborated with neighbouring trusts who would also be affected by an increase in births. We were informed that another Birthrate Plus® assessment was planned for September and that there were plans around the model of care that would deliver the services.
- There were agreed plans to open a further two delivery rooms in June 2015.
- We noted that there was maternity services workforce strategy in place
- We were told that on-going recruitment needed to be successful or the midwife to birth ratio would increase to 1:32. This could impact on the ability to provide one to one care in labour. The trust had agreed that the service could over recruit to accommodate people who do not take up offers of employment. 17 band six midwives had expressed interest in working at the trust and six midwives due to qualify in September had accepted preceptorship posts.

Leadership of service

- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership at ward level. For example, the maternity ward staff were enthusiastic, motivated and spoke highly of the ward manager.

- The Head of Midwifery (HoM) was covering the Head of Nursing role. A matron was acting up into the HoM role but still retained her responsibility for inpatient maternity and the gynaecology service.
- Staff told us that the acting HoM was very visible and came to the wards frequently. However, the HoM was not as visible. Staff told us that they were not sure of the whereabouts of the HoM and had not seen her for some time.
- We were told the Head of Midwifery had access to the trust board but the acting Head of Midwifery did not. The acting HoM provided information and the HoM prepared the Midwifery Report to the board. We saw documentary evidence to confirm this in the trust board minutes of 1st June 2015.
- Staff said they had access to meet the senior managers whose offices were based on the unit. We saw an 'open door' policy in operation.
- It was the staff's impression that members of the trust board were not visible.
- Eighteen staff transferred from County Hospital were supernumerary for four weeks. The practice development midwife developed a programme, which included a meet and greet session and an induction to the trust.
- Community midwives based at Cannock shared an office with admin staff. They had one computer between nine midwives and found it difficult to access emails and other documents on the trust intranet.
- Medical staff told us that the board 'do not really understand the service, particularly in relation to reducing the number of stillbirths, which a trust can never completely reduce. The medical director was 'not very approachable' and they had 'contacted the CEO once, but it was a waste of time'.

Culture within the service

- The trust promoted a positive safety culture and encouraged incident reporting.
- Staff told us that they felt valued and enjoyed working at the trust.
- From our observations and discussion with staff there was a strong commitment to meeting the needs of and experiences of people using the service. In particular midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery.
- Staff reported that a more 'punitive' approach had been noted in recent months. We were shown documentary evidence of management response to an RCA. It was identified that a neonatal registrar had not been called to attend a delivery. Staff were advised that the division wanted actions strengthened and wanted HR action to be taken against any staff who did not request the right staff to attend a birth. We noted that the Intrapartum Care Group had raised their concerns about this approach and were 'appalled and outraged that there would be a disciplinary issue for a midwife who failed to call a NNU Registrar where it was a judgement call'.
- Staff were supported to meet with parents who had suffered pregnancy loss in response to the requirements of duty of candour.

Public and staff engagement

We were told that the Maternity Services Liaison Committee (MSLC) had been re-energised over the last six to nine months. Attendance had improved and membership was more diverse than previously. We were told that the MSLC had input into the refurbishment of the bereavement rooms. However, we did not we did not see or hear of wide public engagement or efforts by the trust to involve users

- We saw minutes of the MSLC meetings held in January 2015. Three lay members attended the meeting. A standard agenda was followed and lay members had the opportunity to provide input and ask questions.

Innovation, improvement and sustainability

- Multidisciplinary training took place for maternity staff in the simulation room. This involved technical skills but also 'human factors' training. We were told that managers had 'seen changes in behaviour in response to this training'. Human factors encompass all those factors that can influence people and their behaviour. Staff corroborated that this training was enjoyable and useful.
- Robotic assisted surgery was being used in gynaecology. This method of surgery caused less pain and enabled a faster recovery for patients.

Services for children and young people

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

Information about the service

The Royal Wolverhampton NHS Trust consists of two hospital sites, New Cross hospital in Wolverhampton and Cannock Chase Hospital in Cannock. The two hospitals amalgamated in November 2014.

The neonatal unit provided seven intensive car cots, seven high dependency cots and 14 special care cots for seriously ill and extremely premature babies. The service catered for 450 admissions a year

At the time of our inspection the only dedicated services for children and young people at Cannock consisted of outpatients clinics which took place twice per week. For this reason information about the Cannock service is included in this report rather than being reported separately.

Services for children and young people include neonatal services for new born babies through to children up to the age of 18yrs.

The neonatal unit is part of the Staffordshire, Shropshire and Black Country New-born Network. Networks were encouraged by the NHS to provide peer support and encourage the spread of good practice.

In addition to medical patients the paediatric unit undertook approximately 2000 surgical procedures each year.

Summary of findings

Overall we found the service to be good.

We found that there was a reactive culture in the service which responded well after events had happened. They shared learning to prevent an event re-occurring and responded to issues which had been brought to their attention.

Similarly the Trust Development Agency (TDA) had completed a review of the paediatric ward earlier in the year, they identified 77 minor issues. We saw evidence during our inspection that all the issues had been dealt with and interventions put in place to prevent them re-occurring, but again the issues were such that proper governance and supervision should have identified.

We found that services were caring and staff were dedicated and knowledgeable.

Services were based on recognised clinical pathways which meant patients received treatment based on the latest information and best practice guidance.

Patient care was individualised and designed to meet the physical and mental needs of each patient. The service responded to people's needs.

The service needed to improve to identify failings and prevent issues occurring in the first place.

Services for children and young people

We saw instances of unsafe practice in relation to services provided to children and young people both in the paediatric day-case unit and the fracture clinic. These were escalated and dealt with immediately, but the service failed to identify the risks themselves.

Are services for children and young people safe?

Good

We found that staff had a good reporting culture when incidents had occurred staff understood the process for reporting and sharing learning.

We saw evidence of good practice in relation to keeping people safe in the neonatal and paediatric areas. However, potential risks were not always identified until external agencies such as the Trust Development Authority (TDA) or Care Quality Commission (CQC) highlighted them.

Hand hygiene was monitored, staff and patients (who had consented) were part of the 'safe hand's' surveillance programme.

Staff were supported to complete their training and had the necessary skills to provide safe care.

CQC inspectors identified and escalated two areas of concern, one in the paediatric day-case unit and the second in relation to services provided to children and young people in the main outpatients fracture clinic.

Local nursing audits were not always effective, information was collated but not always reviewed by senior nursing staff meaning opportunities to improve were missed.

There had been one never event which involved a dental surgical procedure on a paediatric patient, and four serious incidents

Consultant numbers did not meet all aspects of the Royal College of Paediatric and Child Health (RCPCH) 'Facing the Future' guidance.

Neonatal staffing did not meet British Association of Perinatal Medicine (BAPM) guidance.

Incidents

- Incidents were reported electronically on the trust's electronic reporting system. Staff understood how to use the system and saw incidents as part of the learning cycle. A healthcare assistant described how they had reported a safeguarding issue which involved completing a Datix incident report. They told us how

this had been escalated and how feedback was provided in their department by having the incident responses posted in the staff room. We visited the staffroom and saw how information including guidance on incidents and avoiding risks was posted on the noticeboards. Staff also described how incidents were discussed during handovers between shifts.

- The children's services had reported four serious incidents and one 'never event'.
- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Services for children and young people in the trust had recorded one never event between April 2014 and March 2015. The event related to a dental procedure which had been undertaken on a young person. The event was recorded under the paediatric services due to the age of the patients. We saw evidence to show that the incident had been fully investigated and the identified learning had been shared between the dental, surgical and children's services teams.
- The paediatric inpatient ward had highlighted potential risks of never events to staff. A member of the nursing staff had been tasked with highlighting the potential issues to the rest of the team. We saw how they had created a wall chart in the staff room. The chart highlighted the most likely areas within the ward which could lead to a never event occurring. The chart was colourful and drew the attention of staff to the risks and how to avoid them. We were told how the staff member who created it challenged staff about the content testing their knowledge of the risks. Staff we spoke with told us they had found this useful and managers told us that they were looking to expand the system to include other areas of learning.
- The serious incidents related to two incidents of grade 3 pressure sores and two incidents of confidential information being leaked. Pressure sores had occurred in the neonatal unit from nasal tubes rubbing against baby's skin. We were told how the management of nasal tubes had been raised within the team and best practice identified to reduce or prevent further incidents. Staff we spoke with confirmed this. Additional protection was used between the nasal tubes and babies' skin, and more frequent checks were introduced. Following these incidents a robust tool had been developed and shared with the neonatal networks. This was accepted by the network as good practice to mitigate the risk in the future.
- Mortality meetings were a regular feature of the governance of the service. All paediatric deaths were reviewed by a multi-disciplinary team to identify trends and share learning. Meetings took place every month.

Duty of Candour

- Staff we spoke with understood the need to be open and honest with patients and carers about all aspects of care including if care or treatment had gone wrong.

Cleanliness, infection control and hygiene

- We saw that the wards, corridors and public areas of the hospital were clean and tidy. We spoke with housekeeping staff in relation to their duties and how they were supervised. They explained how they had identified areas which they were responsible for. Where cleaning could not be carried out due to rooms or areas being in use, this was highlighted to nursing staff. When the area was free and available to be cleaned they contacted the housekeepers. Cleaning schedules were posted in the ward areas which allowed patients, carers and visitors to understand what work was undertaken and planned.
- Staff were trained in infection prevention and control as part of their induction and during regular mandatory training sessions.
- The paediatric ward was visited in February 2015 by the Trust Development Authority (TDA) as part of their routine monitoring. The visit identified a number of items which impacted on hygiene standards; these included such things as dust accumulating on bed frames and other surfaces. The TDA highlighted 11 action points. Following the findings an action plan was developed to address the issues. We saw how all the issues had been addressed which demonstrated the department's willingness to respond to issues, but further demonstrates their inability to identify the issues for themselves.
- Local audits of processes were not always effective. For example on the paediatric inpatient ward we saw that audits were being completed but when we asked about the analysis and learning from the audits we found that this was not always being undertaken. More senior nursing staff relied on the band six nurses who

completed the audits to raise issues with them if they found any. This meant that trends were not always identified and shared with teams. An example of this was when we reviewed the hand hygiene audit for May. We saw that it highlighted potential issues for doctors not following best practice after having patient contact. The issue had not been identified by senior nursing staff and so had not been challenged or addressed.

- The trust used a 'safe hands' monitoring system to track the movement of staff. The system enabled analysis to be completed to see when, where and how often staff had visited patients, used hand gels or washed their hands. The system worked on a distance to patient ratio which triggers a requirement for staff to clean hands. The gel and soap dispensers had monitors attached, if hand hygiene took place the system recorded this. Managers were confident that the system was effective in monitoring patient contact.
- During the course of our inspection we observed good practice in relation to hand hygiene from all nursing, medical and support staff.
- We saw that hand cleaning gel was readily available throughout the hospital and we heard reception staff reminding people to use the gel when they entered children's wards.
- Nursing staff wore aprons and protective gloves when providing care.
- There had been no Methicillin-Resistant Staphylococcus aureus (MRSA) or **Clostridium difficile** (C.Diff) outbreaks in the paediatric ward or neonatal wards for over twelve months.

Environment and equipment

- We found that equipment for paediatric patients was on the whole maintained well and ready for use. We identified two portable appliances in a store room which had expired electrical safety tests according to the test lables attached to them. However there were several similar devices available in the store should staff require them. Staff immediately labelled the out of date appliances so that they would not be used until they had been checked.
- We examined paediatric resuscitation trolleys on the paediatric and neonatal units and we saw that they were appropriately stocked with regular checks completed and recorded. Physical contents were checked on a weekly basis and trolleys sealed with tamper evident seals. Daily checks were completed which evidenced that the seals had not been broken. We were assured that if a trolley were used and the seal broken, the contents would be checked and restocked or cleaned as appropriate and a new seal applied. This meant that staff could be confident that the drugs and equipment required for emergencies were all in date and ready for use.
- Paediatric resuscitation equipment was available in other areas of the hospital such as the theatre areas. We checked paediatric resuscitation trolleys in maternity theatres, main theatres, day-case theatres. We found the trolleys were properly stocked and regularly checked. Other equipment in the department did meet the care and treatment plan needs of paediatric patients.
- There were many areas and clinics within the trust which were not specifically targeted at paediatric care or did routinely treat children and young people. One such area was the outpatients department at New Cross Hospital. In the fracture clinic we were concerned that a fire door had been wedged open which led to an open flight of stairs. There was no barrier to prevent small children reaching and falling down these stairs. When we escalated this we found the trust responded immediately to make the area safe.
- Neonatal intensive care unit was located within the maternity unit.

- We saw that systems were in place in paediatric areas to ensure patients were protected against the risk associated with improper storage, administration and management of medicines.
- Medicines were stored securely and temperature sensitive drugs were refrigerated and temperature checks were completed and recorded, which meant staff could be confident that drugs were fit for use.There had been 32 incidents of medication errors without harm identified within children's services and reported through Datix, These 32 incidents were reviewed at local unit meetings and Governance meetings by the Paediatric management team. All incidents were investigated by the appropriate manager under NP04 Policy and lessons learned and actions shared through the meetings and minutes. At the time of the inspection, Matron showed the Inspectors a designated drugs preParation room being developed with plans for

automated medication dispensing and general drugs preParation. This designated area and use of automated dispensing will reduce the number of incidents encountered.

Records

- During our inspection we checked a number of different records both electronic and written. These related to the running and governance of the children's services. Records included minutes of meetings, audit logs, risk assessments and patient notes.
- All the notes we reviewed were concise and legible.
- We reviewed a total of twelve sets of patient notes. We did this to check the accuracy of information in the ward reports, to ensure that risk assessments and care plans had been completed in line with the information provided to staff. We saw that records were clear, patient centred and reflected the needs of individual patients and where appropriate the wishes of parents or carers. Some written notes were harder to decipher which may have made the reviewing notes more difficult for staff.
- We saw evidence of patient's risks being assessed on admission and after any significant events. General health assessments, risk of falls, potential for pressure ulcers, medication risks such as allergies had all be completed and reviewed. Patient specific risks relating to individual conditions such as cystic fibrosis and other conditions had also been completed.

Safeguarding

- All staff including administrative staff had received safeguarding training in line with their role. We saw records which showed that 96% of nurses and health care assistants on the paediatric ward and 100% of nurses on the neonatal unit had completed level three safeguarding children training.Level 3 safeguarding training is provided 4 times per year specifically in each of A21 and Neonatal Unit. In addition the training is available every month as part of the rolling programme available within the Trust. Ad hoc requests for training are also provided by the safeguarding team for any members of staff requiring it.
- The trust had appointed a head of safeguarding who had recently reorganised the department and brought together all the necessary staff under one safeguarding umbrella including the adult and children safeguarding nurses, midwifery and learning disability safeguarding leads, the domestic violence lead, and the Looked after Children (LAC) nurse. This not only provided peer support within the safeguarding team but also meant that staff on the wards had easy access to advice from multiple disciplines.
- We saw examples of how incidents or concerns had been reported to safeguarding authorities for further enquiries or investigations. We saw that updates were shared with staff who had reported concerns.
- The trust had a safeguarding children declaration which encompassed all departments. The declaration was published on the trust website.

Mandatory training

- Comprehensive information was collated in respect of staff training. Matrix showed staff groups such as admin, ancillary, trained nurses, student nurses and healthcare assistants. Individual subjects which made up the trusts mandatory training were listed.

Staff and managers we spoke with all saw training as an important part of their role. Training attendance was excellent with most staff groups attaining 100% attendance on all mandatory subjects. Exceptions to 100% attendance were still well attended, for example, trained nurses on the paediatric ward had 98% attendance on information governance courses, 96% had attended paediatric life support and 89% had attended manual handling training. Untrained nursing staff had similar excellent attendance. We saw that untrained nursing staff also attended training on subjects such as tissue viability 74%, health records 71% and blood transfusion 71%. All band 5's and above have completed a degree level foundation neonatal course within 12 months of commencing in post and are progressing to the neonatal intensive care course.

Assessing and responding to patient risk

- Recognised acuity tools were used to assess patient's needs. On the NICU and Neonatal HDU babies are under continuous monitoring and assessment is undertaken. Within SCBU and for transitional care babies the NeoNews system is used to monitor and assess the babies.
- The paediatric services used systems based on recognised national best practice to monitor the health of children and identify deteriorating patients. The neonatal unit NeoNEWS was adapted from the National

Early Warning Score (NEWS). NEWS uses a number of measures to monitor patient's health including such things as heart rate and blood pressure. The NeoNEWS system was based on a traffic light system for escalation.

- Green – where all scores were within the green range; staff continued routine observations based on the patient's needs.
- Amber – If one score fell into the amber range; a midwife intervenes and additional more frequent monitoring is carried out.
- Red or multiple amber scores – Immediate medical team intervention.

This system was understood by staff we spoke with. Senior staff explained how the trust had been instrumental in rolling the system out within the Staffordshire, Shropshire and Black Country New-born Network, so that all neonatal units in the network used the same system.

- We were shown an aid memoir which had been produced for the guidance of nursing staff in children's services. The complex care aid memoir, provided prompts to ensure that consideration was given to all aspects of care and to the involvement of support services such as physiotherapy, dieticians and others. The guidance covered inpatient and home services and included details of charities to signpost people onto.
- We attended the 07.00 nursing handover on the paediatric ward. We saw how patient's needs were discussed as a team. Individual nursing staff were assigned duties for the day and guidance was provided on anticipated issues. The handover also served as a general team learning event with discussion about cases and exchange of ideas within the team. A handover form was used which highlighted issues for individual patients but also included useful information such as the named consultant for the day. The ward nurse in charge of each shift conducted a more in depth hand over in respect of patients on ward A21 and the paediatric assessment unit. This included details of social history, patients who had a do not attempt cardio pulmonary resuscitation (DNACPR) decision in place or other limitation of treatment. The handover also covered safety issues on the wards as well as general matters.

Nursing staffing

- Staffing levels on the paediatric ward were based on and in most instances exceeded guidance from the nursing and midwifery council.
- We were concerned about staffing levels in the bays being used for paediatric day surgery. At the time of our inspection there were seven children or young people in the unit which was staffed by one qualified nurse and one healthcare worker. This would have been adequate for the number and acuity of the patients; however we saw that the practice was for the nurse to leave the unit to escort patients to theatre or to collect them from resuscitation. Whilst this provided continuity for patients during what could be quite frightening experiences, it meant that the remaining patients had only a healthcare worker to see to their needs or respond to emergencies. Some patients using the unit may have undergone procedures which could lead to complications requiring urgent intervention which the healthcare worker would not be in a position to provide.
- We escalated this to the matron who explained that the correct procedure was not being followed. She told us that the day case nurse should not leave the unit until a colleague from the neighbouring assessment unit had come to relieve them, if nurses on the assessment unit were busy the day case nurse should contact the nurse in charge on the ward who would arrange cover. However there was no written procedure to explain this process to staff. Following the escalation a written procedure was created and shared with staff and an additional qualified member of staff was brought on duty to ensure there was adequate cover.
- Planned staff absences were highlighted on the electronic staffing system and offered to ward staff initially and then to bank staff. The trust did not use agency nursing staff other than for child and adolescent mental health services (CAMHS) patients who required one to one supervision by appropriately trained staff.
- Senior nursing staff told us that maintaining the right skill mix of staff was challenging particularly when staff reported sick with little or no notice. We saw evidence of how managers had maintained a safe environment for patients, an example being where no replacement was available to cover the absence of a qualified nurse, two healthcare workers were brought on duty which freed-up time for other qualified staff and ensured that all patients received appropriate care.
- The planned verses actual staffing levels were monitored by senior managers and any failure to meet

the planned levels or cases where planned levels had been exceeded had to be explained together with details of how the vacancies had been filled. For example, we saw how planned levels of health care assistants on the neonatal unit on one occasion were recorded as 174%. The explanation was given that additional staff had been used to provide one to one support and to supplement those registered staff whilst in their supernumerary period on commencement in post..

- Nurses and healthcare workers confirmed that senior nursing staff were more visible on wards when other staff were absent and would assist with general nursing duties. Senior nurses told us that they had protected time to complete administrative tasks but they prioritised patient care.
- Neonatal staffing levels did not meet British Association of Perinatal Medicine (BAPM) guidance. Staff shortages had occurred on 38 occasions during February 2015 according to the ward dashboard. During our inspection of the neonatal unit we saw that one band 5 nurse was caring for two babies in the high dependency unit side rooms. These should have been cared for on a one to one basis. On 3 June 2015 we saw that two extra cots had been placed in the High Dependency Unit increasing capacity. We did not see additional staff although the trust reported that a staff nurse had been redeployed from the childrens ward as backfill and the senior sister had undertaken clinical duties. We were advised that there had been no ITU cots available in the region and therefore nowhere else to accommodate the babies. The capacity situation was resolved with 36 hours. Staff on duty stated that this was a regular occurrence. Senior staff told us that they would not use agency staff and relied on the flexibility of ward staff and bank staff to cover vacancies. The department had a sickness rate of 3.8%. A senior member of staff said “The problem is we won’t turn babies away, how could we”.
- Following the inspection the trust confirmed they had outstanding 1.2 Band 6 neonatal nurse vacancies. The trust had a programme to attract nurses to it. Examples of which were varied training opportunities, a recruitment and retention group and rotation in the community.

Medical staffing

- Medical skill mix within children’s services consisted of 33% consultants, 2% middle career, 57% registrar and 8% junior doctors. Middle career doctors were those with at least three years at senior house office or higher grade within their chosen speciality. The national average for middle grade doctors was 7%. The trust had a higher proportion of registrar level doctors. Doctors we spoke with considered that this did not pose a problem as peer support and support from consultants ensured that patients received effective care.
- Medical staffing in the paediatric services did not fully meet the Royal College of Paediatrics and Child Health (RCPCH) ‘Facing the Future’ recommendations. The RCPCH recommended a team of ten consultants. The unit had seven full time and two part time consultants. An additional full time consultant was undergoing induction. This meant that when the new consultant had completed their induction there would still be one less consultant cover than recommendations suggested were required. We were told that recruitment was continuing and the trust had planned and budgeted for ten. One consultant we spoke with suggested that the department required 12 consultants in order to provide a comprehensive service.Consultant cover in Paediatrics was available between 08.00 and 20.00 on weekdays with plans to increase this to 08.00 to 22.00. Weekend cover was 08.00-17.00. Outside these hours there was an on-call system, which provided junior staff with support.
- Consultant cover in Neonatal unit was available between 09.00-22.00 Monday to Friday with plans to increase to 22.00 on Saturday and Sunday. Weekend Consultant cover in Neonatal is from 09.00-13.00 and on call thereafter, and night shift ward round and handover from 21.00-2230.
- We attended a doctors teaching session followed by the medical handover. The teaching session related to resource management and human factors training following this a simulation session took place. We saw that junior doctors were encouraged to take part and were supported by those with more experience.
- The handover was consultant led and included nine senior house officers or registrars. The handover was structured and included a written handover sheet which could be referred back to if required.

Major incident awareness and training

- The trust had a major incident plan which was available to staff on the intranet. Incident cards to assist staff understand their role were available in ward sisters offices.

- Nurses and health care assistants were mostly aware of the plans. One nurse we spoke with said she could not recall having had any training or information on major incidents, however they did say that they would expect senior nursing staff to take charge and direct the remaining staff in any actions. A healthcare worker told us they had been given basic details during their mandatory training. They told us they were aware that planning took place as they had been contacted at home by the trust and asked if they would be willing to be included in a list of staff who could be called out in the event of a major incident.

Are services for children and young people effective?

Good

Services for children and young people were effective.

Recognised care pathways were followed which ensured patients received treatment in line with the latest guidance.

Engagement with national audits was good with clear analysis and learning being put into practice.

Review of poor audit outcome had resulted in interventions being identified and implemented to prevent or reduce the number of new born deaths.

Evidence-based care and treatment

- We saw that pathways of care were based on national guidance using audit and benchmarking. For example neonatal services engaged with national and international audits.
  - The Neonatal Critical Care Minimum Data Set (NNCCMDS) using the Badger IT system. The data collects information on 29 individual items relating to neonatal care.
  - Neonatal data analysis unit (NDAU) The NDU aims to support UK neonatal units, networks, and NHS Trusts to improve the quality of care for newborns and their outcomes through health services support and research.
  - Vermont-Oxford, An international collaborative organisation of nearly 1,000 centers around the globe that voluntarily submit data about the care and outcomes of high-risk newborn infants. Data on over 2 million babies was used to inform and improve practice.
- We looked at how young people were cared for when they were accommodated and cared for in adult ward areas. Staff on adult wards described how they would deal with young people between the ages of 16 and 18 if they needed or wanted to be on an adult ward rather than in the paediatric ward. The practice described in each of the wards we visited was very similar. The trust had a policy in relation to admitting 16-18 year old's. However, staff we spoke with on adult wards were not aware of a policy We were told that the vast majority of young people were dealt with on the paediatric ward, and most adult areas confirmed that they had not accommodated young people for a number of years.

Pain relief

- The trust pain team provided guidance and assistance to the paediatric services in relation to supporting people with their pain relief.
- Patients and carers we spoke with during the inspection all described having had appropriate and adequate pain relief.
- Staff in the paediatric assessment unit said that on occasions they had been late administering pain relief due to the number and acuity of patients on the ward. We were given an example of a four year old child requiring pain relief following a minor operation, the nurses had been unable to access the medication and administer it due to having to provide care to other patients. This meant that the child had suffered pain and discomfort which could have been avoided.

Nutrition and hydration

- Prior to our inspection we had received some information about meal portion sizes. The information suggested that young people over 16years received portions suitable for a small child.
- We asked staff about this during our inspection and they stated that in their experience the opposite had been true and meals had often been left due to their large size. We noted that meals we saw were more than adequate for the needs of all ages in the paediatric area.
- We saw that there was a regular supply of drinks available for young people.

- Patients who required more intense monitoring had full assessments of their dietary needs and fluid and food charts were available for staff to complete if they were required.

Patient outcomes

- The trust engaged with the Royal College of Paediatric and Child Health (RCPCH) national paediatric diabetes audit. Staff explained how the outcomes had informed the trusts control of diabetes during the last three years. The national paediatric diabetes audit was based on NICE guidance which required that all paediatric diabetes patients over the age of 12 years should be screened against seven care processes. New Cross had scored well in relation to the principle measurement which was Glycated Haemoglobin screening, with a compliance rate of 99% of eligible patients screened. However, in common with many other trusts engagement with other screening methods was very low and screening across all seven NICE processes was only 20%.
- The clinical effectiveness lead in the neonatal unit outlined how the trust had introduced a project aimed at reducing the number of deaths in new born babies. The project involved admitting all women with premature ruptured membranes who were over 28 week's gestation. This was actioned regardless of bed availability.
- We saw evidence that emergency readmission rates for children under one and for children between the ages of one and 17 were both slightly higher than national averages in a number of specialities. Between October 2013 and September 2014 paediatrics saw 1.5% of elective patients and 4.7% of non-elective patients return within two days. This compared with national averages of 1% and 3% respectively. Non-elective colorectal surgery saw a readmission rate of 3% against an average of 3%. Ear, Nose & Throat (ENT) had 2% against an average of 1%. No one speciality had more than six cases of readmissions during the period.
- Local audits on the paediatric ward were not always as effective as they could be. The audits were delegated to the Band six nurses. Information was collated but was not always analysed by managers to identify trends and learning. Managers said they were confident that the nurses would highlight any issues if they found them and therefore did not review the information. When we looked at the hand hygiene audit for May 2015 we saw that one aspect of the audit had recorded that no doctors had washed their hands after having patient contact. As the information had not been escalated there had been no opportunity to feed-back to the doctors and reduce non-compliance through learning.
- We were provided with information regarding medical audits which had been completed. A total of 23 audits had been completed in acute children's services, although it was not clear from the information provided over what period these had taken place. Five of the audits were dated these were:
  - 2014-15 Local Acute Audit – Doctor communication with parents within 24hrs of admission of baby to neonatal unit.
    - Minor non-compliance was identified which resulted in the process being changed so that meetings were recorded on the electronic patient records. Consultants were tasked with overseeing doctors and ANPs to ensure the records were updated.
  - 2014-15 NICE Audit – Are newly diagnosed Type 1 Diabetes patients being referred appropriately.
    - Minor non-compliance was identified which resulted in consultation with local GP's to improve awareness and NICE compliance.
  - 2014-15 Local Acute Audit – Delegated Consent,
    - Minor non-compliance was identified in relation to parent information and consent to MRI scans. - New forms with clear information and consent details were being developed so that staff can clearly identify when parental consent had been given.
  - 2014-15 Local Acute Audit – Infections and choice of antibiotics –
    - Minor non-compliance was identified which resulted in awareness training for doctors in relation to fully documenting decisions on antibiotics on patient notes and on drug charts.
  - 2014-15 Nice Audit – Urine Tract Infections in children.
    - Minor non-compliance was identified which resulted in encouragement to all doctors to consider whether the UTI is upper/lower & whether atypical/recurrent and to document and during handover/on handover sheets, ward rounds, clinical notes and e-discharge.

Competent staff

- Staff we spoke with told us that they were supported by the trust and their managers to complete their registration and revalidation. Medical and nursing staff were required to evidence their work to show that they have maintained a proficient level of competence to continue working.
- We saw evidence that all the nursing staff on the paediatric and neonatal wards had all received an appraisal within the last twelve months.
- Junior doctors described the support they received from consultants which encouraged them to seek advice and improved learning.

Multidisciplinary working

- We saw how different disciplines worked together to provide holistic health care to young people. Diabetic services worked closely with speech and language therapists (SALT) and physiotherapy and occupational therapists.
- Transitional services were in place which ensured that young people who were approaching their 18th birthday were seen by members of adult teams when they saw their usual paediatric team. This assisted with the transfer from the children's services to the adult services so that patients received a seamless service.
- We saw guidance sheets for nursing staff which included reference to other disciplines and services with contact details for specialist staff. A member of staff explained how they had used this when they were considering what additional support a child had required. They explained how the information had reminded them of services and had made contacting them easier as the sheet contained contact numbers.
- We saw how community services were considered and involved both prior to admission and at discharge. This included liaison with schools and school nurses over the educational needs of children.
- The department had a psychotherapistpsychotherapist who was a member of the trust community childrens nursing team, they supported patients and parents or carers. Patients who required psychiatric assessments were referred to the children and adolescent mental health service (CAMHS). CAMHS services were provided by the Black Country Partnership Foundation Trust and staff said that whilst relationships were good, it was difficult to arrange CAMHS assessments due to the availability of the team. Patients who required more intensive support to keep them safe were nursed on a one to one basis.

Seven-day services

- Neonatal services were provided 24/7 with consultant cover between 08.00 and 22.00. Inpatient paediatric services were also provided 24/7. In addition the children's assessment unit and day-case units operated 08.00 to 20.00 daily.
- Out of hours consultant services were on an on-call basis. Junior doctors were very complimentary of on call consultants, they told us that consultants were always happy to assist with advice regardless of the time of day or night, and where required would turn out to provide support.
- The paediatric ward had dedicated therapies staff. Imaging services were available although the imaging services did not have a dedicated paediatric radiologist.
- We met with the clinical lead for radiology who explained that a number of radiologists had an interest in paediatrics and were able to provide imaging, however the interpretation of images was more specialised and only two members of staff one of which was the clinical lead, felt confident to review and report on images. They explained that this meant there was always a delay of several weeks for non-urgent reviews and reports.
- Normal pathways for imaging in respect of serious conditions would be referral to specialist children's hospitals such as Birmingham Children's Hospital; however we were told that referrals to Birmingham could take up to five days. Wolverhampton imaging services were able to complete such imaging but due to availability of the qualified staff, there could be a delay of up to three days. This meant that paediatricians and specialist services in the hospital preferred to wait three days and used in house services rather than wait five days for external referrals.

Access to information

- The trust used electronic patient records, which meant that information was accessible from any location within the trust.

Services for children and young people

- The trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides to policies and procedures to assist in their own role.
- Audit information was shared during meetings and copies were available in the manager's offices if staff wished to review them.
- Learning from incidents and complaints was posted on the staff room walls in addition to being discussed at meetings. This acted as a constant reminder to staff about issues which had affected patient care or welfare.
- Guidance on avoidance of risk was highlighted in the staff room on the paediatric ward.

Consent

- Consent was a high priority for staff in children's services. Parental consent was required for care and treatment for babies and young children. Children over the age of 16 years were considered to be able to make reasoned decisions about their health care, however parental support and agreement was always sought.
- Children under the age of 16 are presumed to lack capacity, but can consent to their own treatment if it is thought that they have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. Otherwise, someone with "parental responsibility" can consent for them.We saw how staff informed children what about what they were going to do and sought consent with phrases like 'is that alright' or 'shall we do that then' this showed how children were involved in and encouraged to understand and be involved in their care and treatment even when parents had consented to procedures being done.
- We observed nursing staff dealing with children both when parents were present and in their absence. We saw that nurses and healthcare workers always explained what they were doing and sought consent with phrases such as 'Is that okay?' or 'shall we do that then?', and similar phrases which meant the child had to respond.

Are services for children and young people caring?

Good

Children's services were caring.

We saw examples of how staff supported children and their families with kindness and empathy. Patients were comfortable in the presence of staff

The neonatal unit and the children's ward do not participate in friends and family test as it is not paediatric focussed. However they do undertake patient feedback by use of the parent passport in neonates, and the comments tree in both areas as well as the caterpillar in children's outpatients. The comments were found to be constructive and positive in all of these areas.

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Children were involved in discussions about their care and treatment. Parents and carers were also engaged in the process and were able to prompt and support young people.

Support was available from a psychotherapistpsychotherapist for children, carers or staff following bad news having had to be given.

Compassionate care

- We saw how staff interacted with patients and their families. We observed staff in all the children's services locations in the hospital. We saw that staff without exception were polite kind and caring. We saw many examples of staff taking time to speak with children or their parents both to explain processes but also to exchange pleasantries. We saw how children and parents were happy to be in the presence of staff and how they greeted each other with smiles and friendly comments.
- The paediatric ward had a large wall picture of a tree, parents and children had been asked to write comments on leaves and stick these to the tree. Comments included such items as "Thank you for making X (name of child) smile and looking after him", "I would like to say a very big thank you to all the staff on the ward for all the care and support they gave. They

were so helpful, caring, loving and understanding. Big hugs and kisses to you all", Children's comments included "I like playing in the playroom" and, "Staff are happy and friendly".
- The neonatal unit and the children's ward do not participate in friends and family test as it is not paediatric focussed. However they do undertake patient feedback by use of the parent passport in neonates, and the comments tree in both areas as well as the caterpillar in children's outpatients. The comments were found to be constructive and positive in all of these areas.

The paediatric areas post 'You said, we did' updates to inform parents and children of changes made as a result of the information fed back to the services.

Understanding and involvement of patients and those close to them

- Parents and carers we spoke with were very complimentary about the nursing staff and doctors who cared for their babies and children. They felt fully informed about their child's condition and the options for treatment.
- We were told that they had been able to make comments and ask questions about care and these had been explained in a way which they understood.
- We were told how even small children were involved in discussions with doctors; doctors would ask a question of the child and wait for a response before then confirming with the parents that the response was accurate. Parents and carers told us this made the child feel that their comments were important and enabled them to say how they felt about their care and treatment and how it had affected them.
- Neonatal nursing staff constantly spoke to babies as they provided care.

Emotional support

- We saw how nursing staff smiled and joked with children and their parents, parents told us that they found the calm and friendly manner of staff helped them cope with their anxiety.
- Children's services had a psychotherapist who staff were able to contact for assistance when patients or relatives or carers had been given bad news. We saw that the psychotherapists contact details were readily available. We were able to speak to the psychotherapist who confirmed their involvement and support to the ward with counselling services and signposting to external agencies.
- The paediatric palliative care system ensured that parents and carers received emotional and where wanted spiritual support.
- We spoke with the lead chaplain who explained how the team of chaplains and volunteers provided compassionate and friendly support to staff, patients and their family members and to carers.
- Chaplaincy team members made regular routine visits to all areas including the children's services; in addition they could be called by staff to attend if there were a particular need. We were given examples of how chaplains had been called to neonatal and paediatric areas to provide support for families.
- The lead chaplain explained how all the chaplains from different faiths were able to provide emotional support and how they could refer on to specific chaplains if spiritual support were required, which was outside their faith.

Are services for children and young people responsive?

Good

Children's and young people's services were responsive.

People received individualised treatment based on their medical and welfare needs. Risk assessments were completed and reviewed in relation to everyday care and treatments.

Elective services were tailored to ensure that school examination timetables were not interrupted. General inpatient services continued school activities in line with curriculum based programmes.

Interpretation services were available. Staff diversity reflected the diversity of the patient catchment area. Information leaflets were in English, with reference to alternative languages in a font size which was exceedingly difficult to see.

Services for children and young people

Guidance was available to staff regarding accomodation for children between 16 and 18 on adult wards where this was either required to meet their physical needs or requested because they preferred not to be on a children's ward.

Service planning and delivery to meet the needs of local people

- The paediatric services had formed excellent links with children's community services this included liaison with schools so that children who were admitted to the ward could continue with the same study programme as their peers.
- Transitional services for young people as they approach adulthood took account of their changing needs. Older children would have joint consultations with nursing and medical staff from adult and children's services so that they and the staff became familiar with each other. This also ensured that the patient's needs were fully understood before transferring wholly on to adult services.
- Neonatal services were centred round the family. The service had two parent's flats on the unit and a further three within the maternity block, where parents who were not from the local area could be accommodated while their child was being cared for on the unit. The children's ward haad an en-suite flat and a parents room offering drinks on the wrad. The trust advised us that there is a refurbishment programme in place to improve these facilities.
- The Wolverhampton area had a very diverse population. When we looked at information available to patients and carers, we found very little reference to foreign languages. Many leaflets had extremely small print which advised people to speak with a healthcare worker if they required the information in another language; however; we asked three members of staff to provide a foreign language version of a leaflet and only one knew how this could be sourced.
- We saw that although there were significant numbers of young people using the fracture clinic service. The trust suggested in the region of 4,000 per year; there were no child friendly areas for young people to sit and no distractions for children to help them cope with what could be several hours waiting.
- Following escalation of safety issues in the paediatric surgical day-case unit, we saw how managers addressed issues and provided staff with a written standard operating procedure so that everyone understood the procedure for qualified nurses leaving the unit. We were told by senior managers that meetings had been arranged with the theatre teams to see how the two services could link to reduce the impact for the day case nurses or to reduce the time involved in the transfers.
- In the plaster room we saw that even small children were having plaster casts removed or adjusted by staff using adult cutting equipment. Adult cutters tended to be larger, noisier and potentially more frightening to small children. We escalated this and some other safety issues in the department to senior managers. We found that the next day the department had created a child friendly area. Seating had been moved to form a barrier between adult and children's areas, child friendly frieze's had been ordered and a variety of toys and games had been purchased. The response to safety concerns had also been addressed. A child friendly plaster saw had also been ordered. This showed that children's services were extremely responsive to people's needs when they had been identified. However, we would have expected the trust to have identified these issues as part of their ongoing governance.
- When we highlighted issues in the fracture clinic in relation to the poor environment for children and young people. The trust responded immediately. Seating was re-arranged to form a children's area; wall art stickers, toys and games were purchased to help distract children during their wait.

Access and flow

- The neonatal and paediatric wards and areas were protected from the capacity issues found elsewhere in the trust. No adult patients were accommodated in children's areas which meant that staff could concentrate on their primary role.
- The neonatal ward catered for premature or sick babies. The unit had around 450 admissions each year. The unit had seven intensive care cots, seven high dependency cots and 12 special care cots.
- Parents were encouraged to help care for their babies whilst on the ward and staff supported them to do so. We were told that this process assisted with discharge as it increased parent's confidence. Discharge procedures were also supported by community based services which visited families at their home.

Services for children and young people

- The lead paediatric anaesthetist advised us that approximately 2,000 operations were carried out on children and young people each year. Of these around 200 were emergency procedures and the rest were elective procedures. Most of these children were recovered within the paediatric ward. Occasionally during out of hour's periods children were recovered in the main adult recovery area; however we were assured that during such times there was always sufficient space to enable children to be kept separate from adults. We were told that patient discharge could be delayed as a result of having to wait for discharge medication to be dispensed. Discharge medicines were known as 'to take outs' (TTO's). An example was given of a one child who was ready to be discharged at 10.00 and waited until 19.00 for the medication to arrive on the ward. Staff told us that it was not unusual for delays of four to five hours. The directorate have identified this as an amber risk following trends in incident reporting and further analysis by the governance team. As a result it is included in the issues being addressed by the medication management task and finish group. The business case for the drugs preparation room was approved and in development .Works were in progress on the ward at the time of the visit.
- Cannock hospital provided two morning outpatient clinics per week for children and young people. This enabled people in the area to engage with services without having to travel to New Cross. There were no paediactric outpatient clinics operating at the time of our visit. We did not see any provision for small children, however the trust pointed out that there was a small play area within the paediatric corridor, and distraction boxes were available in each of the consultation rooms.

Meeting people's individual needs

- Many of the patients who used the children's services had complex needs. Children were assessed for various types of surgery in the pre assessment unit, they were supported in the day-case unit and on the ward if they needed support prior to or following surgery, or for illness or injury.
- We saw that there were information leaflets available to parents and young people which explained medical conditions and in some cases provided contact details for support groups and charities outside the trust.
- Staff told us that they had access to a telephone translation service if it was required. They said that most patients and families who used the service were able to understand English even if it were not their first language.
- We saw that there was an information centre in the hospital and we took time to view a number of publications and information leaflets. We noted that all the leaflets were all in English. We were told that information was available within leaflets on how to obtain them in alternative languages. The advice suggested that for alternative languages people should ask a healthcare worker. We asked four nursing staff of varying rank if they could tell us how we could get information in alternative languages and only one was able to do so.
- The trust had a learning disability lead nurse, who was part of the safeguarding team. They were available to advice or assist staff when dealing with people of all ages who had a learning disability. Nursing staff on the paediatric ward were familiar with the additional needs which some patients required due to their disability, they were knowledgeable about how to support people and their families. We saw that there was appropriate play and learning materials for children and young people of all abilities.
- We visited the critical care unit to assess how young people were dealt with if they needed admission to the unit. We were told that the unit did not routinely take children under 16years, where this did occur the patients were stabilised and transfer was arranged to specialist hospitals such as Birmingham Children's hospital. Staff described how they used the 'Kids Intensive care Decision Support' (KIDS) service at Birmingham Children's hospital. The KIDS team provided expert advice, located suitable intensive care beds and operated a retrieval system to collect and transfer paediatric patients. This ensured that staff had the support they needed to manage children in the department until they could be transferred to a specialist unit. We were told that the department had probably one such case in the last five years.
- Young people under 18 were accommodated and systems were in place to enable those who wished to do so to visit the department to be shown where they would be cared for and the equipment which might be used, this meant the experience was far less stressful.

Services for children and young people

- We saw how educational and clinical needs were personalised to individual patients. The children's ward had its own schoolroom. Staff explained how they liaised with schools and school nurses to ensure that children could continue with curriculum based studies during their stay in hospital. We were also told that clinics such as diabetes clinics did not run during exam periods.
- Young people were sent texts or telephoned to remind them of their appointments.
- Many specialist clinics and services were provided by the trust which were not targeted directly at children and young people but which still had significant numbers of young patients. There did not appear to be a trust wide approach or guidance to ensure that processes and procedures for children and young people were uniform across all services. Some area's such as the ENT clinics did not have child friendly decoration, facilities or distractions for children. Others such as ophthalmology had toys and films to help amuse children; bright child friendly stickers were used in consulting rooms and on equipment to make items appear less intimidating.

Learning from complaints and concerns

- We had received some feedback from service users regarding poor care in the paediatric assessment unit. We saw how the trust had responded to patients comments on NHS Choices and signposted complainants to the PAL's system so that their issues could be investigated and learning identified.
- Staff told us how they tried to address any concerns of patients as they arose to prevent issues developing into complaints. We saw how complaints were recorded, investigated and feedback provided to complainants. One parent we spoke with explained how they had raised concerns about how their child had been cared for during a previous stay in the hospital. They told us that although the matter had been reported and they had been told of an investigation they had not been told what the outcome was. We spoke with senior staff about the incident. They were aware of the circumstances and the investigation which had taken place and that a senior nurse had spoken personally with the parent about the outcome. They advised that the parent must have believed that the enquiry was ongoing, and they went immediately to update them about the result.

Are services for children and young people well-led?

Good

We found that overall children's and young people's service were well-led, however some improvements were required.

There was a culture within the service of reacting to issues rather than identifying them before they became an issue.

In all other respects the service was well led. Staff understood their role and felt supported by managers.

Learning from incidents and complaints was evident.

Vision and strategy for this service

- Staff we spoke with understood their role within the organisation and how they contributed towards the overall vision of the trust.

Governance, risk management and quality measurement

- There were systems and processes in place which should have enabled the trust to satisfy itself that processes were safe, effective, caring and responsive. Local nursing audit systems did not always include analysis by senior nurses, which meant that opportunities were missed to improve services.
- Medical audits did appear to have the required level of scrutiny which enabled outcomes to be measured and tailored to reduce risk and maintain quality.There was a rolling recruitment program to recruit neo-natal nurses Therefore the management appeared reactive. This open recruitment opportunity is seen by the trust as proactive alongside other activities which the site below;
- The neonatal unit had very few vacancies when benchmarked with other services of a similar size1.2 whole time equivalent band 6 vacancies. As a proactive action to ensure retention of staff a recruitment and retention group including all bands of staff commenced approximately 1 year ago. This group has supported recruitment as required and developed a variety of

ideas to promote retention. For example. newsletters, training, staff involvement and engagement events. Supplementary evidence requested and submitted 4/8/15

- Rotation through the 3 levels and shortly to Transitional Care when the trust open an additional 14 cots from September 2015
- Rotate to Paediatrics – good for staff who are RSCN trained and want to keep up their generic skills
- Recruit NNU nurses who are also midwifery trained to practice (1 has just completed her return to midwifery and as a community nurse will also undertake mum's post-natal check)
- Rotation into Community Neonatal Team for 6/12 period
- All new starters after induction are put on the relevant NNU course – either introduction or intensive care level courses(Keele University)
- attend relevant bespoke study days
- Actively encourage staff from other units in the Black Country to spend some time during their neonatal course with us to expand their knowledge
- Recruitment and retention group set up about a year ago, led by band 6s but incorporating a band 7, 5 and 3 to get a wide range of views.
- Improved induction package, commenced newsletter to improve communication
- Raising the profile of the Unit generally

Leadership of service

- Both the medical and nursing staff told us they felt supported by their managers and believed that any issues raised would be properly represented and escalated.
- Local managers were empowered to take responsibility for their own areas and had the autonomy to make changes within their own budget limits. An example of this being the planned re-development of areas within the paediatric ward. The matron described plans to change an older section of the ward which was divided into side rooms in bay areas as bays had proved to be a better environment for the children and parents. A number of rooms had already been converted into four new bay areas which had been very popular with children.
- Senior managers understood their staff and the importance of supporting them to complete their role.

Culture within the service

- There was a culture of support and learning within children's services. Staff and managers reported incidents and used learning from them to improve services.
- We did find that there was a heavy reliance on providence in relation to issues rather than a proactive approach to prevent issues arising in the first place.
- There was a culture of reaction rather than prevention.
- The department and trust were quick to respond when incidents had occurred or when potential risks were pointed out; as demonstrated by their response to issues we had highlighted in the fracture clinic and day case areas.
- In response to the TDA findings the trust in order to monitor actions identified by staff during weekly (and ad hoc) ward manager environmental audits drew up an action planning document proforma. The aim of this proforma was to empower all staff from housekeepers upwards, to follow through items of work. Ward managers were encouraged to keep the action plans in a visible staff area to enable items to be addressed in a timely manner including in the absence of the ward manager. In the case of wards A20 / PAU / A21, each Band 6 Sister was also allocated a specific area of the department to have responsibility for, and to follow-up any outstanding actions. The documents were displayed on notice boards. Comments, rag rating and then final completion dates were added to denote the degree of completeness of each item. The proforma template was discussed at trust level and shared with all Matrons and Heads of Nursing.

Public engagement

- Children's services were very open to parent and carer involvement. Neonatal services were based on a system of assisting parents to care for their child rather than taking responsibility away. The paediatric ward supported and signposted parents and carers to support groups in the community.
- Details about the neonatal unit and paediatric services were available on the trust website together with news articles promoting good work in the departments.

Staff engagement

- Staff were encouraged to engage with the annual staff survey and results were published.

Services for children and young people

- All medical and nursing staff had access to the trust intranet and email systems. Medical alerts, news items and general information were distributed to staff through the intranet.
- Team meetings and handover sessions were used to enable open discussion and learning from incidents, complaints and compliments.

Innovation, improvement and sustainability

- Consultant numbers were being increased to enable the trust to meet Royal College of Paediatric and Child Heath (RCPCH) and National Institute for Health and Care Excellence (NICE) guidance.
- Paediatric ward planned to convert old outdated side rooms into bay areas with modern facilities.

End of life care

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

Information about the service

New Cross Hospital provided care for people who were at the end of their life and had a palliative care team who worked across the hospital and community supporting these people. From data submitted by the trust we saw there were 688 deaths at New Cross Hospital (Apr 2013 – Oct 2013). The palliative team received 937 referrals across the trust (Apr 2014–Mar 2015) 30% of the referrals were for non-cancer patients.

We inspected the service by interviewing staff, reviewing records and undertook observation over three days. We received comments from patients who contacted us to tell us about their experiences and we reviewed performance information about the trust.

During our inspection we visited several wards such as the dementia unit, acute medical unit, trauma and orthopaedic ward, gynaecological ward, haematology unit, oncology wards, care of the elderly ward, medical renal wards, respiratory ward, diabetes ward, the chapel, chapel of rest and the mortuary.

We spoke with 35 staff including nursing, medical, allied health professionals, the chaplaincy, mortuary staff and all of the palliative care team including managers. The palliative care team consisted of one whole time equivalent (WTE) specialist palliative consultant, one specialist palliative registrar, lead palliative care nurse, advanced specialist nurse, two clinical nurse specialists, 0.69 WTE rapid home to die facilitator, one band seven specialist palliative occupational therapist, two band six palliative occupational therapists and one occupational therapy assistant. The mortuary was staffed with one WTE band four. The whole palliative care team worked across New Cross Hospital and the Cannock Chase Hospital. The specialist palliative consultants also worked at Compton hospice and the outpatient's department allowing for continuity of care.

We spoke with five relatives and two patients currently using the service. We reviewed 30 patient care records and 29 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records across a selection of wards, units and recently deceased patients from the bereavement office.

End of life care

Summary of findings

Out of the 94 incidents related to the palliative team, we saw eight were in relation to low staffing levels. We noted some resulted in palliative patients not being attended to or observed as often as they required and "Care was compromised". Staff on surgical wards told us they would struggle to ensure end of life patients received the care that they needed. However, they told us that the palliative team were aware of their pressures and were very supportive.

The palliative team were not solely responsible for end of life patients but they supported the medical and nursing teams in providing specialist advice.

We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. Although improvement was needed to ensure that controlled medicines were safely and appropriately administered.

We reviewed medical and nursing paper care records and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and saw these were well completed.

The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found similarities across both sites. On both sites we found staff were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

The palliative care team had introduced a staff survey, the results identified how approachable, supportive and informative members of the team were.

The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life. Staff adopted practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) , staff returned jewellery in a small box, they were given the choice of the deceased being clothed in their own clothes rather than a disposable paper shroud and the hospital renamed the mortuary the Swan Suite for discrete communication in public areas. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information' leaflet and the bereavement feedback survey were redesigned to have the Swan logo.

The rationale for the Swan logo was to trigger a compassionate response and kind communication. All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.

We noted there was easy access to the palliative care team and they were responsive in supporting ward staff.

On both hospital sites the staff developed a 'Rapid Home to Die Care Bundle' which facilitated a rapid discharge. Staff told us they had used this bundle several times and were able to discharge a patient with a complex package of care within 24 hours.

For both hospital sites the palliative team had a clear vision for their service. The leadership, governance and culture promoted the delivery of high quality person centred care. The team displayed good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice.

We saw the culture was a positive energetic one.

End of life care

Are end of life care services safe?

Requires improvement

Out of the 94 incidents related to the palliative team, we saw eight were in relation to low staffing levels. We noted two resulted in palliative patients not being attended to or observed as often as they required and "Care was compromised". Staff noted in most of the incidents they were unable to have breaks during their shifts. Staff told us and we saw evidence that they were reporting other incidences and these were all reviewed by managers.

Nursing staff on the wards told us there were sometimes insufficient numbers of staff on duty to ensure the needs of patients were being met. Staff on surgical wards told us they would struggle to ensure end of life patients received the care that they needed. We found there was insufficient numbers of staff on duty to be able to safely reposition high risk patients correctly. Incidents in relation to this were not recorded. They told us that the palliative team were aware of their pressures and were very supportive.

The palliative team and medical team worked closely with nursing staff and regularly reviewed deteriorating patients.

We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. Arrangements for medicines were mostly satisfactory although improvement was needed to ensure that controlled medicines were safely and appropriately administered.

We reviewed medical and nursing paper care records and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records and saw these were well completed.

Incidents

- Staff reported incidents via electronic information systems, managers were clear about their responsibilities for reviewing and escalating incidents.
- No 'Never Events' had occurred within the palliative care service between April 2014- March 2015.
- The hospital implemented a system in which any incident throughout the hospital for any palliative or end of life patient could be sent and reviewed by the palliative care lead nurse as well as the responsible ward manager. This meant the palliative team were able to review incidents and monitor trends.
- From June 2014-June 2015 there had been 94 incidents reported across the trust in relation to palliative patients. All had been reviewed by managers and action had been taken in order to reduce harm to the patient and details of 'lessons learnt' were documented most of the time.
- Staff told us they received feedback, learning was disseminated through e-mails. Several staff were able to tell us about one previous incident where a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form had been completed but it had not been discussed with the family. We saw staff across the trust had learnt from this incident. Although improvement was still needed. We saw in Emergency department that five of ten sets of patient records reviewed with DNACPR discussions with family had not taken place.
- We spoke with a nurse who shared concerns that end of life patients with spinal cord compression or spinal cancer should be repositioned with three members of staff. The nurse told us only two members of staff were used to reposition these patients at night due to low staffing levels. We saw the trust policy (2014) advises staff to 'log roll' patients but does not specify the number of staff required. Policies produced by the Spinal Cord Injury Centres of the United Kingdom showed that most repositioning required three members of staff, minimum. We asked ward staff if they logged this as an incident, they told us they did not. We saw that patients were at risk of being harmed and that learning did not take place. We were told that the ward manager was aware and that it happened across the hospital due to staff shortages on the wards.
- The palliative team were able to explain duty of candour and the importance of reporting incidents. The Duty of Candour regulations require a provider to be open and transparent and follow some specific requirements such as when things go wrong with care and treatment, including informing the person and or family.

Cleanliness, infection control and hygiene

- The wards and mortuary we visited were visibly clean, bright and well maintained. In all clinical areas the surfaces and floors were covered in easy to clean materials allowing hygiene to be maintained.

End of life care

- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or whilst caring for people after death.
- Mortuary staff were clear on infection control guidelines and knew how to access hospital policies.
- Personal protective equipment, such as gloves and aprons, were available for use in all clinical areas.

Environment and equipment

- Staff across the hospital told us side rooms were prioritised for end of life patients, staff told us it was rare to have a patient dying on an open ward. The families that we spoke with confirmed that they were offered a side room in a timely manner.
- All equipment in use had been maintained and staff were able to describe the process of reporting faulty equipment.
- The trust used McKinley T34 syringe drivers to deliver consistent infusions of medication to support end of life patients. Staff told us were readily available across the hospital, were regularly calibrated and tested by the medical devices team.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. CCTV was evident in all areas in the mortuary although cameras were not used in the fridge storage area to maintain the dignity of the deceased.
- We saw the mortuary had been recently refurbished and had a range of fridge sizes from bariatric patients to babies.

Medicines

- We reviewed 20 medication administration records across the wards and units inspected and found these were consistently well completed. We were told by staff on the wards we visited that medication for end of life care was available on the ward. For medication that was not commonly used on the wards this was available within two hours from pharmacy.
- Through reviewing records we saw evidence of effective symptom control for patients that were at the end of their life.
- We saw evidence that staff adhered to guidelines of anticipatory prescribing medication, required to keep patients that are end of their life comfortable and pain free.
- From data submitted by the trust we saw 85% surgical staff and 81% of medical staff had been trained in using syringe drivers, we noted the trust target was 95%. We were told by nurses that the palliative team were supportive if they required any assistance with syringe drivers.
- The palliative team developed an annual syringe driver audit (February 2015) in which they checked the correct and safe use and documentation of syringe drivers. We saw any learning points were fed back to ward managers and e-mailed to nursing staff.
- Staff told us they accessed the Adult Medical Guidelines & Palliative & End-of-Life care department guidelines which provided them with guidance on when to prescribe anticipatory medicines.
- We noted that controlled drugs (CD) were handled appropriately and stored securely demonstrating compliance with relevant legislation on all wards except for one oncology ward. On Deansley ward we found some controlled drugs had been packaged and supplied by pharmacy as individual strips placed inside clear bags. We noted that two controlled drugs did not have a batch number or expiry date displayed because they had been cut off the end of the strip. It was therefore not possible to determine if the controlled drug was safe to be administered. We also noted that one of the clear bags had no label because it had fallen off. Labelling of medicines helps to ensure that the correct medicine is selected to use it safely and therefore help to minimise medicine errors. We raised this to the attention of the trust during inspection.

Records

- We reviewed 30 medical and nursing paper care records which included doctor's notes, plans of care and reviews, comfort round charts, food and fluid balance sheets, risk assessments, syringe driver administration charts and a range of care plans.
- Some records were completed electronically and staff had systems in place to remind them to assess patients' pain and vital observations. Observational charts were consistently completed.
- Nursing care plans for all patients including end of life, lacked detail and did not reflect patient's preferences as they were all a standard template and all read the same. They were not personalised or person centred.
- Medical staffing records were consistently detailed and gave a good holistic overview of the patient during every review. We found that patients nearing the end of the life or palliative were frequently reviewed.

End of life care

- Records lacked evidence that families were always kept informed and updated about the patient's care. We spoke with two relatives who told us they had not been kept informed or updated in several days. The palliative team were aware of this issue and told us they would often prompt staff to contact the family and told us sometimes communication was 'reactive' not 'proactive'.
- The Liverpool Care Pathway documentation had been removed as recommended by relevant guidance. The hospital were in the process of piloting 'The Swan' project as a care planning tool and guidance for patients in the last few days of life. Some staff had been trained to use the documentation and implement the scheme, only a small amount of staff had trialled it so far. The wholescale roll out of the project was set for December 2015. However mostly all staff were able to tell us the aims of the project and how to identify someone for the Swan Project.
- We reviewed 29 DNACPR records and found these were consistently well completed. Staff ensured they documented whether the patient had capacity to be involved in the decision making and discussions with families were documented. DNACPR records had been signed and dated by appropriate senior medical staff. Discussions with families were documented in the medical notes as well as the patients preferred place of dying.

Safeguarding

- Safeguarding policies and procedures were in place. Staff understood their safeguarding responsibilities and knew what to do if they had concerns; 76.1% (trust wide) of staff had completed standard safeguarding training and 82.1% of staff from the medical division in which palliative team sits. We found evidence that staff were confident in having sensitive discussions around safeguarding issues with families and patients near the end of their life. We were given examples where staff had acted appropriately.

Mandatory training

- The hospital had a program of mandatory training for all staff, the palliative team were 100% compliance with their mandatory training.
- End of life staff training was not mandatory for all staff groups across the hospital however we saw considerable measures had been taken to train all staff on the new end of life project 'The Swan'. As from May 2015, an end of life care and bereavement study day was being held monthly which would be available to all hospital staff.

Management of deteriorating patients

- Ceilings of care were identified and shared with all the staff involved in their care and treatment. Therefore interventions which control symptoms would always be offered, but more invasive treatment would not be offered.
- Early Warning Score (EWS) observations were monitored for patients and we saw evidence of staff responding to deteriorating patients.
- Risk assessments were in place for patients, and where these directed additional support it was provided.
- The palliative team and medical team worked closely with nursing staff and regularly reviewed deteriorating patients. We were told nurses were very good in escalating any concerns or developments in the patient's condition with the team.
- Nursing staff told us the palliative team would be there immediately to support them if need be. Staff gave us examples of when they needed further support and told us the palliative team were 'Excellent and very supportive'.

Nursing staffing

- The palliative care team consisted of one whole time equivalent (WTE) lead palliative care nurse, one WTE advanced specialist nurse, two WTE clinical nurse specialists, 0.69 WTE rapid home to die facilitator, one WTE band seven specialist palliative occupational therapist, two WTE band six palliative occupational therapists and one WTE occupational therapy assistant. The mortuary was staffed with one WTE band four.
- The team told us they were currently well staffed however to ensure the sustainability of the continual development of the service and the addition of community hospital services they would require staff at the community sites and were putting forward a business case to increase staffing provision.
- Nursing staff on the wards told us there were sometimes insufficient numbers of staff on duty to ensure the needs of patients were met. Staff on medical wards told us they were able to prioritise patients at the end of their lives to ensure their needs were met. Staff on surgical wards disagreed with this and told us they were unable

to prioritise end of life patients and would struggle to ensure they received the care that they needed. They told us that the palliative team were aware of their pressures and were very supportive. They would sometimes move patients to a more well-staffed area to ensure end of life care was not compromised.

- Out of the 94 incidents we saw eight were due to inadequate staffing levels. We noted two resulted in palliative patients not being attended to or observed as often as they required and 'care was compromised'. Staff noted for most of the incidents they were unable to have breaks during their shifts.
- From risk registers submitted by the trust we saw 'inadequate staffing levels, seven vacancies on the oncology ward for June 2015 which has led to increased sickness levels and low morale.

Medical staffing

- The palliative care team consisted of one WTE specialist palliative consultant with links in the community and one WTE specialist palliative registrar. They did not use any locum staff but were looking at expanding their team. We saw the registrar had regular support and feedback from the consultant on a weekly basis. The registrar had told us it was the best out of three other end of life care placements due to the level of support and encouragement to develop skills, expertise and advance learning.
- The two specialist palliative care consultants also worked at Compton Hospice (inpatient and community) and the hospital outpatient's department allowing for improved continuity and management of patients who were using more than one of the services.

Major incident awareness and training

- Staff were aware of the major incident and the business continuity policy, and understood their roles and responsibilities within a major incident.
- There was clear advice and guidance for mortuary staff regarding a major incident within the policy.
- Staff told us about the mortuary's capacity escalation procedures and noted there was enough for 124 deceased patients and had space for a portable refrigeration unit as well as an additional capacity at other mortuaries.

Are end of life care services effective?

Good

We saw measurements had been taken to work on performance indicators and improve the effectiveness of the service. Within the National Care of the Dying Audit 2013 improvements were required and action plan was produced and as a result the Swan Project has been introduced.

We saw that anticipatory medications were prescribed for all patients who were palliative or at the end of their life.

The hospital did not audit the percentage of preferred place of death so they could not be certain of the exact amount of patients that die in their preferred place. Although we saw this was appropriately recorded in the medical notes from the 30 care records that we reviewed. Two out of the five families we spoke with told us these discussions had not taken place.

We saw staff trust wide were well engaged with education and training programs around end of life care and it has taken a priority to ensure the care of patients and families is enhanced.

Palliative care multidisciplinary team meetings were held weekly. Staff told us they had good links in the community for example with coroners, hospice staff, funeral directors and religious community representatives.

DNACPR forms were appropriately completed but capacity assessments were not always completed where appropriate.

Evidence-based care and treatment

- The palliative team worked across both New Cross Hospital and Cannock Chase Hospital so we found that evidenced based care was the same across both sites.
- Following an independent review the Liverpool Care Pathway was discontinued across England by July 2014. The pathway was associated with poor experiences of care because of a lack of tailored, personalised care. The hospital were aware of this and had removed all documentation in relation to the Liverpool Care pathway.
- On reviewing the National Care of the Dying Audit (Hospital) (NCDAH) (2013-2014) results, the hospital was not meeting six out of seven the organisational key

performing indicators (KPIs) and five of the ten NCDAH clinical KPIs such as :- access to information relating to death and dying, access to specialist support for care in the last hours or days of life, care of the dying: continuing education, training and audit, the hospital board did not have a representative, plans were not in place for a formal feedback processes regarding bereaved relatives/friends views of care and clinical protocols were not in place promoting patient privacy, dignity and respect up to and including after the death of the patient. They were meeting the clinical protocols for 'the prescription of medicine for the five key symptoms at the end of life' performance indicator. They did not measure continual progress of improvement since the results of the audit however did develop action plans.

- The Palliative & End-of-Life Care Strategy 2015 addressed areas for improvement and the direction for the service. We saw measures had been taken to correct performance indicators and the hospital had registered for this year's NCDAH audit to see how well they were meeting the targets. We saw leaflets had been developed as a part of the 'Swan Project' to improve the KPI 'access to information relating to death and dying'. We saw considerable steps had been taken to train all staff trust wide in the new Swan Project and specific training for ward staff to improve the KPI 'care of the dying: continuing education, training and audit' and promoting patient privacy, dignity and respect . We noted the board now had a representative and had supported the team in implementing the Swan Project trust wide. The team were currently implementing a more formal feedback processes regarding bereaved relatives/friends views of care and sending out more detailed surveys and comment cards.
- The palliative team were in the process of implementing the Swan Project at both hospital sites as a care planning tool and guidance for patients in the last few days of life.
- Staff adopted the award winning practices of the Salford Royal NHS Foundation Trust such as: the Swan logo being placed on the curtains or the door of the side room to alert staff to be mindful, relatives were given canvas bags with the Swan logo with their relative's belongings as oppose to a plastic bag, staff offered families of end of life patients keepsakes such as photographs (of hands) and handprints, locks of hair (taken discreetly from behind the ear and presented in an organza bag not as previously in a brown envelope) , staff returned jewellery in a small box, they were given the choice of the deceased being clothed in their own clothes rather than a disposable paper shroud and the hospital renamed the mortuary the Swan Suite for discrete communication in public areas. Literature on both hospital sites had been updated and rebranded such as: the personalised care plan, the 'practical information' leaflet and the bereavement feedback survey were redesigned to have the Swan logo.
- The rationale for the Swan logo was to trigger a compassionate response, kind communication and respectful care from any staff member. The logo on canvas bags or outside the doors alerted staff to the presence of dying/deceased patients and identifies the relatives throughout the hospital if they are seen carrying the canvas bag and the logo on the door/ curtain was aimed at triggering a calm and respectful environment on the wards.
- All staff at New Cross Hospital and Cannock Chase Hospital were aware of the project and had recently started the project for the past few patients. During the inspection we found the scheme to be in its infancy stages although all staff were fully aware of the project, what to do and how to implement it should they be caring for a dying patient.
- Despite not having a specific personalised care plan since the removal of the Liverpool Care Pathway 2014-April 2015 we saw staff still adhered to the recommended five priorities of care such as: - recognising that the patient may die within the next few days, decisions made and actions taken in accordance with the person's needs and wishes, sensitive communication had taken place and patients and families were involved in decisions about the care.
- The Priorities of Care for the Dying Person were published in June 2014 by the Leadership Alliance for the Care of Dying People. Taking the five priorities to recognise, communicate, involve, support, plan and do, the SPCT had developed a personalised care plan for each patient in the last days of life with guidance for staff of how to best meet the five priorities of care. The implementation of the Swan provided the means to address the recommendations of the National Care of the Dying Audit and fulfil the requirements set out by the National Leadership Alliance for the care of Dying people.

End of life care

- As recommended from the five priorities of care, we found that care notes included food and drink charts, symptom control was regularly reassessed by medical staff and psychological well-being was assessed often. However it was not always clear spiritual support had been assessed.
- Staff developed guidelines where no national guidance existed, for example with the use of the medicine naloxone when given to palliative care patients to combat the side effects of too much pain relief such as respiratory depression.
- The palliative care consultants engaged in research trials such as:- the hydration in the last few days of life feasibility study and a multicentre randomised controlled trial to assess the impact of regular early specialist palliative care treatment on quality of life in malignant mesothelioma.

Pain relief

- Patients we saw appeared to be comfortable and pain free. When we spoke with family members they confirmed their relatives were pain free.
- The hospital scored 10% worse than the national average for the prescribing of anticipatory medication (NCDAH) (2013-2014). However they were meeting the clinical protocols for the prescription of medications for the five key symptoms at the end of life performance indicator.
- From the 30 care records we reviewed we saw patient's suffering ongoing pain did not have pain care plans in place. Their symptoms were controlled and were regularly reviewed by staff using medication charts and risk assessments. For patients who were on the electronic care record assessments we saw pain was consistently assessed every 12 hours. However, patients who were at the end of the life and were not on the electronic monitoring system did not have an assessment in place to formally record their pain scores.
- We saw that anticipatory medications were prescribed for all patients who were palliative or at the end of their life.
- Out of the 94 incidents only one incident was related to a delay in pain relief for patient receiving end of life care. We saw the patient had been assessed as being in mild pain for a short period of time and the family was informed.

Facilities

- All wards had side rooms which could be used for patients who were dying. Staff in all areas told us they always ensured patients were moved to a side room if they were in the last days of their life and understood the importance of providing the patient and family with privacy.
- Mostly all wards had a 'quiet room' in which staff were able to use if they needed to have private discussions with families such as, breaking bad news. We saw some of these rooms had clutter, staff told us there was plans in place to improve on this and redecorate some of the rooms more appropriately. On the critical care unit we were told the 'quiet room' was through the relative's room. This meant distressed or upset relatives had to walk through a room of other relatives before going through to the 'quiet room'. Staff on the critical care unit were aware that this was not ideal. Rooms were available throughout the hospital for families to stay overnight.
- The mortuary (Swan suite) had recently been redecorated and had a quiet room which had tea and coffee making facilities, soft furnishings, a viewing area and brightly painted walls. The mortuary staff thought this was an excellent facility to be able to support families and allow them to take time with their relatives. They gave us examples of how families would gather and make good use of the area. This was an improvement following the last CQC inspection (2013).

Nutrition and hydration

- The NCDAH (2013-2014) demonstrated that the hospital was worse at achieving the KPIs for reviewing patient's nutritional requirements and reviewing patient's hydration requirements by 5% less than the England average.
- We found evidence that patient's hydration and nutrition needs were assessed.
- Where appropriate, patients were seen by dieticians, we were told new dieticians were supported by the palliative care team and they would discuss what was appropriate and what was not for a patient in the last days of their life. Intravenous fluids were prescribed by medical staff where appropriate in order to keep the patient comfortable. Staff told us they would discuss this with families beforehand.

- Staff were aware of how to keep patients comfortable and had recently implemented the idea of using the patient's favourite drink on oral swabs as oppose to using chlorhexidine mouth wash which can be an unpleasant taste for some patients.

Patient outcomes

- At both New Cross Hospital and Cannock chase we found the hospitals did not audit the percentage of preferred place of death so they could not be certain of the exact amount of patients that die in their preferred place. Staff told us they recorded it in the Somerset software but did not review it. We saw this was also well recorded in the medical notes from the 30 care records that we reviewed.
- It was evident from the care records that if the person wanted to die at home it was a priority for staff and was continually reviewed and discussed with families. Although two out of the five families we spoke with told us these discussions had not taken place. We saw the hospital needed to be consistent in ensuring these discussions took place.
- The NCDAH (2013-2014) demonstrated that the hospital achieved the KPIs for:-staff communicating with the patient and their relatives regarding their recognition that the patient was dying, a review of the number of assessments undertaken in the patient's last 24 hours of life and communication regarding the patient's plan of care for the dying phase.
- The palliative team conducted a service evaluation of the syringe driver prescriptions (January 2015). This identified that prescriptions were not meeting recommended standards and therefore a supplementary prescribing document (syringe driver prescription template) had been created in an attempt to improve prescribing practice.

• Staff conducted an audit for monitoring for steroid-induced diabetes in cancer patients (March 2015). The aim was to determine whether the Hospital Diabetes in Palliative Care guidelines were being met. We were told no patients met the management of steroid-induced diabetes guideline criteria and therefore changes were implemented as per the guideline after guidance from the oncology & haematology directorate audit meeting in March 2015.

- The bereavement office presented their quarterly audit results at the mortality meeting and feeding back how responsive doctors were at completing death certificates and if the doctor has documented discussions with the consultant.

Competent staff

- Members of the palliative care team were qualified to meet people's needs. Documents supplied by the trust indicated that every member of the team was qualified to degree level and some completed master's modules. One had completed the non-medical independent prescriber's course, one had a certificate in counselling, one had completed level two psychology training and all had completed advanced communication skills training in 2010.
- We saw evidence from the specialist palliative care work programme June 2015-June 2016 of ongoing continual professional development and identified training needs for the team.
- The palliative care team provided some training for medical staff in addition to the medical university training course. Medical staff had bi-annual palliative care teaching as a part of the foundation trainee course, core medical training programs and had regular contribution to the oncology and haematology junior doctor teaching programs. Other training for specific staff groups included management of opioids training to respiratory staff, oncology and haematology medical teams and DNACPR training for GPs.
- Staff had developed E-learning packs for use by GPs which was designed for sharing clinical learning from the acute into the community.
- The nursing development programme; new starter induction training included: - end of life care teaching in practice, breaking bad news e-learning and we were told a bespoke teaching programme could be arranged according to development needs identified by line managers. Overseas nurses received an introduction to end of life care.
- The palliative care team had implemented the use of 'Swan Champions' on every ward to ensure there was a palliative link in most areas whose responsibility would be able to disseminate information and learning to staff in their area.
- The mortuary staff had supported the palliative team in developing and delivering training, they had recently started to develop a package to educate student nurses.

End of life care

- We were told a 'Rapid Home to Die' education and training program was currently being rolled out hospital wide. A 'Gold Standard Framework in Acute Hospitals' education and training program had been and continues to be rolled out on the two wards involved in the pilot project.
- The bereavement office staff participated in study days from funeral directors on customer service communication and supporting families. Three out of the six staff had attended this year and the other three staff were due to attend next month.
- The palliative care team told us they had regular annual appraisals.

Multidisciplinary working

- Palliative care multidisciplinary team meetings were held weekly these were attended by the palliative care team, the chaplain, social workers, allied health professionals and medical staff. We saw the team developed an audit to monitor how many meetings took place and a quarterly audit of attendance from all staff, for example we saw the chaplain attended 68% of meetings. They reviewed and discussed complex patient cases.
- All staff throughout the hospital team felt the multidisciplinary team working was excellent and they felt that the palliative team were very supportive.
- The palliative team communicated changes, updates and disseminated information to staff via senior managers briefing, the band seven and eight nursing forum, the 'Grand Round', palliative intranet page and 'all users bulletin' board.
- All palliative consultants from the local areas local areas met weekly to discuss new matters and share good practice.
- Staff told us they had good links in the community for example with coroners, hospice staff, funeral directors and religious community representatives.

Seven-day services

- The palliative team worked 8.30 -17.30 Monday to Friday and had an out of hour's system in place for staff wanting advice, across both sites. The hospice had a telephone advice system in place and local palliative consultants worked a rotation to ensure there was always a consultant available for advice. The hospital consultant told us they liaised with the team if they were concerned about anyone over night or weekend and can handover to out of hour consultants should they need to.
- The trust were aiming to open a seven day service but did not currently have formal plans in place.
- The mortuary were supported by the pathology team who managed the area in their absence. Porter staff were trained to be able to manage the mortuary out of hours. Systems were in place which ensured the safe running of the area whilst the mortuary staff were not present.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A current mental capacity assessment tool was available at the hospital via the intranet and the palliative team told us it had clear guidance on how to complete the forms. However, we reviewed the notes of four end of life patients that lacked capacity, we did not see any capacity assessments.
- We found that medical staff consistently assessed capacity with either a 'yes' or 'no' recorded on the DNACPR forms. According to the trust's policy on completing DNACPR's, the capacity assessment is to be recorded in the clinical notes. When asking staff they were not always able to locate this. We only found nine capacity assessments out of the 29 DNACPR notes reviewed.
- During our visits to the wards we saw and heard several occasions when staff sought the consent of patients before an intervention.
- We found staff were knowledgeable about deprivation of liberty and where appropriate deprivation of liberty assessments were completed with a multidisciplinary approach and families were involved.

Are end of life care services caring?

Good

Summary

We saw the 'keep sakes' as a product of the Swan Project were cherished by relatives. All relatives we spoke with as well as the palliative team confirmed all palliative patients

were checked regularly by ward staff, ensured they were comfortable, had the call bell to hand and appeared well presented at all times. However, one patient told us staff would talk over them when providing care.

Relatives we spoke with mostly felt well informed. One relative told us medical staff maintained good continuity of care and communication.

Compassionate care

- The Royal Wolverhampton NHS Hospital specialist palliative care team user satisfaction survey (March – May 2015) feedback was positive. Two individuals commented that it would have been beneficial to have had help and support from the team earlier in the admission; comments were anonymised so the team were unable to conduct a review into the comments. We saw from the 18 surveys received 15 had written very positive remarks about the staff such as: "Professional", "Wonderful", "Polite", "Answered all my questions", "Gave reassurance", "Considerate" and "Relaxed (atmosphere) and able to speak freely (with staff)".
- As part of the end of life Swan Project relatives were offered 'keeps sakes' of their relatives which included a lock of hair, handprints and photographs. When asking staff how successful this had been they told us families loved it and thought it was an excellent idea. One family told us they thought this was 'Priceless'.
- Within the Swan Project the palliative team had introduced a symbol that was used across all clinical areas to identify patients who were receiving end of life care. Privacy was maintained by keeping the curtains drawn if requested by the patient and or family and the Swan logo would be placed on the curtains to indicate an end of life patient was being nursed in the bay.
- The two palliative patients we spoke with told us that the staff were kind to them at all times.
- One patient told us staff would talk over them when providing care and told us they felt this was inappropriate.
- Relatives told us they thought it was caring that they could spend as much time with their loved one as possible.
- We were told how care after death was of a very high standard and the mortuary staff would ensure the person's dignity was maintained during the care. Mortuary staff gave us examples of assisting a mother dress her small child in clothes that the mother had picked out. The mortuary staff supported her through a difficult time and allowed her to take her time with the child and utilise the Swan suite. We could see the mortuary staff were very passionate about delivering a high standard of care after death.
- One staff member told us they had received a letter from a family thanking them for the dignified death of their relative and for being so caring.
- Staff across both sites told us they gave palliative patients their favourite drink in order to keep their mouth moist as opposed to mouth wash. Staff told us they had ordered cider for one patient.
- Staff gave us an example where the family had arranged with the ward to bring their pet to the discharge lounge after it had closed and staff facilitated this just before the person passed away.
- Staff explained how access to the mortuary was planned and ensured the dignity of the deceased. We saw the patient's privacy was maintained throughout the journey and transfer.

Understanding and involvement of patients and those close to them

- We saw in the notes that discussions with family members took place. Relatives we spoke with mostly felt well informed. However, we spoke with two families who said that communication needed to improve, and they did not feel well informed despite asking nursing staff if they could speak to the medical staff. One family told us none of the staff had updated them in the past week and they had requested to speak to the medical staff daily. We raised this to the nursing staff who told us they forgot to tell the medical staff. Medical staff responded immediately.
- One family told us that that the conversation around DNACPR was dealt with in a sensitive manner and they were taken to a private room to have the discussion which they appreciated.
- One relative told us they had seen several medical staff during their relatives care and treatment and felt that the doctors maintained good continuity of care and communication. We found the medical staff record keeping supported this process as it was consistently very detailed and holistic.
- One patient who was on the trauma ward told us the staff were very busy and they felt as though they had to wait a long time until someone came. They were upset and felt as though they were a burden on staff. We

raised this with the deputy ward manager who agreed they needed more staff. They told us they were not able to give the patient the attention they wanted to and had little time to sit and talk with them. Staff told us the palliative team were very supportive and would give attention to the patient. The patient had not been identified as needing further emotional support or counselling.

Emotional support

- We found one example of the patient not being emotionally supported. Within the 30 care records we reviewed we did not see any evidence of staff emotionally supporting palliative patients. The palliative team told us that improvements were needed to emotionally support patients on the wards. Within the care records we saw several patients suffered with anxiety and this was dealt with medication. The records lacked the details of how anxious the patient was and how often the anxiety was assessed and if they needed additional emotional support.
- The palliative team told us for cancer patients which consisted of 70% of the palliative patients, a clinical psychologist was available.
- We also saw that pre and post bereavement counselling was available for patients known to Compton Hospice.
- The mortuary staff were experienced in providing emotional support for families. We saw the staff had been recognised by the trust and won an award for compassionate care. The mortuary staff told us they would accompany deceased patients to funeral directors if they did not have a family member that would do so. They would ensure everything was seamless and the dignity of the patient was maintained.

Are end of life care services responsive?

Good

Patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available allowing for privacy. Death certificates and cremation forms were completed in a timely manner.

No religious symbols were in place throughout wards, quiet rooms or in the mortuary. Staff showed sensitivity and awareness to the different cultural, religious and spiritual preferences of patients they cared for.

The Swan logo was placed either outside the door of a patient receiving care in a single room or placed on the curtains or above the bed. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible. The Swan canvas bag highlighted to all staff across the trust that the relatives have suffered a recent loss and may require extra support.

We noted there was any easy access to the palliative care team and they were responsive in supporting ward staff. Staff developed a 'Rapid Home to Die Care Bundle' which facilitated a rapid discharge. Staff told us they had used this bundle several times across both hospital sites and were able to discharge a patient with a complex package of care within 24 hours.

The bereavement services had started to send out comment cards to all families with a freepost address to encourage feedback. The service also sent out a survey 6 weeks after death. We saw feedback from one person who said the bereavement office were helpful in providing information and said they were very grateful. Although we reviewed two complaints about insensitive/poor staff attitude towards patients at the end of their lives on two different wards and saw neither ward manager documented any lessons learnt or actions taken.

Service planning and delivery to meet the needs of local people

- There was no dedicated specialist palliative care ward across the trust. People reaching the end of their life were nursed on the main wards in the hospital. As part of the end of life plan those patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. This allowed for privacy. Almost all wards told us they always had the capacity to move a dying patient into a side room if they were not already in one. All relatives we spoke with told us they had been offered a side room and when they accepted this was organised immediately.
- We spoke with staff at the bereavement office which was on site and mainly dealt with registering a death. We found the bereavement office had systems in place if they were unable to reach a doctor to complete a death certificate. Staff told us they rarely need to use this pathway but when they did it was effective. They told us most of the doctors filled the forms in immediately and waiting over 24 hours was rarely an issue.

End of life care

- Cremation forms were filled in the same day of the death certificate to ensure they were given to the families in a timely manner. If staff were unsure if the person wished to be cremated and were unable to get a hold of the family the doctor would complete the forms and if they were not needed they would be discarded of appropriately. We saw this was also responsive in meeting the needs of the family during their difficult time.
- The palliative team were able to provide us with their demographic figures, most all of their patients were white British and 70% were cancer related deaths. The team were aware of the need to monitor these figures to ensure they were able to provide the correct care that met the needs of the local people.
- The palliative team were acting and responding to new referrals in a timely fashion with 95% of new referrals being seen within 24hours across both hospital sites.
- The 'Rapid Home to Die' audit (November 2014) which was collated prior to its implementation. The results showed that although a majority of patients (79%) have a ceiling of care documented, only 29% of these had discussions regarding their preferred place of care at the end of life, or their specific wishes regarding their end-of-life care. Of the 25 patients that were audited 25% had a discharge process commenced, none of which had a successful discharge. The rapid home to die care bundle was then implemented. We were told the audit was due to be repeated.
- The palliative team contributed to a Clinical Commissioning Group (CCG) and led the end of life care strategy group which reviewed their compliance with NICE and looked at areas where they needed to better plan and deliver the service to better meet people's needs.

Meeting people's individual needs

- Across both sites, staff told us they displayed the Swan logo which was placed either outside the door of a patient receiving care in a single room or placed on the curtains or above the bed. This would alert staff to be considerate to the needs of the patient and family at this difficult time and keep the atmosphere as calm as possible.
- The Swan canvas bag was also available trust wide. This highlighted to all staff that the relatives have suffered a recent loss and may require extra support. It was more dignified to receive the deceased patient's belongings in this way rather than in a plastic bag. Staff thought this was a great idea in identifying relatives throughout the hospital.
- The chaplain services showed us their multi-faith spiritual care assessment. This assisted the staff in identifying the patient's spiritual needs. The chaplain told us they had good links in the community with a variety of religions and faiths to be able to cater to the needs of patients. Ward staff had cultural awareness training. Throughout records we noted that the spiritual needs questions in assessments and care plans were often left blank and were not completed by ward staff.
- No religious symbols were in place throughout wards, quiet rooms or in the mortuary on either hospital site. Staff showed sensitivity and awareness to the different cultural, religious and spiritual preferences of patients they care for. They were able to explain procedures for caring for patients with different religions and how they adapted the care accordingly.
- Patients were discharged with their syringe drivers in place to avoid any gaps in delivery of medicine and pain relief.
- We saw that patients who were living with a cognitive impairment had a 'This is me' document in their nursing notes. This enabled staff to better understand their communication requirements and social background to improve their experience of the hospital environment.
- Rooms were available for relatives staying overnight.
- We noted evidence of palliative staff working with the informatics department to develop a palliative intranet which would contain up to date information for staff as well as guidelines and useable documents trust wide. Although we did not see evidence of the target completion date in the specialist palliative care work programme June 2015-June 2016.
- We saw leaflets and booklets were available trust wide to relatives with practical information following a death.
- All relatives we spoke with as well as the palliative team confirmed all palliative patients were checked regularly by ward staff, ensured they were comfortable, had the call bell to hand and appeared well presented at all times.

Access and flow

- The palliative team had a telephone referral, face-to-face and a bleep referral system in place across both hospital sites. We noted the team were easily

accessible and were very supportive of ward staff. Staff told us that if they needed support immediately the palliative team were able to provide a very quick and responsive service.

- The palliative care lead nurse told us they had developed a care pathway for those patients who were in their last days of life and preferred to be cared for at home. The 'Rapid Home to Die Care Bundle' facilitated a rapid discharge. Staff told us they had used this bundle several times across both sites and on several occasions were able to discharge patients with a complex package of care within 24 hours.
- The palliative team consisted of a rapid access discharge nurse whose role it was to develop and implement the rapid access discharge. The bundle had a tear off sheet for the community staff to send feedback about the discharge to the palliative team. It reviewed the effectiveness of the discharge such as transport, equipment and communication. The rapid discharge nurse's responsibility was to support and teach staff how to execute a rapid discharge as opposed to carrying out the discharges. We saw they would go to support and teach staff on the wards. Ward staff told us the bundle had been successful however there was no audit to be able to see the results at the time of the inspection.
- Staff developed an end of life transitional care pathway for 16 – 25 year olds which ensured joint working with children's services and clarifies responsibilities of care for the patient. We saw they were recognised in 2011 and won the Black Country locality stakeholder board 'Innovation Award in Workforce Development', alongside the Royal Awards 'Partnership Working Award' for this pathway.
- Local community hospitals, West Park and Cannock Chase were both under the support of the palliative team and they told us they were aware of how to refer. They were in the process of reviewing the number of palliative patients they saw in Cannock Chase Hospital.
- Palliative patients presented in the medical admissions unit, the palliative team told us they were excellent in flagging up cases or referring to ensure the palliative team were involved from the start of admission.
- The mortuary staff had facilities and systems in place for those patients who were deceased but there was no family to collect the body.
- We were told by the mortuary staff that they had good links with funeral directors in the community and never had any issues with collection.
- Visiting times were open allowing relatives to spend as much time with their loved ones as they needed.

Learning from complaints and concerns

- From data submitted by the trust we reviewed two complaints since April-June 2015 relating to patients at the end of their lives. Both were complaints were about insensitive/poor staff attitude towards family and patients and both had personal belongings missing. Ward managers did not document any lessons learnt or actions taken.
- The bereavement office gave all families' practical information what to do after death which included information on how to make a formal complaint.
- The bereavement services had started to send out comment cards to all families with a freepost address to encourage feedback. The service also sent out a survey 6 weeks after death. We saw feedback from one person who said the bereavement office were helpful in providing information and said they were very grateful.

Are end of life care services well-led?

Good

The palliative team had a clear vision for their service. The leadership, governance and culture promoted the delivery of high quality person centred care. We saw several audits had been undertaken to evaluate and utilised to improve the service. The palliative team displayed good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice.

We saw the culture was a positive energetic one. We noted staff had made efforts to engage the trust wide staff and were determined to improve care for patients at the end of the lives and better support families. We saw team members were very passionate about their job and told us they enjoyed what they did.

End of life care

We reviewed the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust. We saw they had worked on a number of areas to ensure improvement and efforts were made to ensure the sustainability of the service.

The palliative care team had introduced a staff survey, the results identified how approachable, supportive and informative team members were.

Vision and strategy for this service

- The trust had a sound strategy for the service laid out in the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust and further details of the improvements made are detailed in the final subheading.
- We saw there was clear vision on where the improvement projects were going what needed to happen to ensure they took place. The palliative team developed an annual audit in which they reviewed all aspects of their work from research to national audits to improvement plans.
- We saw a strong level of commitment from all staff to all the palliative team's projects and saw the passion from the palliative care team was distributed throughout the hospital which we found was as a result of a clear vision and strategy to engage all staff.
- We saw the palliative team had a clear vision for their service such as:-additional cover for Cannock Chase Hospital and West Park Hospital, seven day face to face specialist palliative care provision, change in lead nurse professional responsibility to include acute and community setting, full implementation of Gold Standards Framework dependent on outcome of pilot, continue to embed the Swan project and introduction of new Palliative/EOLC education packages to support generalist practice.

Governance, risk management and quality measurement

- We saw matron's on the wards conducted random audits to ensure the quality of care and documentation. We noted from the last audit in May 2015 that they focused on end of life care reviewing two patients that were in the last few days of their life. We saw from feedback to the ward that staff were complimentary of a new ward manager, the Swan care plan was noted as fully completed, DNACPR forms were fully completed, the patient and family were involved in care planning, open visiting was encouraged by ward staff, staff were aware of patients wishes and relatives told the matron that staff were respectful of their wishes and responsive to their needs.
- The trust had recently implemented the 'Creating best practice' in which staff identified objectives in which they could improve practice. Objectives were in line with CQC standards, clinical outcomes, risk register, best practice, KPIs, policy and national audits. The end of life 'Creating best practice' had been completed in May 2015. The only emerging issue was that an incident must be recorded if a death certificate was signed after 24 hours of the death. The positive was the engagement from all staff across the organisation for improving end of life care. The deliverables for the next review was to look at improving parking for visitors of dying patients, a proposal for a bid with the University to look at a qualitative study reviewing the Swan Project and increase training for non-clinical staff such as porters.
- The syringe driver monitoring chart audit (February 2015) results led to an update in clinical practices and had influenced the refresher teaching, which commenced April 2015.
- We saw the trust had submitted data for the National Care of the Dying Audit (Hospital) (NCDAH) audit (May 2015).
- The Hospital has made contributions to phase one of NHS England's project to develop a national palliative care currency by collecting detailed data for analysis and have committed to further data collection in phase two. As part of the national currency development project the palliative care team have begun measuring dependency scores and patient related outcome measures of palliative patients.
- We reviewed the risk register which contained risks such:- concerns regarding the completion of all mandatory NICE audits required for the directorate, staffing levels, possibility of injury/ill health to staff and patients from the use of non-safe winged infusion sets contaminated sharps. It did not contain any details around the lack of the Swan Project being fully integrated in the organisation.

Leadership of service

End of life care

- The palliative team felt the trust were engaged with topics around end of life care and were supportive in their efforts to improve the service. They told us the board staff members were visible and were engaged in best practice. The trust had a board representative who staff told us was very engaging and pushed for palliative care to be on the agenda.
- Staff were engaging in a sponsored walk to raise money for the Swan charity. We were told they had recently received a large donation from a family after they had received good care from the hospital.
- All staff we spoke with from the palliative team thought there was excellent leadership for the service and felt well supported. Staff told us how they ensured they emotionally supported one another through difficult and upsetting situations.
- The medical staff told us they felt well supported by the consultant and had regular feedback and appraisals.
- Data submitted by the trust showed that the palliative team displayed very good engagement and attendance at national/international conferences and the West Midlands expert advisory group for palliative care.

Culture within the service

- We saw the culture was a positive energetic one. We noted staff had made efforts to engage the trust wide staff and were determined to improve care for patients at the end of the lives and better support families. We saw team members were very passionate about their job and told us they enjoyed what they did.

Public and staff engagement

- The palliative team told us they had a public representative that would support them in ratifying their ideas and had reviewed documents and policies from a patient and families perspective.
- The palliative care team had introduced a staff survey, seeking feedback from referring ward teams about the Hospital Specialist Palliative Care Team. Initial feedback (March – May 2015) has identified how approachable, supportive and informative members team were.
- Patients with cancer were invited to sit on a user group panel 'Wolverhampton Patient Advisory Cancer Team' to be able provide input in changes to the service. We saw the minutes for the February 2015 meeting where ten staff attended and three patient representatives.
- We saw staff had arranged leaflets, books, DVD's and flyers for the 'Dying matters awareness' day they had organised with the local hospice in order to engage with the public and raise awareness to the importance of end of life plans and bereavement.

Innovation, improvement and sustainability

- We reviewed the Palliative & End-of-Life Care Strategy 2015.This strategy document sets the direction to further improve palliative and end-of-life care across the Royal Wolverhampton NHS Trust. The hospital highlighted areas for improvement in this document ranging from environmental challenges, hospital-wide awareness and engagement, resource capacity of specialist palliative care services, clearly defined integrated pathways to formal recording of palliative patients' wishes.
- We saw they regarded their strengths to be: - organisational leadership and commitment, a passionate and committed specialist palliative care team, person-centred care philosophy and partnership working and research leadership.
- Staff told us one improvement made by the service had been the appointment of a fixed term, rapid discharge pathway facilitator to develop a rapid home to die care bundle, and associated web resources and education programme.
- The hospital had made improvements by developing a unified Do Not Attempt Cardiopulmonary resuscitation form that travelled with the patient across services. This was supported with a newly developed e-learning package.
- Staff were currently piloting the 'Gold Standards Framework (GSF) in Acute Hospitals' on two wards aiming to improve identification of patients in the last 12 months of life and co-ordination of care across services. This focused targets of best practice for the staff to be able to audit care and develop a benchmark against these standards.
- Staff had arranged a new monthly 'Joint Advanced Respiratory Disease Clinic' for patients and a family/ friend will be invited to attend a joint clinic which will be held at the hospice to see both the respiratory and palliative medicine consultant in order to improve the continuity of care and reduce appointments for the patient. We saw the start date was June 2015.
- We saw the trust had worked in partnership with Salford NHS Trust in the implementation and piloting of an

individualised plan of care document for people thought to be in the last few days of life, with supporting education packages and champions in most wards across the hospital.

- The hospital have developed of a breaking bad news e-learning package, aligned with a revised policy and associated 'how to' guide.
- The trust had agreed in principal that an electronic palliative care co-ordination system will be implemented.
- In order to ensure the sustainability of the service the team had put forward a business case to increase the nursing and medical staffing provision of the palliative care team and added support to cover the additional community hospital sites.

Outpatients and diagnostic imaging

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

Information about the service

Outpatients

The general outpatients department at New Cross Hospital held various clinics such as gastroenterology, renal and neurology. Other specialities such as urology, ophthalmics, cardiology, rheumatology, cancer, therapy services, orthopaedics and paediatrics held their own outpatient clinics within their department's buildings. The hospital sees an average of 650,000 outpatients per year.

We visited the general outpatients department, urology, ophthalmology, cardiology, therapy services, children's outpatients and the renal unit. We spoke with 34 staff including nurses, doctors, consultants, clinical nurse specialists, reception staff and allied health professionals. We spoke with eight patients to gain their views of the service received. We reviewed six sets of patient records along with other documents supplied by the trust. We spoke with the outpatients leadership which included the Outpatients Services Manager. Before and during our inspection, we reviewed the trust performance information. We also held listening events for the public.

Diagnostic and Imaging Services

Diagnostic and imaging services provided at New Cross included plain film radiology, emergency department (ED) radiology, computerized tomography (CT), magnetic resonance imaging (MR), ultrasound, nuclear medicine and a symptomatic breast service. The department is supported by an on-site medical physics department. The Radiation Protection Adviser (RPA) sits within the medical physics team. There are Radiation Protection Supervisors (RPS) in CT, main x-ray, ED and nuclear medicine. In addition, the department contract a mobile MR service.

We spoke with 28 staff including the clinical director, the deputy radiology manager, the group manager, radiographers, administrative staff, imaging department assistants, the clinical governance lead, medical physics staff including the RPA, radiologists, ultrasonographer and nurses. We spoke with 8 patients and reviewed 20 records.

Outpatients and diagnostic imaging

Summary of findings

Overall the services within outpatients and diagnostic imaging services required improvement. Most of our concerns related to imaging within safety, effective, responsive and well led. Outpatients was broadly satisfactory.

Within radiology there were concerns with the safety of signage, out of date clinical items and the management of controlled drugs. Clinical imaging protocols and risk assessments were not fit for purpose.

Staffing levels within the renal unit did not comply with NHS England and British Renal Society guidelines. Appointment letters and patient leaflets were only available in English. There was no method of monitoring the length of stay of patients within outpatients to ensure they were provided with food and drink.

There was not a clear vision and strategy within the outpatients and radiology departments. There were clear governance structures and defined reporting systems in place in both departments. However, the governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to individual patient needs.

Are outpatient and diagnostic imaging services safe?

Requires improvement

The renal unit required improvement of the staffing levels for renal patients.

There were a number of safety concerns within the radiography department. There was a lack of staff feedback in relation to shared learning and changes in practice resulting from incidents.

We observed a bed blocking access to the resuscitation trolley in radiography. Call bells for patients were not fit for purpose or checked by staff. In x-ray room nine we found out of date contrast media and clinical items. Some waiting areas and cubicles had no signage requesting patients inform staff if they could possibly be pregnant. The signage on the x-ray doors did not clearly instruct patients, visitors or non-imaging staff not to enter the x-ray rooms.

Records were not adequately maintained when medicines were removed from the storage cupboard. The nuclear medicine (imaging) department did not have a written procedure for optimising/scaling children's doses of radiopharmaceuticals. In the nuclear medicine department (imaging) the main dispensary/radioactive product storage was left unsecured in the daytime.

The procedure to check whether women were pregnant prior to receiving radiography tests required improvement. The nuclear medicine (imaging) service did not have/issue 'written instructions' to females who were breastfeeding and who had undergone a radio nuclide procedure.

Within radiography and outpatients, staff were receiving their mandatory training including safeguarding vulnerable adults and children and were knowledgeable regarding safeguarding processes.

Incidents

Outpatients

- The trust used an electronic incident reporting system to record accidents, incidents and near misses. Staff we spoke with demonstrated knowledge and understanding of the trust incident reporting system. They knew what to report, and had reported incidents.

Outpatients and diagnostic imaging

- A total of 606 incidents had been reported between March 2014 and February 2015. 569 of these resulted in no harm, 28 low harm and nine moderate harm. 156 of these incidents were reported as clinical assessment. 103 were reported as documentation and 78 as treatment or procedure.
- Seven serious incidents requiring investigation were reported. These included three relating to slips and trips, one confidential information leak, one grade 3 pressure ulcer and one suboptimal care of the deteriorating patient.
- Staff told us that learning from incidents was discussed at team and departmental meetings. We saw examples of minutes that demonstrated learning being discussed at meetings. For example the wrong address had been booked by the ward for patient transport. The lessons learnt included that the address should be double checked when transferring the booking from the written booking form to the electronic booking.
- There had been no 'Never Events' (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the outpatients department during the preceding 12 months.

Diagnostic and Imaging services

- Minutes for the Radiation Committee Sept 2014 and the Clinical Governance Subgroup (Radiation) February 2015 meetings indicated that there was no trust executive present at these meetings. The Terms of Reference indicate that the Medical Director is a member of the Radiation Safety Group. The Medical Director has responsibility for implementation and review of radiation safety arrangements and IR(ME)R compliance It is best practice for a trust executive to be present or for the chief executive officer (CEO) to delegate responsibility to chair the committee. Radiation incidents were recorded at these meetings and agreed follow up actions minuted and progress against the actions monitored at subsequent meetings.
- The managers told us they encouraged a culture of open incident reporting across all of the diagnostic modalities and staff we spoke with confirmed this. A band 5 radiographer described an incident on the night of 31st May 2015 – the incident form was completed immediately following the incident.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the hospital incident reporting system. Senior staff we spoke with told us that incidents were discussed at departmental governance meetings. Minutes were made available to confirm this. However, we were unable to identify clear systems and processes to evidence post incident feedback, shared learning and changes in practice resulting from incidents with departmental staff. The Clinical Governance lead said the information was on the electronic incident reporting system and the expectation was for staff to check the outcomes themselves.
- Ionising Radiation (Medical Exposure) Regulations IR(ME)R incidents were reported to the medical physics team.

Cleanliness, infection control and hygiene

Outpatients

- Patients we spoke with felt that the areas were always clean. We observed that the waiting rooms and outpatient's clinic rooms were clean.
- We observed that all staff complied with the trust policy of being bare below the elbow.
- Hand gel was available in all clinical areas. There was not clear signage for the location of the hand gel. However, we saw staff requesting patients use the hand gel on entering the department.
- Mandatory training records showed that 100% of qualified and 80% of unqualified nursing staff had received infection prevention and control training. Staff we spoke with demonstrated knowledge and understanding of cleanliness and control of infection.
- Records provided by the trust demonstrated that 100% of staff had received training in hand hygiene. The hand hygiene assessment completed in November 2014 showed 95% compliance.

Diagnostics and Imaging Services

- The department overall was clean. Staff were responsible for maintaining the cleanliness of the equipment in accordance with infection prevention and control (IPC) standards. However, when visiting two rooms in the morning, there were no cleaning schedules. The information given was that records were not kept but the radiographers did clean the rooms daily.

- Personal protective equipment (PPE) equipment including lead coats were checked and were clean and of good condition.
- Clinical waste bags were used for the waste bins in the toilets. This may be expensive for the trust as not required.
- The Clinical Governance lead reported that they completed the hand hygiene audit on line. When asked what the department's performance was with regards to hand hygiene, they did know what the results were and that the department did not receive any results. Consequently the department staff were not informed of how well they were performing with hand hygiene. Records provided by the trust showed that the hand hygiene assessment completed in January 2015 was 89% compliant.
- The lead nurse in the interventional suite was unable to produce evidence of any hygiene audits or cleaning schedules being completed for the department.
- In x-ray room 9 the contrast agent warming cupboard was found to contain sticky remnants of spilled contrast, which was a high risk for microbial contamination due to the warm environment.

Environment and equipment

Outpatients

- The general outpatient waiting area was very large and well lit, mostly by natural light. All outpatient areas that we visited were tidy, including corridors. The atmosphere was generally calm, even where the clinics were very busy.
- We saw records which indicated that emergency resuscitation equipment had been checked appropriately in all areas we visited.
- We saw evidence of daily performance checks of equipment.

Diagnostic and Imaging services

- A visit to the two CT scanners on site showed that there were no Local Diagnostic Reference Levels. The CT radiographers said that they did not have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended.
- The clinical imaging protocols (operating procedures) were generic in nature. Basic scan parameters were not present that would allow an operator to follow and find operational information to be able to perform a scan safely. For example information relating to the technical settings of the scanner (scan length/mAs/kVp/slice thickness/pitch/dose modulation). This was not following best practice as recommended by the IPEM Medical and Dental Guidance Notes and IR(ME)R 2000 regulations.
- During the course of our inspection we observed that specialised personal protective equipment was available for use within radiation areas. Staff were seen to be wearing personal radiation dose monitors and these were monitored in accordance with legislation.
- Patient call alarms were not checked to ensure that they were in working order. The cords on the patient alarms in the cubicles were not fit for purpose as they did not reach the floor. Patients that fell may not have been able to reach the alarms.
- The resuscitation equipment was checked daily and records were all up to date.
- The ward waiting area was seen to be overcrowded. It was a six bed area with one of the cubicles taken up with equipment e.g. hoists. This reduced the waiting space. We saw a very crowded waiting area with six beds in the remaining five bed areas, all squashed together. One bed was positioned in front of the resuscitation trolley which compromised access to emergency equipment and drugs. In addition there were four patients in chairs. A manager was informed that the resuscitation trolley was not easily accessible.
- The Trust presentation highlighted that obesity was a problem within the local population. It was noted that there was no provision of bariatric seating in the waiting areas.
- A clinical store room in the main department had tea, coffee and snacks on the shelves (for staff). There were also shoes on the lower shelf. There was a lack of appropriate storage for these items. This was pointed out to the superintendent.
- There was some patient signage asking patients to tell staff if they could possibly be pregnant.

Medicines

Outpatients

- Medicines were stored in locked cupboards. Controlled drugs were not stored in the main outpatient

department. We checked the controlled drugs in the renal unit and cardiology outpatients departments. Records demonstrated that daily stock checks were completed.
- Lockable medicine fridges were in place. Records showed that daily temperature checks had been recorded.
- Prescription pads were securely stored in locked drawers. Nurses signed out prescriptions.

Diagnostic and imaging services

- Medicines including controlled drugs were stored correctly and the senior nurses were responsible for medicines and medicine key controls There was no record of what drugs were taken and by whom for any medicines, including controlled drugs. The senior nurse said that staff would leave a note on her desk. The process of monitoring which drugs had been taken was by a weekly stock check. This contravened the Controlled Drugs (Supervision of management and use) Regulations 2013.
- In x-ray room 9 a container with contrast medium was found to be out of date (dated 02/15). Packs of sterile clinical items for example catheters were also found to be out of date. We informed the superintendent radiographer who immediately removed these items.
- We looked at a random sample of the medicines stored in the drug cupboard, and found all of the items looked at were in date.
- The drug fridge in the interventional suite was monitored and records were up to date on the fridge temperatures which were within normal range.
- The drug fridge in nuclear medicine imaging department did not have any recorded evidence of monitoring.
- The nuclear medicine (imaging) department did not have a written procedure for optimising/scaling children's doses of radiopharmaceuticals. Staff reported the use of a 'rule of thumb' formula for scaling doses which did not account for a child scan taking longer than an adult equivalent scan to undertake. This did not follow best practice guidelines, specifically that given by the Administration of Radioactive Substances Advisory Committee (ARSAC). It was seen that calculations on scaling dose were undertaken without written directions from the ARSAC certificate holder (practitioner) and there was no written procedure available for this.
- In the nuclear medicine department (imaging) the main dispensary/radioactive product storage (containing pharmacy only medicines and radioactive medicinal products and waste) was generally kept unsecured during the working day. Staff said that the door was locked at night. This posed a potential security and safety risk as patient's and/or visitors could obtain easy access by opening the unlocked door from the main patient corridor without restriction. Radioactive medicinal products could potentially be tampered with or stolen and this was particularly pertinent to anti-terrorism regimes.
- The radiation protection supervisor (RPS) and radiation protection adviser (RPA) were informed of this risk. The RPA said they would immediately investigate the option of swipe card entry to make access more practical for staff and also maintain security of the sources. They said they would ensure that the room was locked between use.

Records

Outpatients

- Some clinics used written patient records and some electronic records. Clinicians reported no problems accessing records.
- If patient's records were not available (which we were told was rare) a system was in place that the original referral letter from the GP had been scanned in prior to the first appointment, enabling the clerk to access it. For follow-up appointments, results and dictated letters could all be accessed on the electronic systems.
- We reviewed six sets of patient records, three paper records in general outpatients and three electronic records in rheumatology outpatients. All records were complete, with up-to-date typed letters, completed consent forms and demonstrated patient engagement.

Diagnostic and imaging services

- At the time of inspection we saw patient personal information and medical records were managed safely and securely.
- The trust had a central electronic patient records database, the Reporting Information System (RIS). We looked at a total of four patient electronic records on RIS

and saw each record included comprehensive detail of the patients imaging history. We also saw imaging request cards were also scanned into the electronic patient records.
- The quality of patient referral forms was not audited across both sites.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and in use across the trust.

Safeguarding

Outpatients

- Staff told us that they received training in safeguarding for both children and vulnerable adults. Records demonstrated that 100% of staff had completed training in children and adults safeguarding within the different speciality clinics within outpatients. The exceptions to this were: 90% of unqualified and 92% of qualified nursing staff had completed children's safeguarding training within the ophthalmology outpatients department. Within the children's outpatient department 92% of qualified nurses and 100% of unqualified nurses had completed the children's safeguarding training to the required level II. The trust target was for 75% of staff to have training.
- Staff we spoke with demonstrated knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults.
- Staff were able to access advice from the trust safeguarding team and the safeguarding policy was available on the intranet.

Diagnostic and imaging services

- We observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity for example name, date of birth and GP.
- Identification checks on patients were carried out according to IR(ME)R. 20 forms were checked and all had been completed correctly.
- We spoke with three staff including administrative staff and radiographers and they were aware of their responsibilities to safeguard adults and children and who to contact in the event of concern.
- Records showed that 99% of staff had received adult's safeguarding training. 99% of staff had received level I and 88% level II in children's safeguarding.

Mandatory training

Outpatients

- Staff told us that they were able to access their mandatory training such as basic life support, infection control, safeguarding and health and safety and were kept informed by their managers if training was due.
- Trust records demonstrated 94% of staff within the outpatients department had completed their mandatory training.

Diagnostic and Imaging services

- All of the staff we spoke with told us they received ongoing mandatory training and they were responsible for ensuring they kept up to date. Mandatory training included eLearning modules and face to face training.
- Records demonstrated that 94% of staff had completed their mandatory training.

Assessing and responding to patient risk

Outpatients

- Adult resuscitation equipment was stored within the department. We saw evidence that this was checked regularly and that staff signed to show that the equipment was checked and within the expiry dates.
- Processes were in place within the outpatients department to manage patients who presented at risk within the department. For patients in attendance who had a cardiac arrest, the cardiac arrest team would be called and if patients required transfer to the emergency Department then a 999 ambulance call would be made. If patients showed signs of rapid deterioration but were well enough to be transferred, the outpatient staff would urgently transfer the patient to the emergency department.

Diagnostic and Imaging services

- The principal function of the Radiation Safety Committee was to ensure that clinical radiation procedures and supporting activities in the trust are undertaken in compliance with ionising and

non-ionising radiation legislation. The committee met twice each year and received reports from the appointed Radiation Protection Advisers, ensuring all recommendations were achieved.

- The manager told us that all modalities had appointed and trained Radiation Protection Supervisors (RPS), whose role was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures.
- There were regular delays in paediatric reports. The Clinical Director indicated that there was not the level of interest in paediatric radiology within the consultant group to sustain effective report turnaround times. Consequently the turnaround times for paediatric reports were often several weeks.
- A receptionist in the radiology X-ray inpatient reception did not know where the patient alarm was and did not know the emergency number in the event of a clinical emergency for example cardiac arrest. (All of the other staff did know the emergency telephone number).
- The signage on the x-ray doors did not clearly instruct the patients not to enter the x-ray rooms. There was signage to indicate it was a radiation area but no instruction not to enter the room when the red light came on. This was highlighted to the radiation protection adviser (RPA) who felt that the signage was adequate. It was assumed that patients would see the light box which was above the door.
- There was no clear warning signage outside rooms 1 and 2 viewing area for staff or patients. People could enter the X-ray rooms (controlled areas) with no warning of radiation as is required by regulations. This was highlighted to the RPA who said that they would conduct an urgent review of the area.
- The service used an adapted version of the WHO surgical safety checklist, when carrying out all non-surgical interventional radiology procedures. The use of the checklist across all radiological procedures was confirmed by the Interventional Radiologist and senior nurse we spoke with.
- The department (across both sites) had a procedure in place to check whether women were pregnant. Patients were asked the last menstrual period date (LMP) and if this was within 28 days for low-dose or 10 days for high-dose procedures then they proceeded with the examination. However professional bodies (the Health Protection Agency, the Society of Radiology and the Royal College of Radiologists) recommend that LMP is not routinely asked and those patients are asked, “Are you or might you be pregnant?” This avoided assumptions that females outside their dates are pregnant. The written procedure included an instruction to proceed with exposures if the patient said their husband had had a vasectomy. This had the potential risk of irradiating a pregnant woman if she answered ‘yes’ to her husband having received a vasectomy (and she might have had sexual intercourse with another partner.)
- The nuclear medicine (imaging) service did not have/ issue ‘written instructions’ to females who were breastfeeding and who had undergone a radio nuclide procedure. This posed a risk to an infant inadvertently ingesting radioactive material. This issue was discussed with the medical physics expert who advised that written instructions were given out in the non-imaging section but they were not aware that they were not given out in the imaging section. They said that they would immediately provide a letter for staff to issue when needed.

Nursing staffing

- The general outpatients department was up to full establishment. No agency staff were used in this area. If shifts required covering for example for sickness, they used their own staff on the nurse bank.
- Some of the speciality clinics were not as well staffed. Some of the band six urology nurses were acting up as band seven felt they were provided with little support.
- The rheumatology unit manager told us that they frequently had to do clinical work due to staff shortages which detracted from her senior manager role. The staffing concerns were on their risk register.
- The renal unit required more staff to meet the needs of patients. We reviewed the nursing rotas and the dependency of the patients in the renal unit. We found that there was only one qualified staff allocated to four patients on most shifts.
- The staffing concerns had been escalated to the senior management and were on their risk register. We were told that they were actively trying to recruit more staff.

Medical staffing

Outpatients and diagnostic imaging

- The individual specialties arranged medical cover for their clinics. Medical cover was managed within the clinical directorates, who agreed the structure of the clinics and patient numbers.
- Medical cover was provided without the need for locum use.

Imaging and Diagnostic services

- There were 17 radiologists and the department had five vacancies. These vacancies were being backfilled with long term locum posts.

Major incident awareness and training

- The staff we spoke with were aware of their roles in the event of a major incident.
- Major incident training was part of the trust induction mandatory training and policies were available to staff on their internal intranet.

Imaging and Diagnostic services

- Senior managers explained how table top exercises had been carried out to look at contingency plans to continue the service if the information technology systems failed. Emergency testing had been undertaken and a backup plan had been written.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

There were no Local Diagnostic Reference Levels for the two CT scanners. The CT radiographers said that they did not have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended. The clinical imaging protocols (operating procedures) were generic in nature. Basic scan parameters were not present that would allow an operator to follow and find operational information to be able to perform a scan safely.

The radiation risk assessments were not fit for purpose and did not have enough specific detail for the radiation work undertaken in each area. There were no Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.

There were regular delays in paediatric reports within radiography.

Treatments were being provided in line with best evidence-based practice and NICE guidelines in both outpatients and radiography. Staff were able to access continual professional development and most staff had received appraisals. There were low rates of appraisal completion within the children's outpatient departments.

Evidence-based care and treatment

Outpatients

- We saw that treatments were being provided in line with best evidence-based practice and NICE guidelines.
- For example in the rheumatology outpatient's clinic we saw use of protocols and checklists to ensure that patients with inflammatory joint disease receiving biologic therapy were being treated and monitored in line with NICE guidance.
- We saw that a gastroenterology clinical nurse specialist was following the British Society of Gastroenterology guidance in relation to the iron deficiency anaemia clinic she was running.
- Each speciality conducted audits to assess compliance with NICE guidelines in relation to their area of clinical practice. For example, the heart failure clinical nurse specialist had audited the use of NICE recommended medication for heart failure patients. We saw an audit of 100 patients demonstrating 100% compliance.

Imaging and Diagnostic services

- NICE guidance audits were undertaken e.g. NICE guidelines for fibroid conformity.
- The department had an Annual Audit Plan which was presented to us.
- It is a requirement of the IR(ME) Regulations for audits to be carried out to ensure safe exposure and practice. The audit plan did not include reference to IR(ME)R audit. However, on examination audits had been completed to comply with IR(ME) Regulations.
- There were nine reporting radiographers who had dedicated reporting time.
- On a needs basis, some reporting was outsourced. One radiologist said that quality checks had not been carried out on the reports provided by the outsourced supplier.
- The radiology consultants had monthly discrepancy meetings which were minuted and lessons shared and learnt.

- The radiation risk assessments were not fit for purpose and did not have enough specific detail for the radiation work undertaken in each area to include: the risk issue, an assessment of the risk and barriers in place to mitigate risk.
- There were no Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.
- Local Rules within the nuclear medicine imaging department dated 2010, required reviewing in line with best practice.

Patient outcomes

Outpatients

- The number of patients seen as a follow up against the number of new patients rate was worse than the England average from July 2013 to June 2014. This meant that patients may have been followed up more regularly or for longer than the average. This is measured against all other trusts in England.
- We discussed this with the divisional manager and matron for outpatients. They explained that each speciality discusses their figures at monthly governance meetings. One method they used to try and reduce this rate, was to inform patients by letter if their results were normal rather than bringing them back for another appointment. Some specialist nurses were also doing telephone follow-up appointments, for example in gastroenterology and rheumatology.

Diagnostic imaging services

- The six week Diagnostic Targets were being met. A mobile magnetic resonance (MR) unit was used to increase capacity when required to ensure optimum capacity to meet the target.
- The administrative staff check the patient tracking list (PTL) daily prior to booking. Their rule was not to book over six weeks.
- There was a service level agreement in place with the clinical commissioning group (CCG) for GP reports – 90% of exams should be reported within 10 days. This was monitored on a weekly basis. 90% of examinations had been reported within 10 days and 95% within 15 days.
- The department had set their own internal key performance indicators (KPI's) for all other reporting – three weeks for outpatients and four-six hours for ward patents. The Clinical Director said that the outpatient KPI is not always achieved due to workload and staff shortage.

Competent staff

Outpatients

- Staff told us that they had received an annual appraisal and that it was a useful process for identifying any training and development needs.
- Trust data demonstrated that appraisal rates were 100% in most of the outpatient speciality departments. The exceptions to this were in the children's outpatient department where 9% of qualified and none of the unqualified nurses had received their appraisal (seen in documents supplied by the trust). In ophthalmology 86% of qualified nurses and 100% of unqualified nurses had received their appraisal.
- Specialist nurses within the outpatients department provided nurse-led clinics alongside medical colleagues providing care for patients.
- In addition to mandatory training, nursing staff undertook training relevant to the clinic they were running, for example, wound care.
- Specialist nurses were given the opportunity to further develop their skills, for example the heart failure specialist nurse was going to attend a course to learn how to echo patients.
- Medical staff were given protected learning time to carry out training.

Diagnostic and Imaging services

- All of the staff that we spoke to had received their appraisal- a band 5 radiographer felt her appraisal was constructive and felt the appraiser was interested in her personal development and career progression.
- Trust data demonstrated that 86% of staff had received their appraisal.
- All staff reported that they had access to continual professional development training and that it was actively encouraged. The department held a training budget.
- The Medical Physics team annually updated IR(ME)R training for radiology staff and for new non-medical referrers.

- The Medical Physics team provided radiation protection supervisor (RPS) training for new RPS's and also update training for existing RPS's.

Multidisciplinary working

Outpatients

- There was evidence of good multidisciplinary working within different speciality clinics. For example a vascular scientist worked alongside the consultants within the varicose vein clinic. This meant that the results could be discussed and the results provided straightaway to patients.
- The ophthalmology team linked in with the diabetes and oncology teams in relation to diabetic eye disease and eye cancers.

Diagnostic and Imaging services

- Specialist radiologists were part of the multi-disciplinary teams (MDT) for example, gastrointestinal and breast MDT's.

Seven-day services

Outpatients

- Most of the outpatient clinics ran within core working hours 8-5pm Monday to Friday.
- The cardiac outpatients ran a clinic on Wednesday evening up until 9:30 pm.
- Some ad hoc weekend and evening clinics had been run to address waiting list initiatives.
- The children's outpatients department ran fortnightly Saturday clinics for their oncology patients.

Diagnostic and Imaging services

- The radiology services provided a range of services, some covering 24 hour for example emergency department x-ray, seven days a week, whilst some locations provided services within normal and or extended working hours Monday to Friday.

Access to information

Outpatients

- Electronic access was available for pathology, microbiology and radiology results.
- The rheumatology department reported receiving large volumes of paper blood results. This could result in delays highlighting and acting on significant blood test abnormalities as there was no electronic way of highlighting abnormalities. Currently the results were being reviewed by the clinical nurse specialists. The new manager was changing the system so that the requesting doctor was responsible. There were plans for a new system where significant abnormalities would trigger an email to the requesting doctor. This issue had been put on their risk register.
- Radiology reports were available electronically and results were e-mailed directly to the referring consultant.
- There was a trust target to ensure that GPs received letters within 48 hours of the patient's appointment. We saw evidence that this was being monitored and achieved within the outpatient department.

Diagnostic and Imaging services

- Radiology reports were available electronically (across both sites) and results were e-mailed directly to the referring consultant.
- Clinical Governance documents were not easily available (across both sites) to all staff as they were not filed on a shared drive. They were mostly held by the Clinical Governance lead.
- The medical physics expert reported that there were incidences where radiographers found it difficult to challenge GP referrals when incorrect or insufficient information was present to justify the request. For example poor or missing patient medical history or patient demographics missing. Examinations continued to take place where the practitioner and or operator should have been able to reject the request due to lack of information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with demonstrated knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic.
- We saw examples of accurately completed consent forms in records we looked at.

Outpatients and diagnostic imaging

- Staff were aware of the Gillick competency. Gillick competence is a term used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

Diagnostic and Imaging services

- The interventional service held a consent clinic each week for the 'major' interventional procedures which also included a comprehensive consent process which was clearly documented. For all other procedures the same forms were completed on the day of the procedure. There were a range of consent forms to meet the needs of the patient e.g. forms for patients who were unable to consent for themselves.
- Staff we spoke with demonstrated knowledge and understanding of Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards (DoLS).
- The trust had policies and procedures in place for staff to follow in obtaining consent from patients receiving diagnostic procedures.
- Staff were aware of the Gillick competency with regards to gaining consent from children and young people
- The majority of general x-ray procedures were carried out using implied consent from the patient.

Are outpatient and diagnostic imaging services caring?

Good

Patients spoke highly of the staff in both outpatients and radiography. Patients described caring staff that were supportive and treated them with dignity and respect. We observed that staff were courteous, polite and friendly when responding to patient individual needs. Patients told us they were given good explanations of their treatments and were given written information to take home.

Compassionate care

Outpatients

- We spoke with eight patients within general outpatients, children's outpatients, ENT, physiotherapy and cardiac outpatients.
- All the patients we spoke with were happy with the care they had received and were complimentary about the staff. One patient told us in relation to the physiotherapy service, "It is professional and sympathetic to patient's needs, I would be happy to recommend it." Within the children's outpatients, we were told, "the nurses are lovely I have never met a miserable face."
- All the patients told us that they were treated with dignity and respect.
- One patient told us that they had been offered a chaperone. We observed that there were chaperone posters displayed in the general outpatients waiting area.
- We observed that receptionists maintained patient's confidentiality within the reception area.
- We observed that staff were polite, courteous and friendly with patients.

Diagnostic and imaging services

- We saw staff being friendly and polite.
- Staff were courteous when caring for patients and were seen responding to patient's individual needs.
- Patients told us that they were happy with the service provided by the receptionists and nursing staff.
- One patient said, "Can't fault the service, have been treated very well."

Understanding and involvement of patients and those close to them

Outpatients

- Patients told us that they were given good explanations about their care and treatment**.**
- One patient in the cardiac clinic told us, "They explain everything; I've been given leaflets to read at home on procedures**."**
- Another patient in general outpatients told us they were very happy with the care given by all and that things were explained to them both in the clinic by doctors and also by the nurses and receptionists.
- Another patient said their care was offered with dignity and respect and staff had fully involved their partner in all communications.
- Most patients told us they were kept informed about follow-up appointments via letters.

Diagnostic and Imaging services

- One patient said, "The care and treatment is perfect, all staff are polite and explain about the results process."

Emotional support

Outpatients and diagnostic imaging

Outpatients

- We were told by patients the staff were supportive. One patient said, “The staff are friendly, caring and very helpful.”
- If patients received bad news in the gastrointestinal (GI) surgery or medical clinics, there was rapid access to the GI clinical nurse specialist who would come down and support patients.
- If cancer was detected during a cystoscopy procedure within the urology clinic, nurse specialists and senior doctors were available to see and counsel the patients there and then.
- A clinical nurse specialist was based in the main outpatient department to provide support for breast cancer patients. A health care assistant described how staff were employed for long periods of time and the staffing and clinic structure allowed them to build supportive relationships with patients.

Diagnostic and Imaging services

- We observed how a nurse clarified information to a patient until it they understood.
- One patient told us, “The staff are lovely.”

Are outpatient and diagnostic imaging services responsive?

Requires improvement

There was poor signage to both the outpatient and radiology departments. Appointment letters and patient information leaflets were only available in English. Information in other languages (to request leaflets in alternative languages) was written on the reverse of the leaflets but in tiny print that may well have gone unnoticed.

Delay times displayed in some outpatient clinics were not accurate and the delays were longer than shown.

Patients in radiography waited a long time for porters to return them to the ward. A radiographer reported that they regularly attended the department at night for emergencies and waited up to two hours for the patient to arrive from the ward.

Patients requiring ambulances often arrived in outpatients an hour before their appointment and had to wait up to an hour following their appointment to be collected. There was no method of monitoring their length of stay, to ensure they were offered food and drink. There were no vending machines available within radiology to provide food or drink. A water fountain was available but was not clearly visible.

Patients living with dementia and patients with learning disabilities were flagged on the electronic appointment system to alert staff to their individual needs. Staff prioritised these patients and tried to ensure that they were seen first. Translation services were available for patients whose first language was not English.

A scooter service was available within outpatients for people with mobility problems to help them get from one side of the hospital to the other.

Service planning and delivery to meet the needs of local people

Outpatients

- We found there to be poor signage to the outpatients department with directions to different zones within the hospital rather than stating ‘outpatients’. Frequently patients stopped us in corridors asking for directions to different departments.
- There were three check-in desks at the outpatient’s reception. The list of which ‘window’ was dealing with which clinic was not clear as this information was on a board behind the receptionist. We observed some patients came to window one only to be told to move to window three for their clinic’s first check in. The signage could be made clearer for patients.
- There was sufficient seating within the outpatients department for patients. However, there were no diversions offered such as magazines to read whilst patients waited for their appointments.
- Vending machines were available in the hospital to obtain snacks and drinks. However, there was no free water fountain for patients.
- Appointment letters were only available in English. We witnessed a patient who spoke no English who although helped by his friends at the check-in desk appeared very confused by the process. It would have been helpful if they had received some information in their own language before they arrived at reception.
- A tuberculosis (TB) clinic had been set up in response to the local population need being identified as being a high risk of TB.

Outpatients and diagnostic imaging

- Patients said there were always problems parking. A relative of a patient who was in a wheelchair had to park at a local supermarket as there were no spaces available.

Diagnostic and imaging services

- Imaging services were commissioned by the clinical commissioning groups (CCG's) and the radiology department provided the baseline data for the service level agreement (SLA).
- The service met with the GPs on a six monthly basis to discuss service issues.
- An overnight service was provided by an on call radiologist.
- An informal interventional radiology on call service was provided by two radiologists. A network on call service was being developed.
- It was difficult to find the way to the radiology section and to understand that the service was provided over three floors. Signs from the main corridor into the waiting area were not clear.
- There were no vending machines available within radiology to provide food or drink. A water fountain was available but was not clearly visible.

Access and flow

Outpatients

- The referral to treatment percentage within 18 weeks (between April 2013 and November 2014) was better than the England average.
- The percentage of cancer patients seen by a specialist within two weeks of urgent GP referral was better than the England average between January 2013 and September 2014.
- The percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was worse than the England average April - September 2014.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average April - September 2014.
- The "did not attend" (DNA) rate was worse than the England average. The New Cross rate averaged at 8% with the England average at 7%. The outpatient senior manager told us that they were about to introduce text messages to remind patients of their appointments to help to address this.
- There were wipe boards within the separate waiting areas in the general outpatients department which had a column for 'delays to clinics'. Delays of up to 30 minutes were displayed.
- Within the ear, nose and throat (ENT) clinic delays of 20 and 25 min were displayed on the wipe boards. However, patients reported that the delay was longer than this, up to one hour.
- There was a scooter service (0830 am to 4.30pm) available for patients who had mobility problems and needed to get from one side of the hospital to the other and also back to a car parked which was a long distance away. We saw this in operation several times and the service worked well.
- The ophthalmology department had developed an acute service for urgent eye problems, essentially an A&E for eyes. An ophthalmology outreach nurse was based in the emergency department (ED) and GPs and ED staff could refer to this specialist service as required.

Diagnostic and Imaging services

- Ward patients had long waits to return to their wards. It was reported that a ward patient had recently waited four hours for a porter to take them back to the ward. We did question as to why a member of staff had not taken the patient back and then addressed the reason for the waits. The member of staff was unsure whether an incident form had been completed.
- A radiographer reported that they regularly attended the department at night for emergencies and waited up to two hours for the patient to arrive from the ward.
- We noticed on more than one occasion many beds were blocking the CT scanning area and the main ward x-ray waiting area. This needed further management input to aid throughput of patients.
- Staff told us that inpatients were sent for on the portering system but had no control when patients arrived. This often resulted in the six bedded waiting space being overcrowded compromising patient safety, dignity and privacy.
- In response to concerns that ward patients were waiting for radiology tests, the deputy radiology manager attended the trust bed meetings twice a week and was able to identify any patient requests that needed to be fast tracked to facilitate discharge.

Meeting people's individual needs

Outpatients

Outpatients and diagnostic imaging

- The consultants within each speciality informed the appointments department how long was required for individual appointments depending on whether they were new or follow-up patients. The medical staff we spoke with said they were happy with the timing of the appointment slots. One consultant had requested for a longer slot due to introduction of a paperless system which was accommodated.
- Patient transport was available for patients with mobility issues. However, they frequently arrived one hour before their appointment and transport was not booked for the return journey until their appointment had concluded. This meant patients often had to wait for a further hour once their appointments had finished. The transportation was offered by another provider with an agreed contract with the trust. The service level agreement was between the clinical commissioning group and the transport provider. There was a target for 95% of patients to be picked up within 60 minutes. They had achieved 74%. This issue had been raised with the transport provider.
- The healthcare assistants told us that they offered patients drinks if they noticed they had been waiting for long periods. However, there was not a system to monitor how long patients had been present in the outpatient department.
- There was a dedicated ambulance for bariatric patients and large chairs were available within the outpatient department. There was no bariatric couch so patients remained on the ambulance stretcher until taken home. The ambulance crew remained with patients during their appointments and these patients were prioritised to avoid delays.
- Patients living with dementia and patients with learning disabilities were flagged on the electronic appointment system to alert staff to their individual needs. Staff prioritised these patients and tried to ensure that they were seen first.
- Staff received dementia training and a consultant nurse in dementia and a lead nurse in learning disabilities were available to provide advice.
- When the outpatient reception area was refurbished, the colour scheme was designed to help orientate people living with dementia. A bid was put in last year to refurbish the rest of the department which would have included better use of colour schemes to help orientate confused patients, but this was unsuccessful in obtaining funding.
- There was an alert system on the electronic appointment system which should flag if a patient required a translator when booking their appointments. This enabled translators to be booked in advance for patients appointments. A telephone translation service was also available for staff to aid communication with patients whose first language was not English.
- All the patient information leaflets were in English. In very tiny print on the back of these leaflets was a sentence (in different languages) saying that leaflets could be requested in alternative languages. However the print was too small for most patients to notice this. This did not reflect the multicultural population that the hospital cared for.

Diagnostic and imaging services

- When information was provided at the point of booking an appointment, the booking administration team avoided early morning, late afternoon or mobile unit appointments for vulnerable adults and children, including elderly patients (across both sites).
- The trust presentation highlighted that obesity was a problem within the local population. It was noted that there was no provision of bariatric seating in the waiting areas.
- Since the trust secured the Cannock Chase imaging services, the ultrasound lists were booked at a Wolverhampton central booking centre. Wolverhampton patients were sent appointments at Cannock. An increased DNA was noted, on average 22%. This had not been investigated to see if it was attributable to the new location and distance travelled. Patients were not made aware that appointments had been made for them to attend at Cannock.
- Patients were pleased that in magnetic resonance imaging (MRI) and ultrasound, they were able to get the results there and then.
- Many waiting areas and patient cubicles did not have signage at all and where they were placed the text was very small

Learning from complaints and concerns

Outpatients

- Most patients we spoke with did not know how to make a complaint.
- Posters on how to make a complaint were displayed in the physiotherapy outpatients but not in the general

outpatients department main waiting areas. Information was provided within the clinic rooms. This may have posed a barrier to patients making a complaint. There was a comments box in the general outpatients but this was not well advertised.
- Complaints were discussed at monthly governance meetings and then fed back to staff at their team meetings. We saw minutes of these meetings and staff confirmed that learning from complaints was fed back to them. The group manager of outpatients told us they received very few complaints. Governance meeting minutes demonstrated that there were no complaints between October and December 2014 in the general outpatients department.

Diagnostic and Imaging services

- The department received a complaint regarding the lack of patient information for an appointment for a transvaginal (TV) scan. The department immediately rectified this and now sends information about the scan so that patients are aware of what to expect.
- Patients were telephoned to establish the reason for their complaint and to ensure all of their concerns were responded to.
- Complaints and outcomes were discussed at the monthly Clinical Governance meeting.
- Staff were requested to provide statements if involved or mentioned in a complaint. However, the same staff did not see the final response letter.
- Staff did not receive feedback of lessons learned from themes of complaints.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There was not a clear vision and strategy within the outpatients and radiography departments.

There were no local audits of patient satisfaction for example patient surveys within radiography.

There were clear governance structures within outpatients and defined reporting systems in place. The governance systems within radiography had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report. There was no ownership of who was responsible for ensuring the department worked within best practice professional guidelines and IR(ME)R regulations.

Business plans and service improvements for other specialities were not shared with radiology. The department was therefore not able to plan for development of services and impacts on resource and diagnostic targets.

Staff in both departments felt well supported by their managers and were happy working for the trust. There were examples of innovative practice in both outpatients and radiography. A varicose vein clinic (within outpatients) where a vascular scientist was present with the consultant enabled discussion of the results and patients being able to receive their results on the day. The ultrasonographers were training to report plain films. This will offer more scope with regards to plain film reporting and maximise any spare capacity in the department. This was unique and a possible first in the UK.

Vision and strategy for this service

Outpatients

- There was not a clear vision and strategy for the general outpatient service. However, the group manager described their aims and objectives. These included improvements to the environment and tackling capacity issues within the department.
- Some speciality clinics were managed and held within their own outpatient areas within their department buildings. We found examples of clear strategy and vision within cardiology rheumatology and ophthalmology.

Diagnostic and Imaging services

- There was not a clear strategy and vision for the radiology service. We discussed the five-year plan for radiology with the senior managers and they were unable to respond with specific details. They told us they tend to respond to issues as they arise.

Governance, risk management and quality measurement

Outpatients

- There was a structured governance system in place.

- Monthly governance meetings took place which discussed the risk register, complaints and incidents, lessons learnt and actions to take in future and audits. We saw minutes of these meetings.
- A protocol had been introduced to ensure the right patient went into the right room as a result of an incident whereby two confused patients went into the wrong clinic room. Staff we spoke with were aware of the learning from this incident.
- Corporate governance officers also attended these meetings to share lessons learnt in relation to incidents in other areas of the trust.

Diagnostic and imaging services

- There were clear governance structures and clear defined reporting structures in the department to the trust senior management
- The risk register was well managed with regular review – however the department managers were not empowered to identify and report risks within their areas. For example the issues with patients waiting excessive times for porters to return them to the wards, was not on the risk register.
- The governance systems had not highlighted the many safety concerns and shortfalls with protocols and risk assessments specified within this report.
- There was no ownership of who was responsible for ensuring the Department worked within best practice professional guidelines and IR(ME)R regulations. When asked staff confirmed there was no clear accountability or delegation, so could not identify who was responsible taking the lead regarding IR(ME)R and professional development for example. Although there was a written structure of roles and responsibilities within the department. The medical physics staff stated that they were not involved in the process of equipment procurement which did not allow their advice regarding dose optimisation to influence any purchasing decision.
- We informed the trust post-inspection of IR(ME)R concerns (across both sites). We have since had assurance from the trust that these matters have been addressed.

Leadership of service

Outpatients

- Staff both within the general outpatients department and the speciality clinics told us they felt well supported by their managers. The service was managed by a Outpatients Service Manager and a Matron.
- The group manager and matron of outpatients felt well supported from the executive team. They reported good two-way communication between the department and the board.

Diagnostic and imaging services

- Staff we spoke to were happy working for the trust and felt supported by the management team which included a clinical director, the deputy radiology manager and the group manager.
- One of the supervisors reported that they had requested several times the need to have team meetings with her staff. These had yet to be agreed.
- Few staff could say who the directorate management team were.
- The senior radiology management team reported that they felt really supported and listened to by the executive board. The clinical director said that the chief executive was always willing to listen with a good line of communication to the board.

Culture within the service

Outpatients

- Staff we spoke with reported a very positive, open culture where they were encouraged to report incidents.
- Staff described a good working environment where everyone worked together. One member of staff said, “It is a really nice place to work, a good team and good managers, if you knock the door there is always someone there for me.”

Diagnostic and Imaging services

- All staff that we spoke to were happy working for the trust. There was a good staff retention rate. In one year, three radiographers left the department and the same three staff returned.
- A radiologist said that they were happy that they were not involved with the management team and were allowed to focus on their clinical commitments.

Public and staff engagement

Outpatients

- The friends and family test (where patients feedback whether they would recommend the service to their friends and family via questionnaires), had only just commenced in outpatients therefore there were no results available. We observed a friends and family feedback box by the reception area.
- Staff told us they felt listened to and supported by senior managers to make changes they wanted to make.

Diagnostic and Imaging services

- The manager told us that there were no local audits of patient satisfaction for example patient surveys.
- There were no patient 'comment' boxes within the radiology departments.
- Discussions with senior staff (such as superintendent radiographers and radiologists) highlighted that they were not involved with business planning and that any plans were not shared.

Innovation, improvement and sustainability

Outpatients

- We discussed with the senior managers areas of innovative practice that had been implemented within the outpatients department.
- They were proud of their nurse led cystoscopy clinics and nurse led under 35 female and male breast clinics.
- There was also a varicose vein clinic where a vascular scientist was present with the consultant enabling discussion of the results and patients being able to receive their results on the day.

Diagnostic and Imaging services

- Business plans and service improvements for other specialities were not shared with radiology (across both sites). The department was therefore not able to plan for development of services and impacts on resource and diagnostic targets. This also applied to business cases for additional medical or surgical consultant posts.
- The ultrasonographers were training to report plain films. This would offer more scope with regards to plain film reporting and maximise any spare capacity in the department. This was unique and a possible first in the UK.

Outstanding practice and areas for improvement

Outstanding practice

Trust wide

- The trust's SimWard was being utilised to support staff competencies. Staff told us they were in the process of expanding the service externally to provide education and learning to other authorities.

Emergency Services

- We noted effective integration with the rest of the hospital. For example we observed one patient presented to ED with headache and weakness, they were received by an ED consultant and had a scan within ten minutes. They were then received by a stroke consultant and Thrombolysis (treatment to prevent blood clotting) was started in the ED within 20 minutes.

Medicine

- Doctors, nurses and therapists were provided with a stamp by the trust with their name and personal identification number. This enabled other staff to easily track who had completed the record when required.

Surgery

- The trust recently instituted "In Charge" initiative was welcomed by patients and relatives. This was a badge worn by the person responsible for that shift on the ward.
- The innovative system to drain chests after cardiac operations had reduced patient length of stay in hospital.
- There was a group text system in place to ensure the availability of staff and beds on the day of the operation so as to avoid any cancellation.
- The "panel meeting" concept where senior trust staff provided high challenge and high support to wards managers after investigation of incidents. This meeting enabled staff to take the learnings from such events on board and ensure systems were put in pace to prevent reoccurrence.
- There were arrangements in place with Age Concern that certain patients funded by the local CCG could be called upon to transport suitable patients. There was a checklist in place for the driver who would ensure that the patient had all the necessary comforts in the home for example, food and a suitably heated home. The Age Concern drivers would stay with the patient in their home to ensure they are safe to be on their own.

Maternity and Gynaecology Services

- The trust had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.

End of Life Care

- We were told how care after death was of a very high standard and the mortuary staff would ensure the person's dignity was maintained during the care. Mortuary staff gave us examples of assisting a mother dress her small child in clothes that the mother had picked out. The mortuary staff supported her through a difficult time and allowed her to take her time with the child and utilise the Swan suite. We could see the mortuary staff were very passionate about delivering a high standard of care after death.

Areas for improvement

Action the hospital MUST take to improve

Medicine

1. The trust must improve the attitude and approach of some of its staff to patients in their care.
2. The trust must improve the level of detail in patient care records, reflecting individual preferences.
3. The trust must review the amount of monitoring and supporting equipment on its wards.

Outstanding practice and areas for improvement

Surgery

1. The trust must make sure that the recruitment of additional staff that was being undertaken to resolve the transportation of blood is completed in a timely manner.

Critical Care

1. The trust must ensure that regular checks are recorded regarding the cleaning of equipment.
2. The trust must ensure that locally owned risks are identified and recorded on the risk register and have appropriate actions to mitigate them, with timely reviews and updates.
3. The trust must ensure the medicine room is locked to reduce the risk of unauthorised people accessing medicines.
4. The trust must ensure that intravenous medicines are stored correctly to reduce the risk of the administration of incorrect medicines.
5. The trust must ensure that the microbiologist input is recorded within the patient records to support their care and welfare.

OPD and Diagnostics

1. The trust must ensure that when controlled drugs are removed from the medicines cupboard in radiology, this is clearly documented at the time of administration.
2. The trust must insure that governance systems improve so that safety issues and shortfalls in risk assessments and protocols are highlighted and addressed.
3. The trust must insure that there is clear ownership of responsibilities to ensure the radiology departments is working within best practice professional guidelines and IR(ME)R regulations

End of Life Care

1. Controlled medication must be labelled, prescribed to a patient and packaging must not be tampered with.

Action the hospital SHOULD take to improve

Emergency Services

1. The trust should improve staff understanding of the dementia care pathway for patients in the ED
2. Medicine fridge temperature records in the ED should be recorded daily to ensure medicines were stored safely.
3. Evidence of resuscitation status should be included in patient's records.
4. ED staff take up of mandatory training should be improved.
5. The trust should be clear about the use of the paediatric facilities in the ED
6. The trust should improve public information about making a complaint in the ED

Medicine

1. The trust should review the need to undertake transfers late at night of patients to Cannock Chase Hospital.
2. The trust should ensure sufficient and suitably skilled staff are available at all times to meet the needs of patients.

Surgery

1. The trust should make sure that all staff is up to date with the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards so that patients are not put at unnecessary risk of staff not acting legally in their best interests.
2. The trust should make sure that there are process in place to ensure formal "sign in" takes place in the anaesthetic room and that this is recorded.
3. The trust should make sure that a number of required policies and procedures identified from the national emergency laparotomy audit 2014 are put in place.
4. The trust should make sure that patients with bowel cancer can access appropriate clinical nurse specialist.
5. The trust should ensure there are resting seats available for vulnerable patients to avoid them to walk long intervals without resting.

Critical Care

1. The trust should ensure there are procedures in place to record the checking of the resuscitation trolley.
2. The trust should ensure that the trust's vision and strategy is cascaded to all staff.
3. The trust should ensure that all policies and procedures are up to date and have been reviewed appropriately.

Maternity and Gynaecology

Outstanding practice and areas for improvement

1. The trust should improve the quality of record keeping in maternity.
2. The trust should improve the checking of drugs and fridge temperatures where medicines are stored..
3. The trust should ensure emergency equipment is readily available to use.

OPD and Diagnostics

1. The trust should ensure that the renal unit complies with staffing requirements stipulated by the National Institute of Clinical Excellence.
2. The trust should ensure that staff in radiology receives feedback in relation to shared learning and changes in practice resulting from incidents.
3. The trust should ensure that call bells within radiology cubicles are fit for purpose and that there is clear signage outside x-ray rooms alerting patients not to enter and advising women to inform staff if they are pregnant.
4. The trust should ensure that the procedure to check whether women are pregnant prior to receiving radiography tests is improved
5. The trust should ensure that the nuclear medicine (imaging) service issues 'written instructions' to females who are breastfeeding and who have undergone a radio nuclide procedure.
6. The trust should ensure that Local Diagnostic Reference Levels are available for the CT scanners (and other diagnostic procedures) and that CT radiographers have a method (or written procedure available to them) of knowing when an overexposure would be much greater than intended and how this should be reported.
7. The trust should ensure that the clinical imaging protocols (operating procedures) are fit for purpose and that basic scan parameters are present that would allow an operator to follow and find operational information to be able to perform a scan safely and to check that recalled electronic settings within the scanning equipment is in concordance with the written protocol.
8. The trust must ensure that the radiation risk assessments are fit for purpose and have enough specific detail for the radiation work undertaken in each area.
9. The trust must ensure that there are Local Rules or systems of work available for mobile radiography units as required by the Ionising Radiation Regulations 1999.
10. The trust should ensure that paediatric reports within radiography are produced promptly.
11. The trust should ensure that appointment letters and patient information leaflets are available in languages other than English.
12. The trust should ensure that there is a method of monitoring whether patients have been present in outpatients or radiology for long periods to ensure they have adequate food and drink.
13. The trust should ensure that patient feedback is received and acted upon in radiology to improve service provision.
14. The trust should ensure that radioactive medicinal products and waste are securely stored and accounted for at all times.

End of Life Care

1. The trust might like to review staffing levels in particular on the oncology ward and surgical wards.
2. The trust should develop clear guidance for staff on repositioning spinal cord compression and spinal cancer patients.
3. Spinal cord compression and spinal cancer patients must be repositioned according to their assessment and trust policy. Staff should record incidents where appropriate.
4. The hospital might like to improve on communication with families and better recording of their discussions with staff, ensuring discharge is consistently discussed and they are kept informed of patient's conditions.

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This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and Treatment** 12.—(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs; (g) the proper and safe management of medicines; (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated; (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. How the regulation was not being met: Medications management and supply needs to improve within the trust to ensure the safety of people using the services. In particular we saw that medication packaging was used in such a way which would prevent safety checks being undertaken. Some patients did not always receive their medication as prescribed.

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Requirement notices

Records of controlled drugs were not being recorded at the time of administration. We also noted that medication were not always stored securely. The storage of some intravenous medicines was in an untidy manner which could result in mistakes occurring.

All people using the service must have in place plans of care that meets all of their needs. We noted that not all patients conditions although known had an associated plan of care.

Infection control practices did not include regular checks and records of cleaned equipment. The Microbiologist input must recorded in the records to support care and treatment plans.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance** 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

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Requirement notices

(f) evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

(3) The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

(a) a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

(b) any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

How the regulation was not being met:

We saw that not all of the core services used the risk register to identify locally held risks and identify mitigation actions in a timely manner.

The governance process to include shared learning needed to be improved within one of the core services, so that the onus was not on staff to identify the learning but for the local leadership to actively share the learning information.

We noted that the there was a lack of clear ownership with regard to the professional practice guidelines and IR(ME)R.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Nursing care Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staffing 18**.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. How the regulation was not being met: We found that not all core services had sufficient staff to meet all the needs of patients. In addition to this existing

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Termination of pregnancies Treatment of disease, disorder or injury	staff were shortfalls which were having a detrimental effect on staff morale. We also noted where staff were to be supernumerary they were required at times to work clinically to boost the staffing numbers.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **Premises and Equipment 15.** —(1) All premises and equipment used by the service provider must be— (a) clean, (b) secure, (c) suitable for the purpose for which they are being used, How the regulation was not being met: People who use the services and others were not protected against the risks associated with unclean equipment in Critical care. Adequate numbers of equipment for assessment of patients should be available on all wards.