South Warwickshire NHS Foundation Trust

Warwick 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 (including older people's care)	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

South Warwickshire Foundation NHS Trust provides a range of hospital care services and community health services to a community of approximately 270,000 in South Warwickshire and the surrounding areas. The trust provides a full range of district general hospital services at Warwick Hospital to its local population.

There are 441 inpatient beds within Warwick Hospital.

We carried out an announced comprehensive inspection of the hospital from 15 to 18 March 2016. We undertook an unannounced inspection on 29 March 2016.

The trust obtained foundation trust status in 2010.

We inspected this hospital as part of our programme of comprehensive inspections of acute trusts.

We held focus groups with a range of staff in the hospital, including union representatives, black and minority ethnic staff, governors, nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff and allied health professionals. We also spoke with staff individually as requested.

The inspection team inspected the following eight core services at Warwick Hospital

• Urgent and emergency services

• Medical care (including older people's care)

• Surgery

• Critical care

• Maternity and gynaecology

• Services for children's and young people

• End of life care

• Outpatients and diagnostic imaging

Overall, we rated Warwick Hospital as requires improvement with three of the five questions we ask. Safe, effective and well led were judged as requiring improvement.

We have judged the hospital as good for caring and responsiveness. We found that services were provided by dedicated, caring staff. Patients were treated with kindness, dignity and respect and were provided the appropriate emotional support. The trust was planning and delivering services to meet the needs of patients. The emergency department was rated as outstanding for responsiveness.

Safety

- Nurse staffing levels and skill mix were planned and reviewed in line with national guidance. Most areas had adequate staff to ensure patients received safe care and treatment.
- Although the trust had taken a number of actions to promote the Duty of Candour to staff, not all staff had a thorough understanding of this and what this meant within their practice.
- The trust had reported one never event (wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers) in the 12 month period ending February 2016. Although still under investigation at the time of the inspection early lessons had been learnt and shared.

Summary of findings

- The hospitals were seen to be clean and hygienic and most staff followed the trusts infection control policy, were 'bare below the elbow' and used personal protection equipment. There were some incidents of poor hand hygiene.
- All patients admitted to hospital were screened for methicillin resistant staphylococcus (MRSA) to assist with isolation and treatment. There was limited follow up of MRSA screening for patients admitted to the medical wards where we found results of this screening were not routinely recorded in nursing notes.
- Cases of MRSA were low with the trust reporting zero cases from August 2014 and August 2015, however there were 17 cases of C. difficile reported during the same period.
- Mandatory training was, across most areas below the trust's target of 85% and 95% for safeguarding adults and children and information governance.
- The level of safeguarding children's training that staff in certain roles undertook was in line with trust policy, but was not compliant with national guidance. Therefore, we could not be sure that staff had the sufficient knowledge and skills to safeguard children.
- In many wards and departments we saw medicines in unlocked cupboards and drawers. Although some medicines were left unlocked to allow rapid access in an emergency in some areas all medicines were unsecured, not just ones that required emergency access therefore we were not assured that medicines were stored in a way that prevented misuse, tampering or theft.
- Processes and procedures had been developed for women on the postnatal ward to self-administer some medication if they opted to do so.
- In the emergency department (ED), children with minor complaints were not seen in a secure paediatric area, they waited with adult patients, which is not in line with national guidance. During our unannounced inspection; we observed changes to the department had been made. A paediatric sub waiting room had been created within the main waiting area for paediatric see and treat patients, although there were no robust procedures in place for children to be observed for rapid deterioration while waiting in this area.
- Patient records were not always stored securely.
- Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the inpatient stay. This included incomplete risk bed rails risk assessments resulting in the use of bed rails without a completed risk assessment.
- Management of the deteriorating patient was in place in most areas of the trust through the use of early warning score (EWS) and paediatric early warning score were used (PEWS). However there was no such recognised tool in use in the special care baby unit.

Effective

- Care was delivered in line with legislation, standards and evidence-based guidance, however some local and trust guidelines needed updating.
- The mortality rate as indicated by the Summary Hospital-level Mortality Indicator (SHMI) was "as expected" for January to December 2015, at 1.1 against the England figure of 1.0. The trust Hospital Standardised Mortality Ratio (HMSR) (for in hospital deaths only) for January to December 2015 was "within expected range", at 108.0 against the England figure of 100
- Data was submitted for all national audits in 2013/2014, with the exception if the Acute Myocardial Infarction and other ACS (MINAP) audit which was not submitted due to staffing issues. Performance in national audits was generally the same or better than the national average. Actions plans were in place to address areas for improvement action.
- Staff and teams worked well together to deliver effective care and treatment.
- Not all staff had full understanding of the Mental Capacity Act 2005 and their responsibilities and role in the management of patients with capacity concerns. This includes appropriate formal assessment processes and escalation of concerns

Summary of findings

- The individualised care of the dying patient care plan, which was a replacement for the Liverpool Care Pathway, was designed to be used for patients in hospital and community settings. However, this was found not to be fully embedded in the care of the dying in the hospital and was not used by the community teams.

Caring

- Feedback we received from patients was consistently positive about the way nursing and therapy staff treated them. Patients felt safe and cared for and staff were respectful of their needs and preferences and took time to understand personal requirements or to explain the care being delivered.
- The need for emotional support was recognised and provided through a range of support mechanisms including a clinical psychology service.

Responsive

- The flow of patients into and through the hospital was well managed with all areas of the trust taking responsibility for this.
- The trust consistently exceeded the Department of Health target for emergency departments of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month. The percentage of emergency admissions via ED waiting four to 12 hours from the decision to admit until being admitted has been consistently lower than the England average. This meant that patients could access services in a timely way.
- The percentage of admitted surgical patients that started consultant-led treatment within 18 weeks of referral was consistently below the 90% standard between September 2014 and May 2015. In June 2015 this standard was abolished. Between September 2014 and August 2015 the trust's performance for this measure was better than the England average in all but two months. However, the trust consistently met the 95% indicator for non-admitted patients' referral to treatment within 18 weeks and met the incomplete pathways other than for one month February 2015. The percentage of patients waiting more than six weeks for a diagnostic appointment was also consistently better than the national average.
- The number of cancelled operations was better than the national average with no operation cancelled due to the lack of a critical care bed.
- There were specific waiting times for patients diagnosed with and suspected of having a cancer. 95% of all patients who receive an urgent referral for suspected cancer and breast symptoms should be seen by a specialist within two weeks. All patients should receive their first definitive treatment 31 days from diagnosis and, all patients should receive their first definitive treatment within 62 days from urgent referral. From October 2013 to March 2015 the service mostly performed the same as the England average which ranged from 93%-96% for patients waiting for two week referrals.
- Following some challenges in meeting the two week wait for patients referred with suspected cancer and breast symptoms from April to September 2015 this had improved in the three months October to December 2015 and the target was met. From April to September 2015 performance against the 31 day target was mostly the same as the England average and since July 2014 the performance against the 62 day target has been better than the England average.
- Services were planned, delivered and coordinated to take account of people with complex needs, for example those living with dementia or those with a learning disability, with some innovative practices in the emergency department with the use of computer assisted reminiscence therapy.
- Overall complaints were well managed with the trust using the issues raised as an opportunity to learn and improve services.

Well led

Summary of findings

- The trust had a clear vision to provide high quality, clinically and cost effective NHS healthcare services that met the needs of patients and the population that they serve. However there was no service specific written strategy for individual core services and specialties did not appear to have a shared vision or aim.
- There was a governance framework in place which supported the delivery of care although there were some areas of weakness. Whilst the board assurance framework and corporate risk register identified most of the keys risks, there were risks at local level that had not been captured. In addition there were not robust procedures in place to ensure that policies were reviewed in a timely way and reflected national guidance.
- The executive team was stable and well established and was visible and well regarded by both staff and people in the local community who attended an event to tell us about their care.
- There was a lack of oversight of the care for neonates, children and young people across the whole trust.
- The directors identified to provide representation for end of life care services at board level, did not attended of life care meetings and the trust did not have a non-executive director who provided representation of end of life care at board level.
- There was an extremely positive culture within the trust and staff felt respected and valued. The result sf the 2015 staff survey reflected this positive culture with the trust ranked in the top 20% of all trusts nationally.
- In line with previous years in 2015/16 the trust had made a small surplus however they clearly recognised the challenges to maintaining such a position.

We saw several areas of outstanding practice including:

- The use of reminiscence therapy within the emergency department (ED) for patients with a learning disability, dementia and mental health conditions.
- A smartphone application for medical staff containing relevant trust information, policies, clinical guidance and teaching availability.
- The ED staff worked with external agencies to provide services, including substance misuse liaison specialist support for patients.

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

Importantly, the trust must:

- Ensure that regular risk assessments are completed appropriately on admission to medical wards and repeated regularly to identify any changes in patient's risk of harm. This includes bed rail and mobility assessments and nutritional assessments for patients receiving end of life care.
- Ensure that all staff receive safeguarding children training in line with national guidance.
- Ensure that staff have full understanding of the Mental Capacity Act 2005 and their responsibilities and role in the management of patients with capacity concerns. This includes appropriate formal assessment processes and escalation of concerns.

In addition the trust should:

- Ensure that staff in the outpatients department record all incidents.
- Review staff have a clear understanding of the Duty of Candour.
- Ensure that defined cleaning schedules and standards are in place to comply with the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals'.
- Ensure that infection control and prevention policies are embedded into practice, particularly on the medical wards.
- Ensure medicine fridge temperatures are recorded accurately and any deviation from temperature controls acted upon.
- Ensure all medicines are stored safely in locked cupboards.
- Ensure that facilities in the emergency department are suitable for caring for patients with mental health needs.
- Ensure that all mandatory training is completed in line with the trust target.

Summary of findings

- Ensure that all staff have completed the relevant safeguarding adult training to ensure staff are aware of their roles and responsibilities in the identification of safeguarding needs and how to escalate concerns.
- Establish formal cover arrangements for acute palliative care consultant post when they were on leave.
- Continue to implement and monitor use of the swipe card access of the corridor and clean utility room in critical care to ensure safe storage of medicines, records and equipment on critical care.
- Investigate and share learning from the controlled drugs incident on critical care and ensure any corrective actions are completed.
- Ensure that all staff working in critical care receive training and guidance regarding their responsibilities outlined in the major incident plan.
- Ensure that staffing levels meet patient demand, enable adequate care of children by a qualified paediatric nurse and allow monitoring of all patients within the department at all times of day.
- Ensure that patient records are stored securely and completed in line with legislation.
- Review the high number of caesarean sections developing an action plan to reduce these.
- Ensure that there is an early warning score tool for babies on SCBU to ensure that any deterioration of a patient's condition is recognised.
- Ensure all trust policies are up to date and relevant.
- Ensure there are appropriate polices and operating procedures to support processes within the emergency department.
- Monitor pain scores in a consistent manner in the emergency department and ensure that there are formal pain tools used across SCBU and Macgregor ward.
- Ensure that advance care plans (a plan that documents patients' views, preferences and wishes about their future care) are in place for patients receiving end of life care.
- Ensure the annual audit plan for maternity is formally approved, that recommendations address the issues identified and action plans for improvement are developed.
- Develop, approve and implement an annual audit plan for gynaecology.
- Ensure that outcomes for gynaecology patients are clearly presented and reviewed.
- Ensure that nurses on the gynaecology ward receive training relevant to the specialism and acuity of patients admitted to the Beaumont ward.
- Ensure privacy of in patients attending radiology department is maintained.
- Ensure that the use of the individual plan for the dying person is embedded.
- Audit the effectiveness of the end of life care service, including collecting information on the number of patients who have been discharged to their preferred place of care, collecting information on those patients who died in their preferred place of death and audit the effectiveness of the rapid discharge process.
- Ensure arrangements are in place to monitor how quickly women attending midwifery assessment unit are seen and treated.
- Ensure specialist palliative care team referral guidelines are place, and circulated to all wards and departments.
- Reduce the delays for patients being discharged from critical care to the wards.
- Ensure that leaflets and interpreters are available and used for non- English speaking patients.
- Ensure that all complaints are reported to ensure themes are identified and lessons learnt cascaded to staff.
- Ensure that there is clear leadership and overall oversight of care for neonates, children and young people.
- Ensure that the arrangements for governance and performance management operate effectively in the services for children and young people.
- Ensure that all risks are identified on the risk register and appropriate mitigating actions taken.
- Ensure there is a clear process for the documentation and review of risks within the gynaecology service.
- Ensure that each service has a local vision and strategy which is disseminated and understood by all staff so that it is embedded within the service.

Summary of findings

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	Evidence based guidance was used within the department and was relevant and up to date. Multidisciplinary working was a strength of the department and relationships with internal and external services helped to avoid unnecessary attendances and facilitated early discharges. The department took part in local and national audits and showed learning from audit outcomes. Patient's feedback was positive about the care they received and we saw good examples of compassionate care within the department. The department was consistently meeting the four hour target, with escalation processes implemented at the earliest opportunity to allow proactive plans to be put in place to assist flow. All staff were passionate about providing high quality patient care. The department did not fully comply with guidance relating to both paediatric and mental health facilities. Safeguarding children training was not in line with national intercollegiate guidance. Leaders showed a full understanding and drive to improve flow within the department but lacked understanding of safety in relation to care of children. There was a lack of governance to support staff to follow procedures within the ED, including policies in relation to see and treat and triage. Staffing at night time did not always meet demand we observed staff sometimes caring for over twice the number of patients recommended by national guidance. Nursing staffing numbers were increased following our inspection and as a result of an on-going review. Initial assessments were not always carried out in a timely way and escalation of this was inconsistent due to lack of operating procedures to advise staff.

Summary of findings

Medical care (including older people's care)

Requires improvement

Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the inpatient stay. This included incomplete risk bed rails risk assessments resulting in the use of bed rails without a completed risk assessment.

Infection control practices were not embedded with isolated poor practice relating to hand hygiene and the use of personal protective equipment.

All patients admitted to hospital were screened for MRSA to assist with early identification and treatment; however we found results of screening were not routinely recorded in nursing notes. This meant it was unclear whether the patient had a negative MRSA result, or the result had not been reported.

Nursing and medical records were not routinely stored in secure areas, leaving them accessible to unauthorised persons.

Medications were not always stored securely, with doors unlocked or missing and cupboards unsecure.

Patients on a different specialty ward were not reviewed daily by their speciality consultant or medic. However, care of the elderly patients reviewed daily by a medical nurse practitioner.

Staff showed varied understanding of the Mental Capacity Act 2005 and their roles and responsibilities in the management of patients with reduced capacity. There was no evidence in practice of a clear system to ensure these patients were cared for safely and effectively. A few patients had entries in their notes that stated they did not have capacity but there was no record of any formal assessments of their capacity having taken place.

The trust had processes in place to keep people safe and staff were aware of their roles and responsibilities in reporting incidents.

The trust had reviewed medical admission processes, which resulted in an improved patients experience and pathway. The admission area facilitated the flexible use of beds to meet the demands of the service at any one point. This meant that when activity increased, additional beds could be used to relieve pressures within the emergency department (ED).

Summary of findings

The admission area facilitated a review by senior clinician within four hours of arrival with an early decision to admit to hospital or not. Where possible patients were managed through daily attendance at the clinical decisions unit for treatment.
The cardiology and respiratory specialities had introduced a speciality "pull" from admission areas to ensure that any patient admitted with that speciality would be reviewed as soon as possible after admission and transferred to the most appropriate area to manage treatment.
The flow of patients through the hospital was effectively managed and a policy was in place. Bed management meetings were held three times a day to discuss and prioritise bed capacity and patient flow issues. Discharge coordinators and the complex discharge team helped to facilitate appropriate patient discharge. A high percentage of patients had less than two ward moves per admission to hospital.
Wards were visibly clean.
Referral to treatment performance was in line with national targets.
Although there was a high level of nursing staffing vacancies within some teams, staffing levels did generally meet patient needs at the time of our inspection. Medical staffing was in line with national guidance.
Overall, mandatory training in nursing staff did meet the trust target of 85%.
There was some evidence of provision of seven day a week services.
The medical care service was generally well led at a ward level, with evidence of effective communication within ward teams. The leadership and culture promoted the delivery of high quality person-centred care as governance and risk management systems were in place in the service.
The trust performed 'as expected' and 'within expected range' in the two mortality indicators (SHMI and HMSR respectively) and the service had systems in place to review mortality rates. Monthly mortality meetings included reviews of any patient deaths to identify learning and individual development.
Care was provided in line with national best practice guidelines.

Summary of findings

The trust participated in some national clinical audits.
Pain relief was assessed appropriately and patients said that they received pain relief medication when they required it.
Generally, patients received compassionate care and their privacy and dignity were maintained. We saw staff interactions with patients were person-centred and unhurried. Patients told us the staff were caring, kind and respected their wishes.
Most patients felt involved in planning their care, making choices and made informed decisions about their care and treatment.
The trust worked closely with community services to enable an established 'discharge to assess programme', which had been used as a reference centre for other trusts and the reinstatement of care packages up to 14 days after admission to hospital.
There were additional facilities for patients living with dementia and those with learning disabilities. Including activities for patients, the use of "this is me" document and extended visiting hours for families and carers.
The service had good governance processes in place with an audit calendar and evidence of learning. Staff reported receiving feedback regarding incidents that they had reported.
The trust had implemented an application (app) that could be downloaded onto mobile phones, which contained all policies, and procedures, which could be used for advice or direction.
Haematology services had developed a standard of practice for all patients admitted with suspected neutropenic sepsis enabling early intervention and treatment.

Surgery

Good

There was a culture of incident reporting and staff said they received feedback and learning from serious incidents. However, some staff did not always receive feedback on all clinical incidents. Staff were able to speak openly about issues and serious incidents.
The environment was visibly clean and generally staff followed the trust policy on infection control, although, we saw no evidence of domestic staff using cleaning checklists.

Summary of findings

Medical staffing was appropriate and there were good emergency cover arrangements.
Consultant-led, seven-day services had been developed and were embedded into the service.
Staffing levels were planned and reviewed to ensure that patients received safe care and treatment.
Agency and bank staff were used and sometimes staff worked additional hours to cover shifts but this was well managed and patients' needs were met at the time of the inspection.
Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Multidisciplinary working was effective.
Patients outcomes were generally good but not all staff were aware of patients' outcomes relating to national audits or performance measures.
Most staff had received annual appraisals and support systems for staff development were effective, however there were areas of poor compliance with mandatory training.
Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) procedures to keep people safe.
The consent process commenced in outpatients, there were specific consent clinics and consent was reconfirmed at the time of admission.
Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.
Patient care records were appropriately completed with sufficient detail and kept securely.
The service had an effective complaints system in place and learning was evident.
There was support for people with a learning disability and reasonable adjustments were made to the service. However information leaflets and consent forms were not available in other languages. An interpreting service was available and used.
Surgical services were well-led. Senior staff were visible on the wards and theatre areas and staff appreciated this support. There was generally a good awareness amongst staff of the trust's values.

Summary of findings

Critical care

Good

The service demonstrated a good track record on safety with low rates of infection and avoidable harm to patients.
Patient outcomes reported within ICNARC showed the service performed as expected, or better than expected for most outcomes when compared to other similar critical care services.
Staff understood and spoke positively about the safety reporting system in place, and felt that openness and transparency about safety was encouraged.
Staffing levels were compliant with Guidelines for the provision of intensive care services, 2015 ((the core standards) with staffing levels and skill mix planned, implemented and reviewed to keep people safe at all times.
There were clear policies, procedures and training in place to enable staff to keep people safe and safeguarded from abuse.
The environment was clean and well organised, and we saw good compliance with infection prevention and control practices.
Risks to people who used the service were assessed, monitored and managed on a day-to day basis.
Care and treatment was delivered in accordance with best practice and recognised guidance and standards.
There was collaborative working amongst the multi-disciplinary team, and with other services and providers.
Staff had the right qualifications, skills, knowledge and experience to do their job and were supported through appraisal, supervision, training and revalidation.
Patients and those close to them spoke positively about their care and treatment, and felt supported and cared for by staff.
There were clear processes in place for people to raise concerns or complain; these were low in number and managed in a timely manner.
The nursing leadership team were knowledgeable about quality issues and priorities, and took action to address the challenges; there was alignment between the recorded risks and concerns raised by staff.

Summary of findings

Staff satisfaction was high and staff felt engaged with the service leaders.

Maternity and gynaecology	**Requires improvement**		1:1 care in labour not always achieved and the number of caesarean sections and normal vaginal births were worse than the trusts targets. The trust did not provide evidence that any registered clinical staff within the maternity service had completed their level 3 safeguarding children training, which was a national requirement for their role. This meant we could not be sure that all staff have the sufficient knowledge and skills to safeguard children. Records were not always stored securely. Termination of pregnancy records were not consistently completed in line with legislation. There were processes in place for maternity staff to learn from incidents, however, these were not working effectively in practice. Governance arrangements for gynaecology services were not robust and there was no clear vision or strategy for the service. There was a five year strategic plan in place for maternity, although this did not include a review of achievements against previous objectives. Recommendations to ensure that lessons were learned when things went wrong were not always completed within appropriate timescales. Intravenous fluids were not always stored in a safe environment meaning there was a risk they could be stolen or tampered with. The trusts mandatory training target of 85% had not been achieved in either the maternity or gynaecology service. The maternity annual audit plan had not been formally approved. The audit plan did not record the justification for audits. Recommendations did not always fully address the issues identified and action plans were not always completed. The audit plan for gynaecology consisted of five audits over a five year period, one of which had been withdrawn. Two audits had been completed within the last 12 months; the other two audits dated back to 2011 and 2013. Limited information on completed audits was provided.

Summary of findings

Data on patient outcomes for gynaecology patients were not reported and monitored in a central dashboard.
There was a good track record on safety with low rates of infection.
Patients reported that they received good care and that staff were friendly and helpful.
Patient records were completed and observations recorded.
A high number of staff had received their annual appraisal.
Multidisciplinary arrangements worked well.
Safeguarding arrangements were in place and the staff we spoke with had a good understanding what to look out for as well as the reporting process.
When women asked for help, they were responded to in a timely manner or told that they would be helped as soon as possible.
Patients told us that staff were helpful and that they explained things to them in a manner they could understand.
Recent friends and family surveys had reported positive feedback from patients.
The maternity service was proactive in considering a midwifery led unit (MLU) to ensure women's choice was at the forefront of the service.

Services for children and young people

Good

Children and young people were treated with dignity, respect and kindness. Feedback from parents and children were positive. Parents felt supported and told us staff cared about them and their children.
Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We found evidence sharing learning and changing practice as a result of incidents.
Services were clean and staff adhered to infection control policies and protocols. Equipment was checked daily, cleaned and documented.
The service used a comprehensive prescription and medication administration record card which facilitated the safe administration of medicine.
Patient records we looked at were comprehensive.
Medical ward rounds and nursing handovers took place three times a day across the service and were well attended.

Summary of findings

The risks associated with anticipated events and emergency situations were recognised, assessed and managed.
Staff received training on the duty of candour.
Staff understood their roles and responsibilities for safeguarding children. Although mandatory training was generally well attended, safeguarding children training at level three was not in accordance with the intercollegiate guidance 2014 document published by the Royal College of Paediatrics and Child Health (RCPCH), 'safeguarding children and young people roles and competences for health care staff, 2014'. This meant there was a risk that staff may not have the level of competence to respond appropriately to safeguarding concerns.
Although nursing staffing levels did not always meet RCN and Toolkit for High Quality Neonatal Services 2009 recommendations; and the service did not comply with RCPCH standards for having 10 consultants to cover, we found mitigating actions were in place and there was no evidence of a negative impact on the care and treatment children and young children received.
Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
Staff were proactively supported to acquire new skills and share best practice and staff were competent to carry out the care of children and young people.
Services were planned and delivered in a way that was meeting the needs of the local population. The individual needs of children and young people were generally met.
Waiting times, delays and cancellations were minimal and managed appropriately.
The service was part of the integrated paediatric strategy (2014-2019) that included both acute and community provision of services. The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, commissioners and others.

Summary of findings

Staff in all areas knew and understood the vision and values. Staff felt well supported and felt they were well managed.
The arrangements for governance and performance management did not always operate effectively. Governance arrangements were fragmented with no one person responsible for children and young people's services.
Not all risks we identified on the risk register.
It was unclear who had the overall oversight of care for neonates, children and young people. After the inspection the trust told us that the Head of Midwifery had oversight of the service in the hospital.
We found limited evidence of public engagement.
Mandatory training compliance levels did not always meet the trust target. This meant that there was a risk that staff did not have the necessary skills to carry out their role.
There was no recognised early warning score tool for babies on SCBU and no audit for the use of a local tracker and trigger system on Macgregor ward within the last 12 months. This meant that there was a risk that any deterioration of a child's condition may not always be recognised. However, we saw no evidence of this in practice.
There were no formal pain tools used on SCBU.

End of life care

Requires improvement

The trust did not have a clear vision or a strategy for end of life care services; however they had recently appointed a full time consultant with the remit of developing a strategy.
The end of life care service did not have effective processes in place to measure their effectiveness and outcomes.
There were no formal arrangements to cover the acute palliative care consultant post when they were on leave.
Mental capacity assessments around decisions about do not attempt cardio-pulmonary resuscitation (DNACPR) in was only evident in 66% of patients' records.
The acute SPCT had not completed an audit of patients who had been discharged to their preferred place of dying. This meant, because it was not recorded, this information could not be used to improve or develop services.

Summary of findings

The acute SPCT trust did not collect information of the percentage of patients that had been discharged to their preferred place of death within 24 hours. Without this information, they were unable to monitor if they were meeting patients' wishes and how they could make improvements.
The trust had in place a replacement for the Liverpool Care Pathway (LCP) called the Individual Plan of Care for the Dying Person. However, its use was not firmly embedded in the trust's culture.
The directors identified to provide representation for end of life care services at board level, did not attend end of life care meetings.
The trust did not have a non-executive director who provided representation of end of life care at board level, which is a recommendation of the National Care of the Dying Audit of Hospitals.
The leadership team was not able to evidence that they were knowledgeable about quality issues therefore were unable to take actions to address them.
Relatives and patients spoke positively about end of life care. Staff provided compassionate care for patients.
There were arrangements to minimise risks to patients with measures in place to safeguard adults from abuse, prevent falls, malnutrition and pressure ulcers and the early identification of a deteriorating patient through the use of an early warning system.
Patients received good information regarding their treatment and care. The service took account of individual needs and wishes and patients' spiritual needs.
The bereavement support staff provided good support to relatives after the death of a patient.
The hospital had a rapid discharge service so that patients could be discharged to their preferred place of care.

Outpatients and diagnostic imaging

Good

Performance data showed a good track record in safety.
Clinical areas were generally clean and well-organised. Medical records were maintained accurately and securely, and there was an effective records tracking and location system.

Summary of findings

Infection control procedures were followed and the service conducted regular audits.
There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
The service had a system in place to recognise and respond to changes in patient's health.
There was evidence that patients were told when things went wrong and offered an apology.
There were systems in place to ensure the right patient received the correct diagnostic procedure.
Staff were recognising, resolving and discussing incidents but not always recording them in line with trust policy, this meant that learning from incidents was not always shared.
Not all staff had the appropriate level of training for safeguarding children.

Warwick 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 Warwick Hospital

South Warwickshire NHS Foundation Trust provided acute hospital and community services to over 270,000 people in South Warwickshire and the surrounding areas. The hospital has 441 beds and 4356 staff.

In 2014/15, the trust's revenue was £234.8m. There was a surplus of £225,000 for the 2014/15 financial year. The trust predicted it would break even at financial year end 2015/16. However, their actual end of year position was a surplus of £244,000.

The majority of acute services are delivered at Warwick Hospital which provides a full range of district general hospital services. There are 441 inpatient beds within Warwick Hospital, 40 are maternity and seven are critical care beds.

We carried out an announced comprehensive inspection of the hospital from 15 to 18 March 2016. We undertook an unannounced inspection on 29 March 2016.

The trust obtained foundation trust status in 2010.

We inspected this hospital as part of our programme of comprehensive inspections of acute trusts.

We held focus groups with a range of staff in the hospital, including staff side representatives, black and minority ethnic staff, governors, nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff and allied health professionals. We also spoke with staff individually as requested.

Our inspection team

Our inspection team was led by:

Chair: Jenny Leggott, Former Director of Nursing, Nottingham University Hospitals

Team Leader: Bernadette Hanney, Care Quality Commission

The team included 16 CQC inspectors (including two CQC pharmacist inspectors) and a variety of specialists including a safeguarding lead, medical consultants and nurses, senior managers, a surgical nurse, an anaesthetist, a consultant cardiologist, a consultant surgeon, senior paediatric nurses and doctors, a consultant obstetrician, midwife, health visitor, allied health professionals, a palliative care consultant and a palliative care speciality doctor , senior nurse and a physiotherapist both specialising in neurological rehabilitation, a junior doctor, a student nurse and an expert by experience who had experience of using services.

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Warwick Hospital and asked other organisations to share what they knew about the trust. These included the Clinical Commissioning Group, Monitor, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We held a listening event in the evening before the inspection where people shared their views and experiences of services provided by Warwick Hospital. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection from 15 to 18 March 2016 and an unannounced inspection on the 29 March 2016.

We held focus groups with a range of staff in the hospital, including staff side representatives, black and minority ethnic staff, governors, nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff and allied health professionals. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients departments.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Warwick Hospital.

Facts and data about Warwick Hospital

Population served:

The trust serves a community of approximately 270,000 in South Warwickshire and the surrounding areas. The largest population centres are the towns of Kenilworth, Royal Leamington Spa, Southam, Stratford-upon-Avon and Warwick.

Deprivation:

In the 2015 indices of multiple deprivation, the Warwick and Stratford-upon-Avon districts were both in the least deprived quintile. Rugby was in the second-to-least deprived quintile. However, Nuneaton and Bedworth district was in the second-to-worst quintile for deprivation.

Population age:

Estimates and projections (2013) indicated the number of people aged 65 years or older in the Warwick, Rugby and Nuneaton and Bedworth districts was in line with the England average (around 17%). However, Stratford-upon-Avon districts had a higher (more) percentage 24%, than the England average number of people aged 65 years or older.

Ethnic diversity:

The 2011 census showed that all districts in the South Warwickshire area had less than the national average of Black, Asian, Minority Ethnic (BAME) residents (15%). Stratford-upon-Avon districts had a much lower (less) percentage 3% of BAME residents.

Activity:

In 2014/15, the trust had 19,456 elective admissions and 20,751 emergency admissions.

Detailed findings

Hospital Episode Statistics showed that the trust saw 409,913 attendances to outpatient departments at the trust from July 2014 and June 2015.

The number of attendances to the emergency department from April 2013 and August 2015 was 65,875 (NHS England).

Our ratings for this hospital

Our ratings for this hospital are:

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

Information about the service

The emergency department (ED) at Warwick Hospital provides a 24 hour service, seven days a week to the local population.

The department consists of a see and treat waiting area with six see and treat cubicles, a majors waiting area with 12 major cubicles, two paediatric majors cubicles and three resuscitation bays. There is an observation ward within the ED that allows up to five patients to be cared for until they can be discharged or admitted following the return of diagnostic results.

The hospital did not have a separate children's ED; however there was a separate children's majors' area within the adult ED.

The ED saw 65, 875 patients from April 2014 to March 2015, of these patients 13,438 were aged 16 and below, accounting for 20% of attendances.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance only entrance. Patients, who self-presented to the department, reported to reception who would direct them to a clinical area; either see and treat or the majors waiting room from 9am until 10pm. Between 10pm and 9am all patients would be directed to the majors waiting area.

Patients who attended the ED should be expected to be assessed and admitted, transferred or discharged within a four hour period in line with the national target.

Stratford Community Hospital and Ellen Badger Hospital also had a nurse led minor injuries unit (MIU).

The MIUs provide an urgent assessment, diagnosis, treatment and discharge or referral service for adults and children presenting with minor injuries. The trust saw 7,435 patients in the MIUs during the period December 2014 to November 2015.

The MIU at Stratford was staffed by emergency nurse practitioners (ENPs) working autonomously to treat patients with minor injuries such as lacerations and fractures. ENPs are senior nurses with accident and emergency and/or minor injury experience, who have received additional training that enables them to provide treatment for minor injuries and conditions. The ENPs can assess, treat and discharge patients within predetermined guidelines. The MIU at Ellen Badger Hospital was staffed by nursing staff working on the hospital ward.

Both MIUs offered a seven day service. The MIU at Ellen Badger Hospital opened daily 8am to 8pm and Stratford Hospital MIU was open 9am to 5pm. All opening hours were clearly displayed either on the outer hospital door or inside hospital entrances. The boards gave clear redirection information with contact phone numbers if the unit was closed.

During our inspection, we visited all clinical areas and the observation ward. We spoke with 22 patients, 31 staff, and 11 people visiting relatives. We also looked at the care plans and associated records of 46 people. We held focus groups with nursing, medical staff and ancillary staff, as well as speaking to senior doctors and nurses.

Urgent and emergency services

Summary of findings

Overall we rated the ED as good. It was judged to require improvement for safety, good for effectiveness, caring and leadership and outstanding for responsiveness.

- Evidence based guidance was used within the department and was relevant and up to date.
- Multidisciplinary working was a strength of the department and relationships with internal and external services helped to avoid unnecessary attendances and facilitated early discharges.
- The department took part in local and national audits and showed learning from audit outcomes.
- Patient's feedback was positive about the care they received and we saw good examples of compassionate care within the department.
- The department was consistently meeting the four hour target, with escalation processes implemented at the earliest opportunity to allow proactive plans to be put in place to assist flow.
- All staff were passionate about providing high quality patient care.

However, we also found:

- The department did not fully comply with guidance relating to both paediatric and mental health facilities.
- Safeguarding children training was not in line with national intercollegiate guidance.
- Leaders showed a full understanding and drive to improve flow within the department but lacked understanding of safety in relation to care of children.
- There was a lack of governance to support staff to follow procedures within the ED, including policies in relation to see and treat and triage.
- Staffing at night time did not always meet demand we observed staff sometimes caring for over twice the number of patients recommended by national guidance. Nursing staffing numbers were increased following our inspection and as a result of an on-going review.
- Initial assessments were not always carried out in a timely way and escalation of this was inconsistent due to lack of operating procedures to advise staff.

Are urgent and emergency services safe?

Requires improvement

We rated safety within the ED as requiring improvement because:

- The department did not comply with guidance relating to paediatric facilities. This was escalated to the trust and following our inspection actions were being put in place to address this by creating an appropriate environment, however children were not monitored within this area.
- The department did not comply with guidance relating to mental health facilities. Whilst the room used to care for those presenting with mental health conditions had been risk assessed not all risks were mitigated.
- Staffing at night time did not always meet demand we observed staff sometimes caring for over twice the number of patients recommended by national guidance, however nursing staffing numbers were increased following our announced inspection and as a result of an on-going review.
- Initial assessments were not always carried out in a timely way and escalation of this was inconsistent due to lack of written policies and procedures to advise staff.
- Safeguarding children training was not in line with national intercollegiate guidance.
- Not all staff had a thorough understanding of the duty of candour and what this meant within their practice.

However, we also found:

- Incidents were reported appropriately and lessons learnt resulting from them were shared amongst staff regularly.
- Equipment was well maintained and suitable for use throughout the department.
- Consultant provision in the department had recently increased to provide better seven day cover.
- A major incident plan and policy was in place and staff within the ED were aware of their role and responsibilities within this.

Incidents

- There had been no Never Events reported from March 2014 and March 2015 within the ED. A never event is a

serious incident that is wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- The ED reported five serious incidents from August 2014 and July 2015: one relating to maternity/obstetric care in the department, one relating to slips/trips/falls, one was sub-optimal care of a deteriorating patient, one was a medication incident and one was awaiting categorisation.
- An electronic system was used for reporting untoward incidents. All nursing and medical staff within the ED knew how to access and use this system.
- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. Some staff stated that they did not always report staffing shortages or times when demand had increased and they had to look after an excessive amount of patients.
- February 2015 and February 2016, 683 incidents had been reported. Incidents were graded in severity, with the vast majority (503) being no harm, 109 being low harm, 51 being moderate harm and 19 being severe harm. Pressure ulcers accounted for the highest majority of incidents reported (138), of these six were hospital acquired, the remainder occurred prior to attendance. Safeguarding accounted for 117 incidents, staffing accounted for 64 and medication incidents accounted for 50. All incidents were actioned appropriately and all had the action taken documented within the incident database. Information relating to staff feedback was not contained in the incident database.
- Feedback from incidents was varied, staff told us that if there was a theme in incidents then feedback would be given to all staff in the department, but individual feedback was not always provided.
- We saw that an incident newsletter was displayed monthly within the staff room to inform all staff of any incidents that learning had been identified from, or any themes in incidents.
- We saw evidence of mortality and morbidity being discussed during monthly governance meetings, with associated actions being documented where necessary.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Medical staff we spoke with in the ED were aware of duty of candour; however several (five) nursing staff we spoke with had minimal knowledge of this and what it meant in practice.
- Staff told us they knew the importance of being open and honest with patients if something went wrong.
- We saw evidence from previous incident reports that patients were informed by the trust in a timely way if something had gone wrong relating to their care.
- We saw posters around the ED which explained to staff how duty of candour was relevant to their role.

Cleanliness, infection control and hygiene

- Processes were in place within the ED to ensure standards of cleanliness and hygiene were maintained.
- Staff within the ED showed a good knowledge of appropriate infection control procedures and adhered to these throughout their daily practice.
- Throughout our inspection the department was clean and tidy, with alcohol gel dispensers and hand washing facilities available for staff, patients and visitors.
- Nursing and medical staff were compliant with the trusts' bare below the elbows policy and also followed appropriate hand hygiene techniques whilst caring for patients.
- Personal protective equipment was available throughout all areas of the department and was utilised in accordance with the trust's infection control policy.
- Hand hygiene audits should have been conducted monthly. The ED did not report audit results for June, October or December 2015. The average for reported months was 86% which was below the trust target of 95%. We did not see any action plans in place to address months where the audit outcome did not meet the trusts' target. However, we spoke with the trust's infection control lead who was knowledgeable on the areas of infection control that were problematic for the ED. They informed us of improvements that had been made over the past four months to improve compliance with infection control practices which included education, notices and increased availability of alcohol gel.

- Side rooms with doors were available for patients requiring isolation, signs were visible to staff and visitors when this was the case. Medical and nursing staff could explain how isolation procedures were followed within the department and which patients would require isolated care. We saw five occasions where nurses were caring for patients under isolation and followed the necessary techniques to avoid spread of infection and mitigate against infection control risks.
- Equipment was stored within sterile packaging in accordance with manufacturer's guidance across all areas of the department.
- Green 'I am clean' stickers were used across the department to ensure all staff could identify that an item of equipment had been cleaned and was suitable for use.
- Infection control training had been attended by 90% of nursing staff and 100% of medical staff; exceeding the trusts target of 85%.

Environment and equipment

- The design, maintenance and use of facilities was not always appropriate to keep people safe. The department had a secure paediatric area that was in line with Royal College of Paediatrics and Child Health guidance. However throughout our inspection one of the doors to the paediatric area leading from the majors ED was left open regularly, meaning it was unsecured, and although there is limited access from unauthorised people through the ED majors department, this practice does pose some risks to children. This area was used only for paediatric major patients.
- Children with minor complaints were not seen in a secure paediatric area, they waited within the see and treat area along with adult patients. This was not in line the Royal College of Paediatrics and Child Health, and Royal College of Emergency Medicine guidance that states there should be an audio-visual separation from adults and children whilst in the ED and area where children are cared for should be zoned off and secure to protect children. This waiting area also had a large window facing the outside of the ED which made it visible by other patients and visitors. Health Building Note 15-01 states that areas where children wait should allow observation by staff but not allow patients or visitors within the adult area to view the children waiting. We escalated concerns relating to children waiting in the ED to the senior ED team and the trusts' executive team. A risk assessment was completed during our inspection; however this did not address the concerns entirely and focussed on flow through the department as opposed to address deviation from guidance and how risk was mitigated. Leaders within the ED did not initially feel children being seen with adults was a risk and did not feel it necessary to change where children waited. However after our announced and before our unannounced inspection the leaders in ED responded to the issues raised and facilitated the development of two separate children's waiting areas.
- There was also no specific children's waiting area in the MIUs which meant that young children were not effectively screened from the adult waiting room, however there were suitable toys for them within the general waiting area.
- Following our inspection we provided further feedback in relation to the facilities for paediatric patients and during our unannounced inspection we observed changes to the department had been made. A paediatric sub waiting room had been created within the main waiting area; this was for paediatric see and treat patients. This sub waiting area was compliant with guidance, with the exception of the door being secure; plans were in place to have swipe access fitted imminently.
- During our inspection we saw an episode where a paediatric patient aged 15 was seen within the adult area of the ED. We spoke to nursing staff who told us the treatment area had not been discussed with the patient. The age patients were seen in the paediatric area varied with no standard operating procedure in place to inform staff of the correct age per area.
- There was no dedicated mental health room within the department, however one cubicle had been risk assessed for use to care for patient presenting with mental health conditions. Royal College of Emergency Medicine (RCEM) guidance requires assessment rooms to have an alarm system, two doors and no ligature points or objects that could be used as missiles. This cubicle had two doors, a strip alarm system and no ligature points, however equipment and furniture was not secured, resulting in potential for them to be used in a manner that could cause harm to person or environment. Nursing and medical staff were aware of the areas of this cubicle that didn't comply with guidance and knew how to mitigate these risks. Staff

told us that not all items were removed from this room when patients were being cared for; this resulted in the potential for objects to be used in a manner that could cause harm to person or environment.

- We saw that there had been 19 incidents reported in relation to mental health from February 2015 and February 2016. One of the incidents related to a patient who was being cared for in a cubicle not designed for those presenting with mental health complaints where they had thrown unsecure objects at staff including oxygen cylinders.
- Systems were in place to ensure all equipment was maintained and safe for use. Daily checks of resuscitation equipment occurred within the ED. Record books were completed in line within trust policy and trolleys were located in central areas and available should they be required.
- Although MIU's do not have resuscitation trolleys, they do have fully equipped grab bags that are regularly checked and equipment was seen to be in date." Grab bags are small bags with resuscitation equipment that could be used in areas not easily accessed by a trolley. There was a portable defibrillator on the wards at all of the community hospitals which were checked daily. Airway management equipment was also available. The MIUs at Stratford Hospital and Ellen Badger Hospital had access to these defibrillators, if necessary.
- All equipment had received portable appliance testing in accordance with trust policy.

Medicines

- Arrangements for managing medicines, and medical gases were in place to keep people safe, however there were some concerns in relation to storage of medicines.
- Medicines in the ED were not always stored securely to prevent them being stolen or tampered with. We saw that the tamper evident tags on the emergency trollies had not been replaced, and we saw medicines in an unlocked cupboard in a utility room. Staff told us these would be moved. Intravenous fluids were stored in an unlocked room but this was to make sure they could be accessed immediately in an emergency and we saw that a risk assessment had been carried out to support this.
- Emergency medicines were available for use and there was evidence that these were regularly checked. We saw that Controlled Drugs were stored securely. Controlled drugs are medicines which have a requirement to be stored in a secure way and their use recorded in a register.
- We found secure storage of medicines within the MIU at Stratford Community Hospital; for example, medicine cupboards were locked and medicine trolleys were locked and secured.
- Medicines for children were provided in liquid form to aid administration.
- We observed staff preparing and administering intravenous medicines, in accordance with national guidance.
- All records we reviewed contained patient's allergy status and this was confirmed with patients.
- Local microbiology protocols were in place for the administration and prescription of antibiotics, staff accessed these protocols via the trust intranet.
- The ED department allowed certain staff to administer simple analgesia under patient group directives (PDGs). PGDs provide a framework that allows some registered health professionals to administer a specified medicine to patients without them having to see a doctor. Not all staff had received the necessary training to administer medicines under PDGs but this was being planned in within the next six months.
- We saw that appropriate Patient Group Directive (PGDs) were available in the MIU at Stratford Hospital. PGDs were not used at Ellen Badger Hospital as staff do not administer medication at this MIU. Not all staff had received training to administer medicines under PDGs but this was planned within the next six months. These staff did not administer medicines under a PDG prior to undertaking this training but would escalate to a medical or non-medical prescriber to prescribe analgesia if required urgently.
- From February 2015 and February 2016 there had been 50 incident reports classified as medication incidents, with one severe harm and two moderate harm. Medication errors (either too much or too little of a drug given) accounted for 16 of the incident reports, 14 related to delays in antibiotics of over an hour for patients presenting with sepsis and five related to controlled drugs. We saw evidence that all medication related incidents were actioned appropriately with patients being informed if they had received incorrect dosages or incorrect medicines.

- There was not dedicated pharmacy service to the emergency department, but a pharmacist visited the ED daily and could be contacted for advice when needed, including out of hours.
- Pharmacy support was available in Stratford Community Hospital MIU. This assisted the staff to check their stock and ensure routine medication was available.
- People who needed medicines to take away were given a prescription to take to the hospital pharmacy or, when that was closed, supplied with the medicine from the ED or given a prescription to take to a community pharmacy. Some nursing staff had qualified as independent prescribers which meant that they could issue medicines or prescriptions once they had assessed a patient. The pharmacy team provided a stock top up service to the department so that people have access to medicines when they need them.

Records

- Records were generally written and managed in a way that kept people safe, with some concerns in relation to safe storage of patient records.
- Records within the ED were mainly paper based, with the addition of diagnostics and previous attendances being computerised.
- Records for current patients within the department were easily located in the area they were being cared for.
- We reviewed 46 patient records during our inspection and found them to be legible and with correct patient details. Records were generally well completed in relation to interactions and treatment, however time of initial assessment was not recorded on eight patient records and an early warning scores (EWS) not calculated on six patient records from the observations completed.
- Not all records were stored in a manner that maintained confidentiality; records of those waiting for triage were in a tray on the nursing station that was located directly in front of the doors where patients and relatives entered the majors' area, making them visible and accessible to unauthorised person.
- Systems were not in place to monitor and improve where required in relation to records as audits of records were not conducted within the department.
- In the MIU's the electronic records system ensured immediate access to patients' notes. Staff were able to access patient details and previous attendance details as required.

Safeguarding

- Safeguarding training was provided during induction for medical staff, and then yearly for those that continued work within the department. Nursing staff were required to carry out yearly safeguarding updates. Within the ED only 39% of nursing staff had completed level 3 safeguarding children training, and 74% of medical staff. All of staff working in the minor injury units (MIUs) had received children's safeguarding training to level 2 however; only senior staff had completed level 3 training.
- The level of safeguarding children's training undertaken was in line with trust policy, but was not compliant with national guidance. The trust told us that they had interpreted the guidance to mean that in the ED only senior nurses and doctors were required to be trained at level three and they ensured that one member of staff with level 3 training was on each shift. However this was not in line with intercollegiate guidance which states that all registered medical and nursing staff working in MIU's or ED's are required to complete this training. Therefore, we could not be sure that staff had the sufficient knowledge and skills to safeguard children.
- Attendance rates for other levels of children safeguarding were not meeting the trusts target of 95%. 91% of nursing staff and 90% of medical staff had attended level 2 children safeguarding training; however plans were in place to improve this training attendance.
- All nursing and medical staff we spoke with showed a comprehensive understanding of identifying and reporting any safeguarding concerns.
- All paediatric attendance notes were reviewed by a health visitor liaison nurse the day following the child's attendance to the ED. This ensured that there was a clear oversight regarding the safeguarding of children. Any safeguarding concerns missed by clinical staff would be identified during this secondary review. Staff told us that they received feedback from this nurse if they felt records or safeguarding points were not completed fully.
- Paediatric patients' safeguarding status were assessed on their arrival to the department. An alert system was

in place to identify children known to social services or if there had been any previous safeguarding concerns. Reception and nursing staff all knew the symbol that identified these patients.
- From February 2015 and February 2016, 117 incidents relating to safeguarding had been reported by the ED. All of these incidents had been followed up and actioned appropriately.

Mandatory training

- All staff were required to attend mandatory training on topics such as information governance, fire safety, and conflict resolution and infection control. We were provided with data to show how many nursing and medical staff had attended the necessary mandatory training for their role. We found some topics did not meet the trusts target of either 85% or 95% dependant on topic for nursing staff.
- Information governance training had 78% attendance within the last 12 months, with a target of 95%. Fire safety training had 74% attendance within the last 12 months, with a target of 85%. Topics including moving and handling, conflict resolution and basic life support training met the trust target.
- Medical staff training attendance was 100% for all topics.
- No nursing staff had up to date advanced paediatric life support (APLS) training, five doctors (38%) who worked within the ED had attended APLS training. 16 out of 72 clinical staff, excluding medical staff, had received paediatric intermediate life support (PILS) training, equating to 22% of clinical staff.

Assessing and responding to patient risk

- Walk-in patients booked in at reception and were then advised to either wait for majors triage, or see and treat, dependant on their presenting complaints. Reception staff had a list of symptoms that they referred to as patients booked in and then made the decision on where they would be seen. If the reception staff felt concerned about a patient they would inform the nurse in charge.
- There was not a dedicated member of staff designated to the new paediatric waiting area. The majors triage nurse was assigned to oversee this area however this was in conjunction with the triage role and therefore children were not regularly monitored and we were not assured that a deteriorating child would be recognised.
- From December 2013 and January 2015 the median time to initial clinical assessment was from one and two minutes. There was a sharp increase in median time in February 2015 to 12 minutes. From May 2015 and October 2015 this time had fallen to around eight minutes, but was still higher than the national average of five minutes.
- During our inspection we observed wait times of up to one hour for six patients on two consecutive days to receive an initial clinical assessment. Staff told us that if the wait within the see and treat area exceeded 20 minutes then this would be escalated and patients would be directed through majors' triage to reduce wait times. However this did not always occur and during our inspection we saw no standard operating procedure or policy to advise all staff that this was the set procedure. We raised this with the trust and during our unannounced inspection we were provided with a relevant standard operating procedure to advise staff how to escalate patients who had been waiting longer than 20 minutes.
- From December 2013 and October 2015 the median time to treatment increased from 17 to 44 minutes. Performance has been consistently better than the England average of 60 minutes standard in the same period.
- During our initial inspection patients under the age of 16 who were deemed to require minor treatment were seen in the see and treat area along with adults. Following feedback to the trust children were provided with a paediatric specific waiting area for see and treat. All paediatric patients were offered the choice to wait in this facility prior to triage whether they had a major or minor complaint, as appropriate. Following triage they were either moved into a see and treat cubicle and treated there or they were moved to the majors paediatric area, depending on their condition.
- Patients arriving by ambulance would directly enter the majors area where the ambulance crew would either hand over to the nurse in charge or proceed directly into resuscitation if the patient had a life threatening condition.
- Ambulance staff we spoke with told us they sometimes had delays in handing over patients and had to queue in the ambulance entrance corridor. During our inspection we did not witness any ambulance delays or queuing of patients.

- Over the winter period November 2014 to March 2015, 681 ambulance hand-overs were delayed for over 30 minutes (38% of ambulance attendances), 14 of these were delayed for over 60 minutes (1% of ambulance attendances.) This was lower than the national average.
- To measure acuity within the department the early warning score (EWS) and paediatric early warning score were used (PEWS). We reviewed 46 medical records and found that six did not have either an EWS or PEWS calculated.
- The ED developed a rapid assessment and treatment model for the department by developing two experienced band 2 health care assistants through a foundation degree to become assistant practitioners who could work alongside the consultant or nurse in charge of the majors department. This enabled them to cannulate patients, take bloods, perform electrocardiographs (ECGs) give some medicines, plastering and initiating necessary investigations. This meant that when there were long waiting times for majors, patients had received the appropriate tests before being seen by medical staff thus enabling earlier decision making.
- From March 2013 and March 2014 RCEM data showed that the one hour standard "door to needle time" for antibiotics in patients presenting with severe sepsis was being met for 32% of patients attending the ED. This meant the ED was in between the upper and lower quartiles within England.
- The department were working towards a sepsis CQUIN. The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. Within the departments December governance meeting it was noted that they were meeting 50% of their target relating to patients being given antibiotics in one hour. During our inspection we were informed there had been an improvement to 90% in February 2016. Leaders told us this was due to education and earlier identification of sepsis in the department.
- The majority of patients received pressure risk and falls risk assessments on their arrival in the department. Staff had a good knowledge of what steps to take if a patient was identified as high risk.
- Patients who were receiving oncology treatment were provided with red neutropenic packs. This meant that when they presented at the ED they could quickly be identified by all staff as requiring urgent intervention. All staff we spoke with knew what this pack looked like and what to do if a patient presented with this pack.
- Environmental risk assessments had been carried out to minimise risk to people who visited the MIUs. Appropriate plans were in place to manage situations that may occur which would interrupt normal and safe service such as deterioration of a patient.
- Patients were seen on a first come first served basis in the MIUs unless concerns about a patient were raised to nursing staff as having more urgent needs.
- Children were routinely seen in the MIUs. For the period December 2014 to November 2015, 187 children were seen at Ellen Badger Hospital MIU and 1,561 children were seen at Stratford Hospital MIU.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed in line with national guidance from the Royal College of Emergency Medicine and draft National Institute for Health and Care Excellence (NICE) guidance. The department had recently gone through a rota review and feedback regarding the new rota was due to be obtained within the next two months to establish whether it was advantageous over the previous rota.
- Whilst staffing levels generally met planned levels, they were not sufficient to ensure people received safe care and treatment during all times of the day.
- Nursing cover was provided over three shifts, day shifts, twilight shifts and night shifts. Previously all start times had been staggered throughout the day and most nursing staff we spoke with preferred the newer shift pattern as it meant staff took responsibility for departmental duties without it having any impact on time taken out of patient care.
- Guidance recommends that if a department has over 10,000 paediatric attendances per year then 24 hours cover by a paediatric nurse should be provided. In the period April 2014 to March 2015 the ED saw 13,438 patients aged 16 and below. The department had three trained paediatric nurses so were able to provide 12 hours cover per day and were actively recruiting for further paediatric nurse support.
- We observed that during the 12 hours where a paediatric nurse was not on duty the paediatric majors' area was covered by a nurse working in adult majors. This meant they were caring for up to six adults in

majors and any children in the paediatric area at one time which did not meet national guidance for staff to patient ratio and often meant children were left alone in the department whilst the nurse was caring for other adult patients. Staffing at night increased following our inspection and as part of an ongoing review. Following this review, although there was not always a registered children's nurse on duty, there was always a dedicated nurse with paediatric skills allocated to the children's cubicles and waiting areas.

- We saw eight incident reports that related to lack of paediatric staff having an impact on the department within the last six months. On one occasion there were 12 paediatric patients in the department at 9pm with no paediatric nurse on shift.
- During our inspection we visited the department at 10pm and one nurse was caring for six adult patients and four paediatric patients and we noted periods of 30 minutes where there was no member of staff within the paediatric area monitoring the children.
- Guidance states that staffing ratios should be one nurse to four patients within majors, on occasion staff were caring for over twice the recommended volume of patients.
- We escalated concerns relating to staffing levels following our inspection. During our unannounced inspection we saw that paediatric nurse cover had been extended until midnight and one extra nurse was on duty during night shift hours.
- The department had 13.52 whole time equivalent (WTE) nurse vacancies (24%), with an average of 12.8% of shifts being unfilled from September 2015 and February 2016.
- Unfilled shifts in the ED were covered by bank or agency staff. All agency and bank staff we spoke with told us that they had been inducted into the trust and regularly worked within the ED so were familiar with practices and the layout.
- Handover arrangements at shifts changes were in place to ensure people were kept safe by sharing of the necessary information with staff commencing their shift.

Medical staffing

- Within the department there were 13 WTE medical staff. The department had recruited a number of consultants within the last 12 months making a total of 10 consultants working with the ED. There was a 14% vacancy rate within the medical staffing equating to 4.54 WTE.
- Consultant cover was provided in the department for 14 hours per day Monday to Friday and 10 hours per day at weekends. This did not meet with the Royal College of Emergency Medicine's (RCEMs) emergency medicine consultants' workforce recommendations to provide consultant presence in all EDs for 16 hours a day, seven days a week as a minimum. This deficit was mitigated by consultants providing on-call cover.
- Overnight cover was provided by specialist registrars and junior doctors with consultants available on call.
- Medical handover took place twice a day and we observed a medical handover during our inspection. We found it was detailed and gave appropriate information to incoming doctors to be able to meet patients' needs.
- Most ED locum cover was provided internally by those familiar with the hospital and department. If a new locum was working in the department they would be given necessary departmental information about the department and a smartcard to use the computer system. We spoke with a locum doctor who hadn't worked previously in the department and they felt happy with the information and support provided at the beginning of their shift.
- The department did not see over 16,000 paediatric patients per year so was not required to have a consultant with sub-specialist training in paediatric emergency medicine in line with the 2012 Intercollegiate Emergency Standards.

Major incident awareness and training

- The trust's major incident plan had been recently reviewed. A copy of this policy was available within the ED. This policy clearly outlined the role the ED would play should there be a major incident.
- The department had major incident tent stored in a container outside the department. This tent could be used to manage patients who may have been exposed to chemical, biological, radiological and nuclear materials and needed to be isolated and undergo a specific decontamination process.
- We reviewed the major incident equipment which was stored in a cupboard. It was clearly organised and well set out allowing staff easy access to everything they required.
- Staff we spoke with were aware of the major incident plan and the role the ED would take should one be declared.

Urgent and emergency services

- A major incident scenario practice exercise had been carried out the week prior to our inspection. The role of this exercise was to ensure staff were familiar with locating equipment and their role within an incident. Feedback from staff we spoke with was positive regarding this exercise.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the ED as good for effectiveness because:

- The ED used a number of evidence based protocols that followed National Institute for Health and Care Excellence (NICE) guidelines and the Royal College for Emergency Medicine's (RCEM's) clinical standards for emergency departments for the management of such conditions as sepsis and septic shock.
- Multidisciplinary working was a strength of the department and relationships with internal and external services helped to avoid unnecessary attendances and facilitated early discharges.
- The department took part in local and national audits and showed learning from audit outcomes.
- Staff demonstrated a good knowledge of the key elements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards and understood how it related to patient care and also paediatric patients.
- The trust's unplanned re-attendance rate within seven days was generally better than the England average but was not meeting the national target.

However, we also found:

- Pain scores were not always measured consistently throughout the department.
- Not all staff had received an annual appraisal and this was not meeting trust targets.
- There were no current audits specific to the Minor Injury Units
- Although senior nurses at Stratford MIU worked routinely as emergency department nurses at Warwick Hospital ED as part of their normal rota to ensure they maintained these skills, none of the nursing staff based at Ellen Badger Hospital MIU worked in the Warwick Hospital ED. This meant that their competencies would not have been regularly assessed

Evidence-based care and treatment

- Up to date and relevant evidence based guidance and best practice was used within the department to develop services and improve care and treatment.
- The department used a number of nationally recognised pathways known as Clinical Standards for Emergency Departments' guidelines including those for sepsis, stroke thrombolysis and diabetic ketone acidosis.
- We reviewed 10 guidelines within the trust's intranet database. We found that three of these were external guidance and whilst in line with best practice there were no review dates so staff were unclear whether it contained most up to date information. Internal guidelines were all within review date, clear and in line with national clinical guidance.
- The minor injury units (MIUs) used National Institute of Health and Care Excellence (NICE) and Royal College of Nursing (RCN) best practice guidelines to support the care and treatment provided for patients.
- Medical staff told us they often had problems accessing cardiology guidance within the trust intranet, but were aware that the cardiology nurse specialist was addressing this and working on new pathways. The cardiology nurse specialist was introducing departmental teaching to ensure all staff were aware of current best practice. A printed copy of cardiac guidance was available for staff in the ED resuscitation area; medical staff told us they liaised with the cardiology nurse specialist to ensure this was the most up to date version at regular intervals.
- Up to date guidance from the Resuscitation Council was displayed in each cubicle within the resuscitation area. This meant during an emergency situation staff could visualise the necessary processes and treatments. We were advised that new information was displayed following each Resuscitation Council update to ensure it was in line with the most recent evidence based guidance.
- A local audit plan was in place, which contained the current status of each audit and the clinical lead responsible. All of the audits documented had either been completed or were in progress.

Urgent and emergency services

Pain relief

- All the patients we spoke with had been asked about their level of pain and offered pain relief if they required it.
- The ED had a scoring tool to record patients' pain levels. Pain was scored from 0 to 10 with 0 being 'not in pain' and 10 being the worse pain the patient had ever had. Adult patients were asked (where possible) what their pain rating was. The 46 records we examined showed that pain scoring was undertaken, however not all staff used the 0 to 10 score (0 being least pain and 10 being most pain) and sometimes recorded a score from 0 to three (0 being least pain and three being most pain) which meant pain was not assessed consistently. Pain scores were not audited within the department.
- Paediatric patients were asked to score their pain using a similar numbered score, with pictures available to aid children in their decision making. We saw that this was well documented and acted on accordingly.
- In the Stratford MIU, patient records showed that pain assessments were completed regularly and effectively and analgesia was prescribed and administered appropriately. There was no stock medication held at Ellen Badger Hospital MIU. Patients requiring analgesia would be given a prescription, if appropriate, from the GP attached to the MIU.
- The trust performed 'about the same' as other trusts in the two questions from the 2014 CQC accident and emergency (A&E) survey relating to pain relief, including whether staff did everything they could to control patients pain.

Nutrition and hydration

- Patients nutritional and hydration needs were assessed and met within the department.
- All of the patients we spoke with in the majors' area of the department said they had been offered food and drink.
- We saw that staff supported patients who required assistance with eating and drinking.
- Records about each patient that we reviewed showed that staff had documented food and fluid intake effectively, along with necessary assessments in relation to nutrition and hydration.

Patient outcomes

- The trust had a good performance in the 2013/14 RECM audit on asthma in children, with five of the ten measures in the upper quartile compared to other trusts; one measure was in the lower England quartile which related to prednisolone being prescribed on discharge.
- The trust had a mixed performance in the 2013/14 RECM audit on severe sepsis and septic shock. The trust's audit scores were in the top 25% of all trusts for four standards, and in the bottom 25% for one standard. The trust's scores for the remaining seven standards were in the middle 50% of all trusts. The trust did not achieve any of the twelve RCEM standards within this audit.
- The trust performed in the middle quartile of trusts for all measures from the 2013 RCEM audit on consultant sign-off. This audit looked at three patient groups: adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. The standard states that patients in these three groups should have either been seen by or discussed by a doctor of ST4, middle grade equivalent or above.
- The trust performed in the middle quartile of trusts for three of the four measures from the 2013/14 RCEM audit on paracetamol overdose.
- The trust performed in the middle quartile of trusts for all measures from the 2014/15 RCEM audit on initial management of the fitting child; the one fundamental standard was met, two of the developmental standards were not met.
- In the 2014/15 RECM audit on mental health in the ED, the trust did not meet the fundamental standard relating to taking a risk assessment and recording it within the patients' medical records. None of the developmental standards were met. The trusts performance was in the middle quartile of trusts.
- In the 2014/15 RECM audit on assessing cognitive impairment in older people, the trust did not meet the fundamental standard on documenting pain relief and met one of the two developmental standards. Performance against the three aspirational standards, relating to communication of findings with GPs and with carers, was very poor.
- We saw action plans relating to audits and whether the trust had agreed recommendations. Some of these action plans had been advanced further than others within the department. Following the mental health

audit actions had been put in place to improve the environment and enable it to be more compliant with guidance; these actions had been noted as complete. Within the fitting child audit action plan we saw that clearer documentation by middle grade doctors was a required action, we saw this was in progress and due for further review.
- There were no current audits specific to the MIUs.
- From November 2013 and October 2015, the unplanned re-attendance rate was from 4.9 and 6.7%; this was higher than the standard of 5% but below the England average of 7.6%.

Competent staff

- Staff within the ED had the right qualifications, skills and knowledge to carry out their roles.
- The way nurses revalidate their registration will change in 2016 and require more input from their managers compared to the current system. Senior staff told us they were aware of the changes and were beginning to plan how best to implement them.
- The see and treat, and triage, was always conducted by an ENP or senior staff nurse to ensure competency in recognising patient who require prioritisation.
- Staff told us that they received yearly one to one meetings with their senior manager. Data provided to us by the trust showed that 77% of nursing staff, 83% of medical staff and 84% of non-clinical staff had received an appraisal within the last 12 months. This did not meet the trust target of 85%.
- Learning needs of staff were identified and staff given the appropriate time and training to meet these needs.
- Trainee medical staff in the department told us that they were given protected time to attend training and were provided with support to develop by senior doctors.
- Nursing staff told us they were released from duties to attend internal or external training, and supported to attend courses that would benefit their practice.
- Paediatric study days were attended by nursing staff within the ED to help develop skills and enable adult nursing staff to understand signs and symptoms of deteriorating children.
- New staff told us they felt they were provided with the appropriate knowledge for their role and offered continual support during their induction into the department, including working supernumerary with support for several weeks.
- All staff that carried out triage at Stratford MIU were appropriately trained with the exception of safeguarding children training. Senior nurses at Stratford MIU worked routinely as emergency department senior nurses at Warwick Hospital Emergency Department (ED) as part of their normal rota to ensure they maintained these skills. None of the nursing staff based at Ellen Badger Hospital MIU worked in the Warwick Hospital ED which meant that their competencies would not have been regularly assessed.

Multidisciplinary working

- Communication between staff was effective. Shift handovers involved staff providing detailed information on the risks, treatment and care for each patient, the staffing requirements and patient flow through the department.
- We observed treatment of several critically ill patients and saw that the approach to their care was multidisciplinary and well controlled, with clear and concise communication between different teams.
- Staff felt the department had a good working relationship with the ambulance service. A hospital ambulance liaison officer attended the department during times of high demand and staff felt their role meant communication between the services was effective.
- Senior managers and staff within the ED told us they felt multidisciplinary team working was excellent. Regular meetings were held with mental health services, the ambulance service and other support services. These helped to ensure all services had an overview of the current demand on the department and solutions could be sought if delays began occurring. Staff felt this whole system approach helped maintain good relationships with external healthcare partners.
- Adult and child mental health services were available upon referral, provided by Arden mental health acute team and child and adolescent mental health service (CAMHS). Staff told us that although there was sometimes a delay in their attendance they generally had good working relationships. We saw two incident reports relating to a delay in response from the CAMHS team from January 2015 and January 2016.
- Patients presenting with complaints relating to drugs or alcohol could be referred to a substance misuse liaison

specialist. This service was provided by one member of staff who covered the department Monday to Friday during normal working hours, out of hours referrals were picked up the next working day.
- The GP practice, which was adjacent to the hospitals, provided cover during working hours to the MIUs.

Seven-day services

- The department had access to x-ray and computed tomography (CT) services at all hours of the day and night. This meant there was no delay for patients who required imaging.
- Physiotherapy and occupational therapy (OT) services were available seven days a week within the department.

Access to information

- Information needed to deliver effective care and treatment was available to staff in a timely and accessible way.
- Staff, including agency staff, could access further clinical guidelines and pathways on the trust intranet. The trust intranet was easy to navigate around and accessible to all staff. Medical and nursing staff felt that this helped their practice as they could access the information they required quickly rather than having to carry out extensive searches for the document they required.
- When people moved between teams or wards the appropriate information was shared in a timely way. Transfer documents were completed for patients who were being moved to other wards within the hospital, this meant that receiving staff could refer to this document and view the patients previous medical history, treatment and risk assessments completed in a condensed document whilst in the ED.
- On discharge from the MIU, patients were made aware of any follow up care needed and appropriate referrals were made to other departments, for example outpatients, to ensure continuity of care.
- Medical staff could download a smart phone application that had been developed by the trust. This contained clinical guidance, trust policies and available teaching sessions and other supportive information. Staff told us that this application was extremely helpful and a valuable tool. We were informed this application was being constantly updated and improved in line with staff feedback to ensure its practicality and to improve usage.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We witnessed several examples of staff asking patients for permission before undertaking clinical interventions. Every patient that we spoke with said that staff had asked their permission prior to explaining and undertaking treatment.
- All nursing and medical staff we spoke with demonstrated a good knowledge of the key elements of the Mental Capacity Act 2005 or Deprivation of Liberties Safeguards and understood how it related to their care. Staff told us these topics were covered within safeguarding training. We saw evidence of capacity being assessed and documented in medical records for those with cognitive impairments.
- Medical staff we spoke with could tell us about how they would treat a patient who lacked capacity and that they would make best interest decisions in line with legislation.
- We spoke with six nursing staff and three medical staff regarding consent in children. Whilst most staff were able to describe the key elements of Gillick and Fraser competencies not all nursing staff understood consent in children but told us they would ask another member of staff for assistance.
- The nature of the patients treated routinely at the MIUs meant that staff did not need to restrain or deprive liberty. However, staff were aware of policy and had completed mandatory training as required by their roles.

Are urgent and emergency services caring?

Good

We rated care within the ED as good because:

- Privacy and dignity was respected at all times whilst patients were being cared for within the ED.
- All staff consistently displayed caring attitudes during interactions with patients, relatives and visitors.
- Patients felt involved in their treatment and well supported to made decisions.

Compassionate care

- Reception staff were very respectful and polite to patients, offering them assistance with any enquiries they had. We observed examples of reception staff showing sympathy and consideration for patients when they were booking into the department.
- We spoke with 22 patients who were very happy with the care that they had received within the ED. Patients told us the department was "brilliant, really quick and friendly, go out of their way", "excellent experience and everyone is always smiling" and "very positive experience." The main concern patients had was the time they had to wait to be seen, three patients or relatives we spoke with told us they had been waiting up to one hour and felt this had a negative effect on their experience.
- The Friends and Family Test (FFT) is a method used to assess patients' perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. The FFT from September 2014 and September 2015 was consistently above 90%, peaking at 98% in April 2015. The February 2016 data for the FFT showed that 96% of patients would recommend the ED service to their friends and family.
- In relation to the 2014 CQC A&E survey, the trust performed 'about the same' as other trusts or better than other trusts for all 24 questions relating to compassionate care. The trust scored well on questions relating to being treated with dignity and respect and being listened to by medical and nursing staff.
- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, reception staff offered help to a blind patient immediately on their arrival in the department and ensured they had all the information and assistance they required. Patients with mobility problems were also assisted on their arrival in the department by either reception or nursing staff.
- We observed caring interactions at all times during our inspection from medical, nursing and administrative staff, with staff often checking patients comfort levels whilst being cared for in the department.
- Privacy was maintained during interactions and assessment with patients, all staff showed an awareness for protecting patients privacy during their time in the department.
- Curtains were drawn and doors closed when patients were assessed or treated.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and had been fully informed of their treatment and potential diagnosis throughout their visit.
- In the 2014 CQC A&E Survey the department scored better than other trusts in relation to family or those close to patients being able to discuss concerns with a doctor or nurse.
- Family members felt well supported by staff and told us staff explained things in a way they could understand to enable them to support their relative.

Emotional support

- A private room was available for those close to someone who was critically unwell. We saw this room used and that staff regularly checked on families to ensure they felt supported.
- A chaplaincy service was available for all religions where required.
- Nursing staff we spoke with explained the support they would offer to bereaved relatives and showed us the information they had available to provide them with in relation to further support and helplines.
- Staff working in the MIUs understood the impact relatively minor injuries may have on people's physical and emotional wellbeing. They offered emotional support in the department and referred patients to GP's and social services, when required.
- Patients were encouraged to manage their own health care and wellbeing, self-care advice and worsening advice was given on discharge from the MIU.

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

(for example, to feedback?)

Outstanding ☆

We rated the ED as outstanding for responsive because:

- Patients could access services in a timely way. From April 2015 and March 2016, the trust exceeded the target of 95% of all patients to be admitted, transferred or discharged within four hours of arrival to the emergency department every month.

- Services were planned and delivered in a co-ordinated way that met the needs of the local population and providing continuity of care following discharge with some involvement from external organisations.
- There was a proactive approach to understanding the needs for different groups of people. Innovative tools were in place to provide high quality care for those with complex needs including learning disabilities and dementia. Feedback from the use of these tools was positive from staff and patients.
- There was clear evidence of learning shared and improvements made as a result of listening to complaints and concerns.
- Pathways were in place to reduce admissions and improve flow in the department, including the successful use of an ambulatory care pathway and the opening of an acute decisions unit.

Service planning and delivery to meet the needs of local people

- The ED was open 24 hours a day, seven days a week. There were separate areas for majors, minors and the waiting area.
- The department had increased their level of consultancy staffing to provide greater cover over seven days a week.
- The department had recently developed networks with external providers to deliver increased mental health provisions for the local population. We saw evidence that some of these services provided help and support for people with alcohol dependency and substance abuse. Multi-agency meetings took place which included representatives from external mental health providers, ED staff and frequent attender leads, to discuss any potential improvements in services.
- Signage outside the department was sufficient to direct people appropriately. Patients told us that they could navigate around the department with ease and that if they were unsure a member of staff would readily assist them.
- Seating within the waiting area was sufficient for the amount of patients in the department at all times during our inspection.

Meeting people's individual needs

- Services were delivered in a way that took into account the needs of different people, including in relation to age, disability, gender, race and religion, with reasonable adjustments made to accommodate patients during their care and treatment.
- The department met patient's individual needs in a variety of ways and were proactive in utilising new methods to improve communication with those with complex needs.
- The department had a computer-assisted reminiscence therapy available and staff provided us with examples of several situations where this had been used to great effect and improved patients' experiences dramatically. Reminiscence therapy provides cognitive stimulation to improve psychological well-being of patients living with dementia, learning disabilities or other cognitive impairments. Within the departments computer-assisted therapy there were films from a variety of eras, touch screen interactive programmes and the ability for digital life story books.
- There was a clear pathway in place for people with learning disabilities who attend the ED to ensure they were safe and included in their care and treatment. Staff told us that the trust had a learning disability liaison nurse that often provided support to the department if a patient with learning disabilities was being cared for.
- During our inspection we saw a patient with learning disabilities and mental health needs being cared for over a prolonged period in the department. Nursing staff utilised advice provided from the learning disability liaison nurse and also used the reminiscence computer system.
- We saw that the department had a 'distraction box' for patients living with dementia and staff could tell us how these were beneficial to patients and also how reminiscence therapy had been used successfully in conjunction with these. We spoke with staff who had applied for and been appointed dementia advocates, they felt these roles were extremely beneficial to those presenting to the department who were living with dementia.
- 'This is me' information was present within the observation ward, this information helps people with living with dementia to tell staff about their needs, preferences, likes, dislikes and interests.
- The department had access to a frailty nurse who attended the ED to carry out comprehensive geriatric

assessments to establish whether the patient required further input from a frailty unit or social care services following their treatment. Feedback from staff and patients relating to this input was positive

- Within each cubicle of the observation ward there was a dietary board that plastic labelled diet strips could be placed onto. Each strip stated a dietary requirement such as, 'gluten free', 'thickened fluids only', 'diabetic'; this meant that all staff could be aware of patients' dietary requirements and ensure that nutrition was provided appropriately.
- A drug and alcohol liaison specialist worked within the ED during weekdays providing support to those presenting with alcohol or drug related complaints. The purpose of this role was to help people to engage in treatment in hospital and when in the community. Feedback about this service from departmental staff was entirely positive and they felt that this support focussed on supporting people and providing them with best care and help them to engage with healthcare workers.
- The drug and alcohol liaison specialist provided alcohol awareness training for newly qualified nurses involving real patient pathways to help them to understand what is helpful when treating patients under the influence of alcohol. From May 2016 there will be alcohol awareness modules as part of nursing induction. Staff we spoke with felt this awareness helped them to improve patient care and understand patient's complaints in more depth.
- Information in relation to domestic abuse was readily available within the department, along with the ability for staff to refer patients to domestic abuse drop in sessions with an external provider. A domestic abuse policy was in place and staff could explain how they would recognise and address concerns in line with this policy.
- We observed staff taking the time to discuss with young children what the outcome of their x-ray was within the see and treat area. The language and pictures used to show exactly where their injury was, was suitable for the children's ages and parents felt that this was beneficial to help their children feel at ease following painful injuries.
- The department had access to language translation services and face-to-face interpreters, all staff we spoke with knew how to access these when necessary.
- There were a number of information leaflets on display in different areas of the ED which were all printed in English. Staff said that they were able to access the documents online and print in different languages if required.
- Information leaflets relating to common injuries and treatments were available within the MIUs. We saw a patient being handed some leaflets at Stratford MIU when their treatment had been completed. The nurse also gave verbal advice about the patient's aftercare.
- Staff made efforts to meet patients' needs throughout their treatment. We observed one patient who required surgery but was anxious about their pet being at home uncared for. The surgical team made arrangements for the patient to represent at the ED the following morning for further review so she could travel home for her pet. Feedback from the patient was that this was an excellent experience and their anxiety was reduced and was impressed how accommodating to her individual requirements the team had been.
- A private room was available for relatives and those accompanying acutely unwell patients to discuss sensitive situations.
- A poster was visible outside the relatives room adjacent to resuscitation to inform relatives of what may occur if their relative is being resuscitated and why it may be necessary to cease resuscitation efforts. This provided clear information in a considerate way as to what relatives could expect should their relative be critically unwell.
- The children's waiting area had a number of 'distraction' items such as colourful pictures and educational toys.
- Paediatric nurses within the ED wore patterned, colourful tabards to make them easily identifiable and also to help children feel more relaxed in the department.
- There were adequate facilities in waiting areas, with a water machine and healthy options in a vending machine, however families of paediatric patients told us that they would appreciate drinking water facilities within the paediatric majors' area.
- There was a small kitchenette available for relatives and staff that contained a toaster, microwave, small domestic refrigerator and tea and coffee making facilities.

Access and flow

Urgent and emergency services

- The Department of Health target for EDs is to admit, transfer or discharge 95% of patients within four hours of arrival at ED. The department had met the 95% standard since April 2015. The department had performed better than the England average since this time.
- During March 2015 to February 2016, a total of 94% of patients were triaged within 15 minutes at the Stratford MIU and Ellen Badger Hospital MIU, with only one patient not discharged, or transferred within four hours.
- The percentage of emergency admissions via ED waiting four to 12 hours from the decision to admit until being admitted has been consistently lower than the England average. From September 2014 and August 2015, 502 patients waited four to 12 hours and no patients waited over 12 hours from decision to admit to admission.
- From November 2013 and November 2015, the trust had good performance on the percentage of patients leaving the ED before being seen, with an average of 1.6% of patients leaving compared to the England average of 2.6%.
- From November 2013 and October 2015 the median time in ED per patient increased from 120 – 128 minutes. However this remained better than the England average over the same time period which was 136 minutes.
- From December 2014 and December 2015, there were 14 black breaches at this trust where handovers from ambulance arrival to the patient being offloaded to the Emergency Department took longer than 60 minutes. However there have been no black breaches in the period April 2015 to March 2016.
- See and treat saw patients with minor illnesses and/or injuries operated from 8.30am and 10pm, seven days a week. During weekdays this was staffed by a consultant, an emergency nurse practitioner (ENP) and a clinical support worker (CSW). During weekends there was no consultant presence within see and treat and care was covered by two ENPs and a CSW. Access to a consultant was readily available if staff were concerned or required further input in a patients care. The aim of this system was to see, treat and discharge patients within an hour to improve flow within the department.
- Outside of the hours see and treat was operational all adult and paediatric patients would be assessed through majors triage.
- Majors' triage was staffed by a senior staff nurse with addition in house triage training, with a target to have carried out an initial triage assessment within 15 minutes of the patient's arrival. Once a major's patient had been triaged they would then be allocated a room within the majors' area.
- The observation unit formed part of the ED. The unit contained five side rooms and had a criteria to be followed to allow patients to be transferred to this area. Patients who were placed in this area included those awaiting transport, post sedation, awaiting blood results or those requiring further observation including head injuries and intoxicated patients. This area was staffed by a nurse and a healthcare assistance (HCA) at all times and alleviated pressure on the ED where patients required observation only rather than treatment.
- An escalation plan was in place to enable staff to raise acuity and capacity issues with senior hospital staff. The escalation level of the ED was discussed during the hospital's operations meetings which occurred three times daily. All senior nursing staff had a good knowledge of the escalation procedure. A log book was maintained within the department to evidence escalation levels and actions taken.
- The department was supported by the trusts' site management team to manage patient flow. Some of the staff who were part of this management team were based directly next to the ED. The systems used allowed them to have an overview of bed availability in the hospital and also the flow of patients coming into the ED. Staff explained that with this information they were able to plan on an hourly basis and minimise the amount of patients waiting to be admitted. Staff told us that there were meetings held daily where matrons and senior staff discussed bed availability and staffing levels.
- In conjunction with medical care leads, work had been conducted to reduce admissions and facilitate early discharges. An acute decisions unit (ADU) had been opened in January 2015 to allow patients who had been referred by their GP to bypass the ED and go directly to this ward, with the view to reduce pressure on the ED and improve flow. This process was to be reviewed shortly by leaders to assess whether it had improved flow and how this had affected urgent and medical care areas, initial feedback provided was positive.

- Following the introduction of the emergency ambulatory care pathway there had been an improvement of flow with up to 30% of patients being pulled from the ED to go directly to other wards for admission or seen as outpatients.

Learning from complaints and concerns

- There was clear guidance on display in the ED for those using the service to make a complaint or express their concerns. Reception and nursing staff knew what steps to take should a patient wish to complain either formally or informally and could give examples of where complaints had been dealt with appropriately in the past.
- The department received 27 complaints from January 2015 and December 2015. Complaints were discussed within monthly governance meetings. Within meeting minutes from December 2015 it was identified that five of the complaints related to one specific issue, we saw evidence this was being addressed by the senior management team. Any necessary actions or learning points relating to complaints were addressed during these meetings. Leaders within the ED told us that they worked closely with specialties to ensure issues with complaints were fully addressed.
- We saw evidence that changes had been made within the department following negative complaints from patients and relatives; this included extra ENPs on duty during weekends to reduce long waiting times.
- We also saw evidence of people using the service being offered apologies and instances where local meetings were held to discuss patients' concerns or complaint.
- The MIUs had not received any complaints in the past twelve months.

Are urgent and emergency services well-led?

Good

We rated the department as good for well-led because:

- Staff showed a good understanding of the elements that drove their good performance such as consistently meeting the four hour target.
- Leaders recognised and maintained effective relationships with internal and external partners in order to work collaboratively to drive improvements.
- Feedback from staff relating to recent changes in leadership was positive, with changes being welcomed to improve patient care in the department.
- There was an open and inclusive culture within the department with staff enjoying their roles and working within the ED.

However we also found:

- Not all risks within the department had been identified or acted upon in a timely way.
- There were not policies and procedures to support staff within the ED in all aspects of care, for example, policies in relation to see and treat, triage and care of paediatrics.
- Staff were not aware of the departments' strategy moving forward.
- Leaders showed a full understanding and drive to improve flow within the department but lacked understanding of safety in relation to care of children.

Vision and strategy for this service

- Trust visions and values were displayed throughout the ED and staff knew about them.
- Staff we spoke with were unaware of long term plans in relation to the ED and how the department intended to move forward.
- Leaders we spoke with explained how they felt the department should move forward and had a clear vision of improving patient care, however this was not a documented vision shared throughout the service.

Governance, risk management and quality measurement

- There were not written policies and procedures to support staff with all aspects of care. See and treat, triage and use of paediatric area had no accompanying policies or standard operating procedures to inform staff of correct processes or when to escalate concerns in these areas. This resulted in staff managing these areas differently, for example some staff told us that after 20 minutes of patients waiting for assessment in see and treat they would then escalate to the nurse in charge, other staff told us they would not escalate delays relating to any time period of wait.

- Following feedback to the trust a policy was created for the management of children within the department with the new change in waiting areas, a policy for escalating delays in triage was also created.
- Departmental risks were contained within the emergency care division risk register, five of which related to the ED. Senior staff were aware of the top three risks; high nursing vacancies, middle grade shortages and suitability of the departments mental health room. However concerns raised during our inspection, including highlighted risks relating to security and separation of the paediatric area had not been identified by senior staff. Some of these were addressed during the inspection period.
- Weekly clinical and operational leadership meetings were established and we were told their purpose was to monitor clinical and operational workforce governance. Within meeting minutes we saw that all serious incidents, staffing vacancies, performance and incidents were discussed within each meeting. Attendance at these meetings was good from a variety of staff groups.
- Clinical leaders had good knowledge of local and national audits the ED participated in and how the results of these were used to measure quality and improve care and services.
- Within interviews with the ED leadership team we discussed what factors were helping them meet national targets and all staff showed a strong understanding of the underpinning elements that drove their good performance. Leaders explained that the ED four hour target was not just the EDs responsibility but the whole hospital had a role to play in ensuring patients had high quality and timely care within the department. They felt that this helped them continue to meet their targets.
- Division leaders had good relationships with internal and external partners which ensured a complete approach to delivering quality within the service.

Leadership of service

- The department was led by the matron (who was interim until a permanent matron was in place), general manager and a clinical lead who held regular meetings with staff at all levels within the ED, other departments and external providers.
- We saw clear evidence of leaders in this service working closely with their team to develop their service and encouraging more junior staff to contribute to improvements.
- During our interview with the leaders of this service they displayed a thorough understanding of the improvements that were needed to strengthen the quality of their service.
- At times when the service experienced high volumes of attendances, we were told by staff that leaders were visible and worked as part of the team to maintain patient flow. We observed this practice throughout our inspection.
- All staff we spoke with said that their leaders were approachable and visible and they felt confident that they could voice concerns openly and they would be listened to.
- Feedback from staff relating to recent changes in leadership was exceptionally positive, staff felt that previous leadership was not innovative or forward thinking but now changes were being made to improve the department and patient care.
- All staff felt that the ED leadership team valued their wellbeing and job satisfaction.
- Some staff felt that trust leadership could be more supportive of the ED; they told us that they received trust email but that they weren't always motivating and had no relevance to ED, focussing on other areas of the hospital.
- Staff working in the MIUs also had close links with the emergency care matron and felt that all members of the leadership team were visible, approachable and well respected by staff.

Culture within the service

- All staff within the department told us they felt there was a very positive culture and that teamwork and support played a vital role in their day to day practices.
- Medical staff told us they were well supported to attend specialty training programmes.
- Throughout our inspection staff told us that they felt they worked in an open and honest department which was supportive and blame free.
- Nursing staff told us that they enjoyed working in the department and that it had a friendly, close knit atmosphere

- The safety and wellbeing of patients was important to the staff and management of the MIUs. Support plans were in place, where needed and security could be called by staff at Stratford Hospital MIU in an urgent situation.

Public engagement

- Patients were given the opportunity to provide feedback regarding the ED through the Friends and Family Test. Response rates varied from 6% to 33.4% from September 2014 to September 2015.
- Social media was utilised to provide the public with information relating to the ED. For example during times of high demand, to advise the public to use appropriate alternatives where available to avoid delays in care and also to promote appropriate use of ED by advising how much each attendance costs and which complaints could be seen by a primary care provider.

Staff engagement

- Staff meetings were conducted either monthly or six weekly dependant on demand and staff availability. Staff attendance was good at these meetings and staff we spoke with at all levels felt they were beneficial to departmental working.
- Staff feedback was regularly sought whenever changes were implemented in the department; the most recent change of new nursing staffing rotas was currently being review trough staff feedback. Leaders told us that feedback was very valuable as it helped them to shape changes and engage all staff.

Innovation, improvement and sustainability

- Due to recent changes in leadership within the ED it was difficult to establish the sustainability or impact that changes had or would make. However, initial feedback from staff suggested most recently implemented changes had been welcomed and were becoming embedded within the department.
- Not all changes had an associated policy or standard operating procedure (SOP) to inform staff formally of processes. This included the see and treat process and treatment of paediatric patients within the ED. This meant that not all staff were aware of how new procedures worked and therefore reduced the chances of sustainability. Following our initial inspection SOPs were put into place to rectify this
- Leaders informed us of future changes they wished to make in the department including extending physical space and up to date and more accessible equipment.

Medical care (including older people's care)

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

Information about the service

Warwick Hospital is part of the South Warwickshire NHS Foundation Trust and is situated within Warwick. The trust had 22,800 medical admissions from June 2014 to July 2015. Emergency admissions accounted for 45% of inpatient periods, 52% were day cases and 3% were planned admissions. A total of 43% of admissions were reported as general medicine, with 18% haematology and 19% oncology and remaining 20% other specialities.

Three divisions manage medical services; the emergency care division are responsible for the acute admissions unit (AAU), clinical decisions unit (CDU), ambulatory care, cardiology (including cardiac catheter laboratory) and respiratory medicine. The elective care division are responsible for endoscopy, cancer, haematology services and gastroenterology. The integrated community care division manage elderly care, stroke services, diabetes services and discharge team.

There are 10 medical wards, plus an acute assessment unit, clinical decisions unit and endoscopy suite. The trust has 257 inpatient medical beds, with facilities to accommodate 14 additional inpatients during periods of high activity. We visited the following areas:

- Avon ward- general medicine and diabetes
- Aylesford Unit- oncology
- Beaumont surgical ward- gynaecology
- Cardiac catheter lab
- Castle ward- general medicine and gastroenterology
- Charlecote ward- general medicine
- Coronary care unit
- Dugdale ward- inpatient rehabilitation
- Endoscopy unit
- Fairfax ward- acute admissions and escalation area
- Farries ward- general medicine and haematology
- Guy ward- emergency ambulatory care and clinical decisions unit
- Hatton surgical ward-urology, ophthalmology
- Malins ward- cardiology
- Mary ward- respiratory medicine
- Nicolas ward- frail elderly (72 hour admissions)
- Oken ward- acute admissions
- Squire ward- dementia care
- Victoria ward- stroke
- Willoughby- surgical ward

We spoke with 58 members of staff including nurses, doctors, pharmacists, therapists, administrators and housekeepers. We spoke with 17 patients and relatives. We observed interactions from patients and staff, considered the environment and looked at 61 care records. We also reviewed the trust's medical performance data.

Medical care (including older people's care)

Summary of findings

We found that medical services (including older peoples care) was good for being caring, responsive and well led, however it required improvement to be safe and effective.

- Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the inpatient stay. This included incomplete risk bed rails risk assessments resulting in the use of bed rails without a completed risk assessment.
- Infection control practices were not embedded with isolated poor practice relating to hand hygiene and the use of personal protective equipment
- All patients admitted to hospital were screened for MRSA to assist with early identification and treatment; however we found results of screening were not routinely recorded in nursing notes. This meant it was unclear whether the patient had a negative MRSA result, or the result had not been reported.
- Nursing and medical records were not routinely stored in secure areas, leaving them accessible to unauthorised persons.
- Medications were not always stored securely, with doors unlocked or missing and cupboards unsecure.
- Patients on a different specialty ward were not reviewed daily by their speciality consultant or medic. However, care of the elderly patients reviewed daily by a medical nurse practitioner
- Staff showed varied understanding of the Mental Capacity Act 2005 and their roles and responsibilities in the management of patients with reduced capacity. There was no evidence in practice of a clear system to ensure these patients were cared for safely and effectively. A few patients had entries in their notes that stated they did not have capacity but there was no record of any formal assessments of their capacity having taken place.

However we also found:

- The trust had processes in place to keep people safe and staff were aware of their roles and responsibilities in reporting incidents.
- The trust had reviewed medical admission processes, which resulted in an improved patients experience and pathway. The admission area facilitated the flexible use of beds to meet the demands of the service at any one point. This meant that when activity increased, additional beds could be used to relieve pressures within the emergency department (ED).
- The admission area facilitated a review by senior clinician within four hours of arrival with an early decision to admit to hospital or not. Where possible patients were managed through daily attendance at the clinical decisions unit for treatment.
- The cardiology and respiratory specialities had introduced a speciality "pull" from admission areas to ensure that any patient admitted with that speciality would be reviewed as soon as possible after admission and transferred to the most appropriate area to manage treatment.
- The flow of patients through the hospital was effectively managed and a policy was in place. Bed management meetings were held three times a day to discuss and prioritise bed capacity and patient flow issues. Discharge coordinators and the complex discharge team helped to facilitate appropriate patient discharge. A high percentage of patients had less than two ward moves per admission to hospital.
- Wards were visibly clean.
- Referral to treatment performance was in line with national targets.
- Although there was a high level of nursing staffing vacancies within some teams, staffing levels did generally meet patient needs at the time of our inspection. Medical staffing was in line with national guidance.
- Overall, mandatory training in nursing staff did meet the trust target of 85%.
- There was some evidence of provision of seven day a week services.

Medical care (including older people's care)

- The medical care service was generally well led at a ward level, with evidence of effective communication within ward teams. The leadership and culture promoted the delivery of high quality person-centred care as governance and risk management systems were in place in the service.
- The trust performed 'as expected' and 'within expected range' in the two mortality indicators (SHMI and HMSR respectively) and the service had systems in place to review mortality rates. Monthly mortality meetings included reviews of any patient deaths to identify learning and individual development.
- Care was provided in line with national best practice guidelines.
- The trust participated in some national clinical audits.
- Pain relief was assessed appropriately and patients said that they received pain relief medication when they required it.
- Generally, patients received compassionate care and their privacy and dignity were maintained. We saw staff interactions with patients were person-centred and unhurried. Patients told us the staff were caring, kind and respected their wishes. Most patients felt involved in planning their care, making choices and made informed decisions about their care and treatment.
- The trust worked closely with community services to enable an established 'discharge to assess programme', which had been used as a reference centre for other trusts and the reinstatement of care packages up to 14 days after admission to hospital.
- There were additional facilities for patients living with dementia and those with learning disabilities. Including activities for patients, the use of "this is me" document and extended visiting hours for families and carers.
- The service had good governance processes in place with an audit calendar and evidence of learning. Staff reported receiving feedback regarding incidents that they had reported.
- The trust had implemented an application (app) that could be downloaded onto mobile phones, which contained all policies, and procedures, which could be used for advice or direction.
- Haematology services had developed a standard of practice for all patients admitted with suspected neutropenic sepsis enabling early intervention and treatment.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated medical services as requires improvement because for safety because:

- Infection control practices were not embedded. We observed isolated poor practice such as staff not cleaning their hands after contact with patients and staff either not using personal protective equipment using it in line with the trust's infection prevention and control policy.
- Continued monitoring of risks (patient risk assessments) were not regularly completed or updated. For example, bed rail assessments were not always in place when rails were in use, and patients that required a repeat assessment due to an extended stay on the ward were not reassessed. This meant that any risk of deterioration was not identified.
- Medical records were not routinely stored in secure areas, meaning there was a risk that unauthorised persons could access confidential notes.
- Medications were not always stored securely meaning they were not safe from theft, tampering or misuse.
- All patients admitted to hospital were screened for MRSA to assist with early identification and treatment; however we found results of screening were not routinely recorded in nursing notes. This meant it was unclear whether the patient had a negative MRSA result, or the result had not been reported.
- Patients on a different specialty ward were not reviewed daily by their speciality consultant or medic. However, care of the elderly patients reviewed daily by a medical nurse practitioner.

However we also found:

- Staff were aware of their roles and responsibilities in raising concerns and reporting clinical incidents and took actions to respond to the incident and improve processes to prevent reoccurrence.
- Staff reported receiving feedback regarding incidents that they had reported.
- Staff used the national early warning score system to monitor patients observations and were found to record details and escalates concerns in line with guidance.
- Staffing levels and skill mix were planned and reviewed to maintain safety across all clinical areas. Staffing shortages were escalated to the senior nurse on duty, who risk assessed the whole hospital staffing levels to identify areas of risk and moved staff accordingly.
- Mandatory training in nursing staff overall met the trust target of 85%.
- There were effective handovers from individual shifts and between clinical specialties.
- Staff were aware of the duty of candour regulation and able to describe their responsibilities when something goes wrong

Incidents

- There were no never events reported in medical services from October 2014 and December 2015. Never events are defined as "wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers".
- Nursing staff were aware of their responsibilities to raise concerns and to record and report incidents, concerns and near misses both internally and externally. The trust reported 40 serious incidents within the medical services that required an investigation from October 2014 to December 2015. The majority of incidents related to pressure ulcers (14, category three) and slips, trips and falls (13). Pressure ulcers affect an area of skin and underlying tissue and are categorised according to severity. Category one being discolouration of skin and category four being full thickness skin loss with underlying damage to muscle, bone or tendons. Category three denotes damage to full thickness of skin, but not through to underlying tissue. All pressure ulcers reported as a serious incident were category three.
- Trust data shows that there had been an increase in the number of pressure ulcers in the period September 2014 to September 2015 with a substantial spike in activity in September 2015. No trends were identified. In response to the increased incidents, the trust implemented an additional awareness program and issued staff with pocket mirrors to enable reviews of patient's heels. Nursing staff demonstrated this during inspection.

- Staff told us they were aware of the electronic incident reporting system used by the trust and regularly reported concerns using the system. Performance data confirmed that incident reporting was in line with national peer group.
- We saw that teams discussed incidents and associated learning at team meetings along with patient safety and quality issues. We reviewed minutes and newsletters during inspection.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of the duty of candour regulation and able to describe their responsibilities when something goes wrong. Staff were able to describe incidents when they had used the duty of candour principles and we saw evidence of shared learning.
- The emergency care division lead chaired monthly mortality meetings, which discussed all deaths across the trust. Consultants reviewed the notes of patients who had died under their care and report back to the group to identify any learning. Meeting minutes were distributed across the trust to promote shared learning.

Safety thermometer

- Each ward used the NHS Safety Thermometer (a national improvement tool for measuring, monitoring and analysing harm to patients and 'harm-free' care). Current data relating to pressure ulcers, falls, catheter associated urinary tract infections and blood clots (venous thromboembolism, VTE) were displayed locally. Staff we spoke with were aware of the audit process and the outcomes using this information to track compliance.
- Nursing staff were aware of the trusts aims to reduce the number of inpatient falls and wards accessed non-slip slipper socks for patients to promote safe mobilisation. The trust had a falls prevention steering group whose remit included additional training, incident analysis and patient education.
- NHS Safety Thermometer data showed medicine services reported a total of 17 pressure ulcers (category two to four), nine falls with harm and six catheter associated urinary tract infections from September 2014 and September 2015. These were relatively small figures for an organisation of this size. The service monitored incidents and implemented actions to address the risks, for example, the trust used the Surface, Skin inspection, Keep moving, Incontinence and Nutrition (SSKIN) care bundle, which is a nationally recognised tool for pressure ulcer prevention. Validated safety thermometer data showed the trust had a harm free rating of 96% in December 2015.
- In addition to the NHS Safety Thermometer data, some wards displayed safety crosses. This visible method symbolised whether harm had occurred on that day. A red cross indicated harm and a green cross indicating no harm. On inspection, the crosses were infrequently completed and not maintained. The trust reported that this practice was not mandatory, and used locally by some wards as a visual reminder of rates of falls.

Cleanliness, infection control and hygiene

- All areas visited were visibly clean and ward-cleaning schedules were in place.
- All equipment in use appeared clean and "I am clean stickers" were in place. Staff were observed cleaning equipment after use.
- Staff had access to personal protective equipment (PPE), such as gloves and aprons. We observed some staff using appropriate PPE. However, we observed several instances of poor practice. This included the observation of one staff member carrying a used bedpan through the ward with no PPE, and two instances where staff members completed nursing documentation wearing soiled gloves. In addition, there were numerous observed occasions where staff did not clean their hands on entering or leaving the clinical area or after contact with patients.
- We observed infection control information displayed on patient and staff notice boards in ward areas and this included guidance about correct waste disposal, and hand hygiene techniques.
- The trust reported 16 hospital attributed clostridium difficile (C.Difficile) cases from April to December 2015. Incidence was in line with the England average and below the trust upper limit of 24. The service investigated these incidents and took a series of actions to minimise the risk of reoccurrence.

- Four methicillin-susceptible staphylococcus aureus (MSSA) infections were reported from April to December 2015, which occurred in three different months. Incidence was similar to the England average.
- A total of 12 Escherichia coli (E.coli) infections were reported from April to December 2015, which occurred over seven different months.
- The trust reported no cases of MRSA bacteraemia from December 2014 and December 2015.
- All patients admitted to hospital were required to have a MRSA screen within 24 hours. This process involved patients' skin surface being swabbed to see if they had MRSA. Confirmed results usually take several days for reporting and should be recorded in the patients' notes. During inspection, we identified 11 patients who had been in hospital sufficiently long enough to have results from the initial screen recorded however; no results were recorded in any of the notes. On discussion with nursing staff, we were told that the infection control team notify the ward of positive results to ensure appropriate treatment was in place.
- Monthly water sampling was conducted within the endoscopy unit to ensure the water supply was not contaminated. Staff completed regular protein quality checks and random checks of endoscopes to ensure effective decontamination.
- There were processes and procedures in place for tracking each endoscope used. Decontamination records were filed in the relevant patient notes to ensure that equipment could be traced, including details of the staff members responsible for operating and decontaminating them.
- We found that there were sharps disposal bins located as appropriate; to ensure the safe disposal of sharps, for example needles. Labels were completed to inform staff when the sharps disposal bin had been opened.

Environment and equipment

- Medical services wards varied in number of beds and design, but were appropriate to the delivery of service. For example, the haematology ward had a large number of side rooms, which facilitated isolation of patients.
- The admissions area was designed to meet the demands of the diverse admission pathways. The area amalgamated three wards with one access point, which allowed patients access to the appropriate clinical area on admission, based on whether they required assessment or admission. The environment allowed staff to work flexibly across all three clinical areas/ wards to meet the demands of patient acuity and numbers.
- The dementia care ward had appropriate signage and visual prompts to meet the needs of the patients, this included coloured footsteps to bathrooms from the ward areas and pictorial symbols on doors.
- Nursing staff reported having access to equipment to meet individual patient needs, including bariatric chairs and beds and pressure relieving mattresses and cushions.
- We inspected the resuscitation trolley on all wards and found them to be visibly clean and safe for use. Daily and weekly checks carried out demonstrated the equipment was safe and fit for use on most wards. However, the secure tab on the resuscitation trolley was fitted incorrectly on Nicolas ward and was opened without breaking the seal by nursing staff. This meant that unauthorised persons could access equipment and medication. This was escalated to the nursing staff and the tab fitted correctly
- Domestic staff were easily identifiable and during inspection were observed wearing gloves and aprons and changing them between tasks.
- We checked, at random, portable equipment to ensure it had been serviced, maintained and tested (portable appliance testing) as appropriate. Regular tests were completed to ensure portable equipment was safe and fit for use.
- Sharps bins were noted as being appropriate to the clinical area and were found to be assembled and labelled correctly.
- Dirty utility rooms (or sluice rooms) were found to be clean and tidy on inspection, with appropriate waste management processes in place to maintain safety.

Medicines

- Nursing staff were aware of the correct processes and procedures for the administration, recording and safekeeping of medications however; our findings did not consistently reflect best practice.
- We reviewed 33 medication prescriptions and found them to be generally well completed. Records were clear and patients' weight and any allergies to

medicines documented. The records showed people were usually given their medicines when they needed them and any reasons for not giving people their medicines were recorded.

- Medication fridge temperatures were noted to be checked regularly and found to be within appropriate range.
- On Avon ward, the temperature had been recorded as 16 degrees for several days. We escalated this to the pharmacist who explained that the staff had been recording the wrong temperature. The fridges had been fitted with new internal thermometers, which recorded temperatures every 15 minutes and were set to alarm if the temperatures exceeded the recommended levels. This information was logged electronically and reviewed by the pharmacist on a monthly basis. The data collected was reviewed during inspection and confirmed that the internal temperature had not exceeded recommendations. The incorrect recording was escalated to the nurse in charge, who explained the correct process would be discussed with all staff.
- We noted that room temperatures in all wards were checked where medicines were stored on a daily basis. The temperatures varied but were within the correct range for the safe storage of medicines.
- All treatment rooms were unlocked and in one case (Nicolas ward) had no door. This meant that unauthorised persons could enter the rooms. The trust policy was to store medicines in locked cupboards and drawers within the unlocked treatment rooms. However, we found cupboards and drawers containing medicines, which were not locked, and a waste bin containing tablets was accessible. They were not safe from theft, tampering or misuse.
- On Nicolas ward, some medications were kept in an automated medicine dispenser with finger print recognition access, which recorded medication usage and assisted the pharmacy team with stock management and ordering. The pharmacist reported that this equipment had improved efficiencies in cost and time.
- The pharmacy team carried out medicine reconciliation across all wards. Medicine reconciliation is the process whereby the patients current medications are reviewed to ensure the most up to date prescriptions are used. This includes reviewing any GP records and discharge or transfer letters.
- We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date, involving the patients in this process where possible. Medicines interventions by a pharmacist were recorded on the prescription chart to help guide staff in the safe administration of medicines. The team visited all wards each weekday and a pharmacist was available out of hours. They were involved in training nursing staff and supporting them in learning from medicines related incidents.
- Each ward had a designated pharmacist who would attend the ward every weekday and offer support and advice. This pharmacist was also responsible for checking all medication lists for patients being discharged.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.
- We saw controlled drugs were stored and managed appropriately.
- Red tabards were available for qualified nursing staff stating, "Please do not disturb, drug round in progress." These were observed across all inpatient areas; however all staff completing drug rounds did not use them.

Records

- Medical notes were stored in unlocked trolleys at the nurses' station on each ward. This meant when the nurses' station was not manned, there was a risk that unauthorised persons could access notes.
- Medical and nursing notes were legible. Most staff used stamps containing details of the practitioner's name and nursing PIN or medical GMC numbers, which promoted identification of individual practitioners.
- Patients' observation and daily monitoring charts were located at the patient's bedside. We saw these were complete and reflected actions taken by nursing staff. This included intentional rounding charts, which recorded patient interactions such as changing position, and offering oral hygiene.
- Nursing risk assessments varied in completion. Patients were assessed on admission, but repeated assessments or details of assessments were not complete. For example, patients requiring assistance with mobility had

incomplete manual handling assessments, which were either left blank or stated "physiotherapy to complete". We did find separate mobility assessments completed by therapists and recorded within therapy notes.
- A total of 21 patients were observed to have bed rails elevated during inspection. On review of their nursing records, the majority of patients showed incomplete bed rails assessments or manual handling assessments, which stated bed rails needed, with no rationale or bed rail assessment in place. This was escalated to the nurse in charge during inspection.
- Risk assessment documentation was generally stored in separate folders, which were located at the nurses' station, or in cupboards on the ward. In all occasions, the notes were not secured and easily accessible to unauthorised persons.

Safeguarding

- Nursing staff told us they were aware of their responsibilities regarding safeguarding and demonstrated that they were able to access the trust policy on the intranet.
- There were clear systems, processes and practises in place to keep people safe and staff were able to describe previous experiences when they had made referrals to the safeguarding team.
- Staff reported that the trust safeguarding lead was visible and easily accessible. Posters were displayed across ward areas detailing contact details.
- Staff informed us they had completed safeguarding training. Trust records show that 97% nursing staff had completed children and adult safeguarding training and 100% medical staff had completed Level 2 safeguarding children and 94% safeguarding adult training.

Mandatory training

- All wards reported compliance with mandatory training. The trust data for January 2016 showed that mandatory training was meeting the trusts' target of 85% on the majority of the medical wards. Castle ward reported 93% compliance in January 2016.The average mandatory compliance across the remaining medical wards was 86%.
- Mandatory training was logged on the e-rostering system for all nursing staff. This enabled ward managers and staff to identify when training was due.

Assessing and responding to patient risk

- Patients admitted through the medical admissions department were assessed upon arrival by a nurse practitioner and a senior doctor. This process enabled speedy completion of initial assessment in preparation for treatment and consultant review. We observed that processes were in place to ensure that a consultant reviewed all patients' within12 hours of admission, which was in line with London Quality Standard.
- All patients were assessed on admission using national risk assessment tools in nutrition, falls risks, manual handling needs and skin integrity. Initial assessments were completed within 24 hours of admission, with the aim to identify any factor which the patient may need support with and to identify a baseline condition. The admissions booklet was designed to be updated when patients' conditions changed or as a minimum weekly.
- We reviewed 37 admission documents and found 32 contained at least one incomplete risk assessment. The number and type of omission varied between patients, with mobility and bed rail assessments being the most commonly incomplete.
- We identified that five out of 11 patients who should have been reassessed due to length of stay were not reassessed. Meaning that any risk of deterioration was not identified.
- A further three out of 11 patients had been reassessed since admission, however all exceeded weekly reviews, which was outside the trust recommendation of weekly.
- We saw a patient on Nicolas ward had bed rails in situ and on review of the nursing notes, identified that a bed rail assessment had not been completed. This was escalated to the ward sister who ensured that an assessment was completed and appropriate action taken.
- Once admitted to the wards, patients were reviewed regularly by their named consultant and the medical team. The number of formal consultant ward rounds varied according to the clinician; however they occurred a minimum of twice weekly. In addition to the ward round, the nursing and medical teams conducted a "board round" which was a discussion between all staff to review individual patient treatment plans and conditions. These meetings were completed daily in addition to ward rounds.
- Nursing staff on outlier wards reported that the medical teams responsible for the patients care were responsive to their calls for assistance. However, nursing staff sometimes had trouble locating them, having to call the

speciality ward for advice. It was reported that medical teams on outlying wards assisted with the day-to-day management of the outlying patient, with tasks such as rewriting prescription charts and reviewing analgesia.

- The hospital at night service included two clinical nurse practitioners, a bed manager/site practitioner, registrar, specialist trainee and junior doctor. In addition, the team utilised a clinical support worker based in the emergency department (ED) to assist with the care of medical patients. There was sufficient provision of staff to manage the hospital at night and respond to patient needs.
- We observed the handover between day and night services and found it was structured and methodical working through outstanding tasks, patients requiring further review and those at risk of deterioration overnight.
- The clinical night team and critical care outreach team were available to staff out of hours to assist with any concerns of deteriorating patients.
- The trust used an electronic devise for alerting the team on duty to incidents and "jobs" such as the need to review a patient, insert cannula and obtain blood tests. The clinical nurse practitioner prioritised and allocated jobs to individuals. Each member of the team could see the jobs outstanding, and enabled them to offer assistance if they were able. This system appeared to be effective and well utilised by the team.
- Nursing staff used the National Early Warning Score (NEWS) system to record patients' observations, which is a scoring system, which helps to detect if a patient's condition deteriorates. The timelines for repeating observations and escalating concerns had been followed in all cases.
- We saw that the trust used the SSKIN care bundle (a nationally recognised tool standing for Surface, Skin inspection, Keep moving, Incontinence and Nutrition) for minimising the risk of skin damage. This was effectively followed in all the care plans we looked at. Appropriate pressure relieving equipment was in place and we saw that staff could refer patients to a tissue viability nurse when required.
- The nursing staff informed us that the trust had implemented a "deal with heels" campaign to promote the prevention of pressure ulcers to patient heels. Staff used pocket mirrors supplied by the trust to assist with observing heels.
- Patients with high risk of falls were nursed using falls alarms, which would alert staff to occasions when the patient was getting out of their chair/bed. This enabled staff to attend the patient immediately to prevent any harm from falling. This was observed during inspection when a patient with a history of falls on Avon ward attempted to mobilise independently. The alarm sounded and nursing staff attended to assist the patient.
- Trust data shows an overall decrease in trust wide falls over 2015 with a total of 1220 reported falls in comparison to 1285 in 2013 and 1300 in 2014. The trust had a falls prevention steering group who were focusing work streams on training, audits, medication reviews and care plans, which would assist with the identification of patients' risks and management processes.
- The hospital had a policy for management of sepsis (blood infection) and care pathway, which was implemented if sepsis was suspected. Wards did not have "sepsis boxes" available but did have access to appropriate antibiotics from pharmacy. This meant there was a risk that there could be a delay in obtaining all equipment necessary to commence treatment for sepsis. One patient's treatment for sepsis was observed and identified that all treatment required was completed within one hour and 15 minutes from admission. Guidance and the trust target for this is one hour. The sepsis bundle documentation included a sticker, which could be placed in patients notes, which detailed, time of arrival, decision of condition and time of implementation of each treatment. The trust had an annual sepsis care bundle compliance audit scheduled for January 2015. The results were not available for the inspection.
- The hospital had an acute kidney injury mandatory risk assessment for admitted patients aged over 75 years, with a number of conditions such as ischaemic heart disease and diabetes. This process ensured monitoring from admission with timely investigations and escalation to senior clinicians and specialists. Acute kidney injury is a rapid decline in the kidneys ability to filter waste substances and excess water.

Nursing staffing

- Skill mix was appropriate on all wards with sufficient registered and unregistered staff to maintain patient safety during our inspection. The numbers of staff on

each ward varied according to the speciality and ward activity. Staffing establishments had been reviewed in line with ward bed numbers and activity. The medical wards had sufficient staff numbers with the appropriate skill mix to enable effective delivery of care and treatment.

- Ward managers reviewed and reported staffing on a daily basis in line with the trust's safe staffing tool, which took into account nursing activity as well as patient dependency. This enabled senior nursing staff to identify areas of pressure and allocate staffing across the organisation. Farries ward sister adapted the tool to include the increased dependency of the haematology patients who frequently required additional support from nursing staff for clinical treatments such as intravenous antibiotics.
- The nurse bleep holder who had an overview of the clinical areas and could move staff to ensure safe numbers across all inpatient areas reviewed staffing levels.
- All wards displayed planned and actual staffing numbers on duty at the entrance to the ward. All areas were observed to be staffed to the correct numbers during inspection.
- Ward managers worked clinical shifts as part of rostered numbers for three quarters of their time. This allowed two non-clinical working days to complete management duties. We observed all ward managers had an active role in ward activity on their non- clinical working days.
- We reviewed staffing rotas for the month prior to the inspection and found that all wards had sufficient registered and unregistered staff to maintain patient safety.
- All wards confirmed nursing vacancies to varied levels. Farries, Victoria and Nicolas wards detailed vacancies of up to nine qualified nursing staff, which was the equivalent of approximately one third of their full time establishment. The trust had taken action to address the deficit with recruitment taking place and had recruited several qualified nurses from overseas. Some were noted as being in post, with additional staff awaiting a start date.
- The staff on duty across all admission areas flexed to the area of high activity to ensure patient safety. For example, when activity was high in the emergency ambulatory care (EAC) area staff would move from AAU to support. This was assessed and managed by the ward manager or the nurse in charge at the time.
- The trust employed and trained their own bank staff to promote familiarity with trust processes.
- Bank and agency staff were orientated to clinical areas using a checklist. We saw samples of these during inspection.
- Substantive staff told us that it was difficult to obtain agency staff and they often relied on their own staff working additional hours or flexing off duty to ensure patient safety. We observed this during inspection when a member of staff had reported sick for the late shift and the nurse on morning duty agreed to work the late shift. The trust reported that additional hours worked through bank were checked to ensure compliance with the European Working Time Directive (EWTD).
- Nursing staff told us that staffing shortages within the emergency admission area were not recorded as incidents as they occurred frequently. When staffing shortages occurred, risk assessments were completed and issues escalated to the bleep holder. Incident reporting occurred if issues relating to staffing remained unresolved.
- The trust used a template to review staffing across the organisation to identify areas of risk. The system called safe care required staff to detail their dependency and acuity along with staffing numbers. The information was used to identify areas of risk so staffing levels could be adjusted to maintain patient safety.

Medical staffing

- Medical staffing was appropriate with effective out of hours and weekend medical cover provided. Medical staffing within AAU was in line with the national guidance from the Society for Acute Medicine and West Midlands Quality Review Service in the publication "Quality Standards in the AMU" dated June 2012.
- The proportion of consultants (36%) was about the same as the England average (34%), and the proportion of junior doctors (14%) was lower than the England average (22%). The proportion of registrars (44%) was higher than England average (39%).
- AAU and the clinical decisions unit (CDU) had a seven-day service with patients seen upon arrival by a nurse practitioner and within four hours by a senior clinician. Dedicated consultants were on site from 8am

to 8pm, with reduced service at the weekend (8am to 4pm). The department had an electronic system for recording patient arrival and treatment times, which enabled auditing to ensure compliance against national guidance. Data reviewed during inspection confirmed that a consultant saw patients within the recommended 12 hours (London Quality Standards).

- Medical staff within AAU told us they were well supported and had appropriate training in place to support them clinically.
- The emergency ambulatory care (EAC) had consultant cover until 5pm, the consultant for AAU and CDU would cover the department out of hours.
- The medical team had a rolling programme whereby a senior doctor was rostered to work as a "shadow" every one week in eight and they would cover any last minute vacant shifts due to sickness. This meant that there was not a reliance on locum staff.
- We observed the clinical handover between day and night medical teams. This included the handover of the acutely unwell patients across the trust. Patients identified as being at risk were discussed to ensure oncoming staff were aware of interventions or assessments required overnight.
- The endoscopy team had an effective process in place to manage patients requiring an urgent endoscopy with on call provision out of normal working hours.
- The trust had a medical appraisal and revalidation policy in place dated 2016 and reported that all 100% medical staff had an appraisal in place and completed the revalidation process. Revalidation is the process for doctors to positively affirm the general medical council (GMC) that they are up to date and fit to practice.

Major incident awareness and training

- The bed escalation policy and major incident plan were available on the trust's intranet and were updated in September 2015. Staff were aware of trust policies and how to access them.
- The trust had appropriate plans in place to respond to emergencies and major incidents.
- Staff had awareness of what actions they would take in the event of a major incident, including a fire.
- Avon ward was able to demonstrate awareness of their role in the event of an outbreak of an infectious disease. The wards facilities included external access and a small number of negative pressure rooms, which were separate from the main ward. A negative pressure room allows air to flow into the isolation room but not escape from the room, thereby preventing contaminated air from escaping the room.

Are medical care services effective?

Requires improvement

We rated medical services as requires improvement for effectiveness because:

- Staff had varied understanding of the Mental Capacity Act 2005 and were unable to give clear explanations of their roles and responsibilities regarding mental capacity assessments and deprivation of liberty safeguards
- There was no evidence in practice that all staff caring for patients who lacked mental capacity were adhering to one clear system to ensure these patients were cared for safely.
- We found lack of mental capacity documented in only five out of 61 patient records, even though many of these patients were being cared for on dementia or frail elderly wards. Of these five patients, none had formal mental capacity assessments in place.
- Staff told us that there was no formal clinical supervision in place

However we also found:

- Patients care and treatment was delivered in line with evidence-based practice, standards and legislation.
- The trust performed 'as expected' and 'within expected range' in the two mortality indicators (SHMI and HMSR respectively)
- The trust performed about the same as peer group in national audits completed.
- Endoscopy unit had accreditation against national standards set by gastroenterology society.
- Staff effectively managed pain, and had access to specialists for additional training, support and advice.
- Patients' nutritional and oral intake was assessed and accurately recorded.

- Staff were allocated mentors when commencing posts and were given speciality-based competencies.

Evidence-based care and treatment

- Trust policies were current and referenced according to national guidelines and recommendations. These were accessible through the trust intranet for all staff that had current electronic access.
- Patient assessments were based on national tools and covered all aspects of health and social care needs.
- Victoria ward had policies in place that followed the National Institute for Health and Care Excellence (NICE) guidance for stroke in adults. Staff showed awareness of the stroke care pathway and we saw effective treatment planning in nursing and medical records.
- The trust had policies in place for the management of sepsis and acute kidney disease, which were in line with NICE guidance. The pathways were recorded in patients' notes by the use of a sticker, which detailed the diagnosis, treatment type and time of completed processes such as administration of oxygen. This enabled information relating to the condition to be identified and enabled consultants to review compliance against policy and national standard.
- Medical services had also implemented a care pathway for patients admitted with community-acquired pneumonia, which followed the same principles enabling easy identification of treatment received for the condition.
- We saw medical services followed the trust policy for the safe administration of chemotherapy, which was in line with national standards.
- The British Society of Gastroenterology (BSG) guidelines for decontamination were accessible through the trust intranet.
- Medical services followed the trusts audit calendar to capture compliance against policy and procedure. Data captured was displayed on each ward and reviewed by service leads to identify trends and development of any actions required.

Pain relief

- We saw patients' pain assessed regularly and recorded on national early warning score charts (NEWS). We identified 11 patients who had received analgesia and noted their pain score recorded on their NEWS charts. Nursing staff recorded a pain score at each contact for completion of observations and administered analgesia in line with medicine prescriptions.
- Nursing staff told us that patients were referred to the acute pain service for additional support if necessary and they provided additional training and support for both patients and nursing staff. This was not observed during inspection.
- Patients we spoke with confirmed that they had received pain relief medication when they required it.
- We saw a relative inform the staff on Nicolas ward about a patient who had reported being in pain, this was immediately acted upon. The nurse assessed the patient, reviewed the analgesia available and administered the medication in a timely manner.
- Qualified nursing staff in Aylesford oncology unit reported using pictorial faces to aid communication of pain for patients with a learning disability. This was not observed during inspection.

Nutrition and hydration

- Patients were screened for risk of malnutrition on admission to hospital using a recognised assessment tool, the Malnutrition Universal Screening Tool (MUST). Screening should be completed on admission and repeated at weekly intervals, unless clinical condition changes. During inspection, we reviewed the notes of 11 patients who had been in hospital for longer than one week. Five out of 11 assessments had not been repeated since admission and one patient admitted nine days previously had not been assessed. This was escalated to the nurse in charge at the time of inspection.
- Staff accurately recorded patient's daily oral diet intake. This meant that patients would receive a complete and accurate nutritional assessment when information was reviewed, as malnutrition or dehydration would be identified.
- Dietetic support could be accessed by a telephone referral.
- We saw dietetic reviews documented in patients' medical notes, highlighting the implementation of nutritional supplements. Nutritional supplements included fortified soups, drinks and yoghurts.
- Patients who were nil by mouth had signs above their bed to alert staff not to offer the patient any food or drink.

- We audited if patients who were able to drink without assistance, had a drink within reach on Victoria ward. We found two out of eight patients had a drink within reach.

Patient outcomes

- Medical services had processes in place to monitor some patient outcomes and report findings through national and local audits and to the trust board. Information gathered was used by the trust board to benchmark practices against similar organisations.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. The trust performed "as expected" for January to December 2015, at 1.1 against the England figure of 1.0.
- The trust Hospital Standardised Mortality Ratio (HMSR) (for in hospital deaths only) for January to December 2015 was "within expected range", at 108.0 against the England figure of 100
- In the December 2015 national stroke audit (Sentinel Stroke National Audit Programme, SSNAP) the trust was rated as band D having previously been rated as E (A being the best and E the worst). The main categories for poor scoring centred on time taken to scan patients, and the provision of speech and language therapy (SLT). The stroke services reported an improvement in time for scanning and were pleased with the progress made by the team. An action plan was in place, which included increased assessments by the SLT. The division and trust board reviewed the action plan monthly. Nursing staff informed us that they were in the process of transferring all stroke services to another provider with expected completion in 2016/17.
- The hospital did not submit data in the most recent published Myocardial Ischaemia National Audit Project (MINAP) audit for 2013/14. We were told that a member of staff who no longer worked for the organisation had previously collected data. The December 2015 cardiology clinical governance meeting detailed allocation of the role and progress in completing data entry retrospectively.
- The trust did not measure thrombolytic door to needle time for stroke and myocardial infarction patients as patients requiring emergency treatment were transferred to the regional centre.
- The hospital performed similar or better than the England and Wales average in the latest published National Heart Failure Audit (NICOR/ HQIP) for 2013/14 including input from cardiologists and specialists.
- The trust took part in the National Diabetes Inpatient Audit (NaDIA) 2014-2015 audit. Data stated that Warwick Hospital performed better that the national average in eight out of the 17 audit measures and worse than the average in nine. The trust scored well against the choice and timing of meals and medication errors, but less well about staff being aware and knowing enough about diabetes. We were provided with an action plan which detailed a comprehensive training programme to raise staff awareness of diabetes and the associated guidelines available to support them when caring for diabetic patient. All actions were specific and assigned to a specific clinician with dates when they were expected to be completed.
- The relative rates of readmission for both elective and non-elective patients were slightly better than the England average. The risk of readmission for elective medical patients was 96 and non-elective patients 94, which were better than the England average of 100 for each category.
- Endoscopy services were Joint Advisory Group (JAG) gastrointestinal endoscopy accredited, which meant that the service met the accreditation standards framework for aspects such as policies, practices and procedures

Competent staff

- Staff were found to have the appropriate qualifications, skills, knowledge and experience for their roles and the trust had processes in place to identify training needs and compliance.
- We saw that induction programmes for new permanent staff and students included mandatory training at trust level and competencies based on the clinical speciality of the ward. This enabled newly appointed staff to become familiar with trust policies and procedures.
- Learning needs of staff were identified through a training needs analysis, and competency packages were developed. This was observed on the Farries, Oken and Mary wards where competency packs and mentors were allocated on commencement in post. We saw competencies were also available for unregistered staff and allied health professionals (AHPs).

- The clinical night practitioners told us that they audited night time activity such as assistance with cannulation and catheterisation and targeted individual staff and wards where trends were identified to conduct specialist training. The team explained that staff members were encouraged to complete tasks under supervision once theoretical training had been completed. This had helped to ensure competence as staff were assessed or supervised when undertaking skills that were either new or less confidence.
- Staff told us there was no formal clinical supervision provision. However, staff said informal support from their managers was effective and provided when they needed it. Senior staff said they received excellent informal support from their line managers.
- All newly qualified staff were supported through a preceptorship programme, which offered additional training and support.
- Appraisal rates in the medicine service were largely below the trust target of 85% with an average compliance of 77%. However, Charlecote ward reported 47% compliance in the trust March 2016. The wards reported plans in place to address the deficit with appointments arranged for outstanding staff. Castle, Fairfax, Farries, Nicolas and Squire wards were complaint with appraisal rates above the trust target.
- Medical appraisal compliance was 100% across both divisions meeting the trust target of 85%. Medical staff revalidation was also 100% compliant in March 2016.
- Medical teams completed weekly educational meetings to share learning. One of which was observed on Guy ward, when junior doctors completed a training session on the management of liver failure. The training followed a ward round and included a consultant led training session with questions and answers. The medical team reported that these sessions were invaluable to their learning and were in line with their training needs.
- Most wards reported link roles for topics such as dementia, infection control, falls, however; attendance at meetings was affected by nursing vacancies. In addition, staff felt that they were responsible for several topics because of reduced staffing numbers, which affected their ability to perform link roles effectively.
- The medical division reported 100% compliance in dementia training with the exception of Victoria ward with 85% compliance in March 2016.

Multidisciplinary working

- All necessary staff were involved with the assessing, planning and delivery of patient care and we observed patients discussed between specialities for advice on specific care pathways.
- We found evidence in patients' notes that diagnosis and treatments were discussed with regional centres. For example, one patient was discussed with the neurology team for advice regarding management of symptoms.
- Patients' allocation to consultants was determined on admission and unless the patient presented with a condition relating to a specific speciality they would be cared for by the general medical team.
- Respiratory and cardiology consultants attended the admission area to review patients with possible diagnosis and offered clinical advice even if they were not the responsible consultant. This enabled clear diagnostic testing and pathway management. The admitting consultant referred to other specialities as necessary, for example gastroenterology or care of the elderly.
- Overall responsibility for the patient would lie with the consultant responsible for the treatment and care of the patient at that time. For example, during inspection we observed a patient transferred from respiratory medicine to cardiology following treatment for a chest infection. This was in line with the royal college guidance on responsibility and accountability.
- Multidisciplinary team meetings (MDTs) were well attended across all wards. MDT meetings took place on a regular basis to review the progress of patients and plan a safe discharge. On Oken, Malins and Avon wards meetings were observed to be systematic, with staff showing insight into individual patient needs and requirements for safe discharge. This was particularly important for patients with complex needs who required actions and interventions by multiple agencies. We observed patients with complex discharge problems due to physical restrictions being assessed by therapists and social care representatives to ensure equipment and care needs were in place prior to discharge. The MDT enabled all aspects of this process to be discussed and clarified prior to arranging discharge.
- The discharge coordinators who assessed patients with ward staff to identify any ongoing care needs reviewed patients prior to discharge. Patients identified as having ongoing care needs were referred to the social or

continuing care team for assessment. Nursing staff reported robust systems in place and effective working with the external teams to manage patient care safely. Medicine services reported early discharges and a maximum wait of one week for discharge of patients with complex needs.
- Nurses said that relationships with doctors and other professionals were inclusive, positive, and facilitated effective MDT working.
- Medical nurse practitioners were observed attending all ward rounds, and assisted with the planning and review of patient care.
- The medical teams had a checklist for ward rounds that prompted clinicians to review all aspects of care, including a review of clinical condition, diagnosis, and any ceilings of treatment.

Seven-day services

- There was evidence of progress to providing seven day a week services.
- Some allied health professionals (AHPs) such as physiotherapists and occupational therapists provided a seven-day service.
- The AAU consultants provided seven-day cover and were available within the department from 8am to 8pm during the week and 8am to 8pm at weekends. Consultants completed a minimum of two ward rounds daily, which was in line with London Quality Standards.
- The out of hour's medical team consisted of a registrar, two specialist trainees plus an on call consultant. The surgical specialist trainee worked across specialities and assisted in the medical division as necessary. The trust had clear escalation procedures in place and staff reported that consultants extended working days and attended out of hours to support the team in the safe management of patient care. This provision of staff was appropriate to workload by the specialist advisors completing the inspection.
- All wards reported that at weekends, the consultant on duty would review all acutely unwell patients and new admissions. Unless clinically indicated the treatment planned set by the patients named consultant would continue for all other patients. Nursing staff reported that consultants would see any patient escalated to them.
- The cardiac catheter lab operated a Monday to Friday service for diagnostic procedures only with primary cardiac patients transferred to the regional centre. Staff told us that any inpatient requiring this service out of hours would be monitored and if necessary transferred for urgent treatment to the regional centre.
- Local diagnostic services were available daily with out of hour's facilities for emergencies, including x-ray and pathology services. Staff reported no issues with accessing diagnostic testing out of hours.
- Hospital pharmacy provided daily cover with reduced hours at weekends. An on call provision was made for clinical emergencies' and staff could access medications through an emergency store. Nursing staff told us that the trust intranet had a list of medications available and detailed location to assist with collection.

Access to information

- Doctors and nursing staff said they had access to all information needed to deliver effective care and treatment in a timely manner.
- Admission documents and referrals were kept with patient nursing and medical records and we observed these being filed in patient notes to prevent loss and ensure availability to all clinicians.
- Patient observations were maintained at the patient's bedside to ensure that they were easily accessible when being reviewed.
- Results from diagnostic testing were available through electronic databases. Abnormal results were telephoned through to wards and nursing staff escalated to the medical team appropriately.
- Electronical equipment for checking results was available on each ward, and noted to be password protected. During inspection, we saw that staff routinely logged off computers and ensured screens were not visible to unauthorised persons.
- Staff used electronic discharge checklists for patients, which detailed reasons for admission, treatment administered and medications taken. Nursing staff reported that they also completed telephone handovers to other hospitals and nursing homes to ensure that all information was shared and they were aware of any changes to treatment prior to the patient being discharged.
- Doctors completed electronic discharge summaries to ensure appropriate information was available to healthcare professionals regarding patients' discharges. Copies of discharge letters were sent to patients general practitioners to enable continuity of care on discharge.

Medical care (including older people's care)

- Policies were available on the trust's intranet and staff were aware of how to access them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were unable to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and deprivation of liberty safeguards (DoLS). There was no evidence in practice that all staff caring for patients who lacked capacity were making best interest decisions in accordance with the legislation.
- Of the 61 patient records we looked at, including records for patients on Squire ward (dementia care) and Nicolas ward (frail elderly), five detailed that the patient lacked capacity to make decisions. There was inconsistency in the way the patients' lack of capacity was recorded, with different or blank forms contained within the records. On review of medical notes associated with these five patients, there appeared to be no formal capacity assessment considered or in place. Neither was it documented how staff were making "best interest" decisions in accordance with the legislation. Staff were unable to confirm whether these had taken place, or who should have completed them.
- Staff we spoke with, including four nurses on Nicolas ward and two nurses on Squire ward demonstrated a varied understanding of the MCA. Staff were inconsistent with their knowledge of mental capacity assessments and DoLs , some suggesting that capacity assessment was only necessary for invasive procedures, some stated assessments should be completed by the doctors only and other staff stating assessments were completed by anyone trained. One consultant told us that formal assessments were available and should be completed and recorded in the medical notes, however we found no evidence of this.
- The exception to this was the acute admissions areas. During inspection, we observed the acute admissions ward referring a patient to the deprivation of liberty and safeguards team. Staff were able to demonstrate and understanding of mental capacity assessment and deprivation of liberty safeguards (DoLS) referral process. In this case, the patients' mental capacity assessment confirmed the lack of capacity to make decisions regarding treatment and self-discharge. The process enabled staff to administer necessary treatment and prevent the patient from self-discharging which may have resulted in harm.
- Therapists told us that a patient's verbal consent was always obtained before carrying out treatment and we saw evidence to support this in patients' notes.
- The trust reported 97% compliance with annual mental capacity act training.

Are medical care services caring?

Good

We rating medical services good for care because:

- Patients were treated with dignity and respect, and kindness during interactions with staff.
- Data collected through patient satisfaction audits was generally positive and regularly shared with the team.
- Patients told us they felt supported and stated staff cared about them.
- Most patients and those close to them felt involved with decision making and making choices about their care, and felt supported.
- Patients were received compassionate care and their privacy and dignity was maintained.

Compassionate care

- Staff were observed to respect patient's individual preferences, habits, culture, faith and background. Staff were consistently polite and respectful to patients and those close to them, offering support, time and advice as necessary.
- We observed staff interacting with patients and those close to them in a polite and respectful manner. Staff spoke to patients to ensure they were comfortable and asked if they needed any help, for instance changing position in bed.
- Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care. We saw staff using posters that were attached to curtains signifying personal care was taking place and requesting staff and visitors to knock before entering or wait until the procedure was completed.

Medical care (including older people's care)

- Patients told us staff were very good and responsive to their needs.
- Staff were observed being kind and patients told us staff were caring, with compassionate attitudes and well looked after.
- Confidentiality was respected at all times and staff were observed asking patients and relatives into private areas to discuss concerns.
- Hospital performance in the Care Quality Commission Inpatient Survey, published in May 2015, was about the same as other trusts in all questions. The survey was completed by 413 patients.
- The trust participated in the National Cancer Experience Survey, which was published in September 2014. From 1 September to 30 November 2013, 229 eligible patients from the trust were sent the survey, and 361 questionnaires were returned completed. This represented a response rate of 69% once deceased patients and questionnaires returned undelivered had been accounted for. The national response rate was 64%. The trust scored in the top 20% nationally for 25 of the questions including being given clear information. The trust was in the middle 60% of trusts for their performance against 34 indicators. The trust scored in the lowest 20% in one indicator which was patients' views being taken into account by doctors and nurse when discussing treatment.
- The trust reported an overall recommendation rate of 96% in December 2015 for Friends and Family Test results.
- The trust had a slightly higher response rate than the England average in the Friends and Family Test. Locally ward response rates varied from 25% Castle ward and 58% on Avon ward, with an average satisfaction scores on 4.25 out of 5 (Charlecote ward) and 4.76 out of 5 (CCU). The score reflects patient satisfaction with one being very unhappy and five being very pleased with the service.

Understanding and involvement of patients and those close to them

- Most patients told us they felt involved in planning their care, in making choices and informed decisions about their care and treatment.
- Staff communicated in a way that patients could understand and was appropriate and respectful. We observed staff involving patients and those close to them during assessments on the ward giving them time to ask questions or clarify comments.
- We observed therapists supporting and involving patients appropriately with their therapy assessments on all wards.
- We found medical staff took time to explain to patients and those close to them the effects or progress of their medical condition.
- We saw some evidence in care records that communication with the patient and their relatives was consistent throughout the patient's care.

Emotional support

- Most patients we spoke with were very positive about the support they received from the multidisciplinary team.
- Staff showed awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. The AAU reported effective interaction with the mental health team for patients who required assistance with mental health assessments or treatment.
- Patients said the hospital chaplaincy had a visual presence around the hospital and they were happy to meet them.
- Patients had access to a chapel and multi faith room on site.

Are medical care services responsive?

Good

We rated medical services good for responsiveness because:

- The trust consistently exceeded 90% of patients on an incomplete pathway waiting less than 18 weeks from referral to treatment.
- The target in ED to admit, discharge or transfer of patients within four hours of arrival was seen as the responsibility of the medical teams as much as those directly working in ED. Significant work had been undertaken to manage the flow of patients through the hospital including review by senior clinician within four

hours of arrival with an early decision to admit to hospital or not and the flexible use of beds and clinical areas to meet the demands of the service at any one point.

- Patients were seen by specialists in a timely manner and "pulled" to the speciality wards for ongoing treatment. This meant that patients were transferred to the appropriate speciality ward as early as possible after admission to hospital.
- Care and treatment was coordinated with other services and providers enabling a smooth transition between acute hospital and community management reducing delays in discharge processes, such as the reinstatement of care packages.
- The trust had an established 'discharge to assess' programme which enabled patients to be discharged from hospital with a care package to be assessed after a period of time for ongoing support needs. The trust had been used as a reference centre for other trusts and organisations.
- There were additional facilities for patients living with dementia and those with learning disabilities. This included activities for patients, the use of "this is me" document and extended visiting hours for families and carers.
- A high percentage of patients had less than two moves within the hospital per admission.

However we also found:

- Patient information leaflets were limited to English only, with access to translators as necessary. Staff reported using family members for assistance with translation, which was poor practice.

Service planning and delivery to meet the needs of local people

- Medical services did not provide emergency care for patients with a suspected stroke or myocardial infarction with these patients being transferred to the regional centre. Patients transferred to the regional centre were discharged to their local rehabilitation unit for ongoing treatment and bypassed the hospital unless additional treatment was required once discharged.
- The trust provided specialist stroke nurses who assisted with the management of patients admitted to the hospital with suspected strokes or transient ischaemic attacks (TIA- mini strokes). The team assisted with liaison with the regional centre and GPs, assessing patients on admission and offering support throughout the inpatient period. The service was available from 8am to 4.30pm Monday to Friday and 8.30am to 3.30pm on Saturday and 8.30am to 12.30pm Sundays. The service provided emergency treatment and care for patients with a suspected stroke, however, patients requiring hyper acute stroke services were transferred to another provider.
- The trust had nine coronary care beds and a cardiac catheter laboratory, which was for diagnostic tests only. Acute cardiac interventional services were provided at the regional centre. Cardiologists and specialist nurse practitioners reviewed all patients with suspected acute cardiac problems and referred them to the regional centre, tracking progress and providing care once the acute phase of the illness had resolved.
- The Aylesford oncology centre was open six days per week and managed an acute service jointly with ED. Types of cancers were cohorted to specific days per week, for example; patients with colorectal cancer attended where possible on the same day. Feedback from patients to the department suggested that patients obtained greater support from this.

Access and flow

- In June 2015, the admitted and non-admitted operational standards were abolished. The incomplete pathway standard was the sole measure of patients' constitutional right to start treatment within 18 weeks. The trust had consistently met the historical standard for referral to treatment since at least July 2013. The trust reported they achieved two-week referrals for 97% for cancer patients and 31-day target for referral to first treatment in 100% of patients in December 2015.
- In April 2016, the trust reported consistently meeting all cancer targets with the exception of 62 day, 2-week wait referral to treatment times that was 83%, against the trust target of 85%. The trust analysed the data and had improved diagnostic reporting processes to assist with an improvement strategy.
- The trust had changed the admission process for medical patients in December 2015 as part of a six-month trial. Planned admissions (GP referrals) attended the clinical decisions unit for assessment and if inpatient admission was required, the patient was

either move to MAU or to the appropriate ward area. Emergency department (ED) referrals were transferred to the most appropriate unit depending on clinical need.

- General practitioners were able to refer patients directly to the hospital for review and would contact the coordinator to inform them of pending admission. The coordinator would then notify the admissions areas of the patient's condition to ensure that they patient were expected. The staff on AAU were able to demonstrate the process of referral and tracking through the department.
- The introduction of an emergency ambulatory care and clinical decisions unit meant a senior clinician assessment and a decision regarding admission was made in a shorter period. This improved flow through hospital beds and promoted flow from ED to the wards. The CDU was also used as an escalation area for inpatients in the event of increased activity.
- Fairfax ward was situated next to AAU and provided an additional 14 inpatient beds for periods of increased activity. AAU managed this area and staff moved to provide appropriate cover across all admission areas to ensure patient safety.
- Patient pathways did not limit EAC admission criteria and the clinical lead for admission areas told us that there were three basic criteria for patients attending the department. This included, patients should have their own transport, be clinically stable and be free from cross infections (for example MRSA).
- We observed the AAU handover. Where possible patients were allocated to the correct speciality ward, to prevent multiple ward moves and enable specialist care required for the admitting condition. The trust reported a consistent number of ward moves per patient from December 2014 to November 2015 with 96% of patients moving once between admissions areas and ward. This is a high percentage and better than national average. However, during inspection we noted that three outlier patients had been transferred a number of times across inpatient areas. This included one patient who was transferred to two different wards in one day and up to five moves in total.
- To assist with the flow of patients to speciality areas, the cardiology and respiratory teams attended AAU daily to assess patients and "pull" them to the speciality ward. This promoted patients being cared for by the correct clinicians in the most appropriate area and had assisted with reducing the length of stay for patients.
- If an appropriate speciality bed was not available, the patient would remain on AAU until one became available. This was observed during inspection when two patients requiring non-invasive ventilation overnight remained on AAU until a bed became available on Mary ward. This prevented patients being transferred to areas where nursing staff may not have the appropriate clinical skills to manage a patient safely.
- Bed capacity meetings occurred five times a day to discuss and prioritise bed capacity and patient flow issues. The service used historic data to forecast bed capacity and demand. The meeting was structured and methodical.
- The bed capacity meeting also identified any outliers. An outlier is a patient who is cared for on another speciality ward, for example a respiratory patient cared for on a surgical ward. During inspection, we noted that there were nine outliers across the hospital. We saw evidence that a medical nurse practitioner reviewed outliers for care of the elderly daily. In other specialities, reviews were completed by the medical team, but less frequently. The medical reviews were not always consultant led. One medical patient placed on an orthopaedic ward had not seen a consultant since transferring to the ward 21 days previously. A registrar had reviewed the patient every three days apart from one gap of 11 days. The patient was awaiting a care package for discharge, had not been clinically unwell during this time, and was effectively managed by the ward team.
- Patients identified as able to move to another speciality ward were risk assessed to ensure that their condition allowed them to be moved to another clinical area and that nursing staff had the appropriate skills to care for the patient. The responsibility of the patient remained with the admitting speciality team and consultant.
- Complex discharge coordinators were allocated to wards and were responsible for the coordination of discharge processes for all complex cases. This included the liaison with continuing health, social care and care agencies and direct referral to re-ablement. The trust had an established 'discharge to assess' process in

place, which allowed the reinstatement of care packages within 14 days from admission. The service had acted as a reference centre for other trusts in this process.
- Staff reported working closely with the community early referral team (CERT) to facilitate timely discharges from hospital.
- The trust provided 12 frailty beds, which were allocated to patients over 75 years old. This enabled therapists and nursing teams to concentrate on specific aspects of care to promote a safe early discharge. Staff identified the admission cause, and targeted treatment to prevent established care packages being cancelled due to lengthy admissions. If patients required admission over 72 hours, they would be transferred to the care of the elderly wards.
- The admission criteria for the frailty beds was; patient history of dementia or delirium, previous 24 hour or care package in place, admission for falls and new mobility issue from underlying condition such as urinary infection.
- The trust provided an inpatient ward for rehabilitation (Dugdale) which was managed by the allied health professionals and community matron. Patients were identified as requiring a rehabilitation bed and assessed by the therapists for suitability. Once a bed became available, the patient was transferred to the unit for treatment and preparation for discharge.
- The average length of stay for elective patients was 3.1 days, better than the national average (3.8).
- Average length of stay for non-elective patients was 7.5 days in comparison to the national average of 6.4 days.

Meeting people's individual needs

- Nursing staff had a clear understanding of the individual needs of vulnerable patients and had systems in place to promote safety and effective care.
- Most staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workload meant this did not always happen.
- Nursing staff reported that dementia risk assessments should be completed for all admissions over 75 years old. During inspection, we identified that this was completed appropriately.
- Staff used a butterfly symbol to identify patients with a confirmed diagnosis of dementia, or an outlined butterfly to identify patients that may be confused. The symbol was placed on the ward board next to the patients name to help identify patients at risk. However, it was identified that the butterfly symbol was not consistently used. We identified several patients who had a diagnosis of dementia but the butterfly symbol was not consistently present on patients' records, drug charts, name board and ward board. The trust reported that the use of the butterfly symbol was optional, as consent was obtained prior to displaying the symbol.
- The trust had designated dementia care beds on Squire Ward. The ward had been decorated to take into account the patient group and included clearly defined toilets and washrooms, with clear signage and colour coded footprints to follow.
- Dementia boxes and activity blankets were available for patients living with dementia. These were boxes with memory aids and activities, which were designed to either assist patients to recall events and experiences or to provide activities to occupy the patient.
- Qualified nursing staff reported using community teams to assist with the management of patients with learning disabilities and enabling patients' carers to attend the unit to provide support to the patient.
- We saw the 'this is me' document in patient records, completed by relatives appropriately. This helped staff to meet the specific needs of patients living with dementia or learning disability.
- Nursing staff told us that visiting times could be flexed to allow relatives of elderly or patients with a learning disability to maintain family contact through long admissions. This was observed on Farries ward, where the patients established care team attended the hospital to promote reassurance.
- We saw that wards had protected meal times and patients had a choice of meals.
- We observed mealtimes during inspection and saw staff providing patients support and assistance with meals. Patients were prepared appropriately by changing position and offered a choice of meal. Staff assisted patients at meal times in a non-rushed manner, allowing patients' time to eat their meal.
- Wards used red place mats to indicate patients who needed assistance or who were at risk of malnutrition or dehydration and staff were observed using this process effectively.

Medical care (including older people's care)

- During inspection we observed Squire ward offering patients an afternoon tea party to celebrate nutrition day. Patients and relatives were offered cakes and beverages during the afternoon.
- Farries ward also had a relative's room, which was used for relatives of patients who were particularly unwell. The room was reported as well used. Some other wards had quiet area for relatives and patients to use.
- Patient information leaflets were available however; we did not see any leaflets in non-English languages and staff confirmed these were not available. Staff had access to interpreters however; staff told us that patients' family members were used to translate if necessary, despite being poor practice. Staff also told us that in cases where family members were used to assist with translation, visiting times were extended to ensure patients could communicate with the team.
- Nursing staff said that an additional staff member could be requested if a person needed specific one-to-one support, but that this did not always happen due to lack of available staff. Qualified nursing staff told us they assessed the risk and requested additional staff to support the ward.
- Nursing staff reported that specialist equipment such as beds that lower to floor height were available for use from a central equipment store.
- Nursing staff reported working closely with Age UK to provide fresh milk and bread for patients being discharged who were unable to provide shopping on discharge.
- The trust had recently opened a hair salon on site, which was managed by the local college and provided hair and beauty services for patients. Patients were unable to be seen on the wards, but could attend the salon if they were clinically stable.

Learning from complaints and concerns

- Patients generally knew how to raise concerns or make a complaint. The wards encouraged patients, those close to them or their representatives to provide feedback about their care.
- Complaints procedures and ways to give feedback were in place. Patients were supported to use the system using their preferred communication method. Patients were informed about the right to complain further and staff encouraged patients to use the Patient Advice and Liaison Service (PALS).
- The divisions held monthly senior nurse meetings at which incidents were reviewed and lessons learnt.
- There were 38 complaints regarding medical wards and endoscopy from January to December 2015. These related to poor communication, general concerns regarding treatment and waiting times for appointments.
- The trust complaint's leaflet stated that a response would be issued within 25 days of receipt of written complaint. On review of the trust data, approximately half of the medical services complaints were resolved within this time scale, with the remaining half taking up to 60 days depending on complexity. The trust offered meetings with complainants to discuss cases that were more complex.
- We saw many compliment letters and thank you cards displayed in ward areas.

Are medical care services well-led?

Good

We rated medical services good for well-led because:

- Each division had systems in place to monitor and track the quality of service provided.
- The wards within medical care service were well led, with evidence of effective communication within ward staff teams.
- All staff were committed to delivering good, safe and compassionate care.
- Innovation was promoted by the medical service, and staff felt encouraged to develop ideas.
- Specialities had governance processes in place, which functioned effectively.
- Monthly mortality meetings included reviews of any patient deaths to identify learning and individual development.
- All staff had access to current policies and procedures, which were reviewed regularly and updated in line with national guidance.

- There was evidence of innovation, which included the management of patient flow through hospital and the development of an application (app) for a smart phone containing policies, procedure and guidance.

Vision and strategy for this service

- The trust overall had a statement of vision and values which included 'Trusted to provide safe, effective, compassionate care'.
- The emergency care division had a clear vision for admission processes, which had been implemented as a trial in December 2015. The divisions aim was to maintain that process past the trial period, with a view to develop additional pathways that could be managed as outpatient services and prevent inpatient episodes. The division was capturing clinical data to support this process and improve efficiency.
- The emergency care division had a nominated consultant linked to information technology (IT), who worked with the team to ensure that all IT was suitable to patient and clinical needs.

Governance, risk management and quality measurement

- The division leads identified and regularly reviewed the main risks for the services and evidence of this was identified during inspection. Risks identified included staffing levels and recruitment.
- Ward staff told us wards maintained their own risk registers. Risks were numerically graded according to the likelihood and impact. A score of one to 25 was possible with higher numbers demonstrating higher risk. Risks 15 or above were included on the trust risk register and were escalated through regular quality and clinical risk committee meetings. Senior staff said the main risks identified for the service related to staffing pressures.
- Nursing staff on Dugdale ward (inpatient ward for rehabilitation) reported that the community matron managed the wards risk register centrally. Risks identified related to the estate, particularly the bathrooms which had limited room for patients in wheelchairs requiring assistance.
- The divisions held monthly clinical governance meetings with a standardised agenda, which included health and safety, complaints and audits. Information from this meeting was cascaded to the board and to the wards via the ward managers. Evidence of these meetings was provided during inspection.
- Medical services reported monthly mortality audits. These included a review of any patient who had died by their admitting consultant. Information from these meetings was shared with the board and clinical teams for learning and development.
- The divisions had a robust audit calendar, which was used to monitor services and compliance against national and local standards. Information was shared amongst teams locally to promote improvement and reviewed by the trust board as dashboards.
- All wards displayed audit data at their entrance detailing compliance with audits such as handwashing, sickness levels and friends and family responses.
- Nursing staff reported using patient handovers to discuss national alerts or incidents within the trust to ensure staff were aware of learning and changes to practice.
- Staff reported that they were informed of changes to policies through email, with updated versions also shared with teams locally.

Leadership of service

- Three divisions managed the medical services; the emergency care division were responsible for the acute admissions unit (AAU), clinical decisions unit (CDU) and ambulatory care, cardiology (including cardiac catheter laboratory) and respiratory medicine. The elective care division were responsible for endoscopy, cancer and haematology services and gastroenterology. The integrated community care division managed elderly care, stroke services, diabetes services and discharge team.
- The management structure consisted of an associate director of operations, associate medical director, and head of nursing and general managers.
- Each ward area had a band 7 nurse who acted as ward manager. The role was partially clinical 60% and non-clinical 40%.
- Team leaders in the wards generally prioritised safe, high quality, compassionate care and promoted equality and diversity.

- The majority of staff felt respected, valued and supported. Local ward leaders communicated effectively and were visible to teams and staff.
- Most staff said the chief executive and senior leaders were visible.
- Local teams generally had clearly defined tasks, membership, roles, objectives and communication processes.

Culture within the service

- Across all areas, staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Most staff felt listened to and involved in changes within the trust. Many staff spoke of involvement in staff meetings and received newsletters. In the 2015, staff survey the percentage of staff recommending the trust as a place to work was significantly higher than the average for similar trusts, at 73% compared to 58%.
- Senior managers said they were well supported and there was effective communication with the executive team.
- Staff did not express concerns about bullying or harassment. Senior staff complimented the attitude and dedication of all staff in the service.

Public engagement

- The trust and staff recognised the importance of the views of patients and the public. A standard approach was taken to seek a range of feedback with participation and involvement with both the public and staff including surveys, comment cards and questionnaires.
- Information on patient experience was reported and reviewed alongside other performance data but not all staff felt patient feedback was used to make informed decisions about the service.
- Patient satisfaction questionnaires were in use on each ward. This provided the opportunity to patients to give feedback.
- The trust had a volunteer coordinator who assisted to manage volunteers across the organisation.

Staff engagement

- All wards reported regular team meetings with newsletters between meetings.
- Squire ward changed from monthly team meetings to a daily handover and information session. This enabled all staff to be kept informed when they attended for duty as previously staff only attended ward meetings if they were on duty at the time of the meeting. Squire ward was also trialling attaching information to payslips.
- Information was shared electronically to email accounts, in addition to paper format.
- All staff reported that the trust was an excellent place to work.
- Staff reported that they were encouraged to try new things.

Innovation, improvement and sustainability

- Medical staff had access to a SWFT application (app), which detailed processes and policies across the trust. This could be downloaded to smart phones to enable access at any time.
- The ability to flex the number of beds within the admissions area, allowed patients to be nursed in appropriate clinical areas and prevent pressures on the emergency department. The department had been functioning less than three months and had already captured information to support a reduction in admission to treatment times and length of stay.
- The trust used a "speciality pull" in admission areas to ensure a specialist saw patients as soon as possible after admission. Consultants for cardiology and respiratory medicine attended the admission areas daily to review any patients admitted over the last 24 hours and advise on treatment. They made the decision whether the patient needed to be admitted to the speciality ward, and arranged for transfer when a bed became available. This created a flow through the hospital and ensured that patients were being managed in the right areas for their condition.
- The haematology service had introduced a "just in case" emergency pack for haematology and oncology patients which included a card detailing emergency contact numbers and a standard operating procedure for antibiotic cover for suspected neutropenic sepsis. This meant that patients admitted with a suspected infection were treated in line with national guidance and within a timely manner, not having to wait for specialist advice.

Surgery

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

Information about the service

South Warwick NHS Foundation Trust provides surgical services to the population of Warwickshire. The largest population centres are the towns of Kenilworth, Royal Leamington Spa, Southam, Stratford-upon-Avon and Warwick.

There was an elective care division within the trust that consisted of surgery, critical care, oncology, central England rehabilitation unit and out-patients. During this inspection we reviewed surgical services including wards and theatres. At Warwick Hospital surgical service provision includes; general surgery, orthopaedics, trauma care, urology, ear, nose and throat (ENT), dermatology and ophthalmology.

There are 110 surgical beds over five wards, Hatton ward, Willoughby ward, Thomas ward, Greville ward and a 23hr day ward. There is also a day surgery unit with two theatres and five other theatres in the main theatre complex.

In 2014-2015 there were 19,416 spells, with 58% day surgery, 19% elective spells (a spell refers to a continuous stay of a patient using a hospital bed) and 23% emergency cases.

We visited all surgical services as part of this inspection, and spoke with 60 staff including staff on the wards and in theatres, nurses, health care assistants, doctors, consultants, therapists and ward managers. We spoke with 13 patients, and examined 17 patient records, including medical and nursing notes.

Summary of findings

Overall, we rated surgical services as good for safe, effective, caring, responsive and for being well-led.

- There was a culture of incident reporting and staff said they received feedback and learning from serious incidents. However, some staff did not always receive feedback on all clinical incidents. Staff were able to speak openly about issues and serious incidents.
- The environment was visibly clean and generally staff followed the trust policy on infection control, although, we saw no evidence of domestic staff using cleaning checklists.
- Medical staffing was appropriate and there were good emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.
- Staffing levels were planned and reviewed to ensure that patients received safe care and treatment. Agency and bank staff were used and sometimes staff worked additional hours to cover shifts but this was well managed and patients' needs were met at the time of the inspection.
- Treatment and care were provided in accordance with evidence-based national guidelines. There was good practice, for example, assessments of patient needs, monitoring of nutrition and falls risk assessments. Multidisciplinary working was effective.

Surgery

- Patients outcomes were generally good but not all staff were aware of patients' outcomes relating to national audits or performance measures.
- Most staff had received annual appraisals and support systems for staff development were effective, however there were areas of poor compliance with mandatory training.
- Staff had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) procedures to keep people safe.
- The consent process commenced in outpatients, there were specific consent clinics and consent was reconfirmed at the time of admission.
- Patients told us that staff treated them in a caring way, and they were kept informed and involved in the treatment received. We saw patients being treated with dignity and respect.
- Patient care records were appropriately completed with sufficient detail and kept securely.
- The service had an effective complaints system in place and learning was evident.
- There was support for people with a learning disability and reasonable adjustments were made to the service. However information leaflets and consent forms were not available in other languages. An interpreting service was available and used.
- Surgical services were well-led. Senior staff were visible on the wards and theatre areas and staff appreciated this support. There was generally a good awareness amongst staff of the trust's values.

Are surgery services safe?

Good

We rated surgery as good for safety because:

- There was access to appropriate equipment to provide safe care and treatment.
- Staff told us they were encouraged to report any incidents, and serious incidents were discussed at team meetings and ward handovers. Staff were confident in reporting incidents and were aware of the importance of duty of candour.
- We observed the Five Steps to Safer Surgery checklists being completed appropriately.
- The service had procedures for the reporting of all new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care. Some of this information was displayed within the wards and clinical areas.
- Nursing and medical handovers were well structured within the surgical wards visited.
- The environment was visibly clean and most staff followed the trust policy on infection control. Equipment was generally cleaned after use with an 'I'm Clean' sticker placed on to it. This meant that some equipment might have been cleaned several days prior to use.
- There were a number of vacancies for nursing staff in surgery. Safe staffing levels were being achieved by the use of bank and agency staff.

However we also found:

- Domestic staff were unable to show us a cleaning schedule that they followed daily.
- Medicines and waste medicines were not always securely stored.
- One medicine fridge that was recording higher than recommended temperatures.
- Hand gel dispensers were not available in some main ward corridors.
- There were areas of poor compliance with mandatory training and infection control training.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally
- The systems, processes and practices that were essential to keep people safe were consistently identified, put into practice and communicated to staff
- A system and process for reporting of incidents was in place. Staff understood the mechanism of reporting incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- The trust reported four serious incidents in the elective care division from October 2014 and September 2015. However, only two of these incidents occurred within the elective division. There was evidence of learning from each incident with actions being taken for example, ensuring that there is clarity around door security procedures to ensure all vulnerable patients remain safe within the hospital.
- All serious incidents were analysed at surgical governance meetings to ensure that lessons were learnt. This information was disseminated to staff via ward handovers and meetings, through safety practice alerts and pulse, which is a trust intranet newsletter.
- There had been no never events reported in the last 12 months within surgery. A never event is described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Staff were fully aware of the Duty of Candour regulation (to be honest and open) ensuring patients always received a timely apology when there had been a defined notifiable safety incident. A ward sister we spoke to was able to give an example of where the duty was applied.
- The ward sisters and theatre managers 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.
- Surgery and orthopaedic mortality and morbidity meetings occurred monthly. The data was monitored by the divisional team and reported to the trust mortality surveillance committee and the trust board. The minutes of the meeting included some actions to be taken such as checks on the use of antibiotics and the septic proforma to be completed and adequate investigations to be done.

Safety Thermometer

- The NHS Safety Thermometer is a tool for measuring, monitoring and analysing patient harms and 'harm free' care. Data is collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers, catheter urinary tract infections, and falls.
- Some of this information was displayed on the wards, such as number of falls and pressure ulcers. In March 2016 the safety thermometer audit results for Greville ward were 100%, Thomas ward 95.4% Hatton ward 100% and Willoughby ward 100%
- All wards had quality boards which displayed some of the information from the safety thermometer such as falls and pressure ulcers for example Thomas ward reported no pressure ulcers in February 2016, but had five falls reported. Other information about the quality of the service was displayed for example, infection control audits results, results of NHS Friends and Family Tests and the number of complaints, for example, Thomas ward had recorded a 95% compliance with hand hygiene audit in February 2016.

Cleanliness, infection control and hygiene

- The wards and theatres were visibly clean and tidy.
- There was awareness amongst staff about infection control and we observed staff washing their hands and using hand gel between treating patients. We observed all staff using alcohol hand gel when entering and exiting wards and theatres.
- We observed staff complying with 'bare below the elbow' policy.

- Hand hygiene audits from April to December 2015 across all surgical wards and theatres showed 95% - 100% overall compliance.
- Personal protective equipment, such as gloves and aprons were used appropriately and were available in sufficient quantities.
- Instructions and advice on infection control were displayed in the ward for patients and visitors, including performance on preventing and reducing infection.
- The trust's 2015 Patient Lead Assessments of the Care Environment (PLACE) indicators in cleanliness were 98%.
- We saw that domestic staff were not routinely completing a daily cleaning schedule. However, the contractor for domestic services was currently in the process of introducing a checklist that would be used by all domestic staff within the hospital.
- Guidelines for infection control were in use and staff adhered to the trust's infection control policy. Each area had an infection control link nurse.
- The ward lead nurses attended the infection control board where they presented their infection control audit results and discussed any actions plans that had been implemented. This meant that the service was striving to improve and maintain infection control standards and practices to minimalize the risk to patients.
- There had been no incidents of MRSA and Clostridium difficile rate within surgery from January to March 2016.
- Surgical site infection data from October 2015 and January 2016 indicated that the infection rates were generally below the national England average. However, from July and October 2015 the infection rate for total hip replacement surgery was slightly higher than the national average at 1.8% with the national average of 1.1%.
- There was evidence of poor compliance with infection control mandatory training with 60% for clinical staff and 55% for medical staff within the elective division. We saw dates for training were booked in the near future to improve compliance.

Environment and equipment

- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, were regularly checked, and documented as complete and ready for use. The trolleys were secured with tags which were removed daily to check the trolley and contents were in date.
- All resuscitation trolley daily checklists were audited by the hospital resuscitation team who provided feedback to ward managers, if compliance was poor.
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure, and temperature monitors, commodes and bedpans.
- There were systems to maintain and service equipment as required. Equipment had portable appliance testing (PAT) stickers with appropriate dates. PAT is an examination of electrical appliances and equipment to ensure they are safe to use.
- The environments within the wards, day case unit, and theatres were well maintained, clean and tidy.
- Theatre had dedicated storage rooms for equipment and surgical instruments, and these areas were clean and tidy. Corridors were clear of equipment and clutter.
- Staff within the recovery unit said they had all the emergency equipment they required at hand. We observed sufficient equipment available during our visit.
- There was good management and segregation of waste. All bins were labelled to indicate the type of waste to be disposed. Bins were emptied regularly and we observed porters wearing protective clothing when emptying bins.
- All areas we visited were secure with swipe card access for staff.

Medicines

- We saw that medicines and waste medicines were not always securely stored, for example in one of the wards, some of the drawers and cupboards containing medicines were not locked. During our inspection we raised this issue with the nurse in charge and both the ward pharmacist and head pharmacist. We saw evidence that the nurse in charge had requested the estates department to fit a lock to the drawer as a matter of urgency. However, no immediate action was taken for example moving the medication to a secure cupboard or drawer.
- In the theatre suite, all medicines, except controlled drugs, not just those which may be needed in an emergency, were left unlocked, whilst theatres were in use to allow easy access. There was no risk assessment or policy in place to control access to these medicines. This meant that we could not be sure they had not been tampered with.

- Some prescription medicines are controlled under the Misuse of Drugs legislation 2001. These medicines are called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards. The CD registers on the wards were found to be appropriately completed and checked.
- The pharmacy team undertook quarterly audits to check that CDs were managed safely and we saw action plans were in place to improve compliance, for example ensuring that alterations to the records were made in line with national guidance.
- We observed nursing staff locking drugs trolleys during the medicine round when they administered medicines to patients. Nursing staff wore a red plastic tabard that indicated they were administering medicines to alert staff not to disturb them to prevent drug errors.
- We reviewed the prescription and medication charts of 17 patients. These records were clear and fully completed. Patient's allergies to any medicines were appropriately recorded.
- The pharmacy team visited all wards each weekday and a pharmacist was available out of hours. The pharmacist recorded information on the prescription chart to help guide ward staff in the safe prescribing and administration of medicines.
- The trust had just introduced automatic temperature recording devices to provide assurance that medicines were stored correctly. On Willoughby ward, the device was showing that the temperature was outside the specified range, and manual records for the previous ten days showed maximum temperatures above the specified range. Staff were aware of the problem but had not been able to adjust the fridge to give the correct temperature and were carrying out further investigation.
- The prescription chart was designed to promote the safe use of antibiotics and prompted prescribers to include the reason for the prescription and the course duration as well as review regularly. We saw that there was a current antimicrobial prescribing policy and pharmacy staff told us that they had introduced a phone application (App) so that the information was readily available. The trust were members of the West Midlands antibiotic pharmacy group which carried out quarterly audits. These showed that the trust prescribed a higher number of antibiotics than neighbouring trusts, due to their older population.

Records

- We examined 17 patients' medical and nursing records across surgical wards and theatres. These were detailed and included comprehensive pre-assessments.
- The records we reviewed showed that the Five Steps to Safer Surgery checklist record, designed to prevent avoidable harm was completed in full for all patients.
- Medical records and nursing notes were stored securely in trolleys behind the nurse's station and observation charts and risk assessments were stored at the patient's bedside
- Records 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. Records were legible, accurate, and up to date.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet, including out of hours contact details for hospital staff. Safeguarding policies and procedures were in line with national guidelines. Staff received training and had a good understanding of their responsibilities in relation to safeguarding of vulnerable adults and children.
- The surgical teams were able to explain safeguarding arrangements, and when they were required to report issues to protect the safety of vulnerable patients.
- The trust had safeguarding leads for both adults and children and staff knew how they could be contacted. This meant that they were able to report their concerns in order to ensure the safety of vulnerable adults.
- Training in safeguarding for adults and children showed a compliance of 97% for clinical staff and 76% compliance for medical staff against a trust target of 95%. Staff told us that additional training sessions had been booked for the near future.

Mandatory Training

- The electronic rostering system recorded training completed by each staff member and the dates required for renewal. This was used to assist with planning staff training.
- The trust's training records showed that 76% of medical and 86% of clinical staff in the surgical division had completed their mandatory training against a trust target of 85%. The surgical division lead nurse was able

to provide explanation regarding compliance. For example some staff were on maternity or sick leave had not completed their training. We saw evidence of training dates having been booked for staff who had training to complete.
- There was an induction programme for all new staff and staff that had attended felt that the programme met their needs.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical procedures had been assessed and their safety monitored and maintained. For example all elective patients attend a preoperative assessment clinic and the trust used the 'Five Steps to Safer Surgery' checklist, in line with national guidelines
- Patients for elective surgery attended a preoperative assessment clinic where all required tests were undertaken. For example, MRSA screening and any blood tests. If required, patients were reviewed by an anaesthetist and had a dedicated appointment. The anaesthetists could be contacted by the nurses in the clinic for advice and to review patient's notes.
- Risk assessments were undertaken in areas such as venous thromboembolism, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the risks identified.
- The national early warning score (NEWS) was used and staff had attended training. NEWS is used to identify if a patient is deteriorating. Staff used the NEWS to record routine physiological observations, such as blood pressure, temperature, heart rate and the monitoring of a patient's clinical condition. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these. We reviewed patient notes and found NEWS charts were being used to record patients vital signs.
- We observed a patient being admitted to the theatre area for surgery. The consultant had checked with the patient which side the operation was to take place and they confirmed this with the notes. The patient was marked on that side to make sure the correct side was operated on during their surgery.
- The trust had an outreach team and hospital at night team who provided clinical support with deteriorating patients.
- There was 24 hour access to emergency surgery teams, including theatres, and doctors. During the night, there was a senior house officer who covered the surgical wards who was supported by the on call consultant for surgery, hospital at night team and critical care clinical staff.

Nursing Staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using the electronic rostering tool and the Safer Nursing Care Tool. Staffing levels were appropriate to meet patients' needs during our inspection. Staffing levels were also discussed at bed capacity and flow meetings that were attended by the lead nurse for surgery.
- Senior staff told us that nursing vacancy rates were a concern. Information given to us by the trust confirmed vacancy rates were 22% for Thomas ward, 19%, for Willoughby ward, 14% for Greville ward and 9% for day surgery 9.26%.
- The management team told us of various measures they had undertaken to recruit staff, such as overseas recruitment initiatives. Staff were aware of these initiatives and were supportive of them. To support retention, some staff had been offered development opportunities and leadership courses.
- Staff worked extra shifts and agency staff were being used to cover nursing vacancies. Agency staff were being blocked booked for shifts in advance. This assisted with safe staffing levels and continuity of care. All new agency staff had an induction checklist completed to ensure that they become familiar with the ward layout and processes.
- Nursing handovers occurred at the change of shift. We observed handovers on three wards. The handovers occurred in the ward office for all staff and patient privacy, dignity, and confidentiality were maintained.
- We observed handovers that were well structured and used electronic information sheets. The information discussed included patients going to theatre, patients requiring appointments for investigations, patients being discharged, pain management, medication and Deprivation of Liberty Safeguards (DoLS) assessments.

Surgical staffing

- Records provided by the trust show the medical staffing levels. Consultant cover was 47% which is slightly above

the England average of 41%. Middle career group (doctors who had been at least three years as a senior house officer or a higher grade within their chosen speciality) was at 19%, which was higher than the England average of 11%. Registrars were 25%, which was lower than the England average of 37%; junior doctors were 9%, which was lower than the national England average of 12%. Doctors and consultants said they had sufficient cover for their specialities. The trust used locum doctors to ensure that levels of medical cover were appropriate to support patient's needs.

- Doctors ward rounds occurred daily on each ward we observed a ward round which was well organised and structured. There was good interaction between doctors and nursing staff.
- Surgical outliers are general surgical patients who are being cared for on other wards such as medical wards. Surgical outliers were being reviewed daily including the weekends by their surgical team of doctors which meant that their needs were being met.
- Surgical consultants worked weekends and carried out ward rounds to ensure that there was provision of consultant led care and decision making. There was consultant cover for emergency's 24 hours a day.
- Junior doctors had specific personal development plans, a mentor and clinical support. They told us they felt supported and the consultants were accessible, approachable and available when required.

Major incident awareness and training

- There was a major incident policy in place relating to all services within the trust including surgical services. Action cards were available to guide staff on actions to be taken in the event of a major incident
- Some staff told us there had been a major incident exercise recently within the trust.

Are surgery services effective?

Good

We rated surgery as good for effectiveness because:

- Patients generally had good outcomes and received effective care and treatment based on national guidance that met their needs.
- Performance and outcomes met trust and national targets in most areas.
- The trust participated in national and local audits, for example the Patient Reported Outcome Measures (PROMS) which overall showed the trust was matching results seen nationally in PROMS measures for hip and knee replacements, groin and varicose vein surgery.
- The trust participated in the National Hip Fracture Database and performed better than the national averages for all comparable data. Patient's pain, nutrition, and hydration were being appropriately managed.
- The surgical service had a consultant-led, seven day service.
- Staff had awareness of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

However we also found:

- Some trust policies were out of date. This meant we could not be reassured that staff were following the latest guidelines.

Evidence-based care and treatment

- Assessments for patients were comprehensive, covering all health and social care needs (clinical needs, mental health, physical health, and nutrition and hydration needs). Patient's care and treatment was planned and delivered in line with evidence-based guidelines for example nutritional and hydration needs, falls assessment and consent.
- Some policies were out of date such as 'MRSA screening procedure for elective admissions' dated 2015, 'Checklist for Anaesthetic apparatus' dated December 2014 and 'Theatre apparel and etiquette guidance' dated December 2014. This meant we could not be reassured that staff were following the latest guidelines. This was raised with management at the time of our inspection who stated they would review the policies.
- The National Institute for Health and Care Excellence (NICE) and other professional associations for example, Association for Perioperative Practice (AfPP) provide national guidelines on care and treatment. Local policies, such as the consent policy were written in line with these current national guidelines. Staff we spoke to were aware of these policies and knew how to access them on the trust's intranet.

- Venous thromboembolism (VTE) assessments were recorded and were clear and evidence-based, ensuring best practice in assessment and prevention.
- The pre-operative assessment clinic assessed and tested patients in accordance with NICE guidance for someone due to have a planned (elective) surgical operation. Examples included MRSA testing.

Pain relief

- Pain was assessed and managed effectively.
- Patients' records showed that pain had been risk assessed using the scale found within the NEWS chart and medicines were given as prescribed. We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner. Pain management for individual patients was discussed at handovers as required.
- A nurse specialist in pain control was contactable by telephone for advice and would assess patients as required.
- An audit in 2014 of post-operative pain following total hip and total knee replacement showed that patients were generally satisfied with their pain relief, but 50% of patients were still in moderate pain 24 to 36 hours following surgery. An action plan implemented in February 2015 suggested higher doses of medicines to be used and changes in medicines to be considered with the implementation of a post-operative information leaflet. There were plans to carry out a re audit.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess patient's risk of malnutrition. If a patient was at risk of malnutrition or had specific dietary needs they were referred to a dietician.
- There was effective management of patients post operatively who may experience nausea and vomiting, medication was prescribed and offered to patients.
- In all 17 records we reviewed, we observed that fluid balance charts were completed appropriately and used to monitor patients' hydration status.
- Patient requiring assistance with eating and drinking were identified using a red tray system, which alerted staff to assist patients at meal times.
- Patients were given fasting instructions at pre-operative assessment or the ward if they were an in-patient. Patients were offered drinks if there was delay in theatre times to maintain their hydration.
- Depending on the type of surgery they were undergoing, some patients for elective procedures were given a pre-operative drink. The purpose of this drink was to assist with hydration and aid the patient's recovery following their operation.

Patient outcomes

- The trust participated in the National Hip Fracture Database (NHFD) which is part of the national falls and fragility fracture audit programme. The trust performed better than the England average for all comparable data. Such as 79% of patients received surgery on the day or the day after admission compared to the national average of 72%. In 2014, 80% of patients had a pre-operative assessment by a geriatrician, in 2015 this had increased to 93% of patients
- The surgical division took part in national audits, such as the elective surgery Patient Reported Outcome Measures (PROMS) programme and the National Joint Registry (NJR).
- Overall, the trust were in line with the national averages in PROMS measures for hip and knee replacement, varicose veins and groin hernia surgery which measure patient's outcomes of health following surgery.
- The trust had achieved green on all nine indicators in the NJR annual Clinical Report 2015 on hip and knee replacement procedures. The audit rates performance on a red-amber-green scale, where green is best.
- The risk of readmission for elective surgery and emergency surgery at the hospital was better than the England average from August 2014 to July 2015. With 79 for elective compared to 100 for the England average and 87 for non-elective compared to 100 for England average.
- Data from the Bowel Cancer Audit 2014 showed good results for two out of the three measures. 91% of patients were seen by a clinical nurse specialist compared to the England average of 87% and 99% of patients had a CT scan reported compared to an England average of 89%. A CT scan uses a computer that takes data from several X-ray images of structures inside a human's body and converts them into pictures on a monitor. The trust scored lower than the England average for patients discussed at a multidisciplinary

meeting at 94% compared to the England average of 99%. There was a bowel cancer action plan which included actions such as improved data collection methods, informing all relevant personel about data definitions, and disseminating information at lower gastrointestinal strategy meeting.

- Data from the National Emergency Laparotomy Audit 2015 showed the trust had mixed performance. The audit rates performance on a red-amber-green scale, where green is best. One green result was for CT scans reported before surgery, one was reported red for a preoperative review by a consultant and anaesthetist and assessment by a medical consultant for the care of older people specialist in patients over 70 years'. The remaining nine areas scored amber. We saw the emergency laparotomy action plan which included a change in the consultant anaesthetist rota which resulted in a greater proportion of patients receiving care by a consultant anaesthetist, audits and risk assessments of mortality and morbidity following surgery and guidelines on how to access theatres for urgent cases.
- Data from the Lung Cancer Audit 2014 showed that 96% of patients were discussed at a multidisciplinary team meeting which was comparable to the England average of 95%, however 82% of patients received a CT scan prior to a bronchoscopy compare to 91% for the England average and 14% of patients received surgery compared to the England average of 15%. We saw the lung cancer action plan, which included reviewing patient pathways to ensure CT scans were carried out and a review of the specialist nurse role.
- The average length of stay from July 2014 to June 2015 was lower than the England average for elective surgery at 2.4 days compared to 3.3, but higher than the England average for non- elective surgery at 6.2 days compared to 5.2 (England average).
- Patients told us they were happy with their outcomes and felt staff had done everything to assist them and keep them up to date with their progress and next steps.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was an induction programme for all staff. Staff that had attended the induction programme told us this was useful. The induction programme included orientation to the wards, specific training such as fire safety, infection control and manual handling as well as awareness of policies.
- Nursing staff (both agency and permanent) felt well supported and adequately trained in their local areas.
- We saw induction booklets for staff that were completed once the staff member had attended training or deemed competent in a care activity, such as hand washing techniques and setting up equipment for theatre.
- Junior doctors within surgery all reported good surgical supervision, they each had a specific personal development plan which they felt enhanced their training opportunities.
- Trust data for March 2016 showed that within surgery, 89% of clinical staff had received their appraisals and 100% of medical staff against a target of 85%.
- Staff told us there were training opportunities for personal development and to enhance their skills such as cannulation, catheterisation and intravenous therapy.
- Some healthcare assistance within theatre had completed specific competencies to enable them to scrub and assist for certain operations.
- Many of the band 7 nurses and managers had attended a local leadership programme which they felt improved their skills in managing staff and gave opportunities for personal development and career progression.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed that effective multidisciplinary team (MDT) working practices were in place.
- Daily ward rounds were undertaken seven days a week on all surgical wards. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors and physiotherapists.
- There was good multidisciplinary working within the wards to ensure patient care was coordinated. The staff in charge of patients' care were aware of their progress. We saw physiotherapists and occupational therapists assessing and working with patients on the wards then liaising with and updating the nursing and medical staff.

Staff described the multidisciplinary team as being very supportive of each other. Health professionals told us they felt supported and that their contribution to overall patient care was valued.

- MDT communication took place on a regular basis to review the progress of patients and plan a safe discharge. We observed safe discharge of patients which included completion of a discharge checklist, information to the patients GP, follow up appointment for the patient and verbal instructions to the patient and their relatives about after care.
- We observed a patient being admitted to theatre. We saw good interaction between the ward staff and theatre staff which included the handover of patient's notes. All checks were completed and confirmation of fasting and operation to be carried out. The patients were escorted at all times in the theatre environment.
- Staff said that they could access medical staff when needed, to support patients' medical needs.
- Staff could access the learning disability lead, critical care team, pain management team, social workers and safeguarding teams who were able to provide advice and support to the surgical teams.
- We observed the theatre staff working well together as a team, discussing patients' needs, equipment required and planning for the theatre lists.

Seven-day services

- Patients had access to consultant cover seven days per week and other support services, such as physiotherapy, occupational therapy and theatres were available if required.
- Consultants carried out daily ward rounds including the weekends on all surgical wards. Consultants could be contacted out of hours by junior staff if required.
- Surgical patients on non-surgical wards were reviewed daily including weekends to ensure their care was planned and up to date.
- We reviewed an emergency surgical admission that had been seen by a consultant within the recommended 14 hours from time of arrival to the hospital and had a thorough clinical assessment during the morning ward round.
- Emergency theatres were available seven days a week and additional staff were on call, if extra staff were needed to manage emergencies.
- Staff told us they had access to imaging, pathology and endoscopy out of hours. Pharmacy provided an on call out of hour's service.

Access to information

- There were computers throughout the individual ward areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.
- Staff said they had good access to patient related information and records whenever required. Although on some occasions, at least a couple of times per week patient records were not available in pre-operative assessment, when this occurred it was reported as an incident. Actions were taken to ensure patients notes were available these, such as preparing the clinics in advance and requesting notes for patients that had been seen at another site.
- Patient's previous admissions were held electronically and current episodes in paper form and were scanned onto the computer following discharge.
- Staff said that when a patient was transferred from the emergency department to a ward, they had access to the information. Staff received a handover of the patient's medical condition and ongoing care information was shared appropriately in a timely way.
- Discharge summaries to GPs were sent by post and the patient was given a paper copy. We observed on-going care information was shared appropriately at handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood consent, decision making requirements and guidance. The trust had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure, one for children and another for procedures not under a general anaesthetic.
- All consent forms we saw were for patients who were able to consent to their operation/procedure and they were completed in full (they contained details of the operation/procedure and any risks associated with this). Patients were also able to have a copy if they wanted.

Surgery

- There were no consent forms available in other languages. Interpreter services were available.
- The consent process generally occurred in out-patients during the consultation or at a specific consenting clinic.
- Patients were asked for their consent to procedures appropriately and correctly. Patients were asked to re confirm their consent at the time of surgery.
- Consent and operation notes audit completed in 2014, showed areas for improvement. These included input of General Medical Council (doctor's registration number) number, details of leaflets given, and serial numbers of prosthesis to be included. There were plans to re audit.
- Staff told us they had annual training for Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLS). The overall compliance for the trust was 97% for clinical staff and 90% for medical staff against a trust target of 90%.
- We spoke to staff on the wards who told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- We saw one DoLS in place which was completed correctly and the patient's family had been informed and were involved in the patient's care.
- We saw one patient admitted from a mental health hospital for surgical treatment who was being supported by a mental health nurse 24 hours a day.

Are surgery services caring?

Good

We rated surgery as good for caring because:

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support, to enable patients to access services.
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- The staff on the wards and in theatre areas respected confidentiality, privacy and dignity.
- Medical and nursing staff kept patients up to date with their condition and how they were progressing.
- Information about their surgery was shared with patients, and patients were able to ask questions.
- Patients and most relatives said they were kept informed and felt involved in the treatment received.

However we also found:

- The service's Friends and Family Test response rates were below the national average, although 97 % of patients that did respond would recommend the hospital to family and friends.

Compassionate care

- We saw that patients were treated with dignity, respect and compassion when they were receiving care and support from staff.
- Patients felt supported and well-cared. Staff responded compassionately to pain, discomfort, and emotional distress in a timely and appropriate way.
- The staff were kind and had a caring, compassionate attitude and had positive relationships with patients and those close to them.
- Staff respected people's individual preferences, habits, culture, faith and background. Patients we spoke with felt that their privacy was respected and they were treated with courtesy when receiving care.
- Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication
- We saw results of the Friends and Family Test displayed in the wards. The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. We saw posters encouraging patients to give feedback, so the trust could improve the care provided.
- We saw that the response rate varied across the wards. The response rate for friends and family test in surgical wards was below the national average of 36% with a response rate of 25% from March 2015 and February 2016. 97% of patients that did respond would recommend the hospital to family and friends.
- On all surgical wards and in theatre we observed patients having their observations taken for example, blood pressure, temperature, and respiratory rate, with care and dignity.
- We saw that nursing staff introduced themselves appropriately and knocked on the door of side rooms before entering.

Surgery

- We received positive comments from the vast majority of patients we spoke with about their care. Examples of their comments included "staff are caring and thoughtful", "I can't find any faults, we laugh a lot, staff are fabulous they work hard", and "the doctors come round every day and keep me up to date".

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.
- Patients said the doctors had explained their diagnosis and that they were fully aware of what was happening. None of the patients had any concerns regarding the way they had been spoken to. All were very complimentary about the way they had been treated.
- We observed doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Patient records had individualised care plans, which involved the patient in their planning.
- Patients and where appropriate their relatives were kept informed and involved with decisions when appropriate. For example, one patient told us she was waiting for results to decide what would happen next and the doctors were keeping her up to date and involving her in the decisions and choices. Another patient explained how the doctor came back to the ward to speak with her husband about her condition and explained what surgery would take place.

Emotional support

- Patients and those close to them were able to receive support from staff to help them cope emotionally with their care and treatment.
- We observed a nurse on Willoughby ward providing emotional support to a family who were concerned with their relative's condition. Information was shared and time was given for the patient and family to ask questions and clarify the situation.
- The chaplaincy service offered spiritual, religious and pastoral support to patients, relatives, carers and staff and was available for everyone, of any faith or none. The chapel and multi-faith prayer room was open 24 hours every day.

Are surgery services responsive?

Good

We rated surgery as good for responsiveness because:

- Service planning met the needs of the local people and the community.
- Cancellations of operations were less (better) than the national average.
- Complaints systems were effective.
- Access and discharge arrangements were effective.
- The average length of stay for patients' in the service was lower than the national average.
- The readmission rates following surgery were better than the England averages.
- There was support for people with a learning disability, and reasonable adjustments were made to the service provided.
- Arrangements were in place to support patients living with a dementia.
- Dedicated occupational therapist worked in pre-operative assessment to assess patients' needs for medical devices following surgery.

However we also found:

- For non-elective surgery the average length of stay was higher at 6.3 days compared to the England average of 5.2.

Service planning and delivery to meet the needs of local people

- The service understood the different needs of the people it served and acted on these to plan, design and deliver services, for example disabled toilets were available, and showers that accommodated wheelchairs were available on the wards.
- The service planned and delivered services in a way that ensured there was a range of appropriate provision to meet needs, supported people to access and receive care as close to their home as possible. For example some surgical services were available at other trust sites, such as ophthalmology services at Stratford hospital.

- Surgical services had used a mobile theatre unit to assist with waiting lists. The mobile units had been at the trust for five weeks in January 2016 to provide additional capacity for theatre lists.
- There were plans to have additional theatre list on Saturdays during April to assist with waiting lists in ophthalmology.
- The environment and facilities were appropriate and required levels of equipment were available.

· The trust provided monthly reports on quantitative and qualitative data to the local clinical commissioning group.

· The service monitored the use of its theatres to ensure that they were responsive to the needs of patients. The average theatre utilisation during 2015 was 82%.

Access and flow

· The percentage of admitted surgical patients that started consultant-led treatment within 18 weeks of referral was consistently below the 90% standard between September 2014 and May 2015. In June 2015 this standard was abolished. Between September 2014 and August 2015 the trust's performance for this measure was better than the England average in all but two months. Over the same period referral to treatment time (RTT) performance for general surgery was 87%; for trauma and orthopaedics it was 85%. Referral to treatment data measures the length of time from referral through to elective treatment.

- During our inspection we were told of action plans to improve the waiting times which included a review of the surgical pathway, plans to commence Saturday waiting lists and the appointment of a locum in ophthalmology.

· The trust participated in the National Hip Fracture Database (NHFD), which is part of the national falls and fragility fracture audit programme. In 2015, 78% of patients with a fractured neck of femur had surgery within 24 hours of admission, which was better than the national average of 72%. The length of stay in hospital was 12 days, which was better than the national average of 15 days.

· Risk of readmission following surgery at the trust was better than England average for both elective and non-elective surgery with a score of 79 for elective and 87 for non-elective compared to the England average of 100.

· From March and June 2015, 3% of cancelled operations were not rebooked within 28 days. This was better than the England average.

· The average length of patient stay for elective patients was lower than the England average from July 2014 and June 2015. For all elective cases this was 2.4 days compared to 3.3 for the England national average. For non-elective surgery it was higher at 6.3 days compared to the England average of 5.2.

· Surgical services had used a mobile theatre unit to assist with waiting lists. The mobile units had been at the trust for five weeks in January 2016 to provide additional capacity for theatre lists.

- The hospital had a nurse led pre-operative assessment clinic. All patients had a pre-operative assessment, which included for example, blood tests. Some patients could be seen on the same day as attending their out-patient appointment, whereas those patient requiring longer pre-operative assessment appointment were given specific times to come back.
- There were a small number of surgical patients on non-surgical wards and the surgical doctors visited the patients daily. Processes were in place to ensure these surgical outlying patients were appropriately placed on other wards, and that their needs were being met.

Meeting people's individual needs

- Services were planned to take into account the individual needs of patients.
- Patients who attended the pre-operative assessment clinic were given information leaflets such as; you and your anaesthetic, preventing thrombosis, and ensuring good hydration. However, these information leaflets were not available in other languages. Staff told us that documents could be translated upon request.
- Staff told us they had access to translation services in person or via the telephone system.
- Patients were offered advice on smoking cessation, alcohol intake and dietary advice if required during the preoperative assessment.
- There was a dedicated occupational therapist that worked in pre-operative assessment clinics, mainly for orthopaedic clinics. They would discuss with patients their needs for medical devices when they were discharged home, such as toilet raises and hand rails.

These would be delivered direct to the patient's home prior to admission. The occupational therapist could visit patients in their own home to assess their needs if required.

- Staff and patients reported they did not have mixed gender bays on surgical wards.
- The trust had a named dementia lead and a learning disability lead. Staff confirmed they were able to readily access these staff to discuss any concerns and to receive advice.
- Staff used a butterfly symbol to identify patients with a confirmed diagnosis of dementia, or an outlined butterfly to identify patients that may be confused. The symbol was placed on the ward board next to the patients name to help identify patients at risk. During inspection we saw the butterfly symbol used appropriately.
- There were suitable arrangements in place for patients with a learning disability, for example they were given longer surgical preoperative assessment appointments, and their carers were encouraged to attend. Carers were encouraged to stay for longer periods of time with in-patients and could escort them to theatres if appropriate. Patients would be placed first on the theatre list to prevent any delays to treatment. Ward staff would talk with the cares to take into account their specific needs.
- Discharge summaries were posted to a patient's GP upon a patient's discharge. This detailed the reason for admission and any investigation results, treatment and discharge medication. The patients were given a paper copy.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken where required. The care support staff assisted patients with menu choices and ensured dietary needs were met.
- Staff were available to help serve food and assist those patients who needed help. We observed good interaction between staff and patients to encourage them to eat their meals.
- We observed there were 'red trays' to identify patients who needed help with eating and drinking, including when patients were at risk of malnutrition or dehydration.
- There were additional drinks, snacks and yoghurts available on the wards.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Staff directed patients to the patient advice and liaison service (PALS) if they were unable to deal with their concerns directly.
- Staff were aware of how to deal with complaints, but some staff on the wards told us they were not always aware of outcomes from complaints, actions taken or lessons learnt.
- Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- The trust reported 50 complaints within surgery in 2015. Most related to poor communication, delays in treatment and some aspects of care. People were kept informed of the progress of their complaint. We saw actions taken in response to complaints such as template letters implemented, review of capacity and raising awareness of privacy and dignity with staff. medicine
- The ward sisters received all the complaints relevant to their service and gave feedback to staff at ward team meetings regarding complaints in which they were involved.
- Written complaints were managed by the ward manager and lead nurse. A full investigation was carried out and a written response provided to patients.
- Staff told us that some verbal complaints were managed on the wards or in theatres, and were not always reported. Staff told us these complaints were dealt with as soon as they occurred by either the ward sister or matron. This meant that complaints were concluded at service level with no outcomes, themes or lessons learnt being cascaded to staff.
- None of the patients we spoke with had any complaints; several patients said they were aware of how to complain if they needed to.

Surgery

Are surgery services well-led?

Good

We rated surgery as good for well-led because:

- We saw leadership, commitment and support from the senior team within the surgical division.
- Objectives for 2015/16 were in place in the elective division.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services.
- Staff told us that if incidents took place, they wanted to be open and transparent with patients about any failings.
- The culture of learning from incidents was promoted amongst staff, and they told us they were encouraged to report incidents.
- A number of staff we spoke with had been working at the trust for over 10 years and said it was a good place to work.

Vision and strategy for this service

- We saw the trust's values on display within the ward which included 'Trusted to provide safe, effective, compassionate care'. Most staff were aware of these values.
- We saw the elective division produced objectives for 2015-2016 which included for example meeting cancer targets, increasing theatre capacity and introducing apprenticeship scheme in theatre. These were discussed at the surgical services meetings and a monthly divisional performance report was sent to the board.
- We were told of plans to open out-patients and a day surgery unit at Stratford hospital in 2017 to assist with waiting lists and provide care closer to patient's homes.

Governance, risk management and quality measurement

- A governance framework was in place to monitor performance and risks and to inform the executive board of key risk and performance issues.
- Clinical leaders in the elective care division told us they had oversight of all incidents and met with matrons and ward sisters to discuss these. We saw minutes of these meetings where incidents and complaints were discussed. For example template letters were implemented in response to a complaint, and the review of theatre capacity in response to cancelled operations.
- The elective care division had regular board meetings with management representation from all areas of surgical areas including consultants, matrons, and theatre managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed.
- The department managers would hold team meetings within specific wards, day case unit and theatres to cascade information from the elective care division meetings. We saw minutes of meetings where items were discussed, such as the use of the modular theatre and movement of wards.
- Matrons and ward sisters had daily meetings to discuss staffing levels, and bed occupancy to ensure risks were recognised such as low staffing levels and quality of care was maintained. Staff would be moved to different wards to help out or additional bank staff booked if required.
- All serious incidents were analysed at surgical governance meetings to ensure that lessons were learnt. This information was disseminated to staff via ward handovers and meetings, through safety practice alerts and the trust intranet newsletter.
- There were comprehensive risk registers for all surgical areas, which included all known areas of risk identified in surgical services. These risks were documented, and a record of the action being taken to reduce the level of risk was maintained. For example, not enough plug sockets in theatre nine with electrical cable trailing on the floor, this was discussed at the health and safety meeting and all staff alerted to the potential risk; there was only one lift between Hatton ward and ground floor, an emergency telephone had been installed in the lift and a manual override available for the lift. The higher risks were also escalated to the trust's risk register where they were regularly reviewed. The register was up to date, identified the risk, the impact to the patient, the controls in place, with a nominated lead for each risk. The risk register was discussed at the surgical monthly clinical governance meetings.

Leadership of service

Surgery

- There was an associate director of operations, an associate medical director and a head of nursing who lead the elective care division. Each speciality, such as orthopaedics and ophthalmology had a dedicated general manger. We met some of the management team who were dedicated, experienced leaders and committed to their roles and responsibilities.
- Leadership within the surgical division reflected the visions and values of the trust and service to promote good quality care.
- We saw supportive leadership and commitment from the senior team within the elective division.
- Junior surgical doctors reported consultant surgeons to be supportive and encouraging. Junior doctors told us they felt well supervised by consultants.
- Junior staff on the surgical wards and within theatres said they know who the chief executive officer was and the head of nursing and that, on occasions, they had visited the wards and theatres.
- Each ward had a ward sister, supported by a surgical matron, who provided day-to-day leadership to members of staff on the ward. The surgical matron post was vacant, but a new matron had been appointed. The lead nurse for the elective care division was supporting the surgical division until the new matron commenced her post.
- Staff within the surgical division said they were well supported by their managers who they felt would were visible and approachable.
- We observed the theatres were well managed with good leadership. We saw all staff working as a team with defined roles to ensure the safe care of a patient entering theatre.
- There was general agreement from management and staff in the wards and theatres that recruitment and retention of nursing staff was seen as a priority by the trust.

Culture within the service

- Staff felt respected and valued. They were enthusiastic about working for the trust and how they were treated by them as a whole.
- We spoke with a number of staff who had worked for the trust for over 10 and 20 years and all said they felt part of the team and enjoyed working at the hospital.
- Staff worked well together as a team, and told us they were proud to work for the trust.
- Across all wards and theatres staff consistently told us of their commitment to provide safe and caring services, and spoke positively about the care they delivered.
- Most staff felt listened to and involved in changes within the trust; many staff spoke of involvement in staff meetings, and the development of the 23 hour ward and the day surgery unit.
- Senior managers said they were well supported and there was effective communication with the executive team. There was a culture of openness and transparency.

Public engagement

- Patient satisfaction questionnaires were available on each ward and patients were encouraged to complete these. This provided the opportunity to patients to give feedback on any areas they felt needed improvement.

Staff engagement

- Staff were encouraged to share their views at their team meetings.
- The trust held staff engagement sessions during 2015 to promote the hospital values and informed staff of future plans. Staff that attended said they felt involved and valued at these meetings.
- The NHS staff survey from 2015 showed positive feedback, which was better than the national average, for staff who would recommend the organisation as a place to work or receive treatment, for staff motivation at work and for being able to contribute towards improvements at work. Negative results related to staff experience of physical violence from patients, relatives, visitors and other staff and hours of working.

Innovation, improvement and sustainability

- Pre-assessment clinic was conducting a study to identify and assess patients potentially at risk of sleep apnoea. Sleep apnoea, is a sleep disorder characterized by pauses in breathing or instances of shallow breathing during sleep. The scoring assessment identified patients at risk and enabled planning for a safe surgical pathway which may include referral for sleep apnoea assessments and treatments prior to surgery, additional time in the high dependency unit and additional observations to be carried out. This also raised awareness amongst patients and staff. The study had commenced late in 2015 and would be reviewed after 12 months of data was collected.

Surgery

- A new process to identify patient at risk of Acute Kidney Injury (AKI) had been implemented. AKI is a rapid decline in the kidneys ability to filter waste substances and excess water. Patients had a blood test prior to surgery to identify their risk. Patients at risk were given an information leaflet, a sticker was placed on their medical notes to identify the high risk and additional fluids were encouraged post operatively and certain medications avoided.

Critical care

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

Information about the service

Critical care includes areas where patients receive more intensive monitoring and treatment for life threatening conditions. It provides special expertise and the facilities for the support of vital functions and uses the skills of medical, nursing and other personnel experienced in the management of these problems.

Critical care services at South Warwickshire NHS Foundation Trust (the trust) are provided for adults requiring advanced respiratory support (ventilation) and other complex therapies known as level three care, and for patients who require more detailed observation than on a general ward: known as level two care. Services are located in seven beds in the intensive care unit (ICU) at Warwick Hospital which account for less than one per cent of the hospital's 441 beds. Each bed space within the ICU can be operated with a 'barrier nursing' model where a patient is infectious.

A critical care outreach team and a hospital at night service are also available 24 hours a day to assist staff with the assessment and management of deteriorating patients throughout the hospital. The outreach service includes the provision of clinical expertise, leadership and education during and after emergency calls.

From April 2 and September 2015 there were 168 admissions (157 patients) to the ICU. Around two thirds of patients admitted were planned and included surgical and non-surgical admissions; the other third of patients were classed as emergency and urgent admissions.

The service was led by a clinical director who is a consultant in intensive care medicine, a general manager, and a nurse manager, with support from seven other consultants, junior doctors, advanced critical care practitioners (ACCP), nurses, a pharmacist, a microbiologist, allied health professionals, and other staff experienced in the management of people who are critically ill or in an unstable condition.

Clinical staff working within the service are members of the Central England Critical Care Network, and had participated in some network meetings and education events. The service also contributed to the annual quality report produced by the Intensive Care National Audit and Research Centre (ICNARC): an organisation reporting on performance and outcomes for around 95% of intensive care units in England, Wales and Northern Ireland.

During our announced and unannounced inspections we visited ICU. We spoke with 21 staff including managers, consultants and junior doctors, nursing staff, ACCP, physiotherapists, pharmacists, dieticians, support workers, allied health professionals, administrators, and members of the critical care outreach team. None of the patients we met were able to speak with us; however we spoke with three sets of relatives (four people). We observed care and treatment of patients, and viewed six care records and staffing rotas. We reviewed performance data submitted by the trust before and after our visit, and gathered information from staff at focus groups.

Critical care

Summary of findings

We rated critical care services as good for safe, effective, caring, responsive and well-led because :

- The service demonstrated a good track record on safety with low rates of infection and avoidable harm to patients.
- Patient outcomes reported within ICNARC showed the service performed as expected, or better than expected for most outcomes when compared to other similar critical care services.
- Staff understood and spoke positively about the safety reporting system in place, and felt that openness and transparency about safety was encouraged.
- Staffing levels were compliant with Guidelines for the provision of intensive care services, 2015 ((the core standards) with staffing levels and skill mix planned, implemented and reviewed to keep people safe at all times.
- There were clear policies, procedures and training in place to enable staff to keep people safe and safeguarded from abuse.
- The environment was clean and well organised, and we saw good compliance with infection prevention and control practices.
- Risks to people who used the service were assessed, monitored and managed on a day-to day basis.
- Care and treatment was delivered in accordance with best practice and recognised guidance and standards.
- There was collaborative working amongst the multi-disciplinary team, and with other services and providers.
- Staff had the right qualifications, skills, knowledge and experience to do their job and were supported through appraisal, supervision, training and revalidation.
- Patients and those close to them spoke positively about their care and treatment, and felt supported and cared for by staff.
- There were clear processes in place for people to raise concerns or complain; these were low in number and managed in a timely manner.
- The nursing leadership team were knowledgeable about quality issues and priorities, and took action to address the challenges; there was alignment between the recorded risks and concerns raised by staff.
- Staff satisfaction was high and staff felt engaged with the service leaders.
- Staff reported that leaders were clinically focussed and supported innovation.

We also found some areas for improvement:

- Non–compliance with the trust's medicines management policy for secure storage of medicines, recording administration and disposal of controlled drugs, and warning signs to indicate storage of medical gases.
- A lack of restricted corridor access resulting in insecure storage of some staff records and confidential waste.
- Not all staff met the trust target with mandatory training.
- Slightly more patients experienced a delay in their discharge than the national average.
- There was no documented business strategy for critical care, and a mixed understanding of the major incident plan.
- Not all risks that had been identified were dealt with in a timely way.

Critical care

Are critical care services safe?

Good

We rated critical care services as good for safety because :

- There was a good track record on safety with low rates of infection and avoidable harm to patients.
- Staff understood and spoke positively about the safety reporting system in place, and felt that openness and transparency about safety was encouraged; safety incidents were investigated, learning was shared, and improvements made when things had gone wrong.
- There was compliance with The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (the code).
- Staffing levels and correct skill mix were planned, implemented and reviewed to keep people safe at all times. There was a daily presence of experienced consultant intensivists and doctors, nurses and other members of the multi-professional team,
- Risks to people who used the service were assessed, monitored and managed on a day-to day basis.
- Regular staff handovers at shift changes, and daily safety briefings enabled staff to manage risks to people who used the service.
- There were effective policies, procedures and training in place to enable staff to safeguard people from abuse.
- Regular checks were undertaken to ensure the environment and equipment were all in good order, and ready for use.
- Patient records were completed and related to care and treatment plans and observations; they were all stored securely both in paper form and electronically.
- We observed that staff gave and recorded the administration of prescribed medicines and medicinal gases in a person centred way, with the appropriate safety checks carried out.

However we also found:

- There was non–compliance with the trust's policy related to secure storage of medicines, recording of controlled drugs administration and disposal, and use of signs to indicate storage of medical gases.
- There was a lack of restricted corridor access resulting in insecure storage of some staff records and confidential waste.
- There was mixed awareness among staff of the major incident plan.
- Not all staff met the trust target of 95% compliance for mandatory refresher training.

Incidents

- Staff understood how to use the trust's electronic reporting system to report near misses and patient safety incidents, and we saw this happened in a timely manner. Managers and staff could not recall any significant delays in reporting or investigating incidents.
- Incident reporting rates were similar to the England average. None of the reported incidents within the intensive care unit had resulted in permanent patient harm.
- There were no serious incidents or never events attributed to critical care services from October 2014 and September 2015. Never events are serious incidents that have the potential to cause serious patient harm or death and are wholly preventable.
- There had been one never event in another service within the hospital. Staff knew about this and described how the learning from this had been shared with staff in the unit and policy changes made.
- Staff were enabled to keep up to date with safety risks and incidents within ICU as well as other services in the trust which had impacted or were likely to impact on critical care services. All reported incidents within the service were adequately investigated and learning points shared through a range of methods. This included daily safety briefings attended by the multi-disciplinary team, staff meetings, and one to one meetings with line managers, emails, a staff communication book and newsletters.
- Safety data was clearly displayed on notice boards within the ICU. This included key safety indicators and incidents reported to HSIC Safety Thermometer, such as results of audit. A list of learning points from safety incidents that had occurred in other areas of the trust was clearly displayed. Staff provided us with examples of changes to practice following safety incidents relating to medicines errors, and feeding tubes, for example.
- Monthly mortality and morbidity meetings were attended by consultants and other clinical staff, when relevant, to review mortality and morbidity. Notes of meetings included actions to improve care.
- Staff we spoke with were aware of the Duty of Candour regulation (to be honest and open) ensuring patients

always received a timely apology when there had been a defined notifiable safety incident. We were provided with two examples of where it was thought necessary to apply the duty, recorded as a safety incident, and where the processes were recorded in the patients' notes.

Safety thermometer

- The NHS Safety Thermometer is a point of care survey carried out on 100% of patients on one day each month for measuring, monitoring and analysing patient harms, and the amount of patients who are harm free from pressure ulcers, falls, urine infections (in patients with a catheter).
- Staff in ICU contributed to the NHS Safety Thermometer programme and displayed the results in the waiting area.
- Safety thermometer data made available to us was reported over a 12 month period from October 2014 and September 2015. The data we reviewed demonstrated consistent harm free care to patients, with an average of a 95% measure.

Cleanliness, infection control and hygiene

- The ICU was visibly clean and odour free throughout our visit. Staff, patients, and relatives told us they were very satisfied with the cleaning services provided and had no concerns.
- ICNARC data for 2014- 2015 showed that rates for unit-acquired infections were low and comparable with other trusts.
- Hand washing facilities and alcohol based hand rubs with instructions were readily available for patients, staff and visitors in all areas and were being used consistently. This met the requirements of the World Health Organisation guidelines for hand washing, Health Building Note 00-09 Infection control in the built environment, and the department of health code of practice on the prevention and control of infections (the Code).
- Throughout our inspection we saw staff complied with the WHO Five Moments of Hand Hygiene and the trust's infection prevention and control policies. This included being 'bare below the elbow', hand washing before and after every episode of direct contact or care, and correct use of protective personal equipment such as disposable gloves and aprons. Hand hygiene audits carried out in ICU from April and December 2015 showed a range of 95% to 100% compliance. Where there was non-compliance corrective action was taken.
- Monthly audits of infection prevention and control took place and were reported. Results of the audits including Saving Patients Lives and hand washing audits from April 2015 and December 2015 showed consistently good levels of compliance with no outstanding actions required. Where there was non-compliance corrective action was taken, including re-education of staff.
- Numbers of patients who were admitted to ICU with MRSA were consistently better when compared to similar trusts, and admissions with Clostridium difficile (C. difficile) demonstrated comparable rates to other units.
- There were no reported cases of patients with hospital acquired C. difficile or MRSA during the reporting period.
- During our visit two patients with a known or suspected infection were nursed in isolation rooms. There were clear signs to alert staff and visitors to the increased precautions they must take when entering and leaving the rooms and we saw this happened.
- Staff had daily access to a microbiologist, and a pharmacist of adequate experience and seniority who both attended the ICU daily to help identify and mitigate infection control risks. This included advice on the choice and duration of antimicrobial therapy in accordance with local formularies.
- An infection prevention and control nurse worked across the trust to provide advice on the prevention of spread of infection, isolation procedures and decontamination. She visited patients in ICU in response to laboratory results, and documented patient specific instructions for staff to follow.
- Staff received training about infection prevention and control at their induction and as part of their mandatory refresher training. 79% nursing staff and 50% non-clinical staff were compliant with the mandatory training attendance, which was below the trust target of 85%. Missed training sessions were rescheduled to improve attendance.
- There was a domestic team with responsibility for cleanliness and cleaning products available. There were written instructions in place to indicate when the premises and equipment needed to be cleaned.
- Deep cleaning of the environment and equipment was undertaken every time a patient was transferred. 'I am

clean' labels were used to show when items had been cleaned and decontaminated. These showed recent cleaning had taken place and equipment was ready for use.
- Disposable curtains that were used in patient areas, were clean, and were labelled to show dates of their last change. Staff were compliant with the safe disposal of clinical waste. Single use items of equipment were disposed of in clinical waste bins or sharp-instrument containers.

Environment and equipment

- ICU was spacious, well-lit and free from obstruction. The main operating theatre complex and surgical wards were located close to ICU in accordance with the core standards. This enabled prompt transfer between services when required, and access to anaesthetic staff.
- There were designated areas for storage of medical gas cylinders, linen and furniture. However there were no signs on the door of the oxygen store to alert people to the flammable nature and associated hazards of oxygen storage.
- Staff had access to sufficient equipment for monitoring and treating patients to meet their needs. There was sufficient equipment for use in an emergency including resuscitation equipment and equipment used to manage difficult airways. Records showed that regular and consistent equipment checks, maintenance, and stock controls were in place to ensure patients were not at risk of harm from unsuitable or unsafe equipment. Beds and the patients' bed space were checked for safety elements.
- All consumables and equipment we looked at were in date. An equipment replacement programme was in place, which included a risk assessment. These meant resources were appropriately prioritised.
- The facilities generally met the Department of Health guidelines for critical care facilities: Health Building Note 04-02. However bathroom facilities were limited. Bed spaces in the ICU complied with the Department of Health's Health Building note 00-09.
- Resuscitation equipment was accessible and was checked at least daily to ensure it was in good working order and ready to use.
- All patients were visible or had monitoring equipment which meant their condition could be observed from the central nurses' station(s).
- There were separate call bells for patients to summon assistance and for staff to summon emergency assistance. We saw these were in good working order and were responded to in a timely manner.
- Security to the ICU was good. Entry to the unit was controlled by a door bell and all visitors were personally greeted by staff and asked to confirm their identity prior to entry.
- Safety alerts relating to equipment were received and communicated and acted upon in a timely manner.
- We saw a good supply of moving and handling equipment and condition-specific equipment being used to assist and support patients. Staff demonstrated the use of equipment and were trained and assessed as competent to use it.

Medicines

- We saw some medicines stored in unlocked areas accessible by patients, visitors and unauthorised staff. In February 2015 the Trust had carried out a risk assessment to evaluate the need to store medicines in ICU securely to protect them from theft, damage or misuse against the need for immediate access to deal with an emergency. The decision was to install swipe card readers to control access to the treatment room, and to the corridor, and to lock cupboards which contained medicines which were not intended for use in an emergency.
- At the time of our visit we found that the swipe card readers had been fitted but were not activated or in use. The cupboards which should have been locked were also open. We brought this to the attention of the ward manager and pharmacist and saw that the cupboards were locked and the card readers were in use the following day, and on our unannounced follow up visit. However on the unannounced visit we saw a refrigerator used to store medicines was not locked and found other medicines not locked away.
- Controlled drugs (CDs) are medicines which require additional security. We saw these were generally stored, received, administered and disposed of in accordance with trust policy. However, we saw that the CD register in ICU was not fully completed to record the use of a medicine used to start and maintain anaesthesia, and the disposal of part used ampoules in line with Controlled Drugs regulations and trust policy. There was no clear audit trail to account for the medicine. One record did not include the full name of the patient or the

amount used, and had not been countersigned by a second member of staff. We were told that the medicine had been issued to another department in an emergency. It had happened two weeks before our visit and no action had been taken to report this as a safety incident or complete the records. This meant that there was limited assurance that risks were being appropriately managed and that opportunities to improve safety were acted upon.

- We brought this to the immediate attention of the ward pharmacist and ward manager who raised it as a safety incident report, reported it to the Accountable Officer for CDs, and confirmed that an investigation would be carried out. This was also discussed with staff at the safety huddle we observed.
- The pharmacy service met the requirements of the intensive care core standards. The ICU pharmacist had completed specialist critical care training and attended the daily ward round. Nursing and medical staff felt they received a good service and accessed advice and support from the pharmacist at least daily, and as necessary.
- There were clear arrangements for pharmacy support out of hours using an on call system. However, nursing and medical staff said it was rare that they needed to access this service due to the daily presence of the pharmacist on ICU.
- We observed face to face advice and support from pharmacy staff being provided throughout our visit. Interventions and changes to medicines regimes were recorded on the patient medication administration record in a timely and clear manner.
- We saw staff gave and recorded the administration of medicines and medicinal gases in a person centred way, with the appropriate safety checks carried out before medicines were given to patients.
- Stock rotation and control of medicines appeared to be consistent with the department's policy of moving the oldest packaged medicine products to the front of each shelf. All medicines we looked at were in date and in their original packaging.
- The service had introduced a robust system to minimise medicine errors and to address these if they occurred. Medicine error rates were low, however if one occurred the staff member involved would be offered medication error training and asked to complete a reflective exercise that would help them to understand what caused the error. We found that such reflection had resulted in staff identifying circumstances that could cause errors as well as the identification of areas in which they would benefit from refresher training.
- Medicines that required refrigeration were kept in designated refrigerators. We saw evidence that the fridge temperatures were monitored at least daily and were consistently within the required range. Staff were aware of the action to take if the fridge temperature fell outside of expected parameters.
- Staff accessed up to date medicines information such as formularies, safety alerts and guidance on the safe administration of medicines.
- There was a sepsis protocol for prescribers to follow when prescribing antibiotics. There was 24 hour access to the microbiologist for further advice if needed.

Records

- We reviewed six sets of nursing and medical records across the service and saw that they were all completed, dated and signed in accordance with trust policy, and that there was co-ordination between electronic and paper based systems. Patient records, including electronic records, were stored securely to ensure confidentiality and safety. We saw some staff records that were not secured in a filing cabinet in the corridor which we addressed with the ward manager and have covered in the well-led section of this report.
- Patients' vital signs were documented along with cardiac and respiratory indicators of their condition. Fluid intake and output was also recorded and acted upon in a timely manner.
- Records were designed in a way that allowed essential information to be documented, for example, allergies, medical history and current medication. The records contained up to date treatment and care plans and evidence of discussions with the patient, their relatives or those appointed to act in their best interest, where applicable.
- We saw safety goals and risk assessments had been documented and acted upon and evaluated in accordance with national and local requirements.

Safeguarding

- There were policies, systems and processes in place for reporting and recording suspected abuse.
- As part of the trust's mandatory training programme 100% of nursing, medical and non-clinical staff in the

critical care service had completed the required level two refresher training to recognise and respond to safeguarding concerns of children and vulnerable adults and acquired the relevant knowledge of the safeguarding systems in place. Staff demonstrated to us they were clear about their role in raising and escalating any concerns, and gave examples of where this happened.

Mandatory training

- There were arrangements in place for staff to complete mandatory training. We saw that mandatory training covered a range of topics and was provided either face to face or through on-line learning.
- The trust had a target of 85% compliance with mandatory training. From January and March 2015 this service 94% compliant with mandatory training. This fell to 83% from April and June 2015. All staff had completed safeguarding training and equality and diversity training.
- There were some specific gaps in mandatory training. For example, only 76% of clinical staff had completed an annual update in life support and 65% in moving and handling training. 85% of nursing staff and 50% non-clinical staff had completed fire training. Compliance below the target of 85% was mainly attributed to factors such as long term sickness, maternity leave and some training sessions being cancelled due to staff shortages. We saw confirmation of rescheduled sessions for staff who had not attended.
- Staff told us that completion of mandatory training was their responsibility and that managers would monitor attendance and report on any gaps.

Assessing and responding to patient risk

- An electronic risk register was completed to identify and manage patient risks in ICU. Staff we spoke with gave examples that aligned with the register.
- Patients were assessed for the risk of harm on admission and reviewed during their stay. We saw identified risks were documented and responded to in a timely manner. For example: pressure ulcers, venous thromboembolism (blood clots) and sepsis (infection).
- Each patient's progress and clinical risk was reviewed by nurses, doctors and other therapists at a handover report between each shift. Observation of each patient's physiological condition was carried out in accordance with NICE CG 50 Acutely ill patients in hospital.
- Staff were able to describe the contributory factors to patients acquiring infections and pressure damage as well as the preventive measures taken. Staff told us they found specialist nurses accessible and informative in supporting them to manage associated risks. Records we looked at confirmed that risk assessments were carried out, and that specialist advice had been sought and acted upon in a timely manner.
- Consultants from the ICU attended a deteriorating patient group monthly to discuss care bundles with other medical consultants. An annual event to raise awareness of the management of deteriorating patients was held in the staff dining room in July each year, attended by the chief executive officer.
- Nursing staff showed us the sepsis protocol for doctors to follow when prescribing antibiotics and confirmed they had completed recent training in this area, as well as training in management of deteriorating patients.
- A critical care outreach team and a hospital at night service were also available 24 hours a day to assist staff with the assessment and management of deteriorating patients throughout the hospital. The outreach service includes the provision of clinical expertise, leadership and education during and after emergency calls.

Nursing staffing

- The core standards for intensive care units, 2015, were used to establish staffing requirements and staff ratios. A nurse manager with overall responsibility for the nursing service was supported by senior sisters to ensure staffing requirements within the core standards were met.
- We observed that actual staffing levels consistently met planned staffing levels.
- A team of 34 whole time equivalent nurses was allocated to the ICU. There were 4.88 whole time equivalent (14%) nurse vacancies at the time of our inspection, for which there was ongoing recruitment. In the meantime agency and the hospital's own bank staff were used to ensure staffing levels remained safe. All temporary nursing staff were required to have a post-registration qualification in critical care and had to provide evidence of this prior to working in the ICU. They were also required to complete the trust and department induction and orientation. We saw this happened during our visit.
- There was a clinical nurse educator (practice development nurse) responsible for coordinating the

education, training and continuing professional development framework for critical care nursing staff and pre-registration nursing students on placement from university.
- Managers described retention of nursing staff as good. The core standards require for intensive care units with over six beds that the senior nurse for each shift is supernumerary 24 hours a day, without a case load of patients. This was happening Monday to Friday from 8am and 4pm. This meant they were able to act as a clinical co-ordinator. Out of hours support was provided by the critical care outreach team. The trust had an average of six ICU beds occupied over the reporting period.
- There was a link nurse system to ensure two way communications with specialist nurses.
- Nursing staff were supported by a ward receptionist for non-clinical duties such as obtaining medical records and responding to visitors to the ICU. Receptionists described their role and responsibilities accurately and felt well supported by managers and other staff.
- A housekeeper with specific responsibility for maintaining equipment stocks was also employed and we saw this arrangement meant a consistent approach was in evidence.
- There was a standardised written and verbal handover at every shift change.

Medical staffing

- Medical staffing of ICU was compliant with intensive care core standards. Continuity of care was provided by the use of an on call rota. There were two consultants on call for anaesthetics and ICU, one of whom was an ICU consultant who was on site and on call by telephone out of hours. They were not expected to provide services outside of critical care.
- ICU consultants were present on the unit 8am to 6pm Monday to Friday. Daytime resident ICU cover was provided either by an anaesthetic trainee or an advanced critical care practitioner (ACCP). ACCPs were resident 8am to 8.30pm four days a week.
- There were twice daily intensive care ward rounds by an ICU consultant including on Saturdays, Sundays and Bank holidays.
- In December 2015 out of an establishment of 52 whole time equivalent doctors there were 47 in post. This meant 4.32 (8%) whole time equivalent vacancies existed within the service, for which there was ongoing recruitment. In the meantime cover was provided by locum (temporary) staff. All temporary medical staff were required to have a post-registration qualification in critical care and had to provide evidence of this prior to working in the ICU. They were also required to complete the trust and department induction and orientation. We saw this happened during our visit.
- There was a consultant with a lead responsibility for facilitating ongoing learning and development of doctors. Junior doctors spoke positively about their learning experiences and learning support.

Major incident awareness and training

- The trust had a major incident plan which provided instruction about emergency preparedness and business continuity. This included the responsibilities for critical care nursing staff in different major incidents. Nursing staff correctly described their roles and responsibilities in the event of a major incident, and the nurse manager had recently participated in a major incident simulation exercise.
- Medical staff of all levels of seniority had varying degrees of understanding of the major incident plan, with some having no awareness of the department or trust policy and senior doctors had not recently participated in the major incident simulation exercise.

Are critical care services effective?

Good

We rated the service as good for effective because :

- Patients' needs were assessed and care and treatment delivered in line with legislation, standards and evidence based practice, and consistent with national benchmarks. For example, information produced by National Institute for Health and Care Excellence (NICE), the Faculty of Intensive Care Medicine, NHS Blood and Transplant, Resuscitation Council UK and the Royal Colleges.
- The service was part of a local critical care network, and reported patient outcomes to the Intensive Care National Audit and Research Centre (ICNARC). In most areas the service performed well as patient outcomes were comparable or better than other similar trusts.

- Collaborative multidisciplinary working was evident, with support provided by a range of health care professionals including a multidisciplinary critical care outreach team.
- There was a supportive learning environment for staff to develop their skills and competence; 64 % of nurses held a post registration award in critical care nursing, which is above the required standard of 50% set out in the core standards: Guidelines for the provision of intensive care standards.
- All staff, including temporary staff completed a hospital and departmental induction.
- Pain management and nutrition and hydration needs were met.
- Staff demonstrated up to date knowledge of the Mental Capacity Act (MCA) and were generally clear about the procedures to follow when reaching decisions in persons' best interests.

However we also found:

- Not all policies had been reviewed within the stated date.

Evidence-based care and treatment

- Patient's needs were assessed and care was planned in accordance with evidence based best practice guidance from national and special specialist organisations For example: the National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine, British Thoracic Society, and the Royal Colleges.
- Most of the policies we reviewed were in date and had clear review dates; however we found two policies that were not in date: management of people with tracheostomy, and transfer of patients. We brought this to the attention of the manager who demonstrated that work was in progress to update them.
- Pathways were consistently followed, and there was evidence patients were receiving appropriate care, and that their cultural, religious, social and personal needs were identified, documented and respected. All staff had completed mandatory refresher training in this area.
- The hospital was part of the National organ donation programme led by NHS Blood and Transplant and followed NICE guideline CG135 to ensure their criteria were met.
- There was an identified clinical lead for organ donation. Successful referrals for organ donation had increased form previous years.
- The ICU had an identified person to collect and collate audit data to ensure it could be presented in a timely manner to internal and external forums. An audit calendar was maintained at a divisional level, not unit level to ensure a joined up approach with other services.
- All patients were screened for anxiety and depression and for delirium in line with core standards, using nationally recognised assessment tools such as the Richmond Score and Confusion Assessment Method (CAM).

Pain relief

- Staff used a combination of verbal and non-verbal assessments to manage pain.
- Staff had access to, and made occasional referrals to the trust acute pain management team and the palliative care team, and sought and acted on their advice.
- Pain scores were documented in patient records, using recognised techniques and measures. Records we looked at showed there were clear links between patients' pain scores and the pain relief medication given.
- Pain relief medicines were readily available and reviewed regularly with patients by nurses, doctors, and pharmacists.
- Medicines for pain relief were administered only when prescribed by an authorised prescriber, and were recorded in the medicines administration record and clinical notes.

Nutrition and hydration

- Dietitians attended the ICU at least three days a week and access to dietitian support was available Monday to Friday. The dietitian participated in consultant led ward rounds and multi-disciplinary team meetings including a weekly meeting to discuss all nutrition issues.
- The dietician(s) provided training, support and appropriate supervision to junior staff working on the ICU.
- A nutritional assessment of each patient was carried out by nursing staff and the dietitian on admission, and at regular intervals throughout the patient's stay. All patients were weighed daily using a weighing bed and

their weight was recorded and reported. Patients who were unable to take oral intake had other forms of nutrition support, prescribed following nutritional assessment by nursing staff and the dietitian.
- Records we looked at showed measurement, recording and analysis of fluid intake and output.
- Speech and language therapists (SLTs) were accessible to support and advise people with swallowing difficulties and documented their involvement in the patient's notes.
- There were protected meal times to allow staff to assist patients with eating and drinking where needed.
- National and local guidelines for the provision and assessment of nutrition were provided for staff. Patient records we looked at confirmed these were being followed. There was no formal audit of compliance with feeding guidelines as due to the size of the service; however this was monitored and acted upon on a one to one basis by the dietitian and nursing staff.

Patient outcomes

- Staff carried out a number of local, regional and national audits to monitor the effectiveness of the service, and contributed to ICNARC data. The trust performed well when measured against other similar trusts in audits reported to ICNARC (annual report 2014-2015). For example, they had reported similar or better performance for mortality indicators, non-clinical transfers out and unit acquired infections in blood.
- Mortality rates for patients requiring assisted ventilation were generally comparable to other trusts, with no significant variance in performance. There were consistently good rates of compliance with the physiological observation of patients set out in NICE Clinical Guideline 50 Acute illness in adults in hospital.

Competent staff

- Appropriately qualified and experienced staff ran the service in accordance with ICU core standards.
- A practice development nurse who was also a qualified advanced critical care practitioner supported staff to identify training needs and to achieve and maintain the necessary skills, knowledge and competencies for their role through a competency based learning and development programme. This included induction and competency assessments for all newly appointed staff and temporary staff.
- 64% of nursing staff held a post registration award in critical care nursing, which is above the minimum standard of 50% set out in the Core Standards for Intensive Care (2015).
- Student nurses on clinical placement in critical care services were assigned mentors who ensured they were appropriately supervised at all times.
- All staff in the critical care services were provided with an annual review of their competence and performance. Staff in lead roles knew who was in their team and due an appraisal. 88% of nursing staff, 100% of medical staff and 50% non-clinical staff had completed an appraisal in the reporting period. Reports could be produced at any time and this included a list of all staff that were due for appraisal. Poor performance was managed by line managers in accordance with human resources policies.
- 100% of doctors met their professional registration and revalidation requirements.
- Junior doctors worked in the ICU as part of a rotation programme with anaesthetics and were all trained in the management of difficult airways.
- Doctors told us that they found the induction programme and ongoing development well organised and had ongoing support from the clinical tutor.

Multidisciplinary working

- A daily multi-disciplinary (MDT) ward round took place that we observed. It was well attended by a multi-disciplinary team of doctors, nurses, therapists and the pharmacist. Staff openly encouraged feedback from each speciality, and patient treatment plans were updated at the time to reflect the MDT input. Staff spoke positively about the MDT working relationships.
- Staff had a thorough understanding of external MDT relationships for patients who would be discharged soon. A multidisciplinary critical care outreach team was available 24 hours a day as well as a hospital at night service to assist staff with the assessment and management of deteriorating patients throughout the hospital. The outreach service included the provision of clinical expertise, leadership and education during and after emergency calls.

Seven-day services

- Nursing staff provided a 24 hour a day seven day service in accordance with the core standards.

Critical care

- ICU consultants were present on the unit 8am to 6pm Monday to Friday. Daytime resident ICU cover was provided either by an anaesthetic trainee or an advanced critical care practitioner (ACCP). ACCPs were resident 8am to 8.30pm four days a week.
- Therapy staff were available in person or on call across the whole week. If therapy staff were off duty, there was access to certain staff out-of-hours through on call rotas. Otherwise, therapy staff (including physiotherapists, occupational therapists, speech and language therapists and dieticians) were on duty on weekdays. Physiotherapists were also present on the unit on Saturday mornings.
- Access to pharmacy staff and imaging staff that provided clinical investigation and support was also available on this basis.

Access to information

- Most information needed to deliver effective care was available and accessible in good time, either in paper format or electronically. Staff could not recall any incidents of lost records.
- Intranet-based guidance was available for staff who demonstrated confidence and competence in retrieving and entering information on to databases.
- Access to patients' diagnostic and screening tests was good. Staff said results were provided promptly and given the right priority. We saw this happened.

Consent and Mental Capacity Act and Deprivation of Liberty Standards

- Trust safeguarding policies were linked with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were able to demonstrate an understanding of the link and the principles involved.
- Patient records showed that mental capacity assessments and Deprivation of Liberty Safeguard were carried out in line with national requirements and acted upon. Consent to care and treatment was obtained from patients or those appointed to act in their best interest, where relevant.
- The use of restraint of people who lacked capacity was monitored for its necessity and proportionality in line with national legislation and processes were in place to minimise its Staff understood the difference between lawful and unlawful restraint.
- There were no DoLS authorisations in place at the time of our visit. However staff we spoke with had attended relevant training and were able to describe the systems in place for managing patients for which DoLS was relevant.

Are critical care services caring?

Good

We rated caring as good because :

- Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff responded compassionately when people needed support and helped them to meet their personal needs.
- Patients and those close to them felt supported by staff and said staff cared about them; they were encouraged to maintain diaries to record their experience in ICU.
- Information was accessible and provided in a way that people could understand.
- Patients' nursing and medical records were up to date and described their individual needs.
- Patient's privacy and confidentiality was respected at all times.
- Staff saw patients and those close to them emotional and social needs as important and reflected this in their care and treatment.

Are critical care services responsive?

Good

We rated responsiveness as good because:

- The importance of flexibility, choice and continuity of care was reflected in the service.
- There was a flexible approach to nursing staffing allowing staff to take time off during quieter times so that the unit and staff could 'bank' hours, and call staff in to cover busier periods.
- Services were delivered taking the individual and cultural needs of different people into account.
- Care and treatment was coordinated with other services within the trust and with other providers.

Critical care

- There were clear processes in place for people to raise concerns or complain; there were only two reported complaints in the reporting period and they were managed and resolved in a timely manner.
- Bed occupancy was generally in line with the England average. Over the most recent reporting period, July 2015-September 2015, bed occupancy had fallen below the England average and was around 60%.
- There was no evidence that there had been any significant problems with admitting people to the ICU because of a lack of available beds,
- The average length of stay for patients requiring ventilation was lower than other comparable trusts.

However we also found :

- There were no overnight, bathroom or kitchen facilities for relatives which meant their needs may not always be met.
- The service reported slightly worse performance than average for delayed discharges and transfers out, however these were attributed to aspects outside of the control of the service.

Service planning and delivery to meet the needs of local people

- Staff were aware of the needs of the local population and were working in a collaborative manner with specialist services such as the provision of care for people with alcohol or drug-related organ failure.
- Staff were equipped to provide a service that met people's needs outside of their clinical treatment plan. For example, access to chaplains of different faiths, and organisations supporting those experiencing domestic violence.
- Active discussions took place regarding organ donation with patients and relatives. There had been an increase in organ donations from the previous reporting period.

Meeting people's individual needs

- Services were patient centred and met individual needs. We saw that alternative methods of communication were available and used effectively. For example picture boards.
- Staff had access to translation of language services for patients when required.
- There was a small quiet room for relatives; however there were no overnight facilities, kitchen or well-appointed bathroom facilities and relatives routinely waited in the designated waiting area in the corridors.
- Patients living with dementia had a separate care plan.
- Where people had specific needs, for example, a physical or learning disability, specialist advice was sought and acted upon and reasonable adjustments made.
- Patients who were restless and disorientated were observed to be provided with one to one support and given appropriate information and reassurance by staff.
- Only one patient had been ventilated outside the unit in the reporting period. They were ventilated on the coronary care unit for six hours, while awaiting transfer to another unit. An advanced critical care practitioner and an ICU nurse were present at all times.
- Patients discharged from the ICU were reviewed by the critical care outreach team. The outreach team would be made aware of patients prior to transfer in order to receive and review information. There was no limit to the number of reviews. The outreach team also supported staff working in other wards who were caring for patients with tracheostomies , continuous positive airway pressure (CPAP) management for people with breathing problems, central lines(for delivery of fluids, medicines, nutrients or blood products) or receiving non-invasive ventilation therapies.

Access and flow

- Proposed admissions to the ICU were all reviewed by a consultant prior to admission to enable prioritisation of services. The trust performed as expected for early readmissions and late readmissions. The average length of stay was comparable to other trusts.
- The trust reported delayed discharges (four hours) were slightly worse than the national average. 35% of patients were delayed by less than 24 hours with 12% delayed from two and four days. 12% were delayed over four days. There were no complaints from patients or those close to them relating to this. The issue was under review with the trust executive as it was out of the control of the critical care service because of delays in discharges in other wards in the hospital.
- The occupancy status within the hospital was reviewed formally through trust bed management meetings five times a day and through ICNARC data. Bed occupancy

was generally in line with the England average. Over the most recent reporting period, July 2015-September 2015, bed occupancy had fallen below the England average and was around 60%. The trust had an average of six ICU beds occupied over the reporting period. It had four beds occupied 35% of the time, five beds occupied 25% of the time and six or more beds occupied 30% of the time.

- Data was collected in the trust on the amount of elective surgery cancelled. We saw no evidence that a lack of available critical care beds had led to any cancelled surgery.
- Studies have shown discharge at night can increase the risk of mortality, disorientate and cause stress to patients, and can be detrimental to the handover of the patient. ICNARC data showed discharges made from 10pm and 7am were below (better than) the national average for night time discharges from similar units.

Learning from complaints and concerns

- Information about the complaints and concerns procedure and the role of the Patient Advice and Liaison Services (PALS) was displayed in the ICU. Staff and people we spoke with understood the processes involved. The preferred approach was for staff on duty to speak with people at the time the complaints or concerns were raised. The nurse manager would then be informed and would advise staff on how to proceed with any further response. Formal complaints were redirected to the trust PALS.
- Staff and managers told us they received very few complaints or concerns about the critical care services, and could not recall any recent or unresolved complaints. There were a total of 186 formal complaints in the trust in the reporting period. Of those, two complaints were in ICU and had been resolved within the required time frame.
- When complaints or concerns were raised staff received feedback individually and through staff team meetings.

Are critical care services well-led?

Good

We rated the service as good for well-led because:

- Performance data was collected to enable current and future performance management, and was acted upon.
- Staff told us they felt supported by their managers at departmental level and were confident in the arrangements for raising and resolving any concerns.
- Staff demonstrated cohesive working and respect towards colleagues.
- Lines of accountability and responsibility were clearly understood by staff and supported by up to date job descriptions.
- The leadership team were knowledgeable about quality issues.
- Staff reported that leaders were clinically focussed and supported innovation, for example participation in research.

However, we also found :

- There was no evidence of a documented local critical care strategy.
- Risks were not always managed in a timely manner, for example risks related to security of medicines and restricted access to the corridor and clean utility room had been identified as a risk in February 2015, and remained unresolved at the start of our visit.

Vision and strategy for this service

- Staff and managers told us there was no documented local critical care strategy. They were unable to provide examples of how the strategy was aligned with cost improvement plans. The trust told us there were divisional and local service objectives in place. However, the overall trust's values and objectives were clearly displayed, and staff demonstrated an understanding of them and stated how they were reviewed at regular intervals.
- Quarterly staff meetings were held and were well attended. Records of the meetings showed discussion focussed on operational and strategic matters and there was specific discussion about the trust vision and objectives.

Governance, risk management and quality measurement

- In addition to the trust wide electronic risk register there was a local critical care risk register in place to reflect the risks, lines of responsibility and action points. Staff showed an understanding of the key risks that had been identified.
- The risk register was reviewed at the quarterly elective division health and safety meetings. We saw the risks

were generally elevated to divisional and corporate level for review and actions when necessary. However, not all risks were dealt with appropriately or in a timely way. For example the risks of unrestricted access to the clinical room and corridor in ICU were identified in February 2015, recorded on the risk register in July 2015, and had not been resolved at the time of our visit in March 2016. We brought this to the attention of managers and saw immediate corrective action was taken.

- There was an audit attached to each clinical ward round on ICU to ensure clinical risk assessments were properly completed. These audits were reviewed at every clinical governance meeting and demonstrated good levels of compliance with the trust and core standards requirements.
- The governance of the anaesthetic and critical care departments was managed by the elective care division, who attended and reported to the executive board governance meetings. Governance links to the executive board were described by staff and managers as good. We looked at minutes from meetings and saw that issues were escalated and acted upon.

Leadership of service

- The services in ICU were led by a consultant in intensive care medicine, a general manager and a nurse manager.
- Nursing, medical and allied health professional staff spoke most positively about the nursing leadership across the service which they described as strong and supportive. Staff described the nursing leaders as 'organised, visible, accessible, and in control'.
- The trust had provided a leadership programme for general managers which included encouragement of 360 degree feedback. We saw examples of where this happened and were used to improve skills and competencies.
- Staff we spoke with all felt well supported by their line managers and felt confident in the arrangements for raising and resolving any concerns.
- Lines of accountability and responsibility were clearly understood by staff, and all staff had an up to date job description.

Culture within the service

- Staff spoke positively about a culture centred on the needs and experience of the people who use the critical care services and described communication as open and honest. There were regular staff meetings which staff were encouraged to attend and participate in. Notes of the meetings were recorded and shared to ensure people unable to attend were kept informed. We saw this happened during our visit.
- Throughout the trust, a reward scheme to recognise staff who 'Go the Extra Mile' (GEM) was launched in December 2013. No nominations had been submitted for staff in the critical care service.
- There was obvious mutual respect amongst colleagues. We observed good multi-disciplinary communication and team working
- Managers told us that the staff sickness rate for the trust and critical care services was generally below the England average. There was an increase in nursing staff sickness (8%) in critical care services in December 2015.

Public and staff engagement

- Staff felt engaged with the trust executive team through information sessions held by the chief executive officer and divisional director, staff newsletters, and staff meetings. The sessions kept them up to date with staff and organisational changes in the trust.
- Staff spoke positively about the departmental newsletter produced by the practice development nurse which included clinical, managerial and social information.
- Patients were invited to complete a service evaluation questionnaire which was sent to them at home after discharge. The response rate was 45% and showed consistently positive responses.

Innovation, improvement and sustainability

- The service was developing a team of advanced critical care practitioners (ACCP) to cover the anticipated gap in junior doctors and to maintain continuity of patient care and provide a seven day service. Two ACCP were in post, a third was in training and there were plans to recruit a fourth.
- All registered nurses were offered monthly clinical supervision sessions where they were encouraged to reflect on their practice and support each other and suggest ideas for service improvement.
- The service was actively involved in two externally commissioned research projects designed to improve awareness of patient's needs within the critical care service.

Critical care

- A pro-active approach to organ donation was in evidence with an increase in donation rates compared to the previous year.

Maternity and gynaecology

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

Information about the service

South Warwickshire Foundation NHS Trust provided maternity services in Warwick Hospital and the surrounding community as well as gynaecology services.

The service available to women was an antenatal clinic, a day assessment unit; a consultant led labour ward with a maternity assessment unit attached and a combined antenatal / postnatal ward. The maternity unit had two dedicated theatres for elective and emergency surgery. Community midwives were employed by the hospital and cared for women and their babies both antenatally and postnatally; community midwives were aligned to a GP practice or community centre.

In 2014/2015, 2,643 babies were born at Warwick Hospital.

The gynaecology service offered an inpatient ward (Beaumont ward) for women requiring emergency admission; however this ward also accepted a significant proportion of women from other specialities (outliers). The gynaecology service also offered a colposcopy service and an early pregnancy assessment clinic which ran daily Monday to Friday. The main hospital theatres were used for surgical gynaecology procedures.

We visited all areas of the maternity service as well Beaumont ward and the early pregnancy assessment unit. We talked with 42 members of staff, spoke with 12 patients, and reviewed 17 patient records as well as other documentation.

Summary of findings

We rated maternity and gynaecology services as requiring improvement for safety and effectiveness and good for caring and responsive and leadership.

The services required improvement because:

- 1:1 care in labour not always achieved and the number of caesarean sections and normal vaginal births were worse than the trusts targets.
- The trust did not provide evidence that any registered clinical staff within the maternity service had completed their level 3 safeguarding children training, which was a national requirement for their role. This meant we could not be sure that all staff have the sufficient knowledge and skills to safeguard children.
- Records were not always stored securely.
- Termination of pregnancy records were not consistently completed in line with legislation.
- There were processes in place for maternity staff to learn from incidents, however, these were not working effectively in practice
- Governance arrangements for gynaecology services were not robust and there was no clear vision or strategy for the service.
- There was a five year strategic plan in place for maternity, although this did not include a review of achievements against previous objectives.

Maternity and gynaecology

- Recommendations to ensure that lessons were learned when things went wrong were not always completed within appropriate timescales.
- Intravenous fluids were not always stored in a safe environment meaning there was a risk they could be stolen or tampered with.
- The trusts mandatory training target of 85% had not been achieved in either the maternity or gynaecology service.
- The maternity annual audit plan had not been formally approved. The audit plan did not record the justification for audits. Recommendations did not always fully address the issues identified and action plans were not always completed.
- The audit plan for gynaecology consisted of five audits over a five year period, one of which had been withdrawn. Two audits had been completed within the last 12 months; the other two audits dated back to 2011 and 2013. Limited information on completed audits was provided.
- Data on patient outcomes for gynaecology patients were not reported and monitored in a central dashboard

However we also found:

- There was a good track record on safety with low rates of infection.
- Patients reported that they received good care and that staff were friendly and helpful.
- Patient records were completed and observations recorded.
- A high number of staff had received their annual appraisal.
- Multidisciplinary arrangements worked well.
- Safeguarding arrangements were in place and the staff we spoke with had a good understanding what to look out for as well as the reporting process.
- When women asked for help, they were responded to in a timely manner or told that they would be helped as soon as possible.
- Patients told us that staff were helpful and that they explained things to them in a manner they could understand.
- Recent friends and family surveys had reported positive feedback from patients.
- The maternity service was proactive in considering a midwifery led unit (MLU) to ensure women's choice was at the forefront of the service.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated Maternity and Gynaecology as requiring improvement for safety because:

- The trust did not provide evidence that any registered clinical staff within the maternity service had completed their level 3 safeguarding children training which was a national requirement for their role. This meant, we could not be sure that all staff have the sufficient knowledge and skills to safeguard children
- 1:1 care was not always achieved for women in established labour.
- Records were not always stored securely
- Termination of pregnancy records were not consistently completed in line with legislation.
- Intravenous fluids were not always stored in a safe environment meaning there was a risk they could be stolen or tampered with.
- The midwife to birth ratio was 1:31 which meant that the actual birth to midwife ratio, once non-clinical midwives were removed, was higher (worse) than the trust's calculated establishment and the England average.
- There were processes in place for maternity staff to learn from incidents, however, these were not working effectively in practice.
- Non-clinical staff were not compliant with trust targets for safeguarding adults training.
- Overall the trust mandatory training target had not been achieved by staff in the maternity and gynaecology services although some courses had been completed by all staff. 100% medical staff for obstetrics and gynaecology had completed their mandatory training (with the exception of level 3 safeguarding, see above).

However we also found:

- Standards of cleanliness and hygiene were maintained and there was a good track record on safety with low rates of infection.
- The service complied with The Health and Social Care Act 2008: - code of practice on the prevention and control of infections and related guidance (the code).
- Regular staff handovers at shift changes, and daily safety briefings enabled staff to manage risks to people who used the service.
- 99% of midwives and medical staff had completed their obstetric emergency training.
- There were effective clinical policies and procedures in place, although there was no systematic process to ensure staff were aware of these and had read them.
- Staff had access to equipment required and regular checks were made to ensure necessary items were ready for use and available.
- Patient records were completed and observations recorded,
- Women on the postnatal ward were encouraged and supported to self-administer some medication.
- Safeguarding arrangements were in place and the staff demonstrated to us they were clear about their role in rising and escalating any concerns.
- Consultant cover for labour ward met national guidelines.

Incidents

- There were no never events attributed to maternity and gynaecological services from October 2014 and September 2015. Never events are serious incidents that have the potential to cause serious patient harm or death and are wholly preventable.
- The trust used an electronic incident reporting tool to report incidents. Staff were confident in the use of the electronic system and told us that they always reported incidents where it was appropriate to do so. However, some staff told us that when they were very busy they didn't always report incidents, in particular staffing shortages or that they would complete the report after the shift had ended.
- During the period September 2015 to 29 February 2016 there were a total of 75 incidents reported for gynaecology and 424 incidents were reported for obstetrics.
- The trust's incident reporting policy stated that serious incidents should be reported and escalated as soon as possible.
- 87% of maternity incidents were reported within three days. 6% took more than 14 days. Reasons for the delay in reporting were explained as that staff may not be

aware of the incident until a complaint had been received. 99% of incidents were reviewed and actioned by the service within 46 day of the date when they were reported, meaning the learning was shared with the maternity teams in a timely way.

- Over 50% of maternity incidents were closed within two months; however 43% took from three and seven months to be closed. Incidents that took longer to close were delayed due to awaiting final approval by the trust's Central Patient Safety Team. The purpose of this review was to check the incident report form for accuracy and completeness. This meant that although learning may have been shared from the incident, there was a delay in identifying any forms that were incomplete and had not been actioned locally and the opportunity for learning could therefore have been missed.
- All incidents reported by the gynaecology service were categorised as low or no harm and were subject to an initial review by a manager within 50 days of being reported. The majority of gynaecology incidents were reported within three days with all incidents reported within seven days. Incidents took much longer to be closed following review, with 45% taking from two and three months to be closed and a further 23% taking from three and seven months to be closed. The longest an incident was open for was 158 days. Again, this meant that although learning may have been shared from the incident, there was a delay in identifying any forms that were incomplete and had not been actioned locally and the opportunity for learning could therefore have been missed.
- We were provided with two serious incident reports for maternity, one of which related largely to Special Care Baby Unit (SCBU). Review of the second incident report confirmed that aims and objectives were clearly documented along with actions and recommendations in line with National Patient Safety Agency recommendations. There was evidence learning was shared with some midwives and doctors but not all. It was recommended that learning from this incident was included as part of the monthly newsletter, we requested to see this this but it was not provided. One of the recommendations was for all doctors and midwives to complete their grow training. Grow training is designed to inform practitioners about the growth restrictions during pregnancy with an aim to reduce the number of still births. In response to the recommendations a total of nine additional doctors completed their training which brought the total to 69% compliance. 59% of midwives had completed their training. The target of 90% of midwives to have completed the training by end of January and 100% by end of March 2016 had not been met. A paragraph on the importance of grow training had been included in the January newsletter but it did not state why and was not linked to the findings of an incident.
- There had been one serious incident reported for gynaecology services, which had been investigated and reported on. At the January 2016 serious incident it was agreed that once the report had been finalised it should, with formal approval, be downgraded from a serious incident once the report had been finalised with formal approval. Subsequent to our inspection the trust provided evidence that the local CCG lead had approved the downgrading of the incident, however the investigation had not been formally re-presented at a subsequent serious incident meeting. We also requested evidence of shared learning for this incident but it was not provided.
- Staff told us that feedback was received if they had been directly involved in an incident and it was serious. However, the staff we asked could not tell us about any learning that had resulted in from an incident that had occurred in the service or the wider trust in the last few months.
- There was a monthly clinical incident meeting which staff had the opportunity to attend, however, some of the staff we spoke with told us that it was not always practical for them to go if their shift was busy. The maternity department had also recently introduced a weekly meeting to review all reported incidents, however this was an informal review and minutes were unavailable.
- There was a monthly newsletter for maternity staff which included information on how staff could improve care as a result of incidents. However, the information within the newsletters did not state these actions were as a result of previous incidents. Not all of the staff we spoke with were aware that learning from incidents was included in the newsletter. There was no monthly newsletter for gynaecology to share lessons learned with all staff. This meant there were some processes in

place for staff to learn from incidents; however lessons were not effectively shared to make sure action was taken to improve safety within and beyond the affected team.
- We were provided with minutes of the Mortality Surveillance Committee Meeting minutes for the previous six months, although it was noted that gynaecology had no cases of mortality to report during this period.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person. Duty of candour information was contained within the corporate induction for all new staff and incorporated into the annual mandatory health and safety training which was delivered either face to face or through e-learning.
- Most of the staff we spoke with did not initially know what duty of candour was, although they remembered receiving training. After prompting they did say it was about being open and honest when mistakes were made. Staff awareness had been raised through the one-off provision of a leaflet on duty of candour via payslips, and through articles in the patient safety newsletter and Quality Briefing. We saw evidence of serious incidents being shared with patients and where appropriate their family.

Safety thermometer

- The NHS Safety Thermometer is a point of care survey carried out on 100% of patients on one day each month for measuring, monitoring and analysing patient harms, and the amount of patients who are harm free from pressure ulcers, falls, urine infections (in patients with a catheter).
- Safety information was displayed on the gynaecology ward as well as the antenatal / postnatal ward for the previous month which reported 100% of patients received harm free care.
- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm which have occurred included; perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units and a baby having an Apgar score of less than seven at five minutes. (The Apgar score is an assessment of overall new-born well-being). The service did not fully use the maternity safety thermometer at this time, although the head of midwifery informed us that some elements were being used, specifically around being left alone at a time that concerned you. The head of midwifery also stated that they were looking to implement a neonatal nurse care indicator and maternity safety thermometer in the summer of 2016.

Cleanliness, infection control and hygiene

- We observed that the gynaecology ward, early pregnancy assessment clinic, maternity unit and outpatient areas were visibly clean during our inspection.
- Patients told us it was their perception that the areas they used in the wards/unit were clean and that their bedsheets were changed daily.
- There was a service level agreement in place between the trust and the contractors who cleaned patient and public areas which set out the daily and weekly cleaning schedules. Nursing staff were responsible for cleaning equipment and we saw that stickers were placed on items of equipment stating when they had last been cleaned.
- Hand gel was available at each doorway on the wards.
- Side rooms were available on each ward area which could be used to care for a patient who may have an infection.
- Staff wore personal protective clothing as required and this was available throughout the ward areas. We did observe two members of staff on the gynaecology ward who had not observed the bare below the elbows policy.
- Disposable curtains used in patient areas, were clean, and were labelled to show dates of their last change.
- Staff were compliant with safe practices for the disposal of clinical waste. Single use items of equipment were disposed of in clinical waste bins or sharp-instrument containers.

- The hand hygiene audits for February and March 2016 were provided and demonstrated 100% compliance for maternity and gynaecology, although a submission for labour ward had not been provided for March 2016.
- We requested the infection control audits along with accompanying action plans for the previous six months, we were provided with one audit for the gynaecology wad ward which had taken place in January 2016. This demonstrated 95% compliance with two areas, with ward kitchen and care of equipment falling below the trusts target of 90%. Action required had been recorded, but completion of the agreed actions had not. We were not provided with infection control audits for the maternity service.
- There had been no reported cases of MRSA or Clostridium difficile in the preceding 12 months within the maternity and gynaecology service.

Environment and equipment

- The resuscitation equipment on the maternity unit and gynaecology ward was checked daily and the associated emergency medicine was in date. Resuscitaires for new born babies on the maternity unit were also checked daily and these checks were recorded.
- Cardiotocography (CTG) machines which are used to monitor a baby's heartbeat were available on the maternity unit and were in good working order with sufficient numbers of machines available.
- The trust had two theatres on the maternity unit; the second theatre had been identified as a risk and placed on the risk register due to the small size of the theatre as well as equipment hazards (for example trailing leads). The use of the second theatre had been risk assessed with alternatives considered and it had been accepted by the department that although there were risks present, this remained the lowest risk option. We were told that the theatre had only been used on 15 occasions during the past 12 months.
- There were separate call bells for patients to summon assistance and for staff to summon emergency assistance. We saw these were in good working order and were responded to in a timely manner.
- The doors to gain entry to the ward areas were locked and staff gained entrance with swipe cards. Staff identified visitors and who they intended to visit, and then allowed them entry. We were asked to present our identification badges by most staff when first gaining entry to the wards.
- Safety alerts relating to equipment were received and communicated and acted upon in a timely manner.

Medicines

- Medication, including controlled drugs, had been recorded as administered in accordance with trust policy and the disposal of unused portions of ampules had been recorded. It was noted that the authorised signatory list required for staff that order controlled drugs had been recently updated. However there was not a list of specimen signatures for all midwives and nurses administering and accounting for controlled drugs. This meant that if there was a query about a controlled drug that had been administered, the trust would not be able to identify the nurse or midwife responsible.
- Medication was stored in locked cupboards within an unlocked area in each ward. Controlled drugs were stored in an appropriate cupboard. It was noted that on the postnatal / antenatal ward the area used to store medication, behind the nurses station, did contain some unlocked intravenous (IV) fluids as well as the emergency medicine box which included adrenaline. We also observed unlocked IV fluids in gynaecology and labour ward. If medicines are stored in an unlocked environment there is a risk they could be stolen or tampered with. This had not been recorded as a risk on the departments risk register.
- Medicines that required refrigeration were kept in designated refrigerators which were locked. Fridge temperatures were checked and documented daily and were within the required range. Staff were aware of the action to take if the fridge temperature fell outside of expected parameters.
- Each ward / department had an allocated pharmacist who visited once per week to check stock levels and review patient charts. Pharmacy support was available seven days per week with out of hour's arrangements in place.
- Women on the maternity unit were encouraged where possible to self-administer analgesic medication to enable them to take control over the management of their pain. A consent form was signed and a personal chart was used for patients to record administration of their medication and we saw examples of these. A lockable cabinet containing the medication was available for each bed area.

- The ward pharmacist had produced guidelines, explaining drugs, dosages and information for medicines that midwives could issue to patients.
- The pharmacist undertook checks on a random sample of controlled drug entries every three months: the pharmacist signed the controlled drug book as confirmation checks have been performed. We reviewed audits included which demonstrated that all drugs had been safely checked and administered.

Records

- Records for maternity patients were mainly electronic although some paper records, for example, medication and observation charts were still in use. All gynaecology records were paper based. We observed that paper copy records for women on the postnatal / antenatal ward were stored in a locked trolley; records for women on the labour ward were stored in an unlocked cupboard. Records for patients on the gynaecology ward were stored at the nursing station, they were not locked away and the desk was not always manned. This meant that there was a risk that records could be accessed by other patients or members of the public. During the unannounced visit we saw that patient records on the gynaecology ward were left unattended on the nurse's station desk, and contained loose notes which had not been filed. We were told by ward staff that there had been no administration support to assist in filing notes during the previous week.
- We reviewed a sample of patient records for gynaecology and maternity patients and found that records were detailed and that trust and national guidance had been followed and consent had been obtained where it was relevant to do so. Although we noted that some paper records for both gynaecology and maternity had not been dated and did not record the name of the person completing the entry which is not in line with trust policy.
- From a review of a sample of records for termination of pregnancy we noted that these had not always been signed in line with Department of Health (DH) requirements. HSA1 or HSA2 must be completed prior to the procedure taking place and be signed by two doctors. HSA4 must be completed following the procedure by one doctor and this must confirm, 'particulars of any complications experienced by the patient up to the date of discharge'. From a review of a sample of completed forms the signature on one of the HSA1 forms was illegible and one of the HSA4 forms had been completed two days in advance of the procedure having taken place. Staff present during the inspection were unclear of the arrangements for submitting the relevant forms to the chief medical office, and the lead nurse responsible was on annual leave. In absence of suitable cover, there was a risk relevant forms may not be submitted within the required timescales; we raised this with the trust at the time of inspection who agreed to formalise the process and make relevant staff aware of the legal requirement.

Safeguarding

- The service had a safeguarding children policy and vulnerable adult policy which were used to inform all staff of the safeguarding responsibilities and processes.
- Staff were aware of the trusts safeguarding reporting procedure and knew who to contact in the event of a safeguarding concern.
- Safeguarding referrals for a child or vulnerable adult were made directly to the local authority and the midwifery or nursing safeguarding lead was informed.
- A discrete tick box on the patient's notes or computerised records was used to inform staff members that there was additional information about the patient held electronically. When staff saw the box was ticked this would alert them that there was a safeguarding concern and that they needed to view the additional information.
- Staff were confident in talking about the types of concerns that would prompt them to make a safeguarding referral as well as the referral process. We reviewed a sample of records and found these contained relevant information and that safeguarding referrals had been made appropriately.
- 100% of clinical staff and 67% of non-clinical staff on the maternity unit and gynaecology ward had completed their level 1 safeguarding children training, 95% of nursing and 100% midwifery staff had completed level 2 safeguarding children training. We were not provided with evidence that any registered clinical staff had completed level 3 training which was required in line with the intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March, 2014). This meant that, we could not be sure that all staff have the sufficient knowledge and skills to safeguard children

- Although 95% of clinical staff met the trusts target of 95% compliance for safeguarding adults training only 56% of non-clinical staff were compliant.
- All of the staff we spoke with had an awareness of child sexual exploitation and female genital mutilation; we were told that this formed part of safeguarding training.
- An abduction policy including baby security within maternity had been developed and most recently updated in December 2015. There was not a baby tagging system in the maternity unit although entry to the unit was controlled by a buzzer and all visitors were asked to state who they were and their purpose for visiting. This had been added to the departments risk register and a policy on the security of babies had recently been developed which was due to be ratified by the board.

Mandatory training

- There were arrangements in place for staff to complete mandatory training and the trust target was 85% (95% for information governance). Overall the trust target had not been achieved in the maternity and gynaecology services although some courses had been completed by all staff.
- Mandatory training covered a range of topics and was provided either face to face or through on-line learning. Mandatory training included fire safety, health and safety, infection prevention and control, manual handling, information governance, life support, safeguarding, equality & diversity and dementia.
- Medical staff had completed all mandatory training, although we were not provided with data for compliance with level 2 and 3 safeguarding children's training to comply with national guidance for their role. .
- Completion of training varied for nursing and midwifery staff with some training sessions better attended than others. For example, 100% of gynaecology nurses had completed dementia training as well as equality and diversity but only 64% had completed information governance training. 100% of midwives had completed equality and diversity training however 76% had completed fire safety.
- The trust undertook emergency skills and drills training twice per year. They also ran Practical Obstetric Multi Professional Training (PROMPT) an accredited course; this included epidural management, recovery and high dependency unit, hypertensive disorders in pregnancy as well as life support training.
- Safer Childbirth – Minimum Standards for the Organisation and Delivery of Care in Labour states that minimum standards with respect to the immediate care of the newborn require that basic life support skills should be available wherever a baby is born, and this will be provided in the first instance by midwives. It also states that consultants should have advanced life support (ALS) training and we were provided with a statement from the trust that 100% of consultants had completed ALS. 77% of midwives and 100% of medical staff had completed basic life support training. We were also provided with a statement from the trust that 99% of midwifery and medical staff had completed their completed neonatal life support training.
- Staff told us that completion of mandatory training was their responsibility and that managers would monitor attendance and report on any gaps.

Assessing and responding to patient risk

- A modified early obstetric warning score (MEOWS) or modified early warning score (MEWS) tool was used to monitor and manage deteriorating patients on the maternity unit or gynaecology ward respectively. We reviewed a sample of files and found that these were used, with scores completed and calculated accurately and escalated appropriately.
- The trust used an Early Warning Trigger for newborn babies and we saw examples of these having been completed with action taken in accordance with guidance. There was an escalation and transfer policy for seriously unwell babies. Staff knew to use the emergency bleep if they required the immediate attendance of a paediatrician.
- There was an escalation and closure policy for maternity which was last reviewed in February 2016. The policy outlines arrangements for closing the unit due to staffing shortages and /or bed availability.
- Most of the staff we spoke with told us that the escalation policy was implemented appropriately, but it was the perception of some staff that on some occasions more could be done to ensure patient care was managed safely.
- We requested details of the reviews and learning outcomes from when the maternity unit had closed. There had been a temporary closure shortly prior to the inspection, but during this time, no women had been turned away from the service. Prior to this the service had not closed since May 2015.

- In order to ensure a thorough booking and history, the electronic system used for antenatal booking would not allow access to the next page until all risk assessments for women including venous thromboembolism (VTE) assessments had been completed.
- The WHO checklist audit on maternity surgical safety was undertaken and completed in 2015. Guidance from the World Health Organisation (WHO) which aims to improve safer surgery was considered. The audit was undertaken to monitor compliance with the guidance and found 100% compliance with completion of the documentation which was a significant improvement on the previous year. Recommendations were to repeat the audit next year and re-audit sooner if there are concerns. We saw that the WHO checklist had been completed on our inspection.
- An audit on Modified Early Obstetric Warning Score (MEOWS) was completed in 2015, which was undertaken to ensure compliance with the trusts policy on recognizing and managing care of the severely ill pregnant women. All women that needed extra monitoring and support were commenced on a MEOWS chart and for the appropriate reasons. The initial frequency was as per recommendations in the pertinent guidelines and the changes of frequency appropriate and in keeping with the changing clinical condition. The audit demonstrated 100% with the use of the MEOWS chart and frequency of observations.
- From April 2012 to September 2015 the trust's sepsis rate has been lower than or similar to the expected rate. There was a slight increase in the rates in the most recent two quarters (April 2015 to September 2015) when the crude sepsis rate at the trust was 3.2% compared to the national rate of 2.5%. However, cross-sectional analysis (a comparison with other trusts which takes into account the relative volume of cases and is standardised by mother's age) found that the rate at the trust was within expected limits over this time period.
- The management of suspected or confirmed sepsis audit undertaken in 2015 reported that the sepsis pathway had not been consistently followed for all women. The audit included recommendations, and had been presented at the Clinical Incidents and Audit Standards meeting, however, there was no action plan and the recommendations did not fully address the issues identified. The number of cases per month were not reported on separately.
- The trust have developed a home birth and born before arrival guideline. The guideline was ratified in January 2016 and replaced the previous home birth guideline. Guidance sets out arrangements for planning a home birth, care of women in labour, observations required, what to do if there are any concerns as well as managing babies born before arrival.

Midwifery and nursing staffing

- We were provided with evidence from the trust that there were no vacant posts for band 6 and 7 midwives and that there were two whole time equivalent band 5 posts in the final stage of recruitment. When they were in post this would leave a vacancy of 4.5 whole time equivalents (WTE) band 5 midwives, the trust planned to advertise for these posts in May 2016. All band 2 clinical support workers had been fully recruited at the time of inspection. The absence rate for midwives in January and February 2016 was 3% against a target of 3.6%.
- There was a vacancy of just over 9% for gynaecology nursing staff with a turnover of 17.6% for the 12 months ending March 2016 and a sickness rate of 3.9% against a target of 3.6% for the same period. The overall absence rate for gynaecology nurses was 18% in February 2016 and 20% in January 2016.
- We were told by nursing staff on gynaecology that although the ward could become busy at times, it was manageable and the trust did their best to find cover at short notice if staffing did not reach establishment. There were 17 beds staffed by three nurses during the morning shift and two nurses on the afternoon and on night shifts, with assistance from two clinical support workers during the day and one at night. We reviewed a sample of fifteen whole shifts and found that most shifts had the planned minimum number of nurses, although it was noted that two of the morning shifts and one afternoon shift were short by one qualified nurse and that some night shifts were covered by bank and agency nurses only. We were told that where possible bank and agency nurses used by the ward, worked there regularly and were familiar with the ward. During our unannounced inspection the ward was staffed by one bank and one agency nurse. We were provided by a statement from the trust that their use of agency staffing was low and that bank staff work flexibly and have the same training and familiarity with the trust as locally employed staff members

- Safe Midwifery Staffing in Maternity Settings Guidance (NICE 2015) recommends that maternity services determine the midwifery staffing establishment for each maternity service at least every six months. Although the trust's maternity staffing strategy did not reflect this national recommendation the monthly birth to midwife ratio was calculated and reported quarterly to the Clinical Governance Committee. In addition it was stated that it had been agreed by the West Midlands Heads of Midwifery Professional Advisory Group that the Birth Rate Plus table top staffing exercise should be completed as a minimum for each service every three years. Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in the UK maternity units since 1988 and is recommended by the Royal College of Midwives as well as the Royal College of Obstetricians and Gynaecologists
- The trust has undertaken two table top style BR+ staffing exercises in 2012 and 2015. The findings from the table top exercise in 2015 concluded that a ratio of 1:28.9 midwives to women was required.
- The ratio of all midwifery staff to births reported on the maternity dashboard was in the range 1:28 to 1:27 from October 2015 – February 2016. This meant that there were 27 births per midwife, which was comparable with the national average. However, the ratio reported on the dashboard included midwives who worked in a non-clinical role. Removing the non-clinical midwives from the ratio increased the true ratio to just over 1:31 which meant that the actual birth to midwife ratio was higher (worse) than the trust's BR+ calculated establishment and the England average. Both the ratio reported on the dashboard and the true ratio were reported to the clinical governance committee.
- The labour ward should be staffed with seven midwives during the day (Monday to Friday) with six during the day on Saturday and Sunday and in the afternoon and at night. The number of clinical support workers to assist during the day had recently been increased from one to two and the vacancies had been fully recruited to support this. Review of the rotas confirmed that 70% of shifts on labour ward had the required number of midwives; the remaining 30% shifts were short by at least one midwife.
- According to the Royal College of Obstetrics and Gynaecology, Safer Staffing guidance, all women should expect to receive 1:1 care in established labour. The 1:1 ratio reported by the trust during the previous six months ranged from 76% - 85% with Februarys performance at 82.4%. This meant that women were not always receiving 1-1 care in labour. This was also demonstrated in the 2015 CQC Maternity Survey which reported that the trust was worse than other trusts for the question: 'During labour and birth were you and your partner left by midwives or doctors at a time when it worried you?' The score for this was 5.5 out of 10 with 10 being the highest possible score. The trust informed us that they had developed an action plan to address the issues raised by women who provided feedback.
- There was a discrepancy in the number of midwives allocated to the postnatal / antenatal ward in the afternoon between the Maternity Staffing Framework Document (three) and the understanding of staff and provision on the rotas (four). The ward should be staffed by two midwives at night. We were told by a manager that two midwives at night was not sufficient and the trust confirmed that they were planning a review of alternative staffing arrangements within the existing establishment. Midwives were supported by one clinical support worker for each shift.
- A review of the rotas for the postnatal/antenatal ward confirmed that 100% of shifts had the agreed number of midwives per shift.
- There was a discrepancy in the number of clinical support workers clinical managers believed should be on labour ward each shift (two) and the number set out in the Maternity Staffing Framework Document (one).Our review of the rotas demonstrated that 50% of all shifts we reviewed had one clinical support worker allocated, and it was the managers belief that this meant that they were understaffed. We were told by them that additional clinical support workers posts had recently been recruited to and that going forward they expected rotas to be fully staffed.
- Some midwives told us that they did not always have time to take their breaks and that they often stayed behind after their shift had ended to ensure necessary paperwork was completed. This was observed on our unannounced visit as some midwives were still working after the end of their late shift after they had handed over to the night shift.
- A review of incidents reported on the trust's electronic incident reporting system confirmed that from September 2015 and February 2016 there had been a total of 30 incidents reported relating to staffing shortages within the maternity unit. Shortages had been

reported in all areas of the department, and there had been two reports of staffing shortages on the gynaecology ward during the same period. Most reports did not indicate whether the staff shortages had impacted on patients, although some did. One example given was one woman was waiting for stiches for one hour after giving birth due to there not being sufficient staff available.

- We observed a midwifery handover on labour ward which was detailed and effective. Although we did not observe the use of formalised Situation Background Assessment Recommendation (SBAR) system, we did observe that each woman on the unit was discussed by the shift leader and midwives were allocated to women for their shift. SBAR is a tool designed to help staff anticipate the information about patients to be shared with colleagues at the right level of detail."

Medical staffing

- Medical staff within obstetrics and gynaecology had a vacancy rate of 16.8% for junior doctors with no vacant consultant posts. The absence rate for medical staff in January and February 2016 was 7%; the rate provided was not separated between sickness and maternity leave.
- Staff told us that arrangements for medical staff worked well although there was only one junior doctor per shift to cover obstetrics and gynaecology which placed additional pressure on middle grade medical staff. There were no reported incidents of medical staffing shortages and we were told that locums were used as required.
- Consultant cover for labour ward was provided for 60 hours per week as recommended by the Royal College of Obstetrics and Gynaecology Safe Childbirth guidelines. On-call arrangements were in place and we were told that these worked well.
- We observed a medical handover and found that this was effective and that relevant information was communicated clearly, although it was noted that a gynaecology patient admitted overnight for surgery the next day was not discussed at handover. We also noted that SBAR was not used as part of the handover process.

Major incident awareness and training

- The trust had an emergency preparedness policy dated January 2016. Staff were aware there was a policy and would access this via the computer and call senior staff if this occurred.
- We were told that there were two live drills each year, where emergency scenarios were used to ensure staff were kept up to date and that these had taken place and those lessons learned had been summarised and reported on. A drill had taken place during the first day of our inspection. We were provided with the report from the previous drill in June 2015 which involved nine members of staff. The report included a description of the event and what had taken place with a summary of what had been done well and areas for improvement. The areas for improvement were discussed with the nine staff involved; however, there was no wider learning from this.

Are maternity and gynaecology services effective?

Requires improvement

We rated maternity and gynaecology services as requires improvement for effective because :

- Women who required an emergency a caesarean section did not always receive them in line with nationally recommended timescales.
- Some staff had a good understanding of the Mental Capacity Act, but others were unable to explain what this was or where to locate a patient's assessment for capacity on their file.
- The number of normal vaginal births were from 52% and 58% from September 2015 to February 2016 which was lower (worse than) the trust target of 63%. The caesarean section rate from the preceding six months was 28% which was higher than the trust's target of 23%.
- The annual audit plan for maternity had not been formally approved and did not record the justification for any audit planned. Post-audit recommendations did not always fully address the issues identified and action plans were not always completed.

- The audit plan for gynaecology consisted of five audits over a five year period, one of which had been withdrawn. Two audits had been completed within the last 12 months; the other two audits dated back to 2011 and 2013.
- Data on patient outcomes for gynaecology patients were not reported and monitored in a central dashboard.
- There were a high number of patients from a different speciality (outliers) on the gynaecology ward, and nurses had not received training specific to meet the needs of these patients.

However we also found:

- Patients received pain relief when they needed it.
- Patients nutritional needs were assessed and monitored and the patients we spoke with told us the food was pleasant.
- All clinical staff had up to date registration with the relevant professional body and there were arrangements in place to monitor this.
- Multidisciplinary arrangements worked well and teams reported good working relationships with other staff groups as well as external support services.
- All staff including temporary staff employed by the trust completed a trust and departmental induction.
- There were supervision arrangements in place for midwives. The ratio of supervisor to midwives as 1:16 at the time of inspection compared to the recommended ratio of 1:15

Evidence-based care and treatment

- We reviewed five guidelines/policies which were all based on NICE or RCOG guidelines. They were in date; version controlled and showed a record of changes so that staff would know if there had been any updates. However there was no paper or electronic record in place that demonstrated that staff had read and understood new or updated policies which meant that not all staff may be aware of and have read new guidance.
- Pregnant women had their needs assessed on admission and this formed part of their antenatal care. Assessments were comprehensive and covered their health and social care needs, including details of involvement with social services.
- Decisions made about patient care were non-discriminatory and focussed on individual needs and regardless of age, race, religious beliefs or sexual orientation.
- Patient's care and treatment on the gynaecology ward was planned and delivered in line with evidence-based guidelines for example nutritional and hydration needs, falls assessment and consent.
- There was an audit plan for the maternity department which listed the audits completed in 2014/15, those planned for 2015/16 and 'needed' for 2017/18. A total of 13 audits had been completed in 2014/15. The plan did not list any audits that had been planned but not undertaken; therefore it was not possible to confirm whether all the audits planned had been completed.
- For audits that were uncompleted, the audit plan specified the lead responsible but did not specify timeframes for proposed start / completion date or record whether the audit was mandatory or specialist interest. The purpose for each audit along with which professional body's guidelines they related to, for example, National Institute of Clinical Excellence (NICE), Royal College of Obstetrics and Gynaecology (RCOG), or whether the standards related to local guidelines were not clear.
- The audit plan had not been formally approved by the appropriate committee
- We reviewed a sample of audits and found that the aims, objectives, results and conclusions were clearly defined.
- A National Neonatal Audit Programme is run annually; all hospitals are required to submit data against specific criteria. Review of the published findings for Warwick Hospital confirmed that 67% of all babies born at 28 weeks plus six days had their temperature checked within an hour of birth, which was lower than the previous year when 75% compliance was reported. This meant the target of 98-100% had not been met.
- 88% of women who gave birth from 24 weeks and 34 weeks plus six days had been given a dose of steroids, meeting the NNAP target of 85%
- The trust had developed an action plan to improve on performance. The plan included a recommendation to ensure that all data was entered on the system and that a new 'front sheet' had been developed, with an aim to

enter all data weekly and to follow this up as part of the national audit in 2017. It was unclear how this would be monitored prior to the national audit or how this would be communicated to staff.

- The audit plan for gynaecology consisted of five audits over a five year period, one of which had been withdrawn. Two audits had been completed within the last 12 months; the other two audits dated back to 2011 and 2013. This demonstrated that care provided for gynaecology patients was not being regularly assessed in line with evidence based guidance and standards and best practice.
- An audit on the management and outcome of patients with post-menopausal bleeding started in 2013 but was not completed until 2015. We requested details of the audit and the associated action plan. We were provided with the conclusions, recommendations and action plan only. Actions were either completed or due for completion by July 2016. The second audit, 'scan first then review by a special nurse, changing practice in early pregnancy unit' was completed in 2016 but did not have a recorded start date. We requested details of the audit and associated action plan. We were provided with a copy of the audit proposal only. Although requested, the trust did not provide evidence of which clinical forum these audits were presented at.
- The termination of pregnancy service followed the Royal College of Obstetrics and Gynecology guidelines. Relevant screening and tests were undertaken and contraception discussed and medical procedures followed.

Pain relief

- Women attending the labour suite were offered a pool birth, gas and air, and stronger painkillers by injection. An anaesthetist was available 24 hours a day so women had the option to have an epidural inserted, which numbed the body from the waist down to the toes.
- All of the patients and women we spoke with told us that they were able to access effective pain relief in a timely way.
- An audit had not been completed for the management of pain and was not scheduled. An audit on the timeliness of the delivery of epidurals was completed in 2015 and presented at the obstetric clinical incident and audit meeting in February 2016; however this did not consider the effectiveness of epidural anaesthesia.

Nutrition and hydration

- A nutritional assessment of each patient was carried out by nursing staff on the gynaecology ward. Food and fluid charts were completed as required. Patients who were unable to take oral intake had other forms of nutrition support prescribed following nutritional assessment by nursing staff and dietitians.
- Support from the speech and language therapists and dietitians was accessible if required.
- The percentage of women initiating breastfeeding was monitored on the emergency division finance and performance report and on the dashboard. The target was 81% and the year to date score was 78%, however this had improved to 80.5 % in the month of February 2016.
- There was an infant feeding co-ordinator in post. The service had attained level two Unicef Baby Friendly Initiative accreditation in 2014 and were working towards the level three assessment. Women on the maternity unit told us that they received support and advice for breastfeeding their babies' and that they were given advice about breastfeeding as well we bottle feeding and although encouraged to breastfeed, they did not feel pressured to do so.

Patient outcomes

- The maternity department maintained a quality and performance dashboard which reported on activity and clinical outcomes. We reviewed the maternity dashboard for September 2015 to February 2016. Performance was monitored for a range of outcomes which included normal vaginal births, instrumental births, caesarean sections, induction of labour, unexpected admissions to critical care, maternal deaths, stillbirths, blood loss during labour as well as the number of third degree tears.
- Data was provided for all the above outcomes and thresholds had been set as a trigger point for concern. Some of the targets were being met, for example the number of hypoxic cases, abandoned instrumental births; others were not, for example the number of normal vaginal births were from 52% and 58% from September 2015 to February 2016 compared to a trust target of 63%. During the same period the number of elective caesareans was higher than expected with an average of 12.3% against a trust target of 10%. There was quite a variance with a rate of 15% in January 2016

reducing to 8% in February 2016. The average number of emergency caesarean sections for the six month period up to February 2016 was 15.7% and 19% against a trust target of 15%.

- The National Institute of Health and Care Excellence (NICE) has recommended timescales for caesarean sections according to the level of urgency, with category one and two being the most urgent. Category one should be undertaken within 30 minutes of the decision that a caesarean section is clinically indicated and category two, within 60 minutes, but no longer than 75 minutes. We were provided with audit findings of women who underwent a caesarean section in 2014. The audit demonstrated that 38% of category one and 25% of category two had not met the timescales recommended by NICE. The reason for delay had only been recorded in one of these cases. There were no recommendations regarding improvement of meeting the deadlines or recording the reason for delay, meaning that there was not a plan in place to timeliness of providing an emergency caesarean section for women that required this intervention.
- There had been three maternal admissions to the local intensive care unit care during the previous 12 months against a target of less than 12 per annum. The service had recently started recording the number of women requiring a higher level of obstetric care within the high dependency area on the labour ward in order to identify any specific learning needs for the maternity staff. Four cases were reported in February 2016; a target had not been set to monitor this as the data collection was for trend analysis not performance.
- There were 11 massive post-partum haemorrhages (PPH) in October 2015, against a trust target of less than two a month. We were told that this was because procedures had been changed to follow NICE guidance but this had impacted negatively on the care women received. This was acted on promptly, investigated, procedures changed and communicated to staff. Following this action the frequency of PPH's had reduced in subsequent months although was higher than the trust target of less than two in February 2016. The unit continued to monitor this as part of their monthly dashboard.
- The dashboard did not include the number of cases of sepsis per month. Cases of sepsis were reported as incidents and investigated individually; the number of cases per month were not reported.
- From April 2012 to September 2015 the trust's sepsis rate has been lower than or similar to the expected rate. There was a slight increase in the rates in the most recent two quarters (April to September 2015) when the crude sepsis rate at the trust was 3.2% compared to the national rate of 2.5%. However, cross-sectional analysis (a comparison with other trusts which takes into account the relative volume of cases and is standardised by mother's age) found that the rate at the trust was within expected limits over this time period.
- We were provided with an audit which included data on the number of cases of suspected or confirmed sepsis from October 2014 to March 2016 which was 16 and 1.2% of all births. The audit found that not all cases had been managed in accordance with relevant guidance. Recommendations had been made including a re-audit for March 2016.
- There were five neonatal readmissions in December 2015 and eight in January 2016. This was significantly higher than the trust target of zero.
- Data on patient outcomes for gynaecology patients were not reported and monitored in a central dashboard.
- The audit plan for gynaecology consisted of five audits over a five year period, one of which had been withdrawn. Two audits had been completed within the last 12 months; the other two audits dated back to 2011 and 2013. This demonstrated that care provided for gynaecology patients was not being regularly assessed in line with evidence based guidance and standards and best practice.

Competent staff

- There were induction arrangements in place for all staff. Permanent and temporary staff employed by the trust undertook the trust induction as well as a local induction. Staff all told us that they had received their annual appraisal and supervision and that they found this process helpful. We saw that as of March 2016, 91% of medical staff, 80% of midwifery and 81% of non-clinical staff working within the maternity department had received an appraisal, 94% of nursing staff in gynaecology (including colposcopy) and all non-clinical had received their appraisal against a trust target of 85%.
- Supervisors of midwives (SoMs) help midwives provide safe care and were accountable to the local supervising authority midwifery officer (LSAMO). The national

recommendation for a SoM is to have a caseload of 15 midwives. There were slightly less SoMs than the national recommendation with 16 midwives allocated to each SoM. The role of the supervision is under review and due to this training places have been stopped nationally until the final model is established

- The trust provided a preceptorship programme for newly qualified midwives. The programme had recently changed, arrangements allowed new band 5 midwives and nurses to have five weeks working supernumerary across the units / wards within the maternity department or on the gynaecology ward as well as completing a competency assessment. Each preceptor was given a booklet to record assessment of their competencies which must be signed by their supervisor and then be submitted to the practice development midwife.
- The maternity department were running PROMPT training, an accredited skills and drills training course. Skills and drills were also included as part of the mandatory training for midwives and obstetricians. Skills and drills are the accepted format by which healthcare professionals gain and maintain the skills to manage a range of obstetric emergencies. We were provided with a statement from the trust that 99% of all staff had completed their skills and drills training.
- All midwives and doctors were required to complete CTG analysis training, 67% of doctors and 87% of midwives had completed CTG training against a target of 90%. An audit into the high rate of caesarean sections had identified that staff had not always correctly interpreted CTG readings. We were told, although this was not evident in the audit report that this was being addressed through additional training. However, as above current data indicates the trust's target had not been achieved.
- The gynaecology ward often received patients from other specialities (known as outliers) meaning gynaecology staff were caring for patients with a higher acuity than they were trained to care for. For example, orthopaedic patients were regularly admitted to the ward but the staff we spoke with had not received specific training to care for this group of patients.
- The trust records of all professionals as well as their registration number with professional bodies such as the General Medical Council and Nursing and Midwifery Council. All professionals are required to update their registration annually. We were provided with evidence that all doctors, midwives and nurses had a valid professional registration.

Multidisciplinary working

- The staff we spoke with reported good multi-disciplinary (MDT) working both internally and externally. We observed that medical and nursing / midwifery staff worked well together and that the MDT handovers which took place twice daily worked well.
- We saw evidence that there were good communications and links with community midwives and GPs as well as social services. Information was regularly received from social services regarding individuals specifying any support they may be receiving or may need.
- Physiotherapy and occupational therapy services were available six days per week.
- Women were discharged at an appropriate time of day and social care packages were put in place if required prior to discharge.
- Contact was made with social services for women with social support needs or whose children were on the child protection register and appropriate arrangements made.

Seven-day services

- All maternity services were available 24 hours a day, seven days a week. Women could report to the hospital in an emergency via the maternity reception.
- There was a dedicated pharmacy service for the ward areas, the pharmacist checked the stock and audited records each week. The pharmacy service was available six days per week and out of hours using the on-call system if necessary.
- Consultant cover was provided for seven days per week with on-call arrangements out of hours.
- Community midwives provided a 24 hour on call service for home births.
- Physiotherapists were available five days a week during day time hours. At the weekend midwives referred women to the physiotherapy department. If the woman remained in hospital the physiotherapist visited the woman on the Monday. If the woman was discharged home an out-patient appointment was sent to her home address.

- There were portable ultrasound scanners available for trained staff to do emergency scans out of hours if required

Access to information

- Information needed to deliver effective care and treatment was available to staff instantly. Electronic records were used for women in the maternity unit as well as some paper records. Paper records were available for women admitted to the gynaecology ward.
- Electronic discharge records were used for women who delivered their baby at Warwick Hospital. We were told by the community midwives that this worked well and women's health records were available although this had to be downloaded when Wi-Fi access was available.
- For gynaecology patients, a copy of their discharge summary was given to the patient as well as sent to their GP. There were no recently reported incidents of staff not having patient notes available as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Arrangements were in place to seek consent for surgery and other procedures for all aspects of obstetrics and gynaecology; including termination of pregnancy. We reviewed a sample of patient notes and found that consent forms had been signed where it was appropriate to do so.
- Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS) training was included as part of the safeguarding adults training. We spoke with medical staff, nursing staff and midwives about the MCA and DoLS. Most of the medical staff we spoke with had a good understanding of the MCA and DoLS however, nursing and midwifery staff were unsure of how to seek authorisation for deprivation of liberty, how to make a best interest decision for someone or the difference between lawful and unlawful restraint.
- On the unannounced inspection it was observed that there were patients living with dementia on the gynaecology ward who required a mental capacity assessment. The temporary staff on duty staff were unable to show us where these were stored or confirm whether these had been completed.

Are maternity and gynaecology services caring?

Good

We rated maternity and gynaecology services as good for caring because:

- Staff interactions with patients were positive and patients were treated with dignity and respect
- Patients told us that staff were helpful and that they explained things to them in a manner they could understand and that their relatives and / or partners were involved.
- Although the CQC survey in 2015 noted a couple of negative views from women, it was largely in line with other trusts. Recent friends and family surveys reported largely positive feedback and we observed good interactions with patients during our inspection. Recent surveys had reported positive feedback from patients.
- There was a specialist bereavement midwife who provided support and advice to women and their families if their baby died.

Compassionate care

- The women and relatives we spoke with on the maternity unit as well as the gynaecology ward all reported that they received a good standard of care from all members of staff, One woman told us, "I have been very happy with my stay here and the staff have looked after me to a very high standard and kept me updated at all times."
- Results from the February 2016 friends and family test demonstrated positive feedback for maternity and gynaecology with a small number of women from the gynaecology ward who were unsure whether they would recommend the service or not.
- According to the CQC survey of women's experience of maternity services in 2015, the trust performed 'about the same' as other trusts for 12 of 14 questions and worse for two of the questions that related to caring, The maternity management team were unable to provide an explanation as to why the unit not performed well for caring, however an action plan had been developed.
- We observed during our inspection that people's privacy and dignity as well as their cultural needs were respected. And the maternity unit scored about the same as other trusts in relation to privacy and dignity.

Maternity and gynaecology

Understanding and involvement of patients and those close to them

- The women we spoke with in the maternity unit all reported that communication was good throughout their pregnancy and that their partners had been involved.
- Women on the gynaecology ward told us that all staff had communicated well with them and that they had understood about their care throughout during their stay on the ward.
- Staff told us that if women needed additional support to help them understand that they spoke with the safeguarding midwife for advice.
- Women who attended the service for a termination of pregnancy were provided with advice and support from a nurse. All options available to them were discussed and we saw evidence of this in patient files.

Emotional support

- The trust had a bereavement midwife who was responsible for speaking with and counselling women and their families who may have been bereaved during or after childbirth or may have required a termination of pregnancy due to medical reasons. The midwife offered support and advice to women and their families at specific stages but was also contactable if needed. Information detailing various agencies who provide counselling support for women and their families was also provided.
- There was also a perinatal psychology (psychiatry, psychology and specialist nursing) service within the hospital that triaged the referrals and arranged appointments based on women's individual needs.
- There was a bereavement room in the maternity unit specifically designed for women who had suffered a loss. The room was located near the entrance of labour ward to minimise the bereaved families coming into contact with pregnant women or women who had recently given birth. Although, it was noted that the room was not soundproofed which is important because the distress this may cause women from hearing other babies crying or other women in labour.
- There was perinatal psychological support available for women on a referral basis.
- Women who underwent a termination of pregnancy were offered the opportunity to speak with the nurses on the EPAU during their consultations as well as at other times by telephone. Funeral or disposal arrangements were discussed with the women and their preferences were recorded in their medical records.

Are maternity and gynaecology services responsive?

Good

We rated maternity and gynaecology services good for responsiveness because :

- Work on the development of the maternity strategy had considered the local population and neighbouring maternity units as well as the number, range and types of births at Warwick Hospital. The maternity service was proactive in considering a midwifery led unit (MLU) to ensure women's choice was at the forefront of the service.
- There were interpretation arrangements in place for women who were unable to speak English as their first language.
- There were bereavement arrangements in place for women who had suffered a baby loss.
- There were clear processes in place for people to raise concerns or complain.
- When women asked for help, they were responded to in a timely manner or told that they would be helped as soon as possible.

However we also found:

- There were no arrangements in place to monitor performance of the maternity assessment unit (MAU) and how quickly women were seen by a midwife.
- Not all birthing partners had the option to stay overnight.
- There was no evidence of lessons learned from complaints for gynaecology.

Service planning and delivery to meet the needs of local people

- Work on the development of the maternity strategy had considered the local population and neighbouring maternity units as well as the number, range and types

of births at Warwick Hospital and in the community. The service did not offer a midwifery led unit (MLU) therefore low and high risk care in labour was delivered in the same environment

- A business case in 2010 was approved to redevelop the maternity services, including the refurbishment of all bathrooms; this was partially progressed due to delays in building work in other areas of the trust and has since been superseded by another business case.
- The physical environment and equipment were in need of an upgrade to meet emergency care clinical standards and this was noted on the departments risk register.
- A business plan had been drafted in 2016 to propose the development of an MLU at the trust. The department had considered the proposals in response to the Department of Health Maternity Matters: Choice, access and continuity of care as well as the NHS England, National Maternity Review which recommended that women should access a service which is able to offer them a choice of place of birth. Additionally the number of births has reduced since 2010 and it was reported within the business plan that this is due to women choosing to give birth in other local hospital and MLU's. The plan stated that feedback from women in the 2015 survey suggests women want more choice for antenatal care as well as place of birth and that some had chosen to give birth at a local birth centre. The plan identified short falls against some of the Choice standards and that women and their partners will have a choice in the place of birth depending on their circumstances but should include a home birth, an MLU as well as birth in a hospital.

Access and flow

- The average length of stay on the gynaecology ward was 6.8 days, this included the length of stay for outlier patients on the ward from other specialities including medicine, surgery and orthopaedics; this impacted on the overall length of stay. There were no reported delayed discharges for gynaecology patients; delays were only reported for outlier patients on the ward who were included within data reported on for other divisions.
- The patient flow on the gynaecology ward worked well, although there were a high number of outliers on the ward from other specialities. During our inspection we saw that there were an average of three gynaecology patients on the ward and 12 non gynaecology patients. We were provided with data from the trust which demonstrated there were a total of 320 outliers on the gynaecology ward during the period January to March 2016.
- Medical staff from the relevant specialities visited the patients outlying each day to ensure that their condition was regularly reviewed and they had a plan for care and, when appropriate, discharge. There was a capacity management procedure in place, although this did not make specific reference to medical staff visiting outlier patients.
- The maternity dashboard March 2015 to February 2016 reported that a total of 2,639 women had given birth under the care of South Warwickshire NHS Foundation Trust during this period, which included home births. The monthly target was less than 250 women delivering per month which had been met throughout the previous 12 months. The number of births are monitored to ensure capacity is not exceeded.
- Women who attended the maternity unit who suspected they were in labour or had reduced fetal movement or any concerns were assessed by a midwife on the maternity assessment unit (MAU).
- All women attending the MAU were expected to be seen by a midwife within 30 minutes, however, this was not being monitored or reported on. We were told that although there should be a midwife allocated to the MAU 24 hours per day, seven days per week that this did not always happen and that when MAU was not open, women would be sent directly into the labour ward. The service did not analyse data on the number of women sent directly to labour ward because the MAU was not open.
- We were told that the postnatal ward could become full at times and that when this happened additional ward rounds would take place to expedite discharges if clinically appropriate. Some midwives were trained to undertake Newborn and Infant Physical Examination (NIPE) checks to help with discharge and this could be done on the postnatal ward or by midwives in the community.
- The termination of pregnancy service functioned effectively and women were seen quickly after a referral had been made and in line with Department of Health guidance although we noted documentation was not always completed in line with legislation.

- There was an elective caesarean section theatre list each day, Monday to Friday.
- The trust had achieved their target of 90% of women completing their antenatal booking by 12 weeks and six days. This was 99% in March 2016.

Meeting people's individual needs

- Women who used the service who were unable to speak English fluently could access an interpreter service if required. An interpreter could be booked to attend appointments or inpatient services if necessary; a telephone service was also available. The staff we spoke with reported that interpreter services were rarely needed but that this worked well when required.
- Women told us that if they needed to press their buzzer that they were responded to promptly and that they were never left waiting for very long.
- The service provided a range of information to support patients and those close to them in the form of leaflets. Patients and relatives felt they could ask for information, and were able to speak with consultants and other staff by arrangement. Leaflets were not readily available in other languages; however, we were told that these could be produced if required.
- If a patient who used the service had any specific needs, whether these were mental health, social needs or safeguarding, they would contact the midwife or nurse safeguarding lead as well as referring to guidance on the intranet for advice.
- There were limited arrangements for supporting vulnerable women, for example women with learning disabilities, this fell under the remit of the safeguarding midwife who provided support for staff with queries about supporting these women.
- The lead midwife for safeguarding and vulnerable women was also responsible for supporting and providing advice on teenage pregnancies and domestic violence. There was not a separate teenage pregnancy midwife.
- Disabled toilets and showers that accommodated wheelchairs were available on the wards and unit.
- There were limited arrangements in place for women's birthing partners to stay overnight on the postnatal ward as this could only be accommodated in the five side rooms available.
- Leaflets from external agencies also able to provide support were provided to women, and there were strong links with the trust's chaplaincy service.
- Women undergoing termination of pregnancy were given leaflets for counselling or support available from external agencies.
- All of the women we spoke with told us that they were offered a choice of meals which were provided at the bedside if they were unable to obtain their own meal. The patients we spoke with were very complimentary about the food provided.

Learning from complaints and concerns

- The maternity department had set itself a target of receiving no more than two complaints per month for maternity (24 per year). A maximum target number of complaints for gynaecology was had not been established.
- A total of three complaints had been received in the last six months for the maternity service according to the dashboard, although a statement from the trust reported a total of five. A summary from the trust indicated four of the complaints had been responded to within two months, timescales were not provided for the fifth. There had been two formal complaints received for gynaecology during the last six months, both of these had been received in February 2016 and both were ongoing.
- Evidence of lessons learned and shared were requested and examples were provided for three complaints related to maternity; one complaint had been discussed at a clinical incident meeting, one complaint had no recorded evidence of lessons learned and a summary of learning from the third complaint was included in a recent newsletter. There was no evidence of lessons learned for complaints received about the gynaecology ward.
- There were leaflets and posters which explained to patients and the public how they could make a complaint.

Are maternity and gynaecology services well-led?

Good

We rated maternity and gynaecology services as good for leadership because :

- There was a five year maternity strategy which set out clear objectives and was supported by a business case for a midwife lead unit.
- Performance data for maternity was collected and reported on.
- Meetings were minuted and actions mostly carried forward, although we saw that some items for action were missed.
- The staff we spoke with told us they felt supported by their managers at departmental level and were confident in the arrangements for raising and resolving any concerns,
- There were a range of specialist medical staff as well as midwives and nurses
- We observed the wards and units were well managed with good leadership at a local level.
- Arrangements were in place to gauge public perception of the maternity service and we were provided with examples of when these were acted on

However we also found:

- There was no clear vision or strategy for gynaecology services
- It was unclear whether objectives for maternity for the previous year had all been documented and there was limited evidence of review.
- Governance structures and processes for gynaecology required improvement.
- There was no evidence at a local level of how the staff survey was acted upon.
- There was no process in place for ensuring staff had read new or revised policies and procedures.

Vision and strategy for this service

- The trust's values were to provide safe, effective and compassionate care. Most of the staff we spoke with were able to comment on the trust wide values, although did not know them all.
- The vision for maternity was to, ' provide the right care in the right place at the right time by placing the individual at the centre of any models by promoting a better outcome for women and their families, provide integrated care by working together and promoting independence and personalisation of care'. Staff we spoke with were not aware of a local vision or values.
- There was a five year strategy for maternity with five key priorities which were: choice and access, personalised maternity care, quality and safety, integrated care and health and wellbeing. This was underpinned by desired outcomes and specific objectives. The plan had considered strength and weaknesses as well as financial sustainability with a timeline for the implementation of the plan.
- The maternity strategy provided a comprehensive vision of the way forward, although did not consider achievements or outstanding issues identified against the previous plan.
- We requested a copy of the business plan with achievements for the previous year and were provided with a copy of the emergency divisions' review of objectives, there had been two objectives for maternity for the previous year, to reduce the caesarean section rate to below 28% and to develop a maternity strategy for a midwifery led unit. Both were recorded as achieved, although the review date was not recorded. However whilst the strategy for a midwifery led unit had been developed, the caesarean section rate remained high in 2015/16 and still above the trust's target of 23%, from September 2015 to February 2016 the average rate was 27.8%.
- There was no business plan or objectives for gynaecology.

Governance, risk management and quality measurement

- Women's services sat within the emergency care division. The governance arrangements for maternity were well established however they were more fragmented for gynaecology; a new clinical lead for governance within the gynaecology department had been appointed and had been assigned a role to develop governance within the service.
- There was a clinical incident and audit forum (CIAF) (maternity and obstetric) as well as a maternity and obstetric forum (MOF). Both forums reported to the Maternity Risk Health and Safety Group (MRHSG) which reported to the Risk Management Board as well as the Divisional Audit and Operational Group.

- Gynaecology services were in the process of developing and mirroring where appropriate the governance structures of maternity services. Until the structures are in place, we were informed that health and safety and clinical incidents for gynaecology were discussed at divisional level. We did not see evidence that performance for gynaecology services had been discussed committee meetings.
- The CIAF was responsible for receiving information about performance on the dashboard as well as incidents and audits. The MOF considered anything which affected maternity services as well as ensuring guidelines and policies are up to date. The MRHSG had responsibility for assessing and managing risk.
- Review of the CIAF meetings minutes for December 2015 to February 2016 confirmed the maternity dashboard was presented, although a discussion was only minuted for the January 2016 meeting. Audits and incidents were presented and an action plan of items to escalate or take forward to the next meeting was completed, however, it was noted that not all items were carried forward in the action plan. For example at the February 2016 meeting, it was noted in the minutes that an incident were not presented as planned as a paediatrician was not available to present and this was not included in the action plan to carry forward.
- The MOF minutes for the same period demonstrated that the maternity dashboard was also received and discussed at these meetings. A range of other issues were discussed and it was also noted in the February 2016 minutes that audit actions and responsibilities needed to be tabled, and the dissemination of information improved.
- The MRHSG met quarterly, a review of the January 2016 minutes confirmed there was evidence of discussion of the dashboard as well as emerging and ongoing risks and serious incidents which had been reported. An action plan was completed to monitor ongoing items for discussion.
- The managers we spoke with were aware of the top risks on the divisional risk register. There were a total of 11 risks on the maternity risk register, two of which related to the Special Care Baby Unit (SCBU), the risks identified recorded a description of the risk as well as an assessment of the likelihood of the risk materialising and its possible impact. Each risk recorded had details of the current controls in place as well as details of an action plan and progress made, the risk detailed the most recent review date, all of which were in 2015 or 2016 and when it was due for subsequent review which were mostly mid to late 2016. The review frequency was every six to 12 months
- We were provided with a statement from the trust that the risk register included gynaecology, although there were no risks recorded for gynaecology.
- There was no process in place to ensure staff had read and understood new or updated policies which meant that not all staff may be aware of and have read new guidance.

Leadership of service

- We observed the wards and units were well managed with good leadership at a local level.
- The department had a documented accountability structure. Gynaecology nursing and midwifery leads reported into the head of midwifery and general manager for women's and children; medical staff reported to the clinical director.
- There were consultant leads for specific services within obstetrics and gynaecology for example; there were leads for colposcopy, labour ward, uro-gynaecology, oncology and diabetes.
- There were also specialist roles within midwifery and nursing, including, a safeguarding midwife, bereavement midwife, practice development midwife, early pregnancy assessment unit nurse and oncology nurse.
- All midwives had a supervisor of midwives (SoM) who supported their clinical practice and conducted an annual review of their competencies and clinical skills. Midwives told us that arrangements worked well and that they could contact their SoM at any time.
- The staff we spoke with told us that they had good working relationships with their managers and felt able to raise concerns if they needed to and that on the wards they regularly saw their local managers.
- Community midwives reported that they had a good relationship with their local team manager but that they did not regularly see the head of midwifery, however she was approachable and they would be happy to contact her if they needed to.

Culture within the service

- The service was supportive of staff and care provided was patient focussed.

- Staff told us there were good working relationships amongst their peers as well as other disciplines and that South Warwickshire NHS Foundation Trust was a pleasant place to work.
- Staff told us that they were encouraged to report incidents and that they felt confident in doing so and the importance of sharing information with patients and families when an incident occurred involving them; we saw evidence of this in the serious incident reports reviewed.

Public engagement

- Patients were given the opportunity to provide feedback through a range of surveys as well as making a formal complaint.
- There was a Maternity Services Liaison Committee (MSLC), although they had changed their name to the Maternity Partnership (MP). A maternity partnership meeting was held every quarter, the meeting was for women and partners who had used maternity services to meet and discuss feedback and developments within the service. Meetings were also attended by the head of midwifery. Two of the MP members attended meetings to discuss the MLU business case; each had a specific role to consider the suitability of the environment both structurally as well as its interior design.
- The service contributed to the national inpatient survey, national maternity survey as well as the national friends and family test survey.
- We were provided with evidence of issues raised through the different surveys as well as action taken to address these concerns. The action plan from the national maternity survey listed 25 actions for improvement, as at March 2016 six were reported as completed, the remainder were either, 'underway' or 'ongoing'. Timescales for completion had not been recorded; therefore it was not possible to monitor delays in any action having been taken.
- We were informed that action had been taken from other comments gathered locally, for example, visiting hours on the postnatal / antenatal ward had been extended, an overnight fold out bed had been purchased for a birthing partner to stay and additional fund raising was planned to purchase some more.

Staff engagement

- The annual staff survey had not been analysed at departmental / directorate level and therefore it was unclear what issues had been raised by staff who worked within maternity or gynaecology.
- Staff also had the opportunity to provide feedback daily at handover meetings, monthly team meetings as well as during their supervision or appraisal.

Innovation, improvement and sustainability

- The use of a mainly electronic 'paper light' electronic health care records system in the maternity department ensured that all the care the patient had received, along with diagnostic test results, were easily accessible and stored in one place.
- There was a perinatal mental health service and pathway in place
- The service attained level 2 Unicef Baby Friendly Initiative accreditation in 2014 and were working towards level 3 assessment.
- Processes and procedures had been developed for women on the postnatal ward to self-administer some medication if they chose to do so. This meant that they were in control of their own pain relief and did not need to depend on staff.

Services for children and young people

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

Information about the service

The children and young people's service at the South Warwickshire Hospital NHS Foundation Trust provides a service for neonates, children and young people up to and including age 16. Children from 16 and18 years were cared for on adult wards with input from paediatrics as necessary. There were 18 beds and cots located on Macgregor ward, (seven cubicles and two bays containing a total of 11 beds) and 11 level 1 special care baby unit (SCBU) cots.

The service operated on children from the ages of one and 16 years. 50% of day surgery is available on alternate Friday mornings for dedicated day surgery lists for specialities such as general surgery, ear, nose and throat (ENT), dental/ orthodontic surgery, urology, ophthalmology, gynaecology and orthopaedics.

There is a children's emergency department (ED) which was inspected and is reported within the urgent and emergency care services report.

The trust had treated 3,448 children from July 2014 and July 2015, of which 95% were emergency admissions, 3% day cases and 2% elective care.

From January 2015 and January 2016 there had been 976 paediatric operations

performed across eight specialities. The majority of operations were performed in ENT (337) followed by general surgery (180), the ED (trauma) (171), oral surgery (145), and trauma and orthopaedics (118). The remaining 25 operations were performed across the remaining three specialities.

From January 2015 and January 2016 there were 293 babies admitted to SCBU and 52 babies transferred from SCBU to a tertiary unit for more complex care.

During the inspection, and in order to make our judgements, we visited inpatient and outpatient areas. We talked with 10 patients and/or their parents, and 32 staff including nurses, doctors, physiotherapists, a play specialist, support staff and managers. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed 10 care records, eight medication charts and other documentation and performance information supplied by the trust.

Services for children and young people

Summary of findings

We rated services for children and young people good for safe, effective, caring and responsive and requires improvement for leadership:

- Children and young people were treated with dignity, respect and kindness. Feedback from parents and children were positive. Parents felt supported and told us staff cared about them and their children.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We found evidence sharing learning and changing practice as a result of incidents.
- Services were clean and staff adhered to infection control policies and protocols. Equipment was checked daily, cleaned and documented.
- The service used a comprehensive prescription and medication administration record card which facilitated the safe administration of medicine.
- Patient records we looked at were comprehensive.
- Medical ward rounds and nursing handovers took place three times a day across the service and were well attended.
- The risks associated with anticipated events and emergency situations were recognised, assessed and managed.
- Staff received training on the duty of candour.
- Staff understood their roles and responsibilities for safeguarding children. Although mandatory training was generally well attended, safeguarding children training at level three was not in accordance with the intercollegiate guidance 2014 document published by the Royal College of Paediatrics and Child Health (RCPCH), 'safeguarding children and young people roles and competences for health care staff, 2014'. This meant there was a risk that staff may not have the level of competence to respond appropriately to safeguarding concerns.
- Although nursing staffing levels did not always meet RCN and Toolkit for High Quality Neonatal Services 2009 recommendations; and the service did not comply with RCPCH standards for having 10 consultants to cover, we found mitigating actions were in place and there was no evidence of a negative impact on the care and treatment children and young children received.
- Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- Staff were proactively supported to acquire new skills and share best practice and staff were competent to carry out the care of children and young people.
- Services were planned and delivered in a way that was meeting the needs of the local population. The individual needs of children and young people were generally met.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The service was part of the integrated paediatric strategy (2014-2019) that included both acute and community provision of services. The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, commissioners and others.
- Staff in all areas knew and understood the vision and values. Staff felt well supported and felt they were well managed.

However we found that:

- The arrangements for governance and performance management did not always operate effectively. Governance arrangements were fragmented with no one person responsible for children and young people's services.
- Not all risks we identified on the risk register.
- It was unclear who had the overall oversight of care for neonates, children and young people. After the inspection the trust told us that the Head of Midwifery had oversight of the service in the hospital.
- We found limited evidence of public engagement.
- Mandatory training compliance levels did not always meet the trust target. This meant that there was a risk that staff did not have the necessary skills to carry out their role.
- There was no recognised early warning score tool for babies on SCBU and no audit for the use of a local tracker and trigger system on Macgregor ward within

Services for children and young people

the last 12 months. This meant that there was a risk that any deterioration of a child's condition may not always be recognised. However, we saw no evidence of this in practice.
- There were no formal pain tools used on SCBU.

Are services for children and young people safe?

Good

Overall we rated the service as good for safe because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. We found evidence sharing learning and changing practice as a result of incidents.
- Services were clean and staff adhered to infection control policies and protocols. Equipment was checked daily, cleaned and documented.
- The service used a comprehensive prescription and medication administration record card which facilitated the safe administration of medicine. There was a good service provided by the pharmacy team.
- Patient records we looked at were comprehensive. There was a paediatric surgical admission document used for all paediatric surgical patients which was comprehensive and documented the child's journey from admission through to discharge.
- Medical ward rounds and nursing handovers took place three times a day across the service and were well attended.
- The risks associated with anticipated events and emergency situations were recognised, assessed and managed.
- Staff received training on the duty of candour.
- Staff understood their roles and responsibilities for safeguarding children. Although mandatory training was generally well attended, safeguarding children training at level three was not in accordance with the intercollegiate guidance 2014 document published by the RCPCH, 'safeguarding children and young people roles and competences for health care staff, 2014'. This meant there was a risk that staff may not have the level of competence to respond appropriately to safeguarding concerns.
- Although nursing staffing levels did not always meet RCN and Toolkit for High Quality Neonatal Services 2009 recommendations; and the service did not comply with RCPCH standards for having 10 consultants to cover, we found mitigating actions were in place and there was no evidence of a negative impact on the care and treatment children and young children received.

However we found that:

- Mandatory training compliance levels did not always meet the trust target. This meant that there was a risk that staff did not have the necessary skills to carry out their role.
- There was no recognised early warning score tool for babies on SCBU and no audit for the use of a local tracker and trigger system on Macgregor ward within the last 12 months. However, we saw regular monitoring of vital signs which would quickly pick up any deterioration in a babies condition.

Incidents

- A system and process for reporting of incidents was in place. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. This was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- There were no serious incidents or never events reported from October 2014 and September 2015. Never events are serious wholly preventable patient safety incidents that should not occur if the available preventable measures have been implemented by healthcare providers (Serious Incident Framework, NHS England March 2015).
- For SCBU during September 2015 to February 2016 there were 115 child related incidents reported to the women and children's directorate. 94 of the 115 were related to applying the services neonatal trigger and resulted in an admission to SCBU.
- Of the 115 incidents 82 were graded as causing no harm, 14 were graded as low harm and 19 graded as moderate harm.
- From January and December 2015 there was a total of 71 reported incidents on Macgregor ward and the SCBU, five were classed as moderate harm, eight as no harm with the remaining classed as causing no harm. The majority of incidents were due to access, admission, transfer and discharge arrangements (18) and treatment and procedures (16).
- Learning from incidents was shared via team meetings and bi-monthly newsletters. For example, the use of a new neonatal resuscitation proforma and the use of a flow chart that described the process of managing weight loss in a new-born at various stages in the postnatal period.
- Some staff were unsure how learning from incidents happened and could not give an example where learning had taken place. However, one member of staff told us about a blood glucose test that had not been taken, an incident form was completed and reminders for staff to carry out these tests were displayed on the staff notice board.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person.
- Duty of candour information was contained within the corporate induction for all new staff and incorporated into the annual mandatory health and safety training which was delivered either face to face or through e-learning However, three members of nursing staff could not tell us what this was. Duty of candour regulations had been followed in terms of recent incidents.
- Awareness raising had also been undertaken through the one-off provision of a leaflet on Duty of candour via payslips, through articles in the patient safety newsletter and their regular briefing sessions 'Quality Briefing'.

Cleanliness, infection control and hygiene

- From April 2015 and March 2016 there were no MRSA and CDiff cases in the children's and young people's service and no surgical site infections.
- Weekly MRSA swabs were taken and where babies had been transferred back into SCBU the baby was barrier nursed until an MRSA result had been returned.
- There were monthly hand hygiene audits undertaken which showed 100% compliance for both Macgregor ward and SCBU between April and December 2015.
- We saw equipment was dated once cleaned and there was access to PPE including gloves and aprons in all areas visited and staff used these appropriately whilst going about their activities.
- The playroom was cleaned weekly along with the toys and play equipment.
- We observed staff on the ward and SCBU complying with trust infection control policies, such as

management of sharps, hand hygiene, the management of bed linen and the management of clinical waste. There was good access to hand washing and drying facilities, as well as hand sanitising gel.
- However, we had to remind trust staff visiting the Macgregor ward to use the hand gel before entering the ward environment this included a member of medical staff who was also not conforming to the 'bare below the elbow' practice. We raised this with staff at the time of the inspection and corrective action was taken.
- We saw posters on Macgregor ward displaying the five steps to safe hand hygiene which some parents followed.
- We saw cleaning schedules and checks on showers for legionaries' disease in place.
- In the 2014 CQC Children and Young People's Survey, the trust scored 89% for whether the hospital room or ward the child was seen in was considered to be clean which was similar to other trusts.

Environment and equipment

- We checked the resuscitation equipment on all wards and areas and found the equipment was checked daily, cleaned and documented.
- Clinical waste storage was appropriate.
- The environment was safe for children as there was an intercom system in place and CCTV at the entrance to the unit.
- We observed the nurse in charge carrying out the daily safety checks across the service. These checks included checking alarms, portable appliance testing, medicine stock cupboards, resuscitation equipment and temperature checks.
- There had been no audit undertaken for hospital accommodation for children and young people (HBN23) for a number of years since the last refurbishment of the children's ward in 2008. However, there had been on-going improvements, compulsory health and safety compliance assessments and routine assessments undertaken to ensure the ward was fit for purpose.
- However, there had been discussions on completing an audit in 2016 regarding the development of a PAU.
- In the 2014 CQC Children and Young People's Survey, parents and carers of children under 16 years of age were asked to say whether the ward where their child stayed had appropriate equipment or adaptations for their child. The trust scored 89% which was consistent with other trusts.

Medicines

- Fridge temperatures were checked and documented across the service. We checked controlled drugs were stored correctly and the register was completed.
- The service used a comprehensive prescription and medication administration record card which facilitated the safe administration of medicines. Macgregor ward had adapted paediatric medication charts to include the dose per kilogram per medicine and the page where the information on dosage could be found in the British National Formulary (BNF). The BNF is a pharmaceutical reference book that contains a wide range of information and advice on prescribing medication.
- A senior pharmacist visited the ward most days and stock was replenished by pharmacy technicians. Nursing staff told us they received a good service from the pharmacy team.
- The ward manager told us safety alerts relating to medicines were distributed to the ward, and gave us an example from November 2015 about the use of an antibiotic in children under one year.
- We observed nurses administering medicines in accordance with the prescription. We noted that they used oral syringes to measure and administer liquid medicines in line with trust policy.
- We checked 10 prescription and medication administration records in detail. We saw the pharmacist had added advice to guide safe prescribing such as including the duration of treatment for an antibiotic and correcting the dose of paracetamol. However, we did not see a formal record that medicine reconciliations had been carried out. This included taking a detailed medicine history and checking prescribed medicines were correct.
- Macgregor ward scored 100% for its medicines storage handling audit in 2015. The internal checklist used was based on the requirements of the former Standards for Better Health, Core Standard C4d, Safe and Secure Handling of Medicines.
- SCBU audited its correct record keeping for the administration of the following medicines, morphine, atrocurium, intravenous therapies, sucrose and treatment of jaundice.
- Staff told us that waiting for take home drugs was a concern as they felt children were waiting too long for

their medication. However, we saw no incident report to support this claim. Staff told us plans were in place to ensure Macgregor ward had priority over other wards which improved the flow of patients through the ward.

Records

- There had been no formal documentation audits undertaken within the last 12 months across the service. However, SCBU audited its term admissions where the records would be reviewed.
- We looked at 10 sets of patient's records. These were comprehensive and well documented and included diagnosis and management plans, consent forms, evidence of multi-disciplinary input and evidence of discussion with the patient and family.
- We saw the paediatric surgical admission document used for all paediatric surgical patients which was comprehensive and recorded the child's journey from admission through to discharge. Risk assessment tools such as the Glamorgan Paediatric Pressure Ulcer Risk Assessment Scale (used for assessing the risk of pressure ulcers) and the 'three scale paediatric pain tool' were included within the document, along with areas to record medical and nursing actions and all perioperative care.

Safeguarding

- The trust had a safeguarding children policy and safeguarding children supervision guidance which was used to inform all staff of the safeguarding children supervision arrangements so staff fully understood their roles and responsibilities for safeguarding children.
- The Macgregor ward manager attended the bi-monthly safeguarding operational group which was chaired by lead safeguarding nurse for both the acute and community sectors and fed back any issues relating to safeguarding to the ward team via team meetings.
- The trusts safeguarding team were accessible Monday to Friday from 9am and 5pm. All staff we spoke with knew how to contact the team and were aware that out of hours the duty paediatrician or director on call would support them if a safeguarding concern was raised.
- The Safeguarding Children and Young People and Safeguarding Adults Annual Report July 2015 stated there had been a 9% increase of children subject to child protection plans on the previous year in Warwickshire. This had resulted in a more consistent mechanism for reporting and monitoring safeguarding incidents across the trust, using the electronic incident reporting process which had been addressed successfully during the course of this year.
- The annual report also stated the trusts training compliance for safeguarding children across all three levels were: level one: 97%, level two: 95% and level three: 92% against a trust target of 95%.
- For March 2016, SCBU was 100% compliant with level one, two and three safeguarding children training. The Macgregor ward was 100% compliant with level one and two training and 75% of trained nursing staff having level three training. This meant safeguarding children training at level three was not in line with the intercollegiate guidance document published by the RCPCH 2014, regarding roles and competencies for healthcare staff. This stated that trained nurses working with children must be trained to level three regarding safeguarding children. It also meant that there was not a level three safeguarding trained nurse on duty at all times. The services had plans in place to improve these figures.
- Policies relating to child sexual exploitation, female genital mutilation (FGM) and vulnerable adults were robust and up to date.
- In the CQCs Children and Young People's Survey 2014, the trust performed about the same as other trusts for safeguarding and feeling safe in the hospital (94%).

Mandatory training

- Macgregor ward staff received training on equality and diversity (100% compliant), conflict resolution (85% compliant), health and safety (79% compliant), basic life support level one (66% compliant), basic life support level two (87% compliant), manual handling (79% compliant) and infection prevention and control (47% compliant). Equality and diversity and conflict resolution training were the only areas to meet the trust standards of 85%. The service had plans in place to improve attendance at these training sessions.
- For SCBU the unit met its mandatory standards for health and safety (96% compliant), manual handling (96% compliant), equality and diversity (100% compliant) and information governance (96% compliant). However, the infection control training was 84% compliant and did not meet the 85% trust target (target 95% for information governance).

Services for children and young people

Assessing and responding to patient risk

- Both medical ward rounds and nursing handovers took place three times a day across the service. We saw these to be thorough and included the child's history, any results from tests, any planned care and treatment and any contingency plans where necessary.
- Medical handovers were comprehensive and well attended and included full medical details and tests for all patients.
- There was no recognised early warning score tool for babies on SCBU. However, we saw regular monitoring of vital signs which would quickly pick up any deterioration in a babies condition.
- There had been no audit for the use of a local tracker and trigger system on Macgregor ward within the last 12 months. The last audit took place in June 2014. This showed areas for improvement such as the area to document parental concern had been captured in 10% of the charts audited, the frequency of observations had only been captured in 4% of charts, the blood pressure was only recorded on 24% of the charts and no blood pressure monitoring had been recorded. This meant that documentation was poor and would not support recognising the deteriorating child. However, we saw no evidence of this in practice.
- Senior staff told us assurance was provided by regular spot checks conducted on the ward of completion and accuracy of Paediatric Early Warning Score (PEWS). The outcomes of the spot checks were discussed with the ward team at handover. There was no documented evidence that these discussions took place.
- The current PEWS forms had been updated and the PEWS was scheduled to be re-audited in April 2016 on Macgregor ward.
- There were no falls, pressure ulcers or urinary tract infections reported through the NHS Safety Thermometer from September 2014 and September 2015.
- There was no pre-operative assessment for children. However, the service had operational guidelines for day case surgery which had been reviewed in 2014 and further updated in February 2016. The guidelines were in place to ensure all procedures were suitable to be undertaken at the trust and risk of complications (from surgery and anaesthetic) were minimised. We saw these in use when children were escorted to the operating theatres prior to surgery.
- Children admitted as emergencies in surgical specialities were admitted under the surgical team. Children under five who were admitted as emergencies were under the shared care of the paediatricians and the relevant surgical team. Medical staff told us there were informal mechanisms in place if cross referral was needed which worked well.
- Emergency general surgery was undertaken by the general surgeons who were on the on call rota. An informal referral system existed to the two consultant surgeons with a declared paediatric interest for these surgeons where they had children who they feel would benefit from a specialist opinion. There was no formal rota for this referral pathway, and when the two consultants with a declared interest were unavailable, children deemed to be beyond their capabilities, or requiring a further opinion, would be referred to a tertiary centre.
- For elective paediatric lists there was either a consultant anaesthetist or a suitably experienced associate grade specialist, or a registrar (ST3-7) who had completed their three month paediatric attachment at a specialist centre to carry out the list.
- There was always a consultant working in the same theatre suite (DSU or main theatre) during that session and also a duty anaesthetist consultant available for advice and assistance.
- Other lists with occasional paediatric patients the duty consultant anaesthetist would be informed and be available to assist if required and for urgent/emergency cases the duty consultant anaesthetist would discuss the case with the senior anaesthetist on duty.
- If children living with a mental health condition needed additional support, staff would contact child and adolescent mental health service (CAMHS) who arranged a carer or special agency nurse to attend.
- Babies on SCBU could be kept for up to four hours if needing continuous positive airway pressure (CPAP), once it was determined that the baby needed more than four hours support they would be transferred to a tertiary centre. An exception report would be produced to reflect the decision to transfer the baby and would be added to the incident reporting system.
- The service scored the same as other trusts in the questions relating to safety on the 2014 CQC Children and Young People's Survey.

Nursing staffing

- About 40% of shifts on Macgregor ward had three registered nurses on each duty. This meant that the service did not always comply with the RCN 2014 staffing levels for children and young people's services of 1:3 registered nurse per child for under two years old and 1:4 registered nurse to child over two years old. This was not raised as an issue on the risk register and there was no evidence of a negative impact on the care and treatment children and young children received.
- There was a band 7 senior nurse on duty during the day.
- Senior managers told us there was a seasonal variation to the acuity of patients on Macgregor ward, with larger numbers admitted with respiratory illnesses during the winter months. Staffing provisions on Macgregor ward were assessed in May 2014 and November 2014 using a local paediatric acuity tool based on RCN guidance.
- The assessment equated to four qualified nurses on duty during summer months and five qualified nurses during winter months, based on 2014 figures to cover the ward and clinics. We saw four qualified staff on the early and late shifts with one nursery nurse during the day with an additional qualified nurse for clinic. Three qualified staff on the night shift with one nursery nurse.
- SCBU complied with the Toolkit for High Quality Neonatal Services 2015 recommendations of staffing levels ratio of one registered nurse to four babies but did not always comply with the of recommendation of a nursing co-ordinator on every shift in addition to those providing direct clinical care. This would be the case when all three high dependency unit (HDU) cots were occupied and would be an issue until the babies had been transferred out. There was no evidence of a negative impact on the care and treatment patients received.
- The service had a standard operating procedure for nurse staffing escalation dated 2014 which detailed the role of the bleep holder and ward manager and the actions needed to be taken depending on the percentage of staffing shortfall. This was well managed and patients' needs were met
- The overall trust vacancy rate for nursing staff was 12% with band seven and below being 14% and band eight and above 9%.
- On Macgregor ward there were 18.67 whole time equivalent (wte) registered sick children's nurses plus a 0.8wte band 5 nurse on secondment to the paediatric diabetes team, 4.99wte nursery nurses /health care assistants (HCA), 1.4wte play specialists and 1.3wte ward clerks.
- The nurse staffing levels for SCBU were band 7: 1wte (job share) so there was always a band 7 on duty, band 6:16. 8 wte with a 2.3wte vacancy and band 4 5wte with a vacancy of 0.5wte. Interviews had been arranged for April 2016 to fill these vacancies.
- There was a nurse-led clinic for phlebotomy (blood sampling) running three days a week.

Medical staffing

- The paediatric strategy 2014-19 stated that one of its challenges was to succession plan for newly appointed surgeons to have the necessary skills to sustain paediatric surgery. This was on the risk register and the service had plans to address this concern by continuing to train their registrars in paediatric surgery via the Friday paediatric lists and as a result one of their trainees was completing a six month paediatric surgical rotation at a tertiary centre with a view to returning to the service at the trust. There was also the option of a further general surgeon was mentored in order to carry out more paediatric surgery.
- Data from the Health and Social Care Information Centre from September 2004 to September 2014 showed the medical staffing skill mix for consultants was about the same as the England average of 34%. However, there were few junior grade doctors (3%) compared with the England average of 7% and a higher proportion of middle career doctors (27%) compared with the England average of 7%.
- The overall trust vacancy rate was 12% with consultant staff being 13% and other medical staff being 9%.
- Medical staffing did not meet the RCPCH standards 2015 which states acute paediatric units should have a consultant present and available in hospital at times of peak activity seven days a week. There was no consultant on site cover from 5pm to 10pm weekdays and weekends. This was not identified as a risk on the risk register. However, mitigating actions were in place, for example, junior staff would call the consultant who was on call during the period if needed. We found there was no evidence of a negative impact on the care and

treatment children and young children received as a result of a consultant not being on site. There were no incidents reported relating to consultant unavailability or untimely care.

- There were three tiers of doctors on the medical rota. Tier one: This tier consisted of eight staff made up of four general practice vocational trainee scheme trainees and four paediatric trainees. These were paediatric specialty and general practice trainees. There were two trainees on site from 9am and 12 midnight, Monday to Friday.
- At weekends and from 12 midnight and 9am on weekdays, there was one trainee on the tier 1 on site. From 9am and 12 midnight during weekdays, one trainee covered the paediatric ward and emergency department referrals. The second trainee covered maternity (postnatal ward and attended high risk births) and SCBU. There were four shifts on this rota: 9am to 9.30pm, 9am to 5pm, 4pm to 12 midnight, and 9pm to 9.30am.
- Tier two: This tier also consisted of eight staff. There were two paediatric trainees (surgical trainee 4+), one education fellow and five specialty doctors. There were two tier two doctors on site from 9am and 5pm at weekdays, and one middle grade on site at all other times. However, we were told there may be more middle grade doctors on site if there was an outpatient clinic or to support professional activity being undertaken. There were three shifts on this rota: 9am to 9.30pm, 9am to 5pm and 9pm to 9.30am. All posts were currently filled.
- Tier three: There were seven acute paediatric consultants (6.8wte) who undertook this rota. There was a 'consultant of the week' system where there was one consultant 'on take' for all emergencies and carried out a daily ward round, 9am to 5pm, Monday to Friday. The consultant covering the weekend took over for emergencies from 9am Friday to 9am Monday. However, the 'consultant of the week' would undertake the ward round on Friday morning before handing over patients with a management plan at lunchtime on Fridays.
- At weekends there was a consultant ward round in the mornings and all inpatients were reviewed. The consultants were on call in rotation and provided a 24 hour on call service each day. We were told consultants were 'hands on' and no child / neonate was transferred to a tertiary centre without review by a consultant. All resuscitations and stabilisations were led by the paediatric consultant.

Major incident awareness and training

- The trust had an emergency preparedness policy dated January 2016. Staff we spoke with knew about the policy and could describe what they would do in the event of an emergency, major incident or fire episode.
- Staff told us the major incident trainer did not specifically capture or deliver training for major incidents for the paediatric team. There was training for the executive team, hospital bleep holders and on-call managers. In addition to this there was bespoke and specific training on request for example; scenarios for business continuity with general managers, community teams, theatres and ED.

Are services for children and young people effective?

Good

We rated the service as good for effective because:

- Children and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- The service could demonstrate good quality outcomes through benchmarking and peer review as evidenced by the RCPCH Epilepsy 12 national audit, the National Paediatric Diabetic Audit (NPDA), the National Neonatal Audit Programme and National Paediatric Asthma Audit. The service was United Nations Children's Fund (UNICEF) baby friendly level two accredited and were working towards gaining level three accreditation.
- At the time of the inspection the trust was taking part in national 'Hydration and Nutrition Week' to raise awareness of the importance of good nutrition.
- We saw recommendations for acute pain management in children followed, including the assessment of pain, different routes of administration, suggested pain management for common surgical procedures and the control of sickness and vomiting after operations.
- Staff were proactively supported to acquire new skills, share best practice and were competent to carry out the care of children and young people.

- Specialist nurses could be accessed for more complex conditions. Access to the intranet enabled easy access to policies and guidelines.
- Meetings were held with paediatric consultants, registrars and senior nursing staff to ensure robust multidisciplinary approach to problem solving, meeting challenges and taking the service forward.

However we found:

- There were no formal pain tools used on SCBU.
- Appraisal rates for SCBU which was 80% and did not meet the trust standard of 85%.
- The service had not audited its adherence to the child consent for treatment policy for 18 month prior to inspection. An audit into paediatric consent for general surgery was planned for August 2016.

Evidence-based care and treatment

- The service had a range of policies based on the NICE guidelines which staff demonstrated an awareness of. For example, the management of epilepsy in children and young people and diabetes in children and young people.
- The service took part in the RCPCH Epilepsy 12 National Audit and was not an outlier for any of the 12 performance indicators when compared to other paediatric units in the UK.
- There were a number of actions which needed addressing such as improving paediatric assessment, remembering to carry out electrocardiographs (ECGs), a test to show if the heart is working normally, in children presenting with convulsive seizures, an epilepsy nurse to be included in the paediatric strategy, to ensure an magnetic resonance imaging (MRI) was requested as per NICE recommendations and to establish an epilepsy database. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body.
- The service took part in the NPDA 2013/14 and performed similar to other trusts across the country in follow up care, management of medication and follow up to a GP. The NPDA showed improvement in how children's diabetes was controlled and was similar to the national averages. There was still need for improvement in the amount of antibiotic prescription and provision of information and management plan. Action plans showed there was a need to improve documentation.
- Further improvements were needed such as the need to ensure data entry was accurate for audit, to target those with high sugar levels, engaging young people, education on weight needed improving , healthy eating, exercise and a more targeted approach to capturing annual reviews.
- All children living with diabetes were entered on to a national diabetes database so information could be collated to share good practice.
- The service participated in the NNAP which was published in November 2015 and reported on data from 2014. There were a number of actions for all trusts across England which they were addressing.
- The service was UNICEF baby friendly level two accredited and were working towards gaining level three accreditation. The baby friendly initiative awards were based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children's centre services. These were designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways, which would support optimum health and development. Facilities implement the standards in stages over a number of years. At each stage, the trust were externally assessed by UNICEF UK. When all the stages were passed, the trust were accredited as 'baby friendly'. Award tables were kept on the internet website to let the public know how facilities are progressing.
- The trust scored the same as all other trusts in the questions relating to effective in the 2014 CQC Children and Young People's Survey.

Nutrition and hydration

- The service did not use a nutritional scoring tool but undertook the Screening Tool for Assessment of Malnutrition in Paediatrics (STAMP) nutritional audit pilot in 2011. The service had yet to introduce the tool.
- The service carried out a survey in November 2015 which showed Macgregor ward did not use menus and needed a system to deliver nutrition information. However, we saw specific menus used that were soya free and available for children allergic to milk and eggs.
- We saw lunch served on Macgregor ward which looked appetising with a good variety of choice. There was a choice of hot and cold food including lasagne, salads, fruit and yogurts. Children with spoke with told us the food was 'okay'.

- We saw a temperature probe used to ensure the hot food was at the correct temperature.
- The trust PLACE survey showed that the quality of food was rated (93%) which was better than the England average of 88%.
- At the time of the inspection the trust was taking part in national 'Nutrition and Hydration Week'. This aimed to raise awareness of the importance of good nutrition and keeping hydrated. To support the campaign the trust had a local professional football team visit the Macgregor ward to distribute water bottles to all children to promote hydration.
- We saw a 'think before you drink' display that aimed to raise awareness of the sugar content within drinks. It showed the different types of drinks children are likely to consume and the sugar content of each drink.
- The service used fasting guidelines for children prior to surgery which included: clear fluid up to two hours before surgery, breast milk up to four hours before surgery, infant formula/non–human milk up to six hours or a light meal up to six hours before surgery.
- The service had a dietitian who would visit weekly or when requested if more than weekly.
- In the 2014 CQC Children and Young People's Survey the trust scored 61% for the question (asked to parents of children aged 0-7 years): "Did your child like the hospital food provided?" this was about the same as other trusts.

Patient outcomes

- In the NPDA, the service was similar to the England average for both the percentage of children with a HbA1C <58 mmol/l and for the mean HbA1C suggesting that the percentage of children with controlled diabetes was similar to the national average.
- For the NNAP, SCBU had a summary report for January to September 2015 which demonstrated the service was performing worse than the national average for temperature recording within one hour of birth (67%) with a national average of 94%; all babies under 1.5kg undergoing retinopathy (93%) national average 100%; babies less than 33 weeks receiving mother's milk on discharge (50%) national average 60%; and documented consultation with parents by a senior member of the neonatal team (78%) national average 89%. There was an action plan to improve on these outcomes.
- From January and March 2015 the service audited its management of early onset neonatal infection and found all children had C-reactive protein (CRP) and blood cultures taken before starting antibiotics and none needed readmission in the first month of life for sepsis. CRP is a substance produced by the liver in response to inflammation.
- However, only 52% of babies with suspected sepsis had antibiotics within one hour of life, a repeat CRP was carried out in 57% babies; the duration of antibiotics was longer as the blood culture results were delayed and the first line antibiotic (Benzyl Penicillin) was used instead of Benzyl Penicillin+ Gentamicin. This meant that the service needed to change its use of antibiotics.
- The majority of actions in the action plan to improve these results had been implemented and was due to be re-audited in May 2016.
- Multiple admission rates for 1:17 year olds were substantially worse than the England average for diabetes and epilepsy. For diabetes this was 12% with an England average of 14% and for epilepsy 41% with an England average of 27.8%. This had been reviewed and action plans were in place to improve the rates of readmissions. Multiple admissions for asthma (14%) were better than the England average of 16%.
- The emergency readmission rate for non-elective admissions was similar to the England average for both age groupings. For elective admissions, there were no readmissions in the under one age group and a very small number in the one to 17 age group.
- From October 2015 and January 2016 the outcomes from the implementation of the ALT service saw a reduction in the length of stay for patients using the CAMHS, 2.3 days to 1.7 days.
- In SCBU by using high flow oxygen therapy in patients with bronchiolitis, this reduced the impact to the children and families of transfer service was avoiding transfer out of some of the sicker babies, who would have been likely to start on continuous positive airway pressure (CPAP) prior to transfer to tertiary centres.
- Staff told us this was a much better patient service in terms of quality of care for patients than previously where one to two babies were transferred to tertiary care each week over the winter. At present the figures were too small to show a significant difference. Medical staff told us this would be audited once the numbers had increased.
- The aim of initial clinic appointments of newly diagnosed children with insulin dependent diabetes

was to improve their diabetes control and clinical measures before being offered the use of a pump to deliver their insulin. This was better for the child as it gave more time to establish a routine.
- An audit of pain control in recovery in 2015 for children who had a tonsillectomy showed pain was not managed effectively. This resulted in the use of a more potent analgesic used, reducing the pain children experienced for this procedure.

Pain relief

- There were recommendations for acute pain management in children dated January 2014. These included the assessment of pain, different routes of administration, suggested pain management for common surgical procedures and the control of sickness and vomiting after operations. We saw these followed at the time of the inspection.
- There was an acute pain service at the trust which included services for paediatric patients. Children with difficult acute pain management issues or with pain control infusions and devices, for example, patient controlled analgesia (PCA) were visited on a daily basis by the service.
- Guidelines also existed for the management of acute pain in children. Further advice was available within normal working hours from the acute pain team and out of hours from the anaesthetic team.
- There had been no recent pain audits undertaken on Macgregor ward but staff told us there was one planned for June 2016. There was a surgical paediatric pain audit undertaken in 2012 by the anaesthetic department with a re-audit planned for later in 2016.
- There was no nationally recognised pain scoring tool in use on SCBU. Oral sucrose and non-nutritive sucking was used for all painful procedures. Paracetamol and morphine was used when babies did not respond to the oral sucrose. Staff told us they would assess babies' pain on cues from baby such as agitation and crying.
- We saw topical anaesthetic creams applied at an appropriate time before planned operation time, to reduce any pain experienced by the child when commencing an operation. We saw these creams applied to children's hands in the phlebotomy clinic prior to having blood taken.
- The 2014 CQC Children and Young People's Survey the trust scored 87% which was similar to other trusts for parents believing that the hospital staff did everything to help ease their child's pain.

Competent staff

- Appraisal rates for Macgregor ward was 89% and 80% for SCBU against the trust rate of 85%.
- There were regular teaching sessions for junior doctors. For example, we observed a session on neglect which went through the different categories of neglect with narratives, photos, growth charts, evidence and examples of personal experience in identifying and treating neglect.
- The service had introduced a paediatric nurse facilitator (PNF) to support students on placement on the paediatric ward and was introducing the role of an advanced paediatric nurse practitioner (APPN) role in line with the paediatric strategy; one staff nurse was currently on the course.
- Approximately a third of registered nurses on Macgregor ward had undertaken high dependency training. All registered nurses on SCBU were qualified in neonatal intensive care.
- Work was on-going to develop paediatric development days for newly qualified staff involving acute and community teams' placements.
- In June 2014, the acute paediatric department had a very positive quality assurance visit from the West Midlands Deanery. This looked at both the supervision and training of postgraduate trainees, and safety of patient care within the department.
- Elective paediatric general surgery was undertaken by two general surgeons with a declared paediatric surgical interest who conformed to recommendations of the Children's Surgical Forum and underwent revalidation by attending a recognised course at the Royal College of Surgeons (common elective and acute problems in general surgery) every three years. One of the surgeons was an Advanced Paediatric Life Support (APLS) instructor.
- The three ENT surgeons undertook relevant and regular continuing professional development (CPD) on recognised courses such as, the Paediatric ENT Skills Course for consultants run by ENTUK or the Leicester Paediatric Skills Course for consultants.
- The majority of anaesthetists attended internal CPD through monthly audit meetings and over 50% were

either APLS or European Paediatric Life Support (EPLS) trained. All second tier resident doctors had APLS training which meant that an adequately trained member of staff was always on duty.
- All anaesthetists were encouraged to rotate through paediatric lists to ensure they maintained competence in the care of children and so all anaesthetists contributed to paediatric elective lists in order to maintain skills.
- 65% of all operating department practitioners (ODPs) had paediatric life support (PILS) or equivalent. Plans were in place to ensure that all ODPs had PILS by the end of the year to ensure that outside of 'Paediatric Fridays' there would always be a staff member available trained in paediatric life support. Paediatric Fridays were days when dedicated paediatric surgery took place.
- 80% of the recovery staff were PILS trained and 100% had recovery competences.
- Of the 30 staff on Macgregor ward, 11 were PILS trained and three had extended PILS training.
- Student nurses told us there was a 'buddy' system to support their learning and they felt very supported. They told us 'it was a cosy team, nice atmosphere and all staff support one another'.
- In the 2014 CQC Children and Young People's Survey the trust scored 85% for the question (asked to parents of children aged 0-15 years): "Did you feel that the staff looking after your child knew how to care for their individual or special needs?" which was the same as other trusts.

Multidisciplinary working

- The service had introduced joint meetings with the ED and paediatricians to focus on the emergency patient experience and liaison with ward and community paediatric teams.
- Meetings were also held with paediatric consultants, registrars and senior nursing staff to ensure there was a robust multidisciplinary approach to problem solving, meeting challenges and taking the service forward.
- A critically ill child group was established in the trust involving staff from the ED and paediatrics which was chaired by the director of nursing.
- There were regular informal meetings with community staff facilitating robust links with community colleague.
- All babies with special needs were referred to the integrated disability team which consisted of speech and language therapy, occupational therapy, dietetics, physiotherapy and a consultant paediatrician.
- Dietitians attended all clinics for children with diabetes and also undertook individual annual reviews of all children using this service. A psychologist would attend most diabetes clinics but not all and also undertook annual reviews.
- There were no joint medical and nursing handovers and consultant ward rounds took place at 9am daily.

Seven-day services

- The service used the 'NightHawk' imaging system for overnight imaging if required.
- There was access to pharmacy support seven days a week but there was no planned coverage of physiotherapists for the service. Dietitians, speech and language therapists could be accessed when necessary.
- There were two play specialists for Macgregor ward equating to 1.4 wte who worked flexibly over seven days but mainly work during the week. From the beginning of September 2015, the assessment liaison team (ALT) had implemented an extended shift system with Monday, Tuesday, Thursday and Friday cover from 9am and 8pm. Wednesdays were used for non-clinical activity, such as training and administration. On a Wednesday and also when there were particularly high numbers of referrals, the CAMHS locality teams provided the assessments.
- We were told the introduction of the ALT had enabled the team to complete assessments earlier, mostly on the day of referral and had enabled young people to be assessed in the ED, facilitating discharge there without the need for an admission to the ward.
- An out of hour's telephone consultation service had been implemented for the use of the trust. The ED and paediatric ward could access an ALT clinician from the hours of 9am and 9pm on Saturday, for advice with regard to young people where it was unclear whether admission was appropriate or for advice about risk management.

Access to information

- We saw staff accessing the intranet for information on policies and guidelines. Medical and nursing staff told us it was easy to access the system for information.

- Medical staff told us blood results could be accessed on the trusts electronic system and if they wanted the results more urgently they would ring the haematology department directly.
- The paediatric diabetes team were implementing a Diasend service which would enable staff to contact children with diabetes and their families using technology and mobile phone apps for monitoring and managing their diabetes remotely. This would also provide an information server for the paediatric diabetes team. The equipment was being purchased through charitable funds.

Consent

- There was a trust policy for consent to examination or treatment dated November 2014. This included 'children under 16 years old – the concept of Gillick competence.' 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.

The service had not audited its adherence to the consent policy recently. The last clinical audit on child consent for treatment (surgery) was completed approximately 18 months prior to inspection. An audit into paediatric consent for general surgery was planned for August 2016. We were told this audit would be supported by the general surgery consultants and the clinical audit department.

- Mental Capacity Act 2005 training was included in the safeguarding training.

Are services for children and young people caring?

Good

We rated the service as good for caring because:

- Feedback from parents and children were positive. Children and young people were treated with dignity, respect and kindness. Parents felt supported and told us staff cared about them and their children.
- Parents were communicated with and received information in a way that they could understand. Parents and some children and young people understood their care, treatment and condition.

Compassionate care

- All children and young people, along with their parents we spoke with were positive about their child's care. Cards and comments displayed across the service, without exception, told of the kindness and care children had received.
- We observed children and young people being communicated with by nursing and medical staff in a compassionate way. Curtains were drawn around patients to ensure privacy and dignity, and voices were lowered to avoid private and confidential information being overheard.
- The trust scored better than other trusts for seven questions relating to caring on the 2014 CQC Children and Young People's Survey. Four of these related to privacy, being listened to, understanding what was happening and friendly staff and were answers given by 8-15 year olds. The trust scored the same as other trusts for all other questions.

Understanding and involvement of patients and those close to them

- We saw evidence in the clinical notes that children and young people were involved in making decisions about care and treatment. Parents were involved with their child's care and decisions taken. Children were involved in their care whilst going through the care planning processed with their parents.
- One set of parents told us there were too many doctors on the ward round and they felt intimidated and unable to ask questions at that time.
- Children and young people and their parents told us explanations were given to both themselves and their parents were appropriate.
- In the CQC Children's Survey July 2014 the service scored 98% for parents saying staff answered questions before their child's operation or procedure in a way they could understand which was better than other trusts.
- The service also scored 93% for hospital staff telling parents or carers what would happen to their child

while they were in hospital and 97% for parents or carers being involved in decisions about their child's care and treatment. Both of these scores were better than other trusts.

Emotional support

- Children, young people and their parents told us they were well informed about their care and had their questions answered when needed.
- One parent told us they would always come to this hospital because 'it was smaller and more personal' and 'staff had time to talk with them', 'staff were kind and courteous'.
- In the NHS Children's Survey July 2014 the service scored better than other trusts for privacy (98%), being listened to (94%) and staff being friendly (100%).

Are services for children and young people responsive?

Good

We rated the service as good for responsive because:

- Services were planned and delivered in a way that was meeting the needs of the local population. The importance of flexibility, choice and continuity of care was starting to be addressed through their integrated paediatric services.
- Care and treatment was coordinated with other services and other providers.
- Facilities and premises were appropriate for the services delivered. Improvements were being discussed to enhance the services such as developing a PAU and increasing capacity for SCBU.
- The individual needs of children and young people were generally met. The DSU used for paediatric Fridays was a dedicated list for children. The areas were made child friendly with toys, books, computers and TVs. There was no dedicated adolescent area for older children.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Reported complaints were handled in line with the trust's policy. From January and December 2015 the service received four complaints, however, we saw no learning from these.

However we found:

- Not all children were seen or treated in dedicated clinics and operating theatres. The recovery area in the main theatres was not child friendly.
- Transition arrangements from child to adult services were limited within the service and needed further work.

Service planning and delivery to meet the needs of local people

- Staff told us there were some initial plans to introduce a PAU in order to become more responsive to the needs of the population but these plans had not been agreed and it was their perception there was no real thrust to get the plans into action.
- There was a Macgregor club which was ran by play specialists and nurses that offered the opportunity for children and parents to familiarise themselves with whole process of the hospital, operating theatres, using a range of audio-visual aids.
- We saw children and parents taken to the playroom on Macgregor ward on the day of surgery for this process to take place if they did not have the opportunity to attend the Macgregor club prior to the day surgery.
- Admissions to Macgregor ward for children aged 13 years and over was 19% but the ward did not have an adolescent area for older children throughout their stay. The service attempted to ensure there was same sex accommodation but this was not always possible which meant the privacy and dignity experience for young people may be compromised.
- There had been an overall increase in SCBU activity with a 28% increase in outpatient referrals since 2012/13, including an increase in referrals from GP practices within the Coventry CCG (26 referrals in 2012/13 compared with 105 referrals in 2013/14) and an increase in more complex transfers to tertiary centres.

Access and flow

- Children could access Macgregor ward via a GP referral, through the ED or via a midwife referral.
- The service had a paediatric liaison nurse who attended the ED, SCBU and Macgregor ward daily to ensure the ward was kept up to date with admissions.
- The service did not have dedicated rapid access clinics. However, patients who needed a rapid assessment could be seen on the ward by the on call consultant if necessary.

Services for children and young people

- The service met the RCPCH standards of 90% of children seen by a paediatrician or middle grade within four hours of admission and 100% seen within the first 24 hours.
- According to hospital episode statistics (HES) for children under one year of age 18% of emergency admissions were due to acute bronchitis, which was slightly more that the England average of 17%. For children from one and 17 years 12% of emergency admissions was due to a viral infection which was again slightly more than the England average of 11%.
- For patients under 12 months, the median length of stay for elective care was longer than the England average (one day compared to zero days), but shorter than the England average for non-elective care (zero days compared to one day). For one to 17 year olds median length of stay was the same as the England median for both elective care (zero days) and non-elective care (one day).
- The minutes of the finance and performance meeting in November 2015 discussed concerns with the long term sickness of a consultant resulting in eight new patient clinics being cancelled. It was unclear what the period of time this related to. Some of the consultant clinics had been provided by other members of the team and there was month on month variation with clinics not running due to consultant annual leave or being on call
- Activity information was discussed with the consultants with individual plans agreed to ensure contracted activity was delivered. Monitoring of sessions enabled gaps in clinic capacity to be identified and rectified in a timelier manner.
- The paediatric team provided general paediatric outpatient clinics and specialty clinics for asthma, epilepsy, allergy, cardiology, feeding problems, diabetes, endocrinology and neurodevelopment.
- From March 2015 and February 2016 98% of general outpatient paediatric referrals were seen within 18 weeks. This met the trust target.
- There were two and a half clinics provided each week for phlebotomy which took place on Macgregor ward on Mondays and Wednesdays with a GP drop-in clinic on alternate Fridays.
- Each clinic offered appointments to parents for children for all ages up to 16 years with the majority currently referred from outpatient clinics (approximately 75%). Parents contacted the ward directly to agree the appointment date and time. The age range was varied but had approximately 40% of patients aged three years and under. The clinic was provided by a specialist trained nurse and play specialist.
- There were appointments to suit the parents including a drop in session on Fridays, play specialists were available to distract and reduce anxiety along with experienced nursing staff expert in this procedure ensuring a quick procedure.
- Rates of patients who did not attend (DNA) clinic ranged from 12% to 16% which senior managers told us were possibly linked to bookings made at short notice. DNA rates were worse than similar trusts and the management team were looking at identifying best practice for managing DNA's in paediatrics.
- Actions had been identified to improve DNA rates. For example, patients with a long follow up period were periodically reviewed by the consultant with parents contacted to enquire if a follow up appointment was still required and the patient was discharged if not. A text message system was used for appointment reminders and there was a planned survey to parents on reasons for not attending appointments.
- From April 2015 and March 2016 there was approximately 980 children and young people operated upon across the trust. Alternate Friday mornings ('Paediatric Fridays') were used in the day surgery facility for a paediatric day surgery list. There were usually three or four lists containing four to six children on each list. The specialties were general surgery, ENT, dental, ophthalmology and orthopaedics.
- There were approximately 20% of children and young people who were operated upon on lists outside of 'Paediatric Fridays' which were accommodated in day surgery or main theatres with the patients nursed on Macgregor ward. These children were those who needed overnight stay or could not be accommodated on 'Paediatric Fridays'. This meant that patient experience may not be as good as they were treated alongside adult patients.
- The service had guidance on how to prioritise when booking children on a theatre list. For example, children attending as day cases would be prioritised before any in-patient operation and the youngest child was scheduled first giving optimum time for recovery prior to discharge.
- There were dedicated Monday morning lists for children requiring florescent x-ray procedures such as barium

swallows (a test to visualise the oesophagus) and micturating cystoscopies (an examination of the bladder and tubes attached to the bladder) and a Wednesday morning list for any ultrasound procedures to be carried out. These were undertaken by a consultant radiologist with an interest in children's services and nursing staff from Macgregor ward would accompany any children attending the Monday morning lists.

- There was a specified transition service within the paediatric diabetes service which had an agreed process for children moving from the paediatric diabetes service to the adult service. There were monthly shared transition clinics supported by both the paediatric and adult clinical teams for the children to attend where they were alternately seen by the paediatric and adult team members. Information transfer was also seamless as both the paediatric and adult diabetes team used the same patient management system.
- SCBU had an occupancy level of 48%. From April 2015 and March 2016 there were 293 admissions to SCBU with 40 transfers to a tertiary neonatal centre. From January 2015 and January 2016 there were 13 refusals (4%) to SCBU due to a lack of capacity.
- We were told there were 170 children admitted who had been coded with health related groups associated with mental health related issues. The service was unable to discern the number of those children who had been admitted solely because of no mental health beds in another trust being available. From April 2015 and March 2016 there were 18 adolescents admitted to Macgregor ward with a mental health condition which equated to 28 individual episodes.
- The CAMHS had developed an acute liaison team (ALT) for the assessment and management of children admitted with psychological problems to Macgregor ward. The ALT had significantly improved the children's experience by shortening the time to assessment with many assessments completed on the day the referral and also by improved liaison with local services following discharge from hospital.
- From the beginning of September 2015, ALT had implemented an extended shift system; with Monday, Tuesday, Thursday and Friday cover from 9am to 8pm. Wednesdays were used for non-clinical activity, such as training and administration.
- There were no protocols in place for HDU to transfer children to tertiary centres. Transfers were led by paediatric consultants and staff involved depended on staff available and the child's presenting symptoms. Kids Intensive Care and Decision Support (KIDS) a transfer service was used if available.
- An out of hour's telephone consultation service had been implemented for the use of the acute trusts. The ED and paediatric wards could access an ALT clinician from the hours of 9am to 9pm on Saturday, for advice with regard to young people where it was unclear whether admission was appropriate or for advice about risk management.
- The trust scored about the same as other trusts on all questions relating to responsive in the 2014 CQC Children and Young People's Survey.

Meeting people's individual needs

- The DSU used for paediatric Fridays had a dedicated list for children. The areas were made child friendly with toys, books, computers and TVs. There was a dedicated adolescent area for older children throughout their stay. Children received bravery certificates and parents were offered a snack box food and drinks whilst their child was in the operating theatre.
- The service could access a specialist nurse in learning disability from 9am and 5pm Monday to Friday. Children living with a learning disability were placed at the beginning of a theatre list to reduce any anxieties.
- The service had two paediatric diabetes nurses, a ward link nurse for children with respiratory conditions and a ward link nurse for children with complex needs to meet the individual needs of this group of patients.
- For children living with complex needs staff told us they would be guided by the parents for their individual needs. Community nurses would often attend Macgregor ward when there was a child with additional needs admitted to the ward. There was specialised equipment for those children who needed additional assistance with moving and handling, such as a hoist.
- 19% of admissions to Macgregor ward were for children aged 13 years and over. However, Macgregor ward did not have an adolescent area and there had been an increase in the number of children admitted to Macgregor ward with mental health issues. This did not pose a risk to this group of patients but it may affect the quality of their experience whilst staying in hospital.

- There were two nursery nurses who supported parents and staff with play opportunities for children and young people.
- The anaesthetic rooms in the operating theatres were not child-friendly and were very clinical. The recovery area had a decorated screen with a jungle-theme which was the only child friendly piece of furniture in the area.
- For those children staying for a longer period on Macgregor ward, where appropriate schools were encouraged to send in work for children to complete, supported by staff and parents as appropriate.
- There was no dedicated area on Macgregor ward for adolescents to spend time with young people of their own age. The playroom was furnished for younger children.
- Visiting was open. In specific and exceptional cases this was at the discretion of the nurse in charge. There were convertible chair beds by each child's bed for parents to stay overnight if necessary. There was a coffee room adjacent to the main ward for parents and carers to use at any time. There was a quiet room outside of the Macgregor ward for use by parents if needed.
- A television, microwave, fridge, tea and coffee making facilities were available. The ward was situated very near the hospital shop and canteen and parents could bring food and cold drinks back to the ward area. The environment was quiet.
- Breast feeding mothers were offered food from the children's meal trolley. There was a reduced parking rate for patients admitted for longer than a week. The service had Wi-Fi that could be accessed by children and parents.
- SCBU offered donor expressed breast milk to mothers where infrequent demand was required. This was a service whereby milk was donated by mothers who were established breast-feeders and find they had extra milk to their own baby's needs which could be used for mothers who had difficulty in breast feeding.
- Staff ensured parents accessed information leaflets on clinical conditions which were widely available throughout the service. Parents we spoke with told us they had information they needed to inform them about their child's care.
- There was no patient information available in other languages but there was access to translation services if needed.
- The hospital chapel and chaplaincy service was available for patients and parents.

Learning from complaints and concerns

- Reported complaints were handled in line with the trust's policy. Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint.
- We saw literature for children to use if they wanted to make a complaint and we saw literature and posters displayed on Macgregor ward, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- From January and December 2015 there were four complaints had been received, two about Macgregor ward and two regarding paediatric clinics. These related to communication issues and had been resolved in a timely manner. We saw no evidence of learning from a complaint within the service.
- We spoke with parents and their children who all knew how to make a complaint. None of the patients we spoke with had any complaints.

Are services for children and young people well-led?

Requires improvement

We rated well led as requires improvement because:

- The arrangements for governance and performance management did not always operate effectively. Governance arrangements were fragmented with no one person responsible for children and young people's services.
- It was unclear who had the overall oversight of care for neonates, children and young people.
- It was unclear who was accountable and leading the implementation of the integrated paediatric strategy (2014-2019) that included both acute and community provision of services.
- Not all risks we identified on the risk register.
- We found limited evidence of public engagement.

However we found that:

- The vision, values and strategy had been developed through a structured planning process with regular engagement from internal and external stakeholders, commissioners and others.
- Staff in all areas knew and understood the vision and values. Staff felt well supported and felt they were well managed.
- Staff told us the executive team were visible and the chief executive was very approachable, believed in the staff and ensured staff were motivated.
- There were dignity promises and the ward philosophy displayed on the ward and staff could tell us about these and what it meant to them.

Vision and strategy for this service

- The service was part of the integrated paediatric strategy (2014-2019) that included both acute and community provision of services. The strategy was driven by a need to identify the increasing service demand and develop opportunities to integrate acute and community services to provide a more seamless service for children and their families. This was reviewed regularly and showed progress was being made on the strategy. However, it was unclear who was accountable and leading the implementation of the strategy.
- There was a paediatric implementation plan that would work in partnership with community and other public sector and voluntary organisations. There were four work streams which would underpin the strategy and included early intervention, in and out of hospital, life changing and transition.
- There was a project board which included an executive director, clinical leads, general managers, head of midwifery and allied health professionals.
- The strategy for the acute sector formed part of the joint care and acute care plans of the strategy. For the acute plans these included the review of space across the paediatric and SCBU areas, developing a PAU and review of staffing. The joint plans included the development of a children's mental health pathway, transition and integrated services and improving the care of children with complex needs.
- Staff in all areas knew and understood the vision and values.

Governance, risk management and quality measurement

- The governance arrangements across the children and young people's service were fragmented. The reporting arrangements were divided across the obstetric service, the children's service and the surgical service, with no one service leading for children and young people.
- There was a newly appointed peadiatric services clinical lead for governance that was starting to make changes to the governance arrangements. The service was developing a clinical governance subgroup to work with the divisional clinical governance group in order to bring the governance arrangements into one area. This was work in progress. This was not acknowledged on the risk register as a risk.
- The clinical lead for paediatrics attended the Safety Audit and Governance in the Emergency Division (SAGE) meetings with the ED and provided a report on paediatric issues once every six months. At the last meeting in January 2016 children's issues were presented as a verbal report and as such there were no minutes in the report.
- We viewed six months of the trust board papers and found children and young people's services had not been presented within that period.
- We viewed three sets of minutes from the Elective Care Divisional Audit and Operational Governance Group (October and November 2015, and January 2016) and saw children's elective care was not discussed.
- There was a critically ill child group chaired by the director of nursing and a paediatric /ED liaison group which was newly set up. It was unclear how all these were part of the wider children and young people's service.
- The service had a risk register which was reviewed and updated monthly. However, there were two risks included for children and young people. For example, SCBU had one risk which related to the lack of storage space on the unit. The risk had been recently reviewed and staff had been requested to be more diligent about storage.
- Macgregor ward also had one risk on the register which related to the lack of CAMHS provision which was being addressed.
- Whilst staff raised concerns about medical and nurse staffing levels these were not on the register. Staffing levels had been on the risk register previously but had

been taken off. However, we found there was no evidence of a negative impact on the care and treatment children and young children received as a result of staffing levels.
- Senior staff told us they felt there was an underreporting of incidents and were starting to look at the reasons why this was the case. However, we found no evidence of underreporting. There were medical incident meetings which did not include nursing staff. This was an area they felt needed improving.
- Mortality and morbidity meetings occurred monthly. The data was monitored by the divisional team and reported to the trust mortality surveillance committee and the trust board.

Leadership of service

- The children's service was part of the emergency directorate and managed by the women and children's services. The directorate was led by an associate clinical director, an associate general manager and three clinical leads for maternity, paediatrics and neonates.
- Senior managers we spoke with appeared knowledgeable about children, young people and their families' needs, as well as their staff needs. They were dedicated, experienced leaders and committed to their roles and responsibilities.
- For reporting purposes paediatrics had its own management structure and SCBU was part of the obstetric management structure.
- It was unclear who had the overall oversight of care for neonates, children and young people. For example, the paediatricians could not describe how surgery was managed and pointed us to the surgical division for information about surgical rates and admissions. The surgical team were unaware of the paediatricians' workload and neither the surgical team nor paediatricians could describe how the care of children was shard across the disciplines. After the inspection the trust told us that the Head of Midwifery had oversight of the service in the hospital.
- Staff told us the executive team were visible and the chief executive was very approachable, believed in the staff and ensured staff were motivated.
- Local team leadership was well established and effective and staff said their team managers were supportive.
- Staff told us management at ward level was good, they felt well informed and supported.
- There were band 6 nurse away days and role development for future senior nurse leaders in the ward environment.

Culture within the service

- There were dignity promises such as ensuring patients had their privacy protected and ward philosophy displayed on the ward corridors for staff and visitors to see. Staff could tell us about these and what it meant to them.
- Staff told us about the support they received when a child had died. Staff found this to be extremely helpful and gave them the opportunity to talk about their feelings in order to be able to move on from the experience.
- Staff we spoke with said they felt confident that if they needed to report serious concerns following the service's whistleblowing policy that they would be listened to.

Staff engagement

- Staff were engaged and committed to deliver high quality care.
- A newsletter was circulated to nursing staff to ensure effective communication there were trust wide newsletters and opportunities for education and development.
- The chief executive had a 'Rumour Mill' which was accessed on the intranet and included questions which were anonymised from staff for the chief executive to answer.

Public engagement

- There was a Macgregor club which was ran by play specialists and nurses that offered the opportunity for children and parents to familiarise themselves with whole process of the hospital, operating theatres, using a range of audio-visual aids.
- The public were engaged and the service received donations to improve the environment. The Friends and Family Test results was taken seriously with plans to improve where necessary.
- We found limited evidence of other public engagement or children, young people or their parents being involved in designing and running of their service.

Innovation, improvement and sustainability

- The paediatric team had a project working directly with clinical teams to focus on improving patient pathways and the patients experience using service improvement methodologies. The Health Foundation and Sheffield Teaching Hospitals Foundation Trust programme supported the service by training and developing two coaches, one a clinical coach who was a paediatrician on the team and a flow coach who was an operational manager from outside the division to work with the paediatric medical and nursing team to test improvements to the patient pathways using a bottom up approach.
- The level of detail operating theatre staff had gone into in developing guidelines and information on anaesthesia and general intensive care for children in paediatric day surgery. Information on anaesthesia, pre and post operation, analgesia and specialty specific procedures were clear and succinct. Other areas included the involvement of families, information for recovery staff, drugs and equipment and specific roles and responsibilities for each member of staff.

End of life care

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

Information about the service

South Warwickshire NHS Foundation Trust (SWFT) provides a range of services to a population of over 270,000 people in South Warwickshire and the surrounding areas. The largest population centres are the towns of Kenilworth, Royal Leamington Spa, Southam, Stratford-upon-Avon and Warwick. Acute care is provided at Warwick Hospital.

End of life care is delivered on most wards in the hospital, as there are no dedicated wards for the provision of end of life care.

There have been 788 deaths in the trust's hospitals from April 2014 and March 2015.

In addition, significant numbers of patients were cared for in the trust at some time during the last year of their life.

The hospital specialist palliative care team had received 393 referrals from April 2014 and March 2015. 306 (77%) of those referred had a diagnosis of cancer. 87 (23%) of those referred had a non-cancer diagnosis.

The palliative care nurse specialists (PCNS) at Warwick Hospital provided expert clinical advice and support for patients with complex palliative care needs and their families and carers. They worked in partnership with GPs, integrated health teams, other community services and providers.

The PCNS role included:

• Assessment and care planning for patients with complex palliative care needs.

• Information on disease process, treatment, medication, local and national services.

• Advise on symptom control.

• Psychological support for the patient and / or their carer.

The palliative care consultant took referrals from the SPC team based on the complexity of the patients' needs and worked in an advisory capacity with consultants in other specialities

There was a chapel, a multi faith room, and a mortuary and bereavement office at Warwick Hospital.

Before our inspection, we reviewed performance information from and about the trust. During our inspection, we spoke with two patients and three relatives. We also spoke with over 30 members of staff, which included; the specialist palliative care team (SPCT), mortuary staff, chaplains, nursing staff, medical staff, bereavement officer, resuscitation officer and porters. We observed care and treatment and looked at care records and 32 Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) forms. We received comments from our listening event and we reviewed the trust's performance data.

End of life care

Summary of findings

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

- The trust did not have a clear vision or a strategy for end of life care services; however they had recently appointed a full time consultant with the remit of developing a strategy.
- The end of life care service did not have effective processes in place to measure their effectiveness and outcomes.
- There were no formal arrangements to cover the acute palliative care consultant post when they were on leave.
- Mental capacity assessments around decisions about do not attempt cardio-pulmonary resuscitation (DNACPR) in was only evident in 66% of patients' records
- The acute SPCT had not completed an audit of patients who had been discharged to their preferred place of dying. This meant, because it was not recorded, this information could not be used to improve or develop services.
- The acute SPCT trust did not collect information of the percentage of patients that had been discharged to their preferred place of death within 24 hours. Without this information, they were unable to monitor if they were meeting patients' wishes and how they could make improvements.
- The trust had in place a replacement for the Liverpool Care Pathway (LCP) called the Individual Plan of Care for the Dying Person. However, its use was not firmly embedded in the trust's culture.
- The directors identified to provide representation for end of life care services at board level, did not attend end of life care meetings.
- The trust did not have a non-executive director who provided representation of end of life care at board level, which is a recommendation of the National Care of the Dying Audit of Hospitals.
- The leadership team was not able to evidence that they were knowledgeable about quality issues therefore were unable to take actions to address them.

However we also found:

- Relatives and patients spoke positively about end of life care. Staff provided compassionate care for patients.
- There were arrangements to minimise risks to patients with measures in place to safeguard adults from abuse, prevent falls, malnutrition and pressure ulcers and the early identification of a deteriorating patient through the use of an early warning system.
- Patients received good information regarding their treatment and care. The service took account of individual needs and wishes and patients' spiritual needs.
- The bereavement support staff provided good support to relatives after the death of a patient.
- The hospital had a rapid discharge service so that patients could be discharged to their preferred place of care.

End of life care

Are end of life care services safe?

Good

We rated end of life care services as good for safety because:

- Care records were mostly maintained in line with trust policy.
- DNACPR records had been signed and dated by appropriate senior medical staff and there was a clearly documented reason for the decision recorded, this included relevant clinical information.
- The staff within the end of life care service understood their responsibilities for following safeguarding procedures and making sure patients were protected from the risk of harm from abuse. When something went wrong, patients received a timely apology. The service had systems in place to recognise and minimise patient risk and we saw evidence that learning from incidents had been implemented within the service.
- Equipment, for example syringe drivers, were visibly clean, well maintained and fit for purpose. There were mechanisms in place to ensure that equipment was regularly checked.
- Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients who were at the end of their life.
- Infection prevention and control policies, including care after death (last offices) procedures were clearly embedded and followed by staff.

However we also found:

- Staff were unaware of any formal arrangements to cover the acute palliative care consultant post when they were on leave; however the trust told us this was provided by the community palliative care consultant. This meant there was a risk that patients with symptom complexities that were beyond the expertise of the SPCT nurse led service would not be referred to the community palliative care consultant as staff were unclear about the cover arrangements.
- The trust employed two full time palliative and end of life care consultants. This did not meet National Guidance for Specialist Palliative Care, helping to deliver commissioning objectives (December 2012).
- Staff did not always follow the trust's policy about storage of the individual plan of care for the dying person document as this was not always stored in front of medical notes.
- The porters' compliance with safeguarding vulnerable adults training was 18%.
- The mortuary building and equipment were dated and did not comply with health and safety regulations, however, where the areas were deemed not to be compliant, the service had completed a risk assessment and put actions in place to address them.

Incidents

- Staff we spoke with in the specialist palliative care team (SPCT), mortuary and chaplaincy team understood their responsibilities to record safety incidents, concerns and near misses. They understood how to report them using the trust's electronic reporting system the system to collect and report incidents.
- There were no reported serious incidents or never events attributed to end of life care from October 2014 to September 2015. (A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- A review of incidents identified by the service from January to September 2015, revealed there was one medication incident reported, when a syringe driver was not available. There were nine incidents under the category of communication failure. There was also one incident of delayed discharge which had been recorded during this time period.
- During the inspection, we saw that there was evidence of learning from events and incidents. These were discussed at the weekly multi-disciplinary meeting and we saw evidence or a discussion about how the team could improve communication with their patients in meeting minutes. Staff we spoke with told us they received direct feedback relating to incidents.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and

requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- Staff we spoke with in the hospital and mortuary was aware of their responsibilities and principles with regard to Duty of Candour regulation. They were able to provide examples of when an incident had occurred and how they had informed the patient or their relatives of the incident, made an apology and explained how the trust had responded to the incident.

Safety thermometer

- The NHS Safety Thermometer is a point of care survey carried out on 100% of patients on one day each month for measuring, monitoring and analysing patient harms, and the amount of patients who are harm free from pressure ulcers, falls, urine infections (in patients with a catheter).
- There were no dedicated wards for the provision of end of life care at Warwick Hospital. The trust used the NHS Safety Thermometer information, which was ward specific and did not directly relate to the care of the end of life team.

Cleanliness, infection control and hygiene

- The SPCT and mortuary staff were aware of their roles and responsibilities with regard to infection control. They wore clean uniforms with arms 'bare below the elbow' in clinical areas. We saw staff wearing the correct personal protection equipment (PPE) such as gloves and aprons according to the trust's protocol. We observed PPE to be accessible in the mortuary, and on the wards we visited.
- Porters we spoke with said that they were aware of the PPE protocol for the mortuary and said they were able to access and dispose of the necessary equipment as required.
- The mortuary area was visibly clean. We saw daily cleaning checklists available for completion by staff as they cleaned each area. We saw that these were completed routinely and in a timely manner, which provided the trust with assurance that the areas were cleaned regularly, and within a specified time scale.
- Trust infection control guidelines were available to the mortuary staff on the intranet. There were standard operating procedures for managing infectious diseases, which complied with Health and Safety Executive (HSE) Safe Working and the Prevention of Infection in the Mortuary and Post-Mortem Room (2003). The trust provided us with their policy for guidance for care after death in hospital (last offices) procedure. This procedure had been compiled in accordance with the NHS England's Actions for End of Life Care (2014). As part of the last offices procedure (the process where the body was prepared for transfer to the mortuary) nursing staff completed a mortuary admission form. This form included information about actual or potential infections and ensured the porters and mortuary staff were made aware of any infection risks. Ward staff we spoke with, were aware of the procedures to be taken when performing last offices, in order to minimise infection risks.
- The mortuary had sufficient facilities for hand washing, bins for general and clinical waste, and appropriate signage.
- We saw evidence of PPE audits being carried out in the mortuary. There were no concerns raised about availability or usage of PPE by staff.

Environment and equipment

- Equipment was usually available to meet patient needs, for example, syringe drivers and pressure relieving equipment.
- The trust used one type of syringe drives as recommended by the National Patient Safety Agency (NPSA). There was a comprehensive education programme for all nursing staff in the use of this syringe driver. Syringe drivers we saw in use had been set up correctly and were used appropriately.
- The trust provided us with a robust up to date maintenance schedule and up to date asset list of syringe drivers. This included the next service dates.
- The mortuary at Warwick Hospital was equipped to store 51 deceased patients in body storage units (fridges). There were no long-term storage (freezer units). Long-term storage facilities were available in other local hospitals. Three of the fridge spaces were suitable for bariatric patients with specific storage and concealment trolleys to accommodate them.
- Staff told us on occasions, the current facilities were not sufficient to meet the needs of the hospital and local population. The service had purchased temporary storage, which provided 12 extra spaces. There were

plans in place for a full refurbishment of the mortuary, to take place during the summer of 2017. This was to include a larger capacity to accommodate up to 80 deceased patients.

- The temperature of the mortuary fridges was recorded on a daily basis. The fridges were alarmed with alerts which were directed to on-call mortuary staff via the main reception, should the temperature fall outside of the normal range. The mortuary department had a 24-hour seven-day, service level agreement should urgent repair be required.
- We saw that the mortuary staff audited the accommodation and environmental conditions in the mortuary. The mortuary building and equipment, did not comply with health and safety regulations and Health Technical Memorandums (HTM). Where the areas were deemed not to be compliant, the service had completed a risk assessment and put actions in place to address them. It had been identified in 2013, that the accommodation and environmental conditions were dated. Therefore, concerns identified by this audit process had been longstanding. For example:
  - Infection prevention and control issues with regards to transference of bacteria.
  - The age of flooring within the post mortem room, which meant there were slip and trip hazards.
  - Inadequate drainage.
  - Poor moving and handling into and out of the fridges, to the post mortem room and onto and off the post mortem tables.
- The risks regarding the mortuary were identified on the support services risk register. There were plans in place to redesign the mortuary in 2017 that would address the issues identified on the risk register. In response to this, the trust had set up a refurbishment project group, inviting all the department leads, including the moving and handling lead, to be involved in a proposal to refurbish the mortuary facilities. Monthly meetings had been taking place and were recorded on the trust's electronic reporting system. We saw interim measures were in place to reduce the risks so far as reasonably practicable.
- The mortuary was compliant with the annual human tissue authority (HTA) self-assessment completed in June 2015. The HTA were due to visit the mortuary in June 2016, to carry out their routine (three-yearly) assessment.
- There was a chapel and a multi-faith room on site. These were quiet spaces where people could pray or reflect. There was a book for people to write their prayer requests in. The chapel and multi-faith room were open 24-hours a day and were used by patients, relatives, carers and staff. There were also regular services held in the chapel.

Medicines

- There was a guidance document for prescribing palliative medication and for use of anticipatory medication at the end of life. Anticipatory medications refers to medication prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life, so that these medicines can be given if required without unnecessary delay. The document provided guidance on general principles for prescribing medicines for the dying patient, for example:
  - Management of nausea and vomiting.
  - Management of respiratory tract secretions.
  - Management of pain using diamorphine.
  - Management of restlessness and agitation.
  - Use of opioids for pain and shortness of breath.
  - Use of continuous subcutaneous infusion (syringe driver medication).
- We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines.
- Two medication charts were reviewed and there was evidence that there were arrangements for managing medicines, to ensure the patients were given the right drug at the right time. Ward staff demonstrated good symptom management knowledge.
- The medicines for patients receiving palliative care were stored in the clinic room in each ward area. There were no medication incidents reported for patients at the end of life from July 2015 and September 2015.

Records

- Medical records were stored in lockable cabinets. The cabinets were not always locked when we visited the

ward. However, the cabinets were stored behind the nurses' workstation, which reduced but did not eradicate the risk of people who did not have appropriate authority accessing the notes.

- Staff did not always follow guidelines with regards to storage of the individual plan of care for the dying person document. The trust policy stated that this document should be kept in the front of the patient's medical record; with a blue sticker in the nursing notes to alert staff who were providing care that the patient had this document in place. We saw that the individual plan of care for the dying person document was not always stored in front of medical notes. We reviewed ten sets of notes and saw that only one set of nursing notes contained a blue sticker. This meant that the practice of ensuring the care plan was used was not embedded and there was a risk that not all staff would be aware that the patient had an individual plan of care for the dying person document in place.
- The care records and care plans we looked at, were written in line with trust policy. In medical notes for patients approaching the end of their lives, we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment, whilst still supporting the patient and their families.
- There was no electronic recording system for end of life care patients in use, although staff had been involved in the development of an electronic palliative care co-ordination system. The start date for the implementation of this was anticipated to be during 2016 although a specific date had not been identified at the time of the inspection. The End of Life Care Strategy (2008) identified the need to improve co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations. The development of electronic palliative care co-ordination systems was identified as a mechanism for enabling this co-ordination.
- We saw the do not attempt cardiopulmonary resuscitation (DNACPR) forms were stored in green plastic wallets (known as green sleeves) at the front of the patients' notes. This meant the forms were easy to identify.
- We reviewed 32 DNACPR forms across all ward areas and the emergency department. All the forms we reviewed were signed, dated and were countersigned within 24 hours, according to trust protocol. All forms reviewed included a summary of why CPR was not in the patient's best interests. This was in accordance with the trust's policy guidance.

Safeguarding

- There had been no reported safeguarding concerns relating to patients receiving end of life care from October 2014 and September 2015.
- There were arrangements in place to safeguard adults and children from abuse. Staff told us they understood their responsibilities and adhered to safeguarding policies and procedures. Staff were able to tell the inspection team what signs of abuse were, and how to locate the trust policy. In addition, staff were able to identify their responsibilities with regard to reporting safeguarding concerns.
- All hospital staff had to undertake safeguarding training for both children and adults. The level of training required was determined by the staff member's role.
- The trust's target for all safeguarding training was 95%. However, only the chaplaincy team were compliant with this target. This meant the trust could not be assured that the staff within the SPCT had the necessary knowledge and skills required.
- 75% of the SPCT were compliant with safeguarding children training level one and two and safeguarding vulnerable adults. The SCPT did not require to safeguarding children's training at level three.
- 100% of the chaplaincy team were compliant with safeguarding children training level one and vulnerable adults training.
- A separate facilities management company employed the portering staff. Their compliance with safeguarding vulnerable adults training was 18%.
- Another local provider employed mortuary staff therefore their training records were not held by the trust. The trust did not have oversight of this information. However, staff we spoke with were able to identify their responsibilities with regard to reporting safeguarding concerns and how to locate the trust policy.

Mandatory training

- We examined the training records for the SPCT and found mandatory training compliance was below the

trust target of 85% (95% for information governance). This meant the service could not be assured the staff had the necessary knowledge in these areas, fire (75%), infection control (75%), life support (75%), and health and safety (75%). However, compliance with moving and handling, conflict resolution, equality and diversity and information governance training were all above the trust target at 100%.

- The chaplaincy team mandatory training compliance was below the trust target (85% and 95% for information governance) for fire (83%), information governance (83%) and conflict resolution (83%). However, above the trust target for infection control (100%), life support (100%), health and safety (100%), moving and handling (100%) and equality and diversity (100%).
- Portering staff were employed by a facilities management company. The mandatory training compliance for porters was: moving and handling 67%, infection prevention and control 77% and health and safety compliance was 77%.
- The SPCT provided an awareness training session on the care of dying patients, for all nursing staff as part of their mandatory training.

Assessing and responding to patient risk

- We reviewed the healthcare records of ten patients and saw that risk assessments were in place relating to moving and handling, risk of falls, pain control and risk of skin damage, and they were reviewed at the required frequency to minimise risk. We saw actions were documented to take place where risks were identified for example, the risk of developing skin pressure damage was assessed using the waterlow scale, meaning that patients who were at risk were nursed on pressure relieving mattresses.
- Ward staff told us that patients requiring end of life care were identified at a daily board round which was a consultant led review meeting which had replaced the traditional ward round. This had been replaced due to confidentiality issues including risk of other patients over hearing discussions.
- Once the need for end of life care was identified, the ward team would commence the amber care bundle (ACB) or the individual plan of care for the dying person individual plan of care for the dying person document and refer the patient to the SPCT. The ACB was a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the patient die. It consists of four elements:
- Talking to the person and their family to let them know that the healthcare team has concerns about their condition.
- Establishing their preferences and wishes, deciding together how the person will be cared for should their condition get worse.
- Documenting a medical plan.
- Agreeing these plans with all of the clinical team looking after the person.
- The plan agreed as part of the ACB was implemented in the event of any level of deterioration of the patient's condition. The patient could either be transferred to the intensive care unit (ITU), be given further treatment at ward level or have their care managed using an individualised care of the dying document. We were told uptake of use of the Amber Care Bundle was increasing but work was needed to ensure all staff were aware of the ACB and used it when necessary. Staff told us they were working to increase the skills around the identification of the dying patient. The service told us that use of the individual plan of care for the dying person document within the hospital was also increasing. The service was not routinely auditing use of the individual plan of care for the dying person document so were not able to evidence this perception.
- We saw in one case, a patient had both an ACB and an individual plan of care for the dying person document in place. Patients' care should only be supported by one document, not both, which indicated use of the individual plan of care for the dying person document was not embedded within the trust.
- Ward staff told us they referred to the SPCT for guidance and extra advice on symptom control. They made telephone referrals to the team. Ward staff stated they found the SPCT to be helpful and responsive. One staff member provided an example of how the SPCT had assisted a patient who was receiving care in a non-local hospital to return home urgently.
- We saw that the trust used the National Early Warning Score (NEWS) assessment tool for ensuring that deteriorating patients were identified and treated appropriately. The assessment tool scored each patient

according to their blood pressure, pulse, respirations and conscious status, it prompted staff to follow clear procedures, should a patient's vital signs fall out of expected parameters. This meant that there was a system in place to monitor patients' risk of clinically deteriorating, including those patients receiving end of life care.

- DNACPR records had been signed and dated by appropriate senior medical staff and there was a clearly documented reason for the decision recorded, this included relevant clinical information. In the majority of cases, discussions with families were documented in the medical notes.

Nursing staffing

- The SPCT had two full time and one part time palliative care clinical nurse specialists (PCNS) that provided 2.6 whole time equivalent (WTE) cover. This met the National Guidance for Specialist Palliative Care, helping to deliver commissioning objectives (December 2012).
- The SPCT had a practice development clinical nurse specialist (CNS) who did not hold a clinical caseload. This role was to raise both awareness and the profile of end of life care, as well as providing education to the end of life team and across the trust.
- The acute SPCT team were available 9am until 5pm Monday to Fridays. The acute end of life care nurses supported by community based end of life care clinical nurse specialists colleagues provided an on call service on Saturdays, Sundays and Bank holidays from 9am until 5pm.
- 95% of wards had an identified end of life care champion or link nurse who had received additional nationally recognised training. This enabled them to identify patients who required end of life interventions. They acted as a first point of contact for advice to other nursing staff on their ward.

Medical Staffing

- The trust employed two full time palliative and end of life care consultants. One consultant was based at Warwick Hospital and the other was based in the community. This did not meet National Guidance for Specialist Palliative Care, helping to deliver commissioning objectives (December 2012). This guidance stated that for every 250,000 people, the minimum requirements were two whole time equivalent (WTE) consultants in palliative medicine. In addition, the guidance stated there should be two WTE additional supporting doctors, for example a trainee or specialty doctor. South Warwickshire Foundation NHS Trust provided services to over 270,000 people, which meant that they did not have enough doctors to meet national guidance.
- The consultants from SWFT and other providers delivered advice about care for patients at the end of life via a 24 hour consultant advice line across Coventry and Warwickshire. Consultants also covered the third sector (which included a range of organisations such as voluntary organisations and community groups) provided hospice specialist palliative care beds out of hours.
- Staff were unaware of any formal arrangements to cover the acute palliative care consultant post when they were on leave, however the trust told us this was provided by the community palliative care consultant. This meant there was a risk that patients with symptom complexities that were beyond the expertise of the SPCT nurse led service would not be referred to the community palliative care consultant as staff were unclear about the cover arrangements.
- There had been no consultant in palliative and end of life care based at Warwick Hospital for 18 months prior to January 2016 when one was appointed. During the vacancy period, advice and support was provided by phone, by the community based palliative care consultants to PCNS and hospital staff.

Support Staffing

- The SPCT did not have designated administrative or secretarial support, occupational therapist or social worker.
- The mortuary team were employed by another local provider. The mortuary staff at Warwick Hospital comprised one full time locum mortuary technician**.** Additional staff were provided as the need arose. We saw that the mortuary management team used a staffing acuity tool to establish when additional staff were required. We saw evidence of extra staff being provided when needed.
- Porters transported the deceased from the hospital wards to the mortuary and provided out of hours access to the mortuary.
- The trust employed one full time bereavement officer, who was available Monday to Friday 9am to 5pm. The bereavement officer was part of the complaints and

patients advice and liaison team (PALS). This meant that when the bereavement officer was on leave, the staff from the PALS service were able to provide cover for their role.

- The chaplaincy team comprised three part time chaplains and 40 lay volunteer chaplains. The team leader was a Church of England chaplain, they and a second Church of England chaplain worked part time**,** Monday to Thursday and some Sundays. A Free Church chaplain worked within the hospital on Thursday mornings and a Roman Catholic chaplain worked at the hospital on Thursday and Sunday afternoons. Whilst there were times where there was no chaplain based in the hospital (Fridays and Saturdays), the chaplains provided an on-call service outside their working hours.

Major incident awareness and training

- The trust had a major incident plan in place. These listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident. SPCT staff were aware of this
- Mortuary staff were aware of contingency plans and their role within these. The policy stated that the mortuary staff member on-call would attend the site should there be a major incident, which required use of the mortuary. This was so that the capacity of mortuary storage facilities could be assessed.

Are end of life care services effective?

Requires improvement

We rated the service as requires improvement for effectiveness because:

- Whilst the trust did have a replacement for the Liverpool Care Pathway (LCP) called the individual plan of care for the dying person, the use of this document was not embedded in practice on all of the wards. The trust was aware that the care plan was not being used and had planned to review the document. This was discussed at the end of life operational group meeting held in February 2016.
- The service had introduced the amber care bundle (ACB) however, an audit of appropriateness of its use was not carried out or monitored.
- The service had not produced an action plan to address aspects of The Care of the Dying Evaluation (CODE) audit (March 2015) that required improvement.
- Not all patients identified as requiring end of life care were referred to the Special Palliative Care Team (SPCT). Ward staff told us that there were no formal referral guidelines for the SPCT. The SPCT told us, whilst there were referral guidelines in place, these had not been circulated to the wards.
- The SPCT had made progress with an audit programme following the appointment of a palliative care consultant to the acute trust in January 2016. However, any recommendations made were without timescales or action updates for these at the time of the inspection, therefore it was difficult for the service to evidence if actions were being completed and at what pace.
- Out of the 21 do not attempt cardio-pulmonary resuscitation (DNACPR) documents reviewed at Warwick Hospital, four did not have reference to the discussion about DNACPR with the patient or the relatives documented in the medical notes. Mental capacity assessments around decisions about DNACPR in was only evident in 66% of patients' records.

However we also found:

- Policies and procedures were accessible, and based on national guidance.
- Special palliative care team staff were competent in their roles and supported by some effective processes for ongoing professional development. Most staff had attended appraisals and group supervision.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The results were published after the inspection, in April 2016. We reviewed the trust's outcome post inspection. The trust achieved six out of eight of the organisational key performance indicators (KPIs) and scored better than the England average in four out of five of the clinical audit KPIs.
- Since January 2016, the service had started to complete a local audit of anticipatory prescribing to measure the effectiveness and outcomes of the service.
- 95% of wards had an end of life care link nurse who had received training specific to their role.

Evidence-based care and treatment

- Following the removal of the Liverpool Care Pathway (LCP) nationally in July 2013, the trust had developed,

with the regional strategic partnership group (made up of other end of life care providers in the region) a replacement. This was called the individual plan of care for the dying person and it aimed to provide guidance for healthcare professional supporting care in the last hours or days of life. It was in line with the priorities of care for the dying person document. The Priorities of Care for the Dying Person was published in June 2014 by the Leadership Alliance for the Care of Dying People. The five priorities were to recognise, communicate, involve, support, plan and do. Staff told us the individual plan of care for the dying person document stayed with the patient on discharge and was used by the community team. At the time of our inspection, we saw that the document was in use on the wards at Warwick Hospital. However, the SPCT reported that the uptake had been lower than they had anticipated. We did not see evidence that the document was embedded across the trust. We did not see the document in place in the community during the inspection. This demonstrated the lack of integration of the end of life services. The trust was aware that the care plan was not being used in the community and had planned to review the document. This did not appear to have been discussed in the six months of end of life monthly meeting minutes (ending February 2016), which had been provided. The acute SPCT had recently started the process of monitoring the use of the individualised care of the dying patient care plan and had identified how to target staff education to address this issue. Post inspection the service provided information from a snapshot audit of the use of the individual plan of care for the dying person. The audit period was two weeks (weekends excluded) commencing 29 February 2016. 20 patients were included in the audit. A completed individual plan of care for the dying person (IPCDP) was found in 16 (80%) patients' notes. The action from the information gained from the original snapshot audit was to see an improvement when audit was repeated in July 2016, after which the audit findings were to be included in the general end of life care teaching sessions.

- The service audited the numbers of amber care bundles (ACB) used, however it did not collate information on how appropriately it was used. Without this information, the team were unable to monitor if they were meeting patients' wishes and how they could make improvements.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The results were published after the inspection, in April 2016. We reviewed the trust's outcome post inspection. The trust achieved six out of eight of the organisational key performance indicators (KPIs) and scored better than the England average in four out of five of the clinical audit KPIs.
- The SPCT had written clinical guidelines for the prescribing of anticipatory for palliative care patients. The SPCT told us they had completed an audit of anticipatory prescribing. The audit period was two weeks (weekends excluded) commencing 29 February 2016. 20 patients had been included in the audit. The audit found 19 (95%) patients had anticipatory medicines prescribed but there was a substantial amount of variance from the guidelines. Following the audit the service devised an action plan to address issues identified, for example they planned to include audit findings in the general end of life care teaching sessions. They planned to review the prescribing of anticipatory for palliative care guidelines to ensure the document is clearly written to explain ranges and dosing and frequency, and to ensure the document is readily accessible to all, including on the junior doctor application (app) on smart phones, the intranet and on the wards in paper form. The team planned to work with the pharmacy team to ensure that all the ward pharmacists are fully competent and confident with the guidelines so that they can supervise and guide the prescribers on the wards to prescribe appropriately.
- The results of the care of the dying evaluation questionnaire (CODE) completed in March 2015 had been reported. The Care of the Dying Evaluation CODE (2013) is a post bereavement questionnaire developed by the Marie Curie Palliative Care Institute, that aims to assess the overall quality of care provided to patients in the last few days and hours of life and the level of support given to their families during this time. CODE results are not nationally bench marked, each service uses the information to identify areas of improvement for their own service. Of the 47 questionnaires were sent out to relatives of patients who had died at Warwick Hospital from December 2014 to February 2015, 19 were returned giving a 40% response rate. The themes identified from the feedback, related to communication, with a specific focus on recognising and diagnosing

dying and how and when this is communicated to families. Communication related to a patient's treatment, condition, managing expectations, and communication at the time of death and recognising support needs of individual families. The feedback received included:

- 78% of respondents perceived that nurses, and 67% perceived that doctors "always" treated their relative with dignity and respect in the last two days of life by nurses.
- 83% of respondents felt that they were adequately supported during this time.
- 67% "agreed" that the bed and surrounding environment had adequate privacy for him/her.
- 53% stated they had a discussion about what to expect when the patient was dying.
- 72% of those responding considered that their relative had died in the right place.
- 83% of respondents felt that the healthcare team dealt with them sensitively after the death of their relative.

- The service planned to repeat the CODE audit, but at the time of inspection, a date for the re-audit had not been decided.
- The service used SPICT (a guide to identifying people at risk of deteriorating health and dying) as part of the assessment of patients' prognosis. A snapshot audit of adult inpatients at Warwick Hospital (excluding pregnant or postpartum patients) was carried out in October 2015. The audit indicated that Warwick had a very elderly population. There was poor identification of patients who were likely to be in their last year of life and there was poor planning of long-term care for those patients. The findings recommended focussed training to promote the ACB, to disseminate the audit results in grand round, and to build a workgroup to identify barriers to advance care planning. The recommendations were placed on a draft end of life care action plan. There were no timescales or action updates for these at the time of the inspection, therefore it was difficult for the service to evidence if actions were being completed and at what pace.
- The trust did not participate in any national accreditation schemes such as the Gold Standard Framework (GSF). The GSF provided training in relation to end of life care and an accreditation scheme for trusts that consistently meet national guidance. The team told us there were no plans to introduce the GSF at the trust. We were told the trust was in the process of embedding the an accreditation scheme called Transforming End of Life care in Acute Hospitals programme, however during the inspection we did not see this impacting on patient care.
- The service had an audit programme in place for 2016, which aimed to monitor the effectiveness of the end of life care initiatives implemented across the trust over the past few months. Progress of the audit programme had been delayed due to staff shortage. Following the appointment of a whole time palliative care consultant to the acute trust in January 2016, the SPCT planned to progress the audit programme.

Pain relief

- The trust had a guidance document 'general principles for prescribing for the dying patient', for prescribing palliative medicines and guidance for the use of anticipatory medication (prescribed in anticipation of managing symptoms, such as pain and nausea, which are common near the end of a patient's life so that these medicines can be given if required without unnecessary delay) to patients at the end of their life. This met national guidance NICE Clinical Guidance 140 'use of opioids in palliative care'. We saw good evidence of appropriate prescribing, administration and documentation of medication.
- Pain relief was managed on an individual basis and staff told us pain relief was regularly monitored for effectiveness. An audit of pain relief management and symptom management had not been carried out. Without this information, they were unable to monitor if they were meeting patients' needs and how they could make improvements.
- The service did not use a specific pain measurement tool for patients living with dementia or with a learning disability.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to identify patients at risk of malnutrition and they were generally well filled in. It included management guidelines to be used to develop a care plan. The tool was used in line with recommendations from the British Dietetic Association (BDA) and Royal College of Nursing (RCN). Fluid balance and nutritional intake charts were completed and stored at the patient's bedside.

End of life care

- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in as much of the patient's care as was appropriate.
- We viewed guidance on the use of mouth care in the last days of life that included actions to be taken in the event of a patient having a dry mouth, coated tongue or pain or ulceration. Actions included the administration of mouth care when a patient was no longer able to eat and or drink. We observed staff providing mouth care during our inspection.

Patient outcomes

- The service contributed data about end of life care to the National Minimum Data Set. The National Minimum Data Set (MDS) for specialist palliative care services was collected by National Council for Palliative Care on a yearly basis. The aim of this was to provide an accurate picture of hospice and specialist palliative care service activity. Information collected included numbers of patients using the services, mean length of stay or care, demographic information such as gender, age and ethnicity, a breakdown of diagnosis, particularly in the case of conditions other than cancer and contacts between staff and patients and carers. There is no nationally published information on individual trusts available to review for 2014 to 2015.
- The resuscitation officer carried out routine annual DNACPR audits. The trust provided us with the data from a DNACPR audit carried out in November 2015. The resuscitation team had developed an action plan from the most recent documentation audit results. The action plan identified any commonly missed information such as date, hospital number and the specialty with most missed information. The resuscitation team fed back the audit action plan to each specialty and carried out targeted training sessions when necessary.
- The trust took part in the National Care of the Dying Audit of Hospitals (NCDAH) 2014- 2015. The results were published after the inspection, in April 2106. We reviewed the trust's outcome post inspection. The trust achieved six out of eight of the organisational key performance indicators (KPIs):
  - The trust sought bereaved relatives' views
  - In house training included communication skills training for care in the last hours or days of life for medical staff, registered and unregistered nursing staff and allied health professionals.
  - The trust had more than one end of life care facilitator.

However the audit also found that:

- There was not a lay member on the trust board with responsibility or role for end of life care.
- The trust did not provide face to face access to specialist palliative care 9am to 5pm, Monday to Sunday. This did not meet the recommendation from the NICE guidelines for 'End of life care for adults', which states "Palliative care services should ensure provision to: Visit and assess people approaching the end of life face-to-face in any setting between 9am and 5pm, seven days a week".
- Of the five clinical audit quality indicators assessed in the NCDAH 2014- 2015, the trust scored better than the England average in the following areas:
  - They had documented evidence within the last episode of care that it was recognised the patient would die in the coming hours or days, and this had been discussed with a nominated person important to the patient.
  - The trust had documented evidence the patient was given an opportunity to have concerns listened to and the needs of the person important to the patient were asked about.

However the audit also found that:

- The trust did not have documented evidence that a holistic assessment of patient's needs regarding an individual plan of care was available to the patient in the last 24 hours of their life.

Competent staff

- We saw records that demonstrated that the SPCT had received clinical supervision and 100% of staff had an appraisal in the last 12 months.
- The SPCT were aware of recent developments within their specialities including changes in national guidance. The SPCT provided evidence of additional training they had attended, which included training in complementary medicine, pain and symptom management and spiritual care.
- The amber care bundle (ACB) was launched at Warwick Hospital in July 2014. The trust told us in November 2015; the amber care bundle was used across 21 wards in acute and community hospitals and had been implemented for 82 patients since April 2015. The

number of patients started on the amber care bundle had significantly increased since July 2015 with 28 patients recorded in September 2015. Since July 2015, additional training and support for teams was in place, in order to embed the use of the amber care bundle across the hospital. Training was provided at preceptorship development days and band two induction programmes. In addition to this, training of specialist nurses continued and there had been individual sessions for haematology and orthopaedic consultants.

- Study days for advance care planning training "let's get talking" were available to all staff. The funding for these sessions ended in July 2015. Members of the service and other key providers for palliative care in Warwickshire were now in the process of devising a communication training day that targeted trust staff in greater numbers. We were not provided with future dates for the training at the time of inspection.
- 17 staff from Warwick Hospital had completed a nationally recognised training course in conjunction with a specialist palliative care team clinical nurse specialists and the local hospice. The training was designed to enable and empower teams of health and social care practitioners from acute, community or care home settings to lead on the delivery of high quality care to patients and their families at the end of life. The staff who had attended the training was fulfilling the role of the end of life care link nurse on the wards. 95% of wards had a trained link nurse. The staff who attended the training completed a questionnaire to provide an evaluation. Of those who attended the training, 100% of the responders noted that the training had changed their nursing practice. For example, they felt more confident in raising issues for discussion with medical colleagues, in the management of symptoms at the end of life, in their abilities to communicate with patients about their preferences at the end of life. They stated they were more confident in their ability to communicate with families and offer support.
- The palliative care champions attended champion meetings approximately four times per year. These meetings were facilitated by the SPCT and assisted staff in maintaining competency for their palliative care link or champion role. However, these meetings were not minuted, therefore those unable to attend were not able to access the information shared at these meetings. The palliative care champions or link nurses shared relevant knowledge, processes and skills to their ward teams during team meetings. We saw evidence of feedback from link nurse or champions to ward staff on the Castle ward team newsletter.
- Staff were competent using syringe drivers. Syringe driver training took place 12 months a year across Warwickshire. All registered practitioners were required to attend medical device training as part of essential skills (qualified nursing staff mandatory training) in order to be competent to use the syringe pump. Device training was repeated every three years.
- The SPCT nurses provided palliative and end of life care training to care staff across the trust. The training included syringe driver training, basic end of life care, symptom control, advance care planning and CPR decision-making.
- The acute and community palliative care consultants jointly took responsibility for providing palliative and end of life care training on all topics to GPs, nursing home staff, practice nurses and hospital and hospice doctors and nurses.
- Chaplaincy provided training on spiritual care to trust staff as part of the trust's induction. They provided training to staff regarding talking about death.
- The service's psychology team delivered training in use of the distress thermometer. The distress thermometer screening tool was for assessing psychological distress in people affected by cancer. Use of such tools to assess patient's emotional and physical needs was a requirement of the NICE guidelines for supportive and palliative care.
- Mortuary staff were aware of recent developments in anatomical pathology technology. They maintained their awareness of recent developments by accessing information through the association of anatomical pathology technology and the human tissue authority (HTA) website. The mortuary team did not have regular formal supervision. The mortuary manager addressed performance issues, concerns, and complaints individually.
- The mortuary team provided training to porters in the trust's procedures for transporting bodies to the mortuary and the use of equipment. The porters told us that they felt they had the necessary training. The porters also told us they supported each other with training needs and an experienced porter accompanied new staff to ensure that they followed protocols.

End of life care

- The resuscitation team provided the basic life support and immediate life support training on site. They attended emergency calls within the hospital where resuscitation was likely to be required, to offer shadowing and role modelling opportunities. The team was responsible for the trust's resuscitation policy.
- The trust had a 'Rapid Discharge Home to Die' e-learning package which 30 staff had completed at the time of inspection.
- The SPCT delivered information sessions during "Dying Matters" week May 2015, across the trust as a means to raise awareness of end of life issues to the staff and general public.
- The bereavement officer provided one to one training for junior doctors on completion of death certificate and cause of death.

Multidisciplinary working

- The palliative care nurse specialists (PCNS) provided expert clinical advice and support for patients with complex palliative care needs and their families and carers. They worked in partnership with GPs, integrated health teams, other community services and providers. The PCNS role included assessment and care planning for patients with complex palliative care needs, providing information on disease process, treatment and medication. In addition, they advised on local and national services, advised on symptom control and psychological support for the patients or their carers.
- The palliative care consultant attended upper gastrointestinal, lower gastrointestinal, lung and haematology multidisciplinary (MDT) meetings to provide support and guidance. They had also developed a pathway for patients with cancers of unknown primary origin.
- We saw evidence the SPCT attended weekly (MDT) meetings at the local hospice, with the community teams, to ensure continuity of care of the patients moving from Warwick Hospital to the community or the hospice. We attended a MDT meeting during the inspection. During the meeting, the team discussed the current caseload and shared information between the team, discussed family support issues; however, preferred place of care and death was discussed, but not routinely recorded. There were no systems in place to collate and share this information and as a result, the information could not be used for audit purposes to drive improvement. There were no allied health professionals such as occupational therapists, physiotherapist, psychologists or social workers represented at the multi-disciplinary meeting.
- The SPCT service worked in partnership with GP practices within Warwickshire. The integrated health teams, community specialist palliative care teams, care homes (nursing and residential), the local hospices, the local county council, the voluntary sector organisations, local support groups and Marie Curie Cancer Care.
- We saw the referrals to the SPCT came from a wide source of wards across the hospital and the team actively promoted referrals for patients with cancer and those with a non-cancer diagnosis. The SPCT told us they worked hard to build up a good working relationship with all ward teams. They told us staff on all wards had been supportive of the SPCT.
- Not all patients identified as requiring end of life care were referred to SPCT. Ward staff told us that there were no formal referral guidelines for the SPCT. Without formal referral guidance, ward staff would not have all the required information to assist them to identify patients who would benefit from a referral to the palliative care team. The SPCT told us, whilst there were referral guidelines in place; these had not been circulated to the wards.
- We reviewed ten sets of patient records and saw documented evidence of a multidisciplinary approach to care. We saw documented examples of communication of planned care between healthcare professionals. We also saw that medical staff acted upon guidance from the specialist palliative care team.
- The bereavement office and mortuary's main professional contacts were doctors, nurses, mortuary technical staff, SPCT, coroner's officers, police, registrar of births, deaths and marriages, hospital chaplains and funeral directors.
- The mortuary team supported both the acute and community teams with the transfer and storage of deceased patients.

Seven-day services

- The SPCT were available for face-to-face consultations 9am until 5pm on Monday to Fridays. SPCT nurses also provided on-call service 9am until 5pm on Saturdays, Sundays and Bank holidays.

- Consultants from the service and other providers (the hospice) delivered a 24 hour consultant advice line across Coventry and Warwickshire.
- The hospice nurses provided out of hours advice to patients, families, and healthcare professionals. Ward staff we spoke with had used both on-call services and had found them helpful.
- The mortuary service and bereavement office were open from 9am until 5pm Monday to Friday with an on-call service outside these hours. The service told us arrangements were in place to issue death certificates out of hours on the grounds of religious or cultural needs. The on-call hospital site manager coordinated this.

Access to information

- The DNACPR forms were stored at the front of the patients' notes in a green plastic envelope (green sleeve). They were easily identifiable; this meant they were accessible in an emergency.
- Once in place, the care of the individual plan of care for the dying person document stayed with the patient including on discharge. The community team received the care of the individual plan of care for the dying person document on the patients' discharge to ensure continuity and access to relevant information. Information needed for the patient's ongoing care was shared appropriately, in a timely way and in line with relevant protocols.
- The team were liaising with local GP's about the implementation of an electronic recording system to ensure all patients receiving end of life care's notes could be viewed remotely.
- Staff had access to electronic information, such as policies, national guidance and minutes of meetings.
- There were end of life resource folders kept on the wards and in clinical areas. These provided staff information on where they could obtain additional support or advice and details of aspects of symptom management and care for patients at the end of life.
- Staff had access to castle (Care and Support Towards Life's End) website. This website was primarily for health and social care professionals working in the fields of palliative and end of life care within Coventry and Warwickshire. It provided up-to-date information, local contact details (including primary care, care homes, hospitals and hospices), clinical tools, guidelines and information about education events.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Most patients did have their mental capacity assessed in accordance with the requirements of the Mental Capacity Act 2005 (MCA) and associated code of practice. We saw clear information and guidance about the Mental Capacity Act 2005 (MCA) on the intranet.
- Staff told us they received training on consent and MCA. When patients did not have mental capacity to consent to care and treatment, staff were aware of what actions to take. Training records indicated that all the SPCT had received training on the MCA.
- We looked at 32 DNACPR forms. We saw eleven forms were brought into the hospital from the community (patient held) these had been completed either on a previous admission or in the community. Twenty one forms originated on the patients' current admission.
- We saw evidence in most cases staff had discussed DNACPR decisions with patients or their relatives. Out of the 21 DNACPR documents that were started on the patients' current admission, four did not have reference to the discussion about DNACPR with the patient or the relatives documented in the medical notes. We did see evidence of discussion with the family and the patient in 17 of the medical notes.
- In the 21 forms started on the patients' current admission, nine patients were deemed not to have mental capacity, we saw evidence of formal mental capacity assessments being carried out and recorded, for decisions around DNACPR for six patients (66%). However, three patients had no formal documented capacity assessment. In two cases, where the patients who had been deemed not to have capacity, there was no evidence of formal documented capacity assessment or discussion with their next of kin. The service could not evidence either the patient or the next of kin were informed of the DNACPR decision. We raised this with the trust at the time of inspection.
- A relative told us, that staff had actively involved their relative in their care. They had handled the discussion about withdrawing care sensitively and had sought consent from the patient as they had mental capacity.
- The ward managers we spoke with demonstrated knowledge of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005.

End of life care

- All clinical staff received training on the resuscitation policy at induction, and then annually within essential skills training. This included the need for a person-centred approach, the early identification of patients for whom CPR decisions should be explored as part of an anticipatory care plan, decisions in an emergency situation, decisions for those that lack capacity, engagement with family, friends and others. The training also included details relating to actual process and guidance on documentation. Further training had been delivered in the form of presentations at grand round, senior nurses meetings and other local groups and departmental meetings. All training was based on current national guidance produced by the British Medical Association (BMA), Royal College of Nursing (RCN) Resuscitation Council (UK) and Mental Capacity Act 2005.

Are end of life care services caring?

Good

We rated end of life services to be good for caring because:

- Relatives we spoke with were happy with the care that their relatives had received.
- Staff carried out care to patients in a respectful and careful manner. Staff spoke to patients politely and respected their privacy and dignity by knocking on doors and asking for consent to proceed with tasks.
- Patients were involved in making decisions about their care and staff spent time talking to patients and their relatives. Patients and those close to them were communicated with and received necessary information in a way that they could understand.
- Patients' privacy and confidentiality was maintained.
- Staff provided patients and their relatives with support to cope emotionally with their care and treatment.
- The trust had a policy for advance care planning. Advance care planning is a process of discussion between an individual and their care provider. It might include the person's concerns, what is important to them, their understanding of their illness, their preferences for types of treatment or where they wish to be cared for. However, we did not find any evidence of advance care planning in the ten sets of patients' notes we reviewed.

Compassionate care

- We spoke with two relatives; they told us the end of life care on the wards was compassionate, kind and professional. They were positive about the care provided to their loved ones who were at the end of their life. One relative said they had nothing but praise for the care provided. Their relative was "always treated with dignity, that "all staff were superb". Relatives told us they had been kept informed of what was happening by the medical team. They told us discussions with staff had been handled sensitively. One relative said that the staff were doing their best to manage their loved ones pain and staff respected their dignity and privacy. They told us staff had spoken to their relative sensitively and compassionately. Relatives told us they had been supported by the SPCT who had explained all aspects of care and pain management. They said they could not fault the care provided.
- One relative did say they had not been asked if they would prefer a side room and they did not feel they could request this.
- We saw cards on a number of wards from relatives of deceased patients giving praise for the care the ward team had provided.
- Staff carried out care with a kind, caring and compassionate attitude. Staff spoke to patients politely and respected their privacy and dignity, asking for consent to proceed with tasks. We saw that staff spent time talking to patients and those close to them.
- The hospital had a chaplaincy service. Relatives told us they had been offered spiritual support and had been referred to the hospital chaplain. We saw a number of letters of thanks addressed to the chaplaincy team for the care they had provided.
- We observed that staff handled bodies in the mortuary in a professional and respectful way.
- The mortuary staff and porters told us that they did not have any concerns about the way ward staff cared for patients shortly after death.

Understanding and involvement of patients and those close to them

- We reviewed 10 patients' records across the wards. We saw that patients were involved in their own care and relatives were kept involved in the management of the patient (with patient consent). We saw documented discussions with patients and their families regarding

care and treatment. Patients and relatives we spoke with told us that the staff communicated with them in a way that helped them understand their care, treatment and condition.

- The SPCT, chaplaincy team and bereavement officer, provided support for patients and those close to them at end of life. Staff we spoke with told us they were aware of and used the chaplaincy service. Staff were aware how to refer patients to them. Staff told us that the chaplaincy team were helpful and easy to access. We saw staff making a referral to the chaplaincy service during our inspection. The chaplain responded to the referral within four hours.
- The chaplaincy team held worship services in the hospital chapel, the Sunday Holy Communion service was broadcast live on the hospital radio station.
- The bereavement officer and mortuary staff told us they arranged visits for relatives who wished to view the deceased. They ensured that people could take the time they needed and did not rush, so that they could say goodbye to their relatives and ask any questions they may have.
- The trust had a policy for advance care planning. Advance care planning is a process of discussion between an individual and their care provider. It might include the person's concerns, what is important to them, their understanding of their illness, their preferences for types of treatment or where they wish to be cared for. However, we did not find any evidence of these documents in the ten sets of patients' notes we reviewed.
- Staff told us they could organise free parking for relatives of patients receiving end of life care, via security, so they could spend the maximum amount of time with their relative.
- We saw a display board on Victoria ward providing information about end of life care, which had been set up by a member of the team. Ward staff felt it introduced the idea of the care needs at the end of life and provided a useful resource for relatives.

Emotional support

- Ward, nursing and medical teams offered emotional support in addition to the palliative care team.
- Support for carers, family and friends was also provided by the chaplaincy and bereavement services.
- When relatives were present at the time of death, the ward staff explained that the bereavement service would contact them the next working day. The bereavement officer was available from Monday to Friday 9am to 5pm, with a telephone message service outside of these hours.
- The bereavement officer provided relatives with information on how to register a death as well as other useful information, such as cremation papers and the coroner's office. The bereavement office staff told us that they were not trained in counselling, their role was to signpost people to further services. They returned property to family and carers and liaised with them around the issue of death certificates.
- The chaplaincy service provided support for patients and their relatives irrespective of their individual faith, or if they did not follow a faith. They could be called upon 24 hours a day seven days a week.
- The patients and visiting family members we spoke with, told us they felt emotionally supported by all the staff involved in their care.

Are end of life care services responsive?

Good

We rated end of life services as good for responsiveness.

- 91% of patients were seen within 24 hours of referral, with 71% of patients seen on the same day of the referral.
- The discharge planning process was supported by a discharge coordinator, using continuing healthcare funding and could be facilitated within 48 hours.
- Care and treatment was coordinated with other services and other providers. The acute special palliative care team (SPCT) had good working relationships with their community colleagues, which ensured that when patients were discharged, their care was coordinated.

However we also found:

- The trust had a policy for the rapid discharge of patients to their preferred place of death. However, the service was not collecting information on preferred place of care or collecting information on those patients who died in their preferred place of death.
- We did not see a formal triage and prioritising system for the SPCT referrals.
- The service produced information leaflets for bereaved families. However, the leaflets were only available in

English. We observed an occasion where a translator was not accessed for a patient unable to speak or read English. Staff had involved the patient's relative in the communication process and had not felt it necessary to access a translator.

Service planning and delivery to meet the needs of local people

- The hospital SPCT had received 393 referrals from April 2014 and March 2015. 306 (77%) of those referred had a diagnosis of cancer. 87 (23%) of those referred had a non-cancer diagnosis. 91% of patients were seen within 24 hours of referral.
- Whilst there were no designated beds for end of life care at Warwick Hospital, the staff delivered end of life care in most wards with the support from the SPCT.
- The acute SPCT did not collect information of the percentage of patients who died in their preferred place of care or those had been discharged to their preferred place of death within 24 hours.
- The trust had a policy for the rapid discharge of patients to their preferred place of death. This process aimed to support the timely discharge of patients at the end of life, to enable them to die at home or in their place of choice. The service was not auditing the effectiveness of the rapid discharge process. Staff we spoke with were aware of the rapid discharge process but stated they used an alternative, continuing health care (CHC) fast track process. Staff said that discharges could usually be achieved within 48 hours. The service told us a delayed discharge was reported as a clinical incident. One incident, related to discharge had been reported from July 2015 and September 2015. The reasons for delay included lack of hospice at home capacity and problems sourcing appropriate packages of care via community healthcare.
- Staff we spoke with told us, when patients were being transported for what was likely to be their final journey, for example to home or hospice, the local ambulance service had informally agreed to provide a two-hour window transport slot. We did not see evidence of this on inspection.
- The service worked with a regional strategic partnership group, made up of other end of life care providers in the region. We saw that the DNACPR documents and care of the dying documents had been devised and were being used by all services within this group.

Meeting people's individual needs

- The hospital did not provide a designated ward area for those patients requiring end of life care. End of life care was delivered on all the hospital wards.
- Where possible, staff tried to allocate patients who were receiving end of life care side rooms, in order to offer quiet and private surroundings for the patient and their families. Isolation pods had been installed on many wards which could be used to facilitate privacy and dignity for end of life patients. However, patients at the end of life, on occasions, had to be cared for in the ward bay areas, as the use of single rooms were prioritised for patients who required isolation.
- The wards had access to appropriate facilities for relatives, for example, comfortable chairs and hot drinks.
- Nursing staff told us, there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends unlimited time with the patient.
- Whilst there were no designated facilities on the hospital site for overnight accommodation, wards could provide recliner chairs for those who wished to remain at their relatives' bedside. Some wards made their day room available for relatives to use on such occasions.
- The service produced a leaflet called 'information and advice for bereaved families and friends'. This leaflet contained practical guidance about the steps that need to be taken following the death of a relative or friend, such as information on the support provided by the bereavement officer, coroner involvement, collecting the medical certificate, registering a death and beginning funeral arrangements. The service also provided a leaflet specifically to assist parents when a child had died and following the loss of a baby. Ward staff provided the leaflets to bereaved relatives. However, there was no information available to relatives about what to expect during the dying phase. The leaflets were only available in English.
- Staff told us translation services were available 24 hours per day through a telephone service and there were generally no delays in accessing this service when needed. However, we observed an occasion where a translator was not accessed for a patient unable to

speak or read English. Staff had involved the patient's relative in the communication process and had not felt it necessary to access a translator. This is not considered best practice.

- There was a chaplaincy service at Warwick Hospital. The team provided spiritual and pastoral care and religious support for patients, relatives and staff across the trust. Patients could refer themselves or staff alerted the chaplaincy team if a patient asked to see them. A member of the chaplaincy team visited the wards daily and patients usually contacted the service during these visits.
- For patients who wished to take communion, but could not attend the chapel, the chaplain or an authorised member of the team brought communion to their bedside.
- The bereavement officer liaised with bereaved families and coordinated the issue of the medical certificates, so that the death could be registered and the funeral arranged. The bereavement officer could book appointments with the registry office for relatives.
- The mortuary viewing area had been recently decorated, it was clean, bright and there were toilet facilities and a seating area. The service was able to provide Holy Books and some religious artefacts, or kept the room free from anything religious, depending on the relatives' preferences. Staff were available to answer questions and signpost relatives to appropriate people if they had any questions or queries.
- The trust had a Macmillan Cancer Support information and support centre at the Aylesford unit. It provided people affected by cancer, access to comprehensive, appropriate information and support. The centre was open from 8.30am to 4pm Monday to Friday. The service offered a drop in facility for information and support, health, financial and life management advice. The team at the centre could signpost patients to other healthcare professionals and provide details of local and national support services and organisations. Details about complementary therapies and outreach sessions in the community were also available from this service.
- The trust had a named lead nurse for learning disability and a named nurse to support people living with dementia.

Access and flow

- The hospital specialist palliative care team had received 393 referrals from April 2014 and March 2015. 306 (77%) of the patients who had been referred to the SPCT had a diagnosis of cancer. 36 (9%) of the total amount of referrals for the year were for patients with cancers of an unknown primary. 87 (23%) patients who had been referred had a non-cancer diagnosis.
- We did not see a formal triage and prioritising system for the SPCT referrals. From March 2014 and April 2015, 91% of patients were seen within 24 hours of referral, with 71% of patients seen on the same day of the referral. The service specification stated that all patients identified as having an urgent need, would be contacted by the SPCT within a maximum of two working days or as clinically appropriate. The specialist nurses saw non-urgent patients within five working days. The service was meeting these targets
- There was a telephone referral system for the SPCT. Informal triaging took place throughout the day and any urgent referrals, for example where a patient was in pain, were prioritised. The SPCT told us, whilst there were referral guidelines in place; these had not been circulated to the wards.
- The SPCT were visible on the wards. Nursing staff knew how to contact them. Referrals were made by telephone contact and ward staff told us there were no delays for patients to be seen.
- The SPCT used the a defined discharge criteria which set out circumstances where a patient would be discharged, for example if the patients dies, declines further contact with the team or if they had completed an agreed episode of care. All discharged patients could self-refer to the service if future needs developed.
- Patients that arrived in the medical admissions unit who required end of life care, were generally identified through history taking or because they carried a green sleeve wallet with advance care plans and decisions regarding cardio pulmonary resuscitation held therein. The green sleeve initiative is a Coventry & Warwickshire-Wide process
- The team told us that occasionally discharges from hospital were delayed due to difficulty in commissioning services, such as available community care packages or transport. Ward staff told us that discharge could be delayed if patients were waiting for a suitable care package at home.

End of life care

- The porters told us that they were able to respond to calls made requesting deceased patient transfer promptly. This was usually within 15 minutes and they told us they were able to prioritise accordingly. Ward staff did not have concerns about these response times.

Learning from complaints and concerns

- There were five complaints specifically related to end of life care for the last 12 months (from March 2015 and March 2016). Three complaints had been investigated and had not been upheld. One complaint had been partially upheld and one was under investigation. We saw that complaints were dealt with within a month of being received and where actions were indicated, plans were in place to address the issues identified.
- Staff we spoke with told us that when a complaint was received, a manager from another department investigated the complaint so that an independent view was taken.
- The service provided an example of a complaint that had been investigated and the learning from this resulted in a change to practice. Staff had also met with the family involved and apologised.
- The mortuary team had not received any formal complaints from July 2014 and June 2015.

Are end of life care services well-led?

Requires improvement

We found that end of life services required improvement for leadership because:

- The trust did not have strategic plan for delivering care at the end of life. The service told us at the time of inspection, they were not working specifically to a strategic plan for end of life care.
- The leadership team did not always ensure routine local audits were in place to measure the effectiveness and outcomes of the service. Without this information, the service was unable to monitor for example, if patients died in their preferred place of death.
- The leadership team was not able to evidence that they were knowledgeable about quality issues therefore were unable to take actions to address them.
- The directors identified to provide representation for the service at board level, did not attend end of life care meetings and were unable to evidence that they were knowledgeable about issues that affected end of life care.
- The end of life care team did not have a direct reporting structure to board level.
- The trust did not have a non-executive director who provided representation of end of life care at board level, which is a recommendation of the National Care of the Dying Audit of Hospitals.
- The trust had a replacement for the Liverpool Care Pathway (LCP), called the individual plan of care for the dying person. Whilst the special palliative care team (SPCT) were working with staff to improve usage, it was not embedded practice across the hospital
- Acute end of life care services did not have a defined risk register. However, we did see risks within end of life care, such as environmental issues in the mortuary were recorded on the support services risk register.
- The mortuary building and equipment were dated and did not comply with health and safety regulations, however, where the areas were deemed not to be compliant, the service had completed a risk assessment and put actions in place to address them
- The service did not have oversight of information, such as training records for staff employed by other providers, such as mortuary staff.

However we also found:

- Across end of life services, the culture and morale of staff was good. Staff were positive about their experience of working at the trust and were committed to delivering good and compassionate end of life care.
- Staff were committed and motivated to provide an improving service.

Vision and strategy for this service

- The trust did not have a strategic plan in place for end of life care. Leaders told us at the time of inspection, although they had recognised this, they were not presently working on a strategic plan. but work had been commenced on developing a strategy and was in the objectives set for the new consultant
- One whole time equivalent consultant in palliative medicine had been appointed in January 2016 to work clinically in the acute hospital and to lead on end of life care strategy for the trust. Prior to this appointment,

there had been an 18-month gap in palliative and end of life care consultant provision to the acute trust. Following the appointment of a consultant to the Acute Hospital Palliative Care Team the whole team (acute and community) planned to undertake a comprehensive audit programme.

- The trust held monthly end of life care meetings. We were provided with minutes from the meetings held in December 2015 and January 2016. The end of life care group had devised a draft action plan for 2015-16 based on the five priorities of care for the dying patient (The Priorities of Care for the Dying Person Duties and Responsibilities of Health and Care Staff – with prompts for practice was published June 2014 by the Leadership Alliance for the Care of Dying People). This action plan was devised before the appointment of the palliative consultant lead and formed the plan of activities for the current year. However, there were no timescale dates for completion or action updates on items identified on the action plan.

Governance, risk management and quality measurement

- The trust did not have an end of life strategy or associated action plans to identify priorities to improve care and treatment delivered at the last stages of life.
- At the time of inspection, the service did not have end of life strategic group. Leaders told us an end of life care strategic group meeting was planned, to which the operations group would report, who would then report to the clinical governance committee. There was no date for the start of the end of life care strategic group.
- The Commissioning for Quality and Innovation (CQUINs) payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. The trust had CQUINs for patient's preferred place of death and fast track end of life care in 2014 and 2015. However, there were no current CQUINS associated with end of life care.
- Historically the leadership had not always ensured local audits were in place to measure the effectiveness and outcomes of the service. For example, the acute SPCT did not collect information about how many patients died in their preferred place of death to enable them to monitor if they were honouring patient's wishes or if they needed to improve this. Since the palliative care consultant for the acute trust had been employed in January 2016 we saw local audits such as an anticipatory medication were planned and in the process of being completed. The team monitored its performance through their annual report. We saw a copy of the Specialist Palliative Care Annual Report 2014 – 2015 (dated July 2015). This information was presented at the end of life care meeting, which then provided feedback and raised concerns to the clinical governance risk committee who then in turn reported to the executive board.
- Acute end of life care did not have a risk register. However, issues were identified in the support services risk register with regard to the mortuary building and equipment, not being compliant with health and safety regulations and Health Technical Memorandums (HTM). We saw the mortuary had actions in place to address these issues and there were plans in place to redesign the mortuary in 2017.
- The trust did not have oversight of information, such as training records for staff employed by other providers such as the mortuary staff. The mortuary staff training records not held by the trust. The trust did not have oversight of this information.
- The mortuary building and equipment were dated and did not comply with health and safety regulations, however, where the areas were deemed not to be compliant, the service had completed a risk assessment and put actions in place to address them. The risks regarding the mortuary were identified on the support services risk register. There were plans in place to redesign the mortuary in 2017 and a refurbishment project group had been set up.

Leadership of service

- The palliative care service was accountable to the integrated and community care directorate of the trust. The SPCT had moved from cancer services in the previous six months prior to inspection. This aimed to improve access to palliative care for patients with a non-cancer diagnosis.
- The acute SPCT was led by the palliative care consultant. There had been no consultant in palliative and end of life care based at Warwick Hospital for 18 months prior to January 2016 when one was appointed. SPCT staff we spoke with told us that there was now good leadership of the SPCT and all of the ward staff we spoke with knew who the leads were for end of life care.

End of life care

- There were two board members responsible for end of life care. The director of nursing and the medical director shared the responsibility as board representatives for end of life care. Staff were aware of who the board members were. However, the end of life care meeting was chaired by the deputy director of nursing rather than the executive board representatives. This meant the end of life care service did not have a direct reporting structure to the board to enable end of life care issues raised and discussed at the end of life care meeting to be addressed.
- The trust did not have a non-executive director representing end of life care.
- The chaplain, mortuary team and bereavement officer told us that they felt supported and listened to by their line management.
- All staff we spoke with were aware of who their immediate managers were, they were aware of the roles of the senior management team within their directorate and executive team.
- The acute SPCT was led by the palliative care consultant. SPCT staff we spoke with told us that there was good leadership of the SPCT since the appointment of the palliative care consultant in January 2016. All of the ward staff we spoke with knew who the leads were for end of life care.

Culture within the service

- The SPCT staff we observed were respectful and maintained patients' dignity, there was a person centred culture. We saw staff responding to patients' wishes.
- Staff we spoke with on the wards told us of their commitment to provide safe and caring services they spoke positively about the care they delivered.
- All staff spoken with during the inspection acknowledged the importance of high quality end of life care. Ward staff were positive about the support provided by the SPCT.
- The SPCT said they felt valued and respected by their peers and the trust management. Staff said there was a culture of openness within the trust.
- The mortuary staff demonstrated a strong team ethic, describing the trust as a good place to work.

Public engagement

- The service used the questionnaire 'care of the dying evaluation questionnaire' (CODE). The bereavement officer sent the questionnaire to relatives eight weeks after their bereavement. The service told us they intended to use the results to inform the basis of future service delivery and educational needs. The service told us, findings from this pilot survey were presented and discussed with the relevant clinical teams across the trust, with a view to identifying how these areas could be addressed and to recognise and share good practice. At the time of the inspection, there was no evidence of how the results had informed a change in practice.
- The trust carried out surveys for patient and staff satisfaction, although these did not specifically identify end of life care results.
- The SPCT organised a promotion stand within the hospital during the national Dying Matters Week with display boards and leaflets. This was to raise awareness about end of life care to staff, patients and those close to them.

Staff engagement

- The trust carried out surveys of staff satisfaction, although these did not specifically identify end of life care results.
- We did not see any evidence of team meetings within the SPCT.

Innovation, improvement and sustainability

- Amber care bundle training was included in the newly qualified nurse preceptorship programme and in health care support workers induction.
- "Death and Cake" sessions were provided as part of the dying matters week. These sessions aimed to provide support to staff to enable conversations and explore themes around dying.
- Twenty band six nurses across the trust attended a nationally recognised end of life training course in 2015. This provided intensive training in symptom control and challenging communications. This was collaboration between Warwick Hospital, the local hospice and the trust's community consultants.

Outpatients and diagnostic imaging

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

Information about the service

South Warwickshire NHS Foundation Trust provides outpatient and diagnostic imaging services to the population of Warwickshire and is the main provider of acute services for south Warwickshire.

Outpatient's service provision for adults and children includes; ophthalmology, cardiology, dermatology, ear, nose and throat (ENT), orthopaedics, fracture clinic and one-stop clinics including urology, deep vein thrombosis (DVT) and trans-ischaemic attacks (TIA).

Outpatient clinics are held at Warwick Hospital, Stratford Hospital, Royal Leamington Spa Rehabilitation Hospital and Ellen Badger Hospital. The majority of clinics are provided at the largest site, Warwick Hospital and are supported by the Warwick Hospital diagnostic and imaging department. Outpatient clinics are routinely held Monday to Friday with established weekend and evening clinics for some specialities.

From July 2014 to June 2015 the trust facilitated 456,345 outpatient appointments across all sites with 375,989 at Warwick Hospital. 37% of appointments at Warwick Hospital were new appointments, 53% were follow-up appointments, 6% of patients did not attend (DNA) and 4% were cancelled by patients.

We carried out an announced inspection at Warwick Hospital from 15-18 March 2016. We visited a number of clinics and diagnostic services at this site including ophthalmology clinic, children's clinic, ENT clinic, X-ray department, outpatients department, patient access team, outpatient and radiology booking departments and medical records departments. We spoke with 30 members of staff, 13 patients and viewed six sets of patient's records.

The focus of this report is for acute outpatients and diagnostic services provided at Warwick Hospital. Provisions at the other three sites will be reported on within the South Warwickshire NHS Foundation Trust community reports. Services at all sites are run by the same management team, for this reason it is inevitable that there will be some duplication within reports.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatients and diagnostic imaging services as good for safe, caring, responsiveness and well-led. We do not have the methodology to rate the effective domain. The service was judged to be good overall because:

- Performance data showed a good track record on safety, patients were told when things went wrong and there were systems in place to ensure that patients received the correct treatment.
- Mandatory training levels were overall better than the trust's target and most staff had received an up to date appraisal.
- The service had systems in place to ensure the safe administration of ionising radiation for staff and patients and these systems were regularly audited and reviewed.
- There were good infection control procedures in place and the service was visibly clean and well organised.
- The department had recently started working towards accreditation in a national scheme for diagnostics imaging and specialities were undertaking regular audits based on national guidelines.
- Waiting times for diagnostic imaging was consistently better than the England average.
- Referrals to treatment times were in line with the national average and the service had a robust system to manage waiting lists including risk assessments.
- The outpatients and diagnostic services had developed good working relationships with internal and external teams to support service delivery.
- There was a strong emphasis on developing staff to strengthen the workforce and provide opportunities for staff's personal development.
- We found the service to be caring towards their patients and each other. Patients were treated with dignity and respect.
- The radiology department had a strategy to improve their service and had introduced a 'Four Tier' model of progression in response to the national shortage of radiographers, which included assistant and advanced practitioners'

Are outpatient and diagnostic imaging services safe?

Good

Overall, we rated outpatients and diagnostics as good for safe because:

- Performance data showed a good track record in safety.
- Clinical areas were generally clean and well-organised. Medical records were maintained accurately and securely, and there was an effective records tracking and location system.
- Infection control procedures were followed and the service conducted regular audits.
- There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
- The service had a system in place to recognise and respond to changes in patient's health.
- There was evidence that patients were told when things went wrong and offered an apology.
- There were systems in place to ensure the right patient received the correct diagnostic procedure.

However, we also found,

- Staff were recognising, resolving and discussing incidents but not always recording them in line with trust policy, this meant that learning from incidents was not always shared.
- Not all staff had the appropriate level of training for safeguarding children.

Incidents

- Staff understood their responsibilities to raise concerns and had access to the trust wide electronic reporting system to record safety incidents including those that had resulted in low or no harm. Staff we spoke to were aware of the system and explained that incidents were allocated to senior nursing and medical staff to investigate.
- Staff who were not tasked with investigating incidents, such as junior nursing and administrative staff told us that they would discuss incidents with senior staff and line managers before reporting them. They were able to provide clear examples of when they would report an

incident. But some staff told us that sometimes after discussion with managers, if a solution was found there would be no need to record this on the electronic system as an incident. This practice was not in line with the trust's incident management policy. This meant that not all incidents were reported and therefore, incident trends and learning could not always be shared amongst all departments.

- There had been no never events reported for this service from October 2014 to September 2015. A never event is described as wholly preventable incidents, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- From January to December 2015 there were 143 incidents reported for outpatients and diagnostics at Warwick Hospital. This figure was comparatively low to similar trusts treating a similar number of patients. Staff in outpatients told us that most incidents that occurred in the clinics were managed by the individual specialities and not always recorded as incidents for outpatient clinics which meant that they were not always aware of the outcomes or the lessons learned.
- Incidents were graded in severity from low to no harm, or moderate to severe harm. 136 of the 143 incidents were graded as low or no harm and included incidents such as delays for patient transport, cancelled clinics and mislabelled diagnostic requests. One of the incidents categorised as low harm related to a sigmoidoscopy (an investigation of the bowel) procedure carried out for a patient. Infection control procedures had not been followed which resulted in the patient being at risk of cross contamination. The incident was also reported as a serious incident to the Strategic Executive Information System (STEIS) by the surgical department who had been holding the clinic in the outpatients department. We saw evidence that the patient had been told about the incident and offered an apology. Staff told us that they had reviewed all cleaning protocols as a result of the incident. Of the remaining seven incidents, four were categorised as moderate and three as severe with no particular theme, the three severe incidents related to ophthalmology.
- Staff in radiology told us about an incident that occurred in the department in March 2015 which had caused delays and cancellations, that impacted on the rest of the hospital. The issue had arisen when there had been a lack of porters due to short notice sickness. A root cause analysis was conducted and highlighted a number of issues including a lack of communication between departments, so time slots for diagnostics could be double booked which sometimes meant that porters' workloads were not properly co-ordinated. We saw evidence that the incident was robustly investigated and the department had introduced an electronic clinical task management system which prevented double booking time slots and prioritised tasks using a specific algorithm. There had also been the introduction of daily handovers between departments to highlight any potential operational pressures. The incident that staff described had not been included in the 143 reported incidents we were told about.
- We saw evidence from radiology meetings that showed that they recognised the culture of incident reporting needed to be reviewed as some areas of the hospital were reporting incidents that the radiology department would not normally record. For example, if a radiographer was late to theatres, surgery would record this as an incident if it impacted on service delivery, such as operations running late. Staff in the radiology department did not do the same if they were delayed by other departments.
- The Ionising Radiation (Medical Exposure) Regulations, or IR(ME)R, is a framework which deals with the safe and effective use of ionising radiation when exposing patients and designed to minimize the risk of unintended, excessive or incorrect medical exposure. Radiology errors, including when the wrong dose had been given to a patient or a patient had received the wrong type of diagnostic test, were reported to Care Quality Commission in line with the regulations. In 2015 the service recorded 14 incidents related to radiation, four of which were reportable under IR(ME)R regulations due to levels of radiation being 'much greater than intended' (MGTI). This included an instance of a patient who needed a scan of their abdomen and received a scan of their brain due to an incorrect label placed on the request by the doctor requesting the scan. We saw evidence that learning from these types of incidents was discussed at departmental meetings and displayed on staff notice boards.
- The Ionising Radiation Regulations 1999 (IRR99), aim to protect staff working with ionising radiation. This legislation requires radiology services to produce 'local

rules', which is a set of rules describing what systems and processes are in place in individual services to protect staff. The radiology department had developed their 'local rules', which were displayed in all relevant areas and reviewed when necessary. Staff working with ionising radiation at the trust were required to wear a dosimeter in line with the regulations, regular audits were conducted and an annual report published to ensure that effective measurements were in place to protect staff. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

- We saw evidence that patients were told when things went wrong and they had received an apology. All staff we spoke to were aware of the principles of Duty of Candour regarding being open and transparent. Managers we spoke to were aware of their responsibilities in regards to Duty of Candour when there was a notifiable safety incident. We saw that there were paper copies of the trust's policy in outpatient areas.
- The Royal College of Radiologists issued an interim statement in October 2015 with guidance to follow in regards to errors in radiology reports and Duty of Candour. The statement included the recommendation that radiological errors or discrepancies should be discussed in regular 'discrepancy meetings' by all radiologists to share learning and that if these discrepancies led to the need for an apology in line with Duty of Candour, this should generally be delivered by the clinician who delivered the care. We saw evidence that the radiology department held regular discrepancy meetings which were well attended by staff at all levels to share learning.

Cleanliness, infection control and hygiene

- The outpatient and radiology clinical areas that we visited were visibly clean. There were some cleaning schedules in place and staff told us that the areas were cleaned daily by nursing and housekeeping staff. The trust told us that the contractor that supplied domestic services trust wide were introducing a checklist which would be used by all domestic staff within the hospital. Staff in specific clinics, such as ophthalmology where specialised equipment was used, cleaned and maintained their own equipment to ensure safety.
- There were two sluice areas in the outpatients department, one was for clean utilities and one was for dirty utilities post procedures. We saw that both of these areas were visibly clean and well organised. There were relevant guidelines for handling the cleaning materials and personal protective equipment (PPE) such as plastic gloves and plastic aprons were available in all areas.
- There was sufficient sanitizing hand gel throughout the clinics and radiology department and we observed staff use these regularly and observed 'bare below the elbows' practice in line with national guidance for clinical areas.
- The department conducted regular hand hygiene audits in line with the trust's infection control programme. From April 2015 to January 2016 compliance to monthly hand hygiene audits in outpatients and radiology averaged at 98%.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot pedal operated lids. Bins were not overfilled.
- The trust had undertaken annual 'Patient Led Assessment of the Care Environment' (PLACE) assessments and the 2015 results showed 98% for cleanliness.
- There were no designated rooms for seeing patients with communicable diseases, such as influenza or tuberculosis. Staff told us that if it was necessary to isolate a patient they would find an appropriate room for consultation and treatment and staff would use appropriate PPE, such as aprons and disposable gloves, and then that room would be thoroughly cleaned after treatment in line with infection control procedures.

Environment and equipment

- Most of the outpatient clinics were held in the main outpatients department, and clinics such as ophthalmology and cardiology were located in different areas of the hospital with their own reception and waiting areas.
- The radiology department and outpatient departments had separate reception areas and waiting rooms.

Outpatients and diagnostic imaging

- The main outpatients' department reception area was open plan and well lit. Patients who arrived at reception were signposted to a space where they could wait to book in. This was some distance from the reception desk which allowed for privacy and confidentiality to be observed. There was also a designated waiting area in main outpatients for children which was separated from the main waiting area.
- The main outpatients' reception led to the clinic rooms and further waiting areas for the various clinics held. During our inspection we observed that there was adequate seating and no patients were standing.
- Clinics were well signposted and the outpatients department used coloured symbols on the floors to direct people to the area that they needed. Patients that we spoke to said that the colour coded signs were very useful.
- We examined the resuscitation trolleys located throughout the departments. The trolleys were secure, sealed and accessible. We found evidence that regular checks had been completed and documented.
- The radiology department carried out risk assessments for all new or modified use of radiation in line with national guidance. The risk assessments addressed occupational safety as well as risks to patients and the public. For example, we saw all equipment used in radiology such as x-ray machines and computerised tomography (CT) scanners had undergone scheduled risk assessments to ensure that levels of radiation were as low as reasonably practicable.
- There were clear signs in areas where ionising radiation was used, including lights and warning notices. In areas where non-ionising radiation was used, such as ophthalmology and dermatology clinics, where staff used high power lasers and intense pulsed light therapy, we saw that there were working instructions for these areas and access was restricted to staff authorised to use the area.
- The radiology department had clear guidelines on which specialised PPE should be used for specific procedures, such as lead aprons. Staff told us that they were always able to access appropriate PPE to carry out procedures. The department carried out annual audits of specialised PPE to ensure that they were still appropriate for use and defective equipment was disposed of appropriately.
- Electrical equipment that we saw had all had portable appliance testing in line with national health and safety guidelines.

Medicines

- Staff in outpatients told us that there were limited medications held in the treatment rooms and no controlled drugs. If a specific medication was required they could access it via the outpatients' pharmacy, such as topical skin creams.
- Sometimes when diagnostic scans are carried out the patient is injected with a chemical contrast agent to improve the clarity and diagnostic accuracy of the scan.The Royal College of Radiographers (RCR) provided updated guidance on how administration of these agents should be managed in February 2015. The trust had a comprehensive medicines management policy and contrast agent administration process. These set out who was authorised to request the medication and how it was to be formally recorded as a patient specific directive (prescription) in line with RCR recommendations. All requests for contrast agents were reviewed and accepted by the consultant radiologist and formally recorded in line with RCR recommendations and the trust's policy.
- The radiology department was undertaking an audit based on RCR guidelines in relation to the administration of contrast agents and allergic reactions at the time of our inspection. Early findings showed that they were mostly working in line with the guidelines and they had updated their protocol and escalation process, disseminated the learning to staff and planned to conduct further audits.
- Radiology staff had access to anaphylaxis treatment if a patient had an allergic reaction to contrast agents. This was kept in a locked cupboard.
- Medicines and preparations for treatments were kept in locked cupboards and refrigerators with a key code access which was changed regularly. Temperatures for fridges were recorded and fridges had a visual alarm which alerted staff to changes in temperature.
- Medication prescription pads were kept in locked safes in individual treatment rooms.
- In outpatients clinics we saw information that was given to patients relating to their medication including how to take them, why they were taking them, who to contact if they were concerned and possible side effects. In the

trust's internal patient feedback survey for December 2015, 96% of patients who had given feedback for outpatient clinics said that they had received timely information about their care and treatment.

Records

- The service was in the process of converting all paper records to electronic records to ensure that complete records were always available and to minimise the use of paper. At the time of our inspection 26% of all records had been converted.
- Staff told us that there was 99% availability of patient's records for all clinics and we saw audits from November 2015 to March 2016 that showed the availability of records for outpatient clinics.
- The medical records department monitored availability of records and used a tracking system so if records were missing staff were able to establish when and where they were last requested. Staff in outpatient clinics told us that if patient records were unavailable for clinic they would prepare a temporary record with details of the last appointment for follow-up appointments, or referral letter for first appointments. The temporary file was then added to the patient's original records.
- We viewed six sets of patient's records, one of which was on the electronic system and there were no obvious omissions and appropriate information.
- We visited the medical records department where all patients' records were kept. This was a building with restricted access and used a key code for entry. The medical records department operated Monday to Sunday to ensure that records were available to all departments including outpatient clinics.

Safeguarding

- All nursing staff we spoke to told us that they had been trained in safeguarding for adults and children to level 2. The trust's target for completion of this training was 85%, in outpatients department all medical and nursing staff had completed this training and in radiology 93% of clinical staff had received the appropriate training in safeguarding children and all had received the appropriate level of safeguarding training for adults.
- Staff working with children and young people should have appropriate training in safeguarding children. Level 3 training is for clinical staff that have key roles in assessing and treating children and young people. Training for Medical staff who worked in outpatients was recorded by their various specialities and reported in the appropriate areas of this report. No nursing staff in outpatients had received level 3 training. We asked staff about this and they told us that they had access to the safeguarding lead and children's nurses in the children's specific outpatient clinics (separate to main outpatients) who had level 3 training if they required advice. This was not in line with the intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March, 2014). This meant that, we could not be sure that all staff have the sufficient knowledge and skills to safeguard children.
- We spoke with optometrists in the ophthalmology clinics who worked with children on a daily basis and they had all received safeguarding children level 2 training, this was in line with national intercollegiate guidance.
- The department had clear guidance on who staff could contact if there were safeguarding concerns. There were clear protocols to follow in instances of 'suspicious non-accidental injuries', vulnerable patients that missed appointments, and female genital mutilation (FGM).
- Staff showed us the area in patients' electronic notes where they would record any safeguarding issues and how this was highlighted on the electronic system.
- The radiology department had clear processes in place to ensure that the right patient received the correct radiological scan. This included checking with the patient verbally and checking the written referral against the patient's electronic record.
- The World Health Organization's (WHO) surgical safety checklist had been adapted in radiology to fit the local requirements for the department in relation to non-surgical interventional procedures, such as needle biopsies. Staff conducting procedures were required to confirm the patient's name, age, procedure site and consent before starting treatment and record that this had been done on the checklist. The trust provided us with the results of audits from January to March 2016 which showed that on average 97% of staff across the trust were recording these checks, this met the trusts targets.
- The radiology department had placed 'pause and check posters' within all treatment rooms to remind staff to check that the right patient was receiving the right imaging service.

Outpatients and diagnostic imaging

Mandatory training

- Mandatory training consisted of fire safety and awareness, information governance, infection prevention and control, manual handling, health and safety, equality and diversity, basic life support, conflict resolution training, and safeguarding adults and children levels one and two. As of March 2016 over 90% of all staff in outpatients had completed their mandatory training, over 80% of all staff in radiology had completed all mandatory training with the exception of clinical staff in basic life support which was at 76%.
- All staff that we spoke to said that they were up to date in mandatory training; senior staff in the outpatients department told us that whenever possible they allocated specific times in the week to allow staff to complete mandatory training modules via e-learning.

Assessing and responding to patient risk

- The outpatient and diagnostic services had systems in place to assess risks to patients. They had processes in place to monitor and maintain patients' safety.
- Referrals were triaged upon receipt to ensure that most urgent patients were seen first. Staff in booking centres told us that they highlighted all urgent referrals and urgent and routine referrals were sent to the consultants for specialities to approve.
- At the time of our inspection the trust had a backlog of appointments in ophthalmology which was a national problem and a backlog in cardiology outpatients due to staff shortages. We saw that there were regular weekly meetings held between the specialities to manage the waiting lists. Consultants had conducted 'virtual clinics' to assess the risk to patients waiting for appointments and prioritise patients who needed to be seen more urgently. Extra evening and weekend clinics had also been held to manage the lists.
- Outpatient and diagnostic services used the National Early Warning Score (NEWS) in line with the National Institute for Health and Care Excellence (NICE) guidelines (CG50 Acute, illness recognising and responding to the deteriorating patient). This was a colour coded system staff used to record routine physiological observations such as blood pressure, temperature and heart rate with clear procedures for escalation if a patient's condition deteriorated. Nursing staff that we spoke to were able to describe the process and explained who they would contact in an emergency.
- Each diagnostic area had a Radiation Protection Supervisor (RPS) whose main role was to ensure that staff complied with requirements of IRR99 and the local rules. Details of who the RPS was in each diagnostic area was clearly highlighted at the entrance of each area along with working instructions for the areas. IRR99 requires all radiology departments to consult with a Radiation Protection Advisor (RPA) for specific areas such as risk assessments. The radiology department had an RPA who assisted with risk assessments and staff told us that they were able to contact them if they required advice. The contact details of the RPA were also included in the local rules.
- The department had clear guidelines on who was entitled to make a request or referral for diagnostic imaging in accordance with IR(ME)R. For example, all medical and dental practitioners were entitled to act as referrers; other healthcare professionals could act as referrers after undergoing a specific training programme and appropriate checks by the trust.
- There were clear signs and information in the radiology department informing people about areas and rooms where radiation exposure was taking place.
- The radiology department had guidelines to ensure that female patients and staff of child-bearing age were able to inform staff if they were, or might be pregnant.
- Contrast induced nephropathy occurs when patients display symptoms of acute kidney injury (AKI) after receiving intravascular contrast agents (sometimes used in urology and other specialities to enhance imaging results) and there is no other reasonable explanation for the suspected injury. The trust had comprehensive guidance on how to manage patients suspected of AKI which followed the NICE and Royal College of Radiographers (RCR) guidelines. Appropriate risk assessments were included in the radiology integrated care pathway. We spoke with medical staff who were able to describe the process and what their actions would be.
- Diagnostic reference levels (DRLs) should be set in line with IR(ME)R guidelines to ensure that patients receive the minimum radiation exposure as is clinically necessary; the level should be based on specific patient groups. The radiology department manager was

responsible for ensuring that DRLs were displayed in each appropriate area and regular audits were carried out with changes made when necessary. We saw evidence that DRLs were regularly checked and reviewed.

Nursing staffing

- There is no national baseline acuity tool for nursing staffing in outpatients. Staff that we spoke to at all levels said that staffing levels were adequate for the clinics and services that were delivered. During our inspection we observed that staffing levels were adequate and there was an appropriate skill mix including healthcare assistants (HCAs), registered nurses, allied health professionals and clinical support workers.
- At the time of our inspection the vacancy rate for registered nursing staffing was 3%, this equated to one full time member of staff. Senior staff told us that having this vacancy allowed staff from other areas of the trust to be re-deployed into this post for a temporary measure to support flexible working arrangements and also provided opportunities for junior staff to take on extra responsibilities with supervision.
- The general manager of outpatients was responsible for ensuring that staffing levels were appropriate for all clinics. We saw how staffing was pre-planned four weeks ahead of clinics in line with demand and where cover was required due to sickness or annual leave this was mainly covered by bank staff (bank staff were employees of the trust who agreed to work extra shifts). Senior staff told us that shifts were very rarely uncovered.
- From March 2015 to March 2016 there had been no shifts covered in outpatients by agency staff, all extra shifts had been covered by bank staff. Staff told us that if agency and bank staff were required they would need to complete an induction and the department had a specific competency checklist which would be signed. We saw the policies and competency checklists that would be used for staff in these groups and these covered specific areas including health and safety, access to information and infection control procedures.
- In outpatients clinics staff used a 'clock-in' and 'clock-out' system. Staff told us that this was to ensure that when clinics finished all staff could be accounted for as the clinics were located in different areas of the trust.
- Clinical nurse specialists (CNS) provided direct expert care to patients in a number of specialities including oncology, rheumatology and urology.

Radiology staffing

- There was a vacancy rate of 18% in the radiology department. We saw evidence that recruiting to these vacancies had been challenging for the department since 2014. The department had developed a strategy to strengthen staffing in these areas by introducing the 'four-tier model' of progression in radiology and had introduced assistant practitioners who worked under supervision.
- In radiology, consultant cover was provided on-site jointly between the trust and an external provider Monday to Sunday 24 hours per day. On weekends trust consultants provided on-call cover 7am to 1.30pm and 6pm to 9pm, and were also on site 1.30pm to 6pm each weekend and bank holiday. Between the hours of 9pm to 7am, all procedures were performed by trust staff and reporting was outsourced for CT.
- The radiology department had formed a consortium of radiologists and staff told us they covered vacant consultant shifts from the consortia. The radiologists in the consortia were employed by the trust so this meant that they were already familiar with the systems in place and were able to access all information and resources they needed.
- A percentage of radiology scanning and reporting was outsourced to the consortia and an external agency to help manage demand due to the national shortage of radiographers and radiologists. We saw that this process was regularly reviewed and audited.
- Staff told us that there was a structured handover process for staff in radiology when any operational and capacity issues could be discussed.

Medical staffing

- In the outpatients department medical staffing was provided by the specific specialities that were holding the clinics such as rheumatology, cardiology, ophthalmology and audiology. Some of the clinics were also held by visiting consultants from other trusts that worked with South Warwickshire NHS Foundation Trust.
- A small percentage of clinics were cancelled at short notice (five weeks or less than appointment date) due to

consultant unavailability due to sickness or annual leave. The trust's patient access policy acknowledged that unfortunately this might happen and set out clear guidelines on how to manage the process.

Major incident awareness and training

- The trust had a comprehensive major incident policy and staff were able to tell us where this was located on the trust website and within the department.
- In radiology there were effective arrangements in place in case of a radiation or radioactive incident occurring. This included the 'local rules' which provided clear guidance on how to isolate faulty equipment and report it to the RPA and general manager.
- The trust also worked with external partners to develop their response to chemical, radiological, biological and nuclear agents.
- Managers in radiology and outpatients had received training and attended major incident exercises to test and review their business continuity plans.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate the service for effectiveness. We found:

- Care and treatment was delivered in line with evidence based guidance.
- There was a programme of audits conducted across most specialities to improve care.
- The department had recently started working towards accreditation in a national scheme for diagnostics imaging.
- Staff were proactively encouraged to develop new skills.
- Most staff had received an up to date appraisal and identified individual training needs.
- The service worked well with internal and external teams to plan and deliver care and treatment.

Evidence-based care and treatment

- Specialities within outpatients and diagnostics services delivered care and treatment in line with the National Institute of Health and Care Excellence (NICE) and national guidelines where relevant. For example, in radiology a flow chart had been developed to report urgent findings in line with national guidance.
- There was a clear audit programme for specialities in key areas such as bowel screening and diabetes management in line with NICE guidance.
- We saw that in specialities such as cardiology care and treatment was delivered in line with NICE guidelines. A recent national audit conducted in rheumatology regarding early inflammatory arthritis had resulted in educational activities for GPs to encourage early referral for better patient outcomes and a plan to re-audit in the future.
- Proformas for audits in outpatient clinics were in place so that waiting times and cancellations could be recorded and reviewed.
- The radiology department used DRLs in line with national guidance to inform the way that ionising radiation was used to ensure that levels of radiation were continuously reviewed.
- Local rules were clearly displayed and reviewed regularly.
- The Medicines and Healthcare products Regulatory Agency (MHRA) is a government body whose function includes the regulation of medicines and equipment used in healthcare. MHRA guidelines are that professionals in health care are required to demonstrate that they have appropriate training in the use of medical devices. The trust used medical device training log books for individual staff to record their competencies in using devices. We saw that a sample audit of the log books for 369 staff members had been conducted in 31 departments including radiology and outpatients in January 2015 and May 2015. The results of the audit showed that there was variable compliance in recording the data ranging from 0% and 100% and an action plan was devised to improve compliance. Overall compliance had been 61% in January and this had risen to 67% in May, the trust planned to continuously audit this process.

Pain relief

- Staff in outpatient clinics were able to give patients simple analgesia and recorded instances of this on patients records, staff told us that this did not happen very often.

- Patients that we spoke to during our inspection had not required pain relief during their appointments.
- Outpatient clinics included a pain management clinic and staff told us that they had access to clinical nurse specialists at the clinic.

Patient outcomes

- The radiology department was working towards participating in the Imaging Services Accreditation Scheme (ISAS). The department had a consultation in January and planned to work towards accreditation after implementing other service improvement plans such as acquiring additional equipment to increase capacity.
- Medical staff within outpatients and diagnostics undertook local and national audits on a regular basis. We saw that there was a comprehensive audit programme covering all specialities that worked in outpatients. For example, in radiology, audits had been conducted in relation to management of intravenous contrast reactions and cervical imaging for emergency patients aged over 65. These audits were both in progress at the time of our inspection.
- An audit had been completed in June 2015 by the radiology department in line with the Royal College of Radiologists guidelines in regards to needle biopsies for breast screening. The results showed that the inadequate rate of biopsies (that is the percentage of biopsies where sampling was not adequate to obtain a result) was 4%, which was well within the standard set at 20%.
- There were approximately 1.47 follow up appointments to each new appointment, which was better than the England average.

Competent staff

- As of March 2016, 97% of outpatient staff and 95% of radiology staff had received an up to date appraisal. Staff told us that the appraisal was the opportunity to discuss any developmental needs and additional training needs in line with their job roles and responsibilities.
- Medical revalidation is a process that medical staff have to complete in line with the General Medical Council in order to be able to continue practicing. The process requires medical staff to provide evidence of continuing professional development to show that they are up to date with current guidelines. All medical staff in outpatients and diagnostics were up to date with the revalidation requirements.
- Revalidation is the new process that all nurses and midwives in the UK will need to follow from April 2016 to maintain their registration with the Nursing and Midwifery Council and allow them to continue practising. The service had guidance on display in staff areas, highlighting what the requirements are and directing staff to speak to senior staff if they had any questions.
- Nursing staff in outpatients were given bespoke training in specific specialities to develop competencies in different areas. Staff told us this allowed them to gain new skills and also meant that they were able to work confidently in other areas.
- The radiology department had a five year plan which started in 2014 to develop their workforce strategy based on a four tier model of progression. The model was formed of assistant practitioners, practitioners, advanced practitioners and consultants. The trust told us that staff were given training and supervision in the various aspects of radiology based on accredited schemes and in-house training.
- Outpatient clinics had access to paediatric nurses from the separate children's outpatients department (this area is covered in more detail in children and young people's section of the report). Staff in outpatient clinics were trained in safeguarding level two for children and said that if they needed advice they would contact either the paediatric nurse or the safeguarding lead.

Multidisciplinary working

- Outpatients and diagnostics teams worked with speciality teams across the trust and external providers to plan and deliver care and treatment.
- The trust had a patient access policy which described the process for managing patients who were waiting for treatment or care in outpatient clinics and diagnostics. The focus of the policy was for fair, equal and timely access for all patients and compliance to national targets and policies. The trust had a team of staff dedicated to ensuring that the procedures described in the policy were followed. The patient access team worked closely with outpatient clinics and the radiology department to book appointments and manage waiting lists. We saw that weekly meetings were held and

represented by staff in outpatients, radiology and various specialities including cardiology and ophthalmology to discuss ways to utilise resources to meet demand.

- Staff told us that the radiology department worked as part of a consortium of radiologists, this practice has been recognised as an effective way of developing operational delivery networks and managing the national shortage of radiographers and radiologists.
- The radiology department worked with an external provider to ensure that report turnaround times for imaging met clinical guidance. A proportion of routine images were sent to an external provider for reporting, these were audited both by the external provider and internally by the trust. In line with national guidelines and trust policy, discrepancies were discussed and learning was shared amongst radiology staff.
- Visiting consultants from other trusts worked within outpatients. We spoke with one consultant who told us that they were usually supported by a familiar team in outpatients and they worked well together.
- The outpatients department had worked with the local ambulance trust to have a member of the ambulance staff based at the trust to assist with transport for patients who needed support to get to and from appointments.
- We saw that the radiology department worked closely with the emergency department (ED) to co-ordinate care and prioritise treatment for more seriously ill patients.
- There were a number of CNSs that worked in main outpatients and across the other three sites and ran nurse-led clinics alongside consultant-led clinics to help facilitate one-stop clinics in areas such as cardiac rehabilitation, rheumatology and urology.

Seven-day services

- Radiology department had an established seven day service in place, with extended hours to meet clinical demands and plans to increase the provision of services to meet demand. Consultant radiology cover was also provided seven days a week in line with national recommendations by Sir Robert Keogh in the review 'Transforming Urgent and Emergency Services in England' published in November 2013.
- The radiology department provided cover 24 hours a day, seven days a week for the dedicated ED X-ray rooms. CT scanning was available 24 hours a day seven days a week. Between the hours of 9pm and 7am, the reporting of the CT scans was outsourced to an external provider. MRI scans were available at Warwick Hospital Monday to Thursday 8am to 8pm and from 8.30am to 4.30pm Friday to Sunday.
- Clinics for specific specialities were routinely held on weekends this included obstetrics and gynaecology, TIA and urology. Bookings teams and medical records teams also worked on the weekends to support the trust.
- Staff told us that extra clinics were sometimes held in the evenings for specific specialities to manage demand and meet individual needs.

Access to information

- All clinic rooms had access to computer terminals to allow staff timely access to patient information such as x-rays, blood results, medical records and physiotherapy records via the electronic system.
- All permanent and temporary staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance, and e-learning. Staff that were unfamiliar with the systems in the departments, such as new staff or visiting consultants who had already received an induction, were supported by more experienced members of staff with access to information.
- Diagnostic imaging departments used the picture archive communication system to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Staff used systems to check outstanding reports and staff were able to prioritise reporting and meet internal and regulator standards.
- There were systems in place to flag up urgent unexpected findings to GPs and medical staff. This was in accordance with the Royal College of Radiologist guidelines.
- GPs used a dedicated number to contact the bookings teams to make referrals. Letters to GPs should be sent out after the patient had attended their appointment, the trust told us that compliance to this standard was

variable and the trust had plans to review their administrative processes to identify the issues, this was due to be completed late in 2016 and was on the divisional risk register.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at consent forms in several departments and found they were used appropriately to record patients' valid consent.
- Staff that we spoke to were able to describe the relevant consent and decision making requirements relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLs) in place to protect patients. Patients' consent was obtained as per trust procedures.
- Staff told us that MCA was covered as part of the mandatory training in safeguarding which over 90% of all staff in outpatients and radiology had completed.

Are outpatient and diagnostic imaging services caring?

Good

We rated the service overall as good for caring because:

- Patients told us that they were treated with kindness, respect and compassion.
- We saw staff taking the time to interact with patients and those accompanying them.
- The service conducted their own surveys to receive feedback from those using service.
- Patients spoke positively about the care they had received.
- Patients were offered support to manage their treatment and conditions.

Compassionate care

- Patients and those close to them were generally treated with compassion, kindness, dignity and respect including when receiving personal care.
- We saw staff taking the time to interact with patients in a respectful and considerate manner. We saw a member of the nursing staff sitting with and supporting a young patient whilst they waited for their parent to arrive before receiving treatment.
- Patients and their relatives that we spoke with told us that the staff were generally kind, friendly and respectful.
- Patients were given the opportunity to be accompanied by a friend or relative for consultations and there were chaperones available to all areas.
- We saw staff knocking doors before entering treatment rooms to respect privacy and dignity.
- Changing facilities were located in areas that were discreet and there were small individual waiting areas for clinics where patients had to change into gowns for their examinations.
- In the radiology department there were some occasions when an in-patient would be brought into the reception area where outpatients waited. This would be until the patient was booked in at the reception and then the in-patient could be taken to a more suitable area with appropriate curtains to maintain privacy. Staff told us that this was not ideal and this would factor into the re-design of the service and they did their best to ensure that these patients were moved to a more suitable area as soon as possible.
- Patients spoke positively about the caring and respectful attitude of staff. They told us that staff had introduced themselves to them and were attentive to the needs of patients with disabilities and mobility problems.
- The outpatients and diagnostics departments conducted their own Friends and Family Tests and in December 2015 they scored 92% in regards to the question asking if they felt they had been treated with kindness.

Understanding and involvement of patients and those close to them

- Staff communicated with patients in a manner which allowed patients to understand their care and treatment.
- Patients told us that they were kept informed of waiting times by nursing staff and in some clinics there were electronic screens that showed waiting times. In other clinics there were laminated boards on the walls which showed waiting times, we did observe that at some times these were not updated as staff were busy with clinics.

Outpatients and diagnostic imaging

- Patients that we spoke to after their appointment said that they had received information about when they would receive their test results and if they required further diagnostics or treatment what that would consist of.
- We saw information leaflets that were given to patients that clearly stated who they should contact if they had any concerns. These were available in English and staff told us that they could be printed in other languages when required.

Emotional support

- Staff that we spoke to were aware of the impact that a person's treatment, care or condition could affect them both emotionally and socially. Staff were open about how their own personal experiences helped them to empathise with patients and their loved ones.
- Patients who may need extra time to ask questions or understand their treatment such as patients living with dementia were given extra time for their appointments.
- We saw information for various support groups for patients and carers to contact.
- The department had access to clinical nurse specialists who were able to support patients and staff when they were concerned about their diagnosis.
- The outpatients department had a relatives room which could be used for staff to explain further treatment options or if a patient had received news which was upsetting about their condition.

Are outpatient and diagnostic imaging services responsive?

Good

We rated the service as good for responsiveness because:

- Services were planned to meet the needs of the local population.
- Waiting times across diagnostics were better than the England average.
- Clinics and diagnostics were planned to meet patient's needs and demand including extra clinics.
- One stop clinics were in place to minimise the amount of attendances for individuals.
- The services had protocols and procedures in place to manage patients with complex needs including those living with dementia and learning disabilities.
- Patients were offered a choice of appointments to suit their individual needs.

Service planning and delivery to meet the needs of local people

- The radiology department had developed their service to provide 24 hour cover, seven days a week for all modalities to meet the needs of local people and provide greater flexibility for diagnostics.
- Some outpatient's clinics had been designed as 'one-stop' so patients could undergo tests and a consultation within the same appointment, these included specialities such as urology, podiatry and diabetic clinics.
- Clinics were also held at weekends and evenings in specific specialties and to manage waiting lists.
- The outpatients department had a number of wheelchairs at the main entrance which people were able to use by inserting a coin or token into the slot to unlock the chair from the stand.
- The outpatients department was clearly signposted and there were volunteers throughout the hospital who were able to help direct people to various areas of the trust.
- Signs for the radiology department were not as clear upon arrival, but patients that we spoke to told us that they had found it with help from staff and volunteers.
- The department had a number of information leaflets related to procedures and treatments that were sent to patients before their appointments. All information was printed in English and staff told us that these leaflets could also be printed in other languages and formats if required.
- Staff in the outpatients and radiology booking departments told us that if a patient required an interpreter this was arranged for the appointment at the time of booking. We saw the area on consent forms that interpreters would sign to indicate that the patient had understood the information as written.
- The bookings department had specific flowcharts for booking appointments; this included allocating extra time for patients with complex needs. Staff told us that they also highlighted any extra assistance people may need in a specific section of the patient's notes.

Outpatients and diagnostic imaging

- Outpatients and diagnostics imaging services had access to interpreters via the telephone if required; they were available at the time of the appointment.
- The trust had car parking facilities available and patients told us that often they arrived up to an hour early for appointments as finding parking was sometimes problematic and spaces were limited. This resulted in some patients describing a longer wait for their appointment times.

Access and flow

- Referral to treatment time (RTT) is the term used to describe the period between when an appropriate referral for treatment is made and the date of the initial consultation or treatment. The Department of Health stated that as of June 2015, 92% of all patients waiting to receive treatment on 'incomplete pathways' (at the end of the reporting month) should be seen within 18 weeks. This figure represented patients who were to be 'admitted' to receive their treatment and those that were 'non-admitted' to receive their treatment. Prior to June 2015 the indicators were 95% of all 'non-admitted' patients to have received treatment within 18 weeks and 90% of 'admitted' patients to be seen in 18 weeks,92% of all patients on 'incomplete pathways' should be seen within 18 weeks of referral.
- From December 2014 to November 2015 the trust consistently met the 95% indicators for non-admitted patients referred to treatment within 18 weeks. The 92% target for 'incomplete pathways' was also consistently met except for February 2015 when a combination of staffing levels due to sickness and implementation of a new IT system had an impact on performance.
- From July 2014 to June 2015 the percentage of patients who did not attend (DNA) was 6% which was lower than the England average of 7%. The department had clear guidance on how to manage DNA appointments in the patient access policy. Staff told us that DNA rates were monitored and reviewed.
- The service used partial booking for patients attending follow-up appointments. This system allowed patients to book appointments within a specific time scale and at a time that suited their individual needs.
- There were specific waiting times for patients diagnosed with and suspected of having a cancer. 95% of all patients who receive an urgent referral for suspected cancer and breast symptoms should be seen by a specialist within two weeks. All patients should receive their first definitive treatment 31 days from diagnosis and, all patients should receive their first definitive treatment within 62 days from urgent referral. From October 2013 to March 2015 the service mostly performed the same as the England average which ranged from 93%-96% for patients waiting for two week referrals. From April 2015 to September 2015 the two week referral time was slightly worse than average ranging from 91%-94% whilst the England average was consistently above 94% at that time. In the same time period, performance against the 31 day target was mostly the same as the England average and since July 2014 the performance against the 62 day target has been consistently better than the England average.
- From January 2015 to January 2016 the percentage of patients waiting more than six weeks for a diagnostic appointment ranged from less than 1% and 3%. This was consistently better than the England average which ranged from 2% and 3%.
- Senior staff told us that an external review had helped them to identify areas where they could maximise their resources and develop working relationships with external providers to improve their provision. We saw evidence that the radiology department had plans to improve this performance by introducing more services in the community and presenting a business case to secure a further CT scanner and other equipment.
- The number of follow up appointments compared with first appointments influences how many newly referred patients can be seen and meet the waiting times standards. A lower ratio improves patient flow. From July 2014 to July 2015 the trust's follow up to new rate was 1.47 which was consistently lower than the England average which ranged from 2.1 and 2.3.
- Patients who were referred for outpatients and diagnostics were able to book their appointment via an NHS 'Choose and book' system which allowed them to choose a time that was more convenient for them, or they could contact the outpatients and radiology booking teams directly. Staff in the booking teams also contacted patients if a referral was received from a GP or other referrer that was urgent.
- There were laminated boards in outpatients' clinics to show average waiting times, during our inspection we observed that these were not always updated regularly.

In the outpatients phlebotomy clinic a digital screen automatically updated the time for patients. Patients told us that staff came around the waiting areas and advised them if clinics were running late.

- The department had proformas to audit clinic waiting times, we requested data for the audits but the trust did not provide them. Staff told us that 13% of patients waited longer than 30 minutes for their appointment time and 14% of clinics started late. Staff that stayed on late for late running clinics were given the time back at a mutually agreed time, senior staff told us that staff would usually volunteer to work longer and if necessary they would ask for assistance from the other speciality departments. During our inspection we did not see any excessive waiting times, patients that we spoke with that had been in the department did not report any excessive delays of over 30 minutes except for two patients who had arrived early to secure parking.
- Some clinics had an electronic screen which showed patients the expected waiting time for their appointment time. The department had been looking at a number of ways to deliver this information to patients attending these clinics including installing more electronic screens.
- The trust told us that clinics were only cancelled or delayed when absolutely necessary and the trust's patient access policy set out the procedure for prioritising these appointments whilst managing existing waiting lists which included consultant review of patients' records and communication with the patient to rearrange an appointment. The trust's target for cancelled clinics was 2% and from August 2015 to January 2016 the trust average of clinics cancelled was better than the target, achieving less than 1% in December 2015 and January 2016.

Meeting people's individual needs

- The patient access policy provided clear guidance for referrers and staff booking outpatient appointments on how to manage the process including taking into account patient's individual needs. Staff that we spoke to in outpatient's booking teams told us that extra time was allocated to patients who may need support for their appointment such as patients living with dementia, patients attending for the first time and in circumstances when an interpreter may be required.
- The main outpatients department waiting area was appropriate for wheelchair users and some of the clinics within main outpatients had smaller separate waiting areas which were not always suitable for wheelchair users. Staff told us that individual consultations could be moved to different areas of the department to meet the needs of individual patients.
- The main outpatients waiting area had a canteen which was run by a volunteer organisation and patients were able to access hot and cold drinks and snacks. Staff were able to order 'lunch boxes' from the hospital catering service for patients who were waiting in the department for any length of time, for example, patients who were waiting for transport home after an appointment or treatment.
- There was a separate waiting area in main outpatients for children who were accompanying adults and attending for appointments. The area was equipped with toys, books and other distraction items for children.
- Support with transport was available to patients that had mobility problems. The trust worked with the local ambulance trust and had a member of the ambulance staff who was present in the outpatient's department reception and waiting area co-ordinating transport for patients to and from their appointments Monday to Friday. Transport was normally arranged by the referrer for the patient and staff in outpatients were also able to arrange transport when necessary.
- Patients who were living with dementia were given extra time for appointments and staff told us that if the patient did not have a carer or relative with them they would arrange for a specialist dementia liaison nurse to be present or contactable at the time of the patient's appointment. Staff in outpatients had also received specific dementia awareness training, there was also guidance and details of who to contact for assistance throughout the department.
- Patients with learning disabilities were also given extra time for appointments and staff had details of who to contact in the trust if they needed advice.
- There was appropriate seating for bariatric patients and staff told us that they had special equipment to assist if these patients needed help with mobility or to lift them if they fell.
- Some staff in OPD had attended a training session in regards to deaf awareness and sign language.

Learning from complaints and concerns

Outpatients and diagnostic imaging

- All information leaflets contained details of who to contact with concerns and details of how to contact Patient Advisory Liaison Service (PALS) if they wished to make a complaint.
- There had been four complaints recorded from March 2015 to February 2016 for the outpatients department. These related to staff attitude and care and treatment in clinics, we saw no evidence that learning from these complaints was shared with staff in outpatients department. Staff told us that if a verbal complaint was made at the time of the appointment they would try and resolve it at the time and involve senior staff if necessary or appropriate. If the matter could not be resolved they would direct the individual to the PALS.
- The radiology department received four written complaints from March 2015 to February 2016 all of these complaints related to results of diagnostics. Staff told us that in radiology they had received some verbal complaints regarding attitude of staff and this had been communicated to staff through team meetings and staff noticeboards, we saw that staff had been reminded about the importance of effective communication and compassion.

Are outpatient and diagnostic imaging services well-led?

Good

We rated the service as good for well-led because:

- The radiology service had a clear strategy for improvement which was realistic.
- Staff that we spoke to were aware of the trust's vision and values.
- There were robust systems in place to manage and review waiting lists using a multi-disciplinary team approach.
- Staff felt that their local leadership team was approachable and visible.
- Staff at all levels were encouraged to share their ideas through departmental meetings and events.
- The consortium of radiologists provided resilience in the face of national radiographer shortages.

However, we also found:

- Not all staff were aware of the strategy for the service they were in.
- Staff were open about incidents, but not always recording them in line with trust policy.
- There was not a process in place to ensure learning was shared across divisions.

Vision and strategy for this service

- Staff that we spoke to at all levels were aware of the trust's vision and values which were 'To provide high quality, clinically and cost effective local healthcare services that meet the needs of local people' by being Safe, Effective, Caring and Trusted (SECT).
- There was an overall strategy to improve the services in radiology and outpatients department which included 'Four-tier model' for progression within the radiology department and ISAS. We saw plans to increase provision of all services with the expansion of the Stratford Hospital site in line with the trust wide improvement plan.
- In outpatients and radiology bookings there were plans to join all booking teams together to ensure consistency and improve the patients experience by being able to co-ordinate appointments at single point of access. Not all staff we spoke to were aware of the strategy for the service they were in, all staff spoke of the plans for expansion at the Stratford Hospital site.
- The radiology department had undertaken an external consultation in 2014 to improve their performance and had devised a realistic strategy to achieve the priorities and deliver good quality care. Senior staff in radiology we spoke to were proud of the achievements they had made in developing assistant practitioner and advanced practitioner roles to meet the national demand for radiographers. At the time of our inspection six staff had been introduced into these roles and were gaining competencies under supervision in various modalities.
- The strategy for outpatients was focussed on developing access and managing waiting times through the patient access team. The trust had recently installed new telephony software in the bookings departments that had improved performance. Staff who worked in outpatients clinics told us that the strategy for outpatients was to have more space and to continue to develop staff.

- Staff told us that because the various specialities in outpatients worked under different management teams that had their own separate strategies, they were not always aware of the plans for change in outpatient clinics.

Governance, risk management and quality measurement

- The trust had three divisions which specific services were managed under; these were elective care, emergency care and support services. Areas of the outpatients and diagnostics services were managed under all three divisions. For example, radiology and cardiology were managed by the emergency care division, the management of outpatient clinics operations fell under the support services division and outpatients bookings fell under the elective care division.
- Incidents were reported by individual specialities and staff told us that they would only know about incidents related to their area and were unable to describe how learning was shared across the divisions.
- Staff were not always recording the details, actions and outcomes of all incidents, including those that had not caused 'actual harm' but had impacted on service provision for example clinic delays. This meant that learning was not always shared within a department or service and trends could not always be identified.
- In most areas there were governance frameworks to support the delivery of the strategy and good quality care. We saw evidence that the radiology department had regularly discussed their governance processes, these were not yet embedded and the department had plans to improve the way that incidents and the associated learning were managed. This included encouraging the discussion of all incidents amongst all staff by holding regular meetings for staff at all levels.
- The patient access team had regular governance meetings that included staff from a variety of departments including health and safety and human resources.
- There were no specific governance meetings for staff in outpatients. Governance meetings were held for the various specialities and there was no clear process for staff in outpatients to receive feedback from these meetings.
- Cardiology and radiology risks were recorded on the emergency divisional risk register and outpatients clinics risks were recorded under support services divisional risk register. General Managers for each area were aware of their own risks. Staff told us that the main risks were lack of space in all areas and the stability of the IT system.
- There was a clear system and process in place to manage waiting lists and monitor targets for waiting times. The patient access team had developed a colour coded risk rating system so that patients who had been waiting the longest or who had been identified as having the greatest clinical need were highlighted to receive appointments.
- In outpatients department staff described robust plans for staff development and training opportunities including speciality training but they were unsure where the information or plans were recorded. We spoke with staff who had the opportunity to develop from HCA to registered nurse with the support of local managers and the trust.
- The radiology department had a robust system in place to monitor and quality assure the proportion of work that was outsourced externally.

Leadership of service

- Overall leadership of the service was split between the three divisions. Leadership at local levels consisted of general managers of specific specialities, senior nursing and medical staff. Staff that we spoke to knew who their individual local leaders were and felt that they were approachable and that they would feel confident raising concerns with them. Staff also told us that they had seen the chief executive officer in the department and had the opportunity to speak with them; staff told us that they did not see other members of the executive team as often.
- Nursing staff in outpatients described how they had been supported by their general manager to achieve new skills and competencies which had led to a number of promotions for staff.
- The general manager and clinical lead of the radiology departments had regular meetings with staff at all levels and told us they were proud of the achievements they had made and the team they had developed. The bookings teams were managed by two separate divisions and staff told us that this was sometimes

confusing as they had the same targets but different managers. Senior staff told us that as of April 2016 all booking teams would be managed by the patient access team to allow more co-ordinated working. The relatively new general manager for the patient access team had introduced a number of changes including the new telephony system and risk rating protocols for managing waiting lists. This had been achieved by holding a number of meetings which included patient representatives.

- We asked the trust for details of managers and clinical leads in outpatients and radiology who had attended leadership and management training and the trust supplied us with details of two members of staff that had attended training within the last five years.

Culture within the service

- Staff that we spoke to told us that they felt that they were respected and valued members of the team and they worked together to care for patients and make the patient's whole experience better.
- We saw that staff were routinely reminded to observe the trust's code of conduct and maintain professional standards including respect and dignity. Staff were encouraged to challenge any behaviour that was not in line with those standards.
- We saw evidence that the service was working towards meeting the requirements of the Duty of Candour. We saw plans in outpatients for staff to attend bespoke training
- Staff in bookings departments spoke of the importance of their role as part of the whole patient experience and some felt that their role had not always been acknowledged or recognised in the past by some parts of the trust. Some staff felt that recent changes to the way they worked such as the introduction of the new telephony software and re-organisation of managerial arrangements had made them feel more valued.

Public engagement

- Outpatients and diagnostics services conducted their own Friends and Family Test; individual feedback cards were available for all clinics and specialities. The cards were handed out by volunteers and staff were encouraged to hand them out to patients and those accompanying them.
- Patient representatives regularly attended booking improvement meetings.
- Patient's representatives formed a part of the governor's board and we were told that they had been involved in the planning for new developments. We spoke with one governor who told us that they felt that their views were listened to and they had felt a part of the decision-making process specifically in regards to the improvements in the radiology department.
- Staff told us that patient peer groups were supported in rheumatology and diabetes.

Staff engagement

- The outpatients and diagnostics services had regular team meetings. Outpatient staff had the opportunity to attend team building events and were encouraged to share ideas of how to improve their service. Staff told us that these events gave them the opportunity to express any concerns they may have and also the opportunity to develop new ideas.
- The radiology department had regular monthly meetings attended by staff at all levels.

Innovation, improvement and sustainability

- The radiology department had introduced a 'Four Tier' model of progression in response to the national shortage of radiographers, which included assistant and advanced practitioners'
- Outpatients and diagnostics services had developed operational delivery networks with a number of external providers to meet the needs of local people.
- We saw that plans to improve radiology and outpatient services with the development of the Stratford Hospital site were focussed around improving access for local people and long-term financial benefits with the reduction of outsourcing and development of staff.
- The consortium of radiologists was recognised within the NHS as a way to sustain service delivery with the challenges of staff shortages in radiology departments nationally.

Outstanding practice and areas for improvement

Outstanding practice

- 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.
- The use of reminiscence therapy within the emergency Department (ED) for patients with learning disabilities, dementia and mental health conditions.
- A smartphone application for medical staff containing relevant trust information, policies, clinical guidance and teaching availability.
- The ED staff worked with external agencies to provide services, including substance misuse liaison specialist support for patients.
- Processes and procedures had been developed for women on the postnatal ward to self-administer some medication if they opted to do so.

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Ensure that regular risk assessments are completed appropriately on admission to medical wards and repeated regularly to identify any changes in patient's risk of harm. This includes bed rail and mobility assessments and nutritional assessments for patients receiving end of life care
- Ensure that all staff receive safeguarding children training in line with national guidance.
- Ensure that staff have full understanding of the Mental Capacity Act 2005 and their responsibilities and role in the management of patients with capacity concerns. This includes appropriate formal assessment processes and escalation of concerns.

Action the hospital SHOULD take to improve

In addition the trust should:

- Ensure that staff in the outpatients department record all incidents.
- Review staff have a clear understanding of the Duty of Candour.
- Ensure that defined cleaning schedules and standards are in place to comply with the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals'.
- Ensure that infection control and prevention policies are embedded into practice, particularly on the medical wards
- Ensure medicine fridge temperatures are recorded accurately and any deviation from temperature controls acted upon.
- Ensure all medicines are stored safely in locked cupboards.
- Ensure that facilities in the emergency department are suitable for caring for patients with mental health needs.
- Ensure that all mandatory training is completed in line with the trust target.
- Ensure that all staff have completed the relevant safeguarding adult training to ensure staff are aware of their roles and responsibilities in the identification of safeguarding needs and how to escalate concerns.
- Establish formal cover arrangements for acute palliative care consultant post when they were on leave.
- Continue to implement and monitor use of the swipe card access of the corridor and clean utility room in critical care to ensure safe storage of medicines, records and equipment on critical care.
- Investigate and share learning from the controlled drugs incident on critical care and ensure any corrective actions are completed.

Outstanding practice and areas for improvement

- Ensure that all staff working in critical care receive training and guidance regarding their responsibilities outlined in the major incident plan.
- Ensure that staffing levels meet patient demand, enable adequate care of children by a qualified paediatric nurse and allow monitoring of all patients within the department at all times of day.
- Ensure that patient records are stored securely and completed in line with legislation.
- Review the high number of caesarean sections developing an action plan to reduce these.
- Ensure that there is an early warning score tool for babies on SCBU to ensure that any deterioration of a patient's condition is recognised.
- Ensure all trust policies are up to date and relevant.
- Ensure there are appropriate polices and operating procedures to support processes within the emergency department.
- Monitor pain scores in a consistent manner in the emergency department and ensure that there are formal pain tools used across SCBU and Macgregor ward.
- Ensure that advance care plans (a plan that documents patients' views, preferences and wishes about their future care) are in place for patients receiving end of life care.
- Ensure the annual audit plan for maternity is formally approved, that recommendations address the issues identified and action plans for improvement are developed.
- Develop, approve and implement an annual audit plan for gynaecology.
- Ensure that outcomes for gynaecology patients are clearly presented and reviewed.
- Ensure that nurses on the gynaecology ward receive training relevant to the specialism and acuity of patients admitted to the Beaumont ward.
- Ensure privacy of in patients attending radiology department is maintained.
- Ensure that the use of the individual plan for the dying person is embedded.
- Audit the effectiveness of the end of life care service, including collecting information on the number of patients who have been discharged to their preferred place of care, collecting information on those patients who died in their preferred place of death and audit the effectiveness of the rapid discharge process.
- Ensure arrangements are in place to monitor how quickly women attending midwifery assessment unit are seen and treated.
- Ensure specialist palliative care team referral guidelines are place, and circulated to all wards and departments.
- Reduce the delays for patients being discharged from critical care to the wards.
- Ensure that leaflets and interpreters are available and used for non- English speaking patients.
- Ensure that all complaints are reported to ensure themes are identified and lessons learnt cascaded to staff.
- Ensure that there is clear leadership and overall oversight of care for neonates, children and young people.
- Ensure that the arrangements for governance and performance management operate effectively in the services for children and young people.
- Ensure that all risks are identified on the risk register and appropriate mitigating actions taken.
- Ensure there is a clear process for the documentation and review of risks within the gynaecology service
- Ensure that each service has a local vision and strategy which is disseminated and understood by all staff so that it is embedded within the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014 Safe Care and treatment** Regulation 12 (2)(a) (c) Safe care and treatment Care and treatment must be provided in a safe way for service users including assessing the risks to the health and safety of service users of receiving the care or treatment. Persons providing care or treatment to service users must have the qualifications, competence, skills and experience to do so safely. Patient risk assessments were not fully completed on admission and generally not reviewed at regular intervals throughout the inpatient stay. The level of safeguarding children's training that staff in certain roles received was not compliant with national guidance. Staff did not have a full understanding of the Mental Capacity Act (2005) and their responsibilities and role in the management of patients with capacity concerns.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...