Care Quality Commission

Chesterfield Royal Hospital NHS Foundation Trust

Chesterfield Royal Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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Chesterfield Royal Hospital was built in the 1980s and became a foundation trust in 2005. The hospital serves five local districts with a population of approximately 441,000. There is a small ethnic minority population, with over 96% of the population belonging to a white ethnic group. Life expectancy for both men and women in two districts (Chesterfield and Bolsover) is worse than the England average.

The hospital provides 682 inpatient beds and employs over 3,500 staff. In the year 2013-14, there were more than 71,000 inpatient admissions and 257,000 outpatient attendances; over 67,000 patients attended the accident and emergency department.

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a low risk trust according to our new intelligent monitoring model. Our inspection was carried out in two parts: the announced visit, which took place on the 21,22,23 and 24th April 2015; and the unannounced visit which took place during the evening of the 2 May 2015.

Our key findings were as follows:

- All of the services we inspected were found to be caring. Staff were kind and caring towards patients, and treated patients with dignity and respect. Most patients and visitors we spoke with were complimentary about the care they were receiving.
- Overall we observed the hospital and clinic environments were visibly clean, hygienic and well-maintained. Improvements were needed in relation to the storage of clinical waste in the Eye Centre, within the Outpatients service. Patients told us they were impressed with the standards of cleanliness. There had been 30 cases of C difficile (a bacteria which causes diarrhoea) infection in the year up to February 2015 which was worse than the England average. Fifteen of the 23 (65%) confirmed patients with C difficile had one or more lapses in the quality of care identified as part of the investigation process. There had been two cases of Methicillin Resistant Staphylococcus Aureus (MRSA) reported between April 2013 to Nov 2014, both occurring in 2013. The trust had 17 cases of Methicillin-Susceptible Staphylococcus Aureus (MSSA) throughout the same period but this was similar to the England average. MRSA and MSSA are types of bacteria that can cause infections. We found there were systems in place to deal with infection prevention, and control and we observed staff to be following the trust guidelines.
- Nursing staffing levels had been reviewed and there had been an increase in nursing and midwifery staff. We found the day time staffing levels were in line with national guidance and generally, both the day and night time staffing was in line with the numbers of staff the trust had identified they needed. There was an escalation process in place so that staff could flag if they were concerned about the staffing levels on each shift. In some areas, particularly within medicine, staff didn't feel there were always enough staff on duty overnight. Some of the staff told us they didn't report their concerns about the night staffing levels through the incident reporting system. We raised this with the trust and they took action straight away to review their staffing levels at night. There was a reliance on bank and agency nursing staff in some areas and like many trusts, they faced difficulties recruiting nurses.
- There had been an increase in the number of midwives, and although the trust was not meeting national recommendations for birth to midwife ratios, staffing was comparable with other maternity services across the region. The trust was not able to provide a band six registered children's nurse to be on duty at all times. This was due to difficulties in recruiting suitably experienced children's nurses.
- Medical staffing was at safe levels in most of the services we inspected; however in some areas there were vacant posts and reliance on locum medical staff.

Summary of findings

- Patients were provided with the assistance they needed to eat and drink and the risk of malnutrition or dehydration was assessed. Speech and language therapists provided support to ward areas to carry out swallowing assessments, and dieticians provided nutritional advice.
- Patients' pain was assessed and generally well managed. There were no specialised tools in place to assess pain in those with a cognitive impairment such as a learning disability or those living with dementia. Women in labour were given a choice of pain relief and provided with non-pharmacological options such as aromatherapy and the use of a birthing pool. Epidural pain relief was available on request, and the waiting time for this was within an acceptable 30 minute timeframe.
- Monitoring by the Care Quality Commission had not identified any areas where medical care would be considered a statistical outlier when compared with other hospitals. The trust reported data for mortality indicators, the summary hospital-level mortality indicator (SHMI) and hospital standardised mortality ratio (HSMR). These indicate if more patients were dying than would be expected given the characteristics of the patients treated there. The figures for the trust were as expected. Information about patients' outcomes was monitored. The trust participated in all of the national audits it was eligible for. Where improvements were identified, the trust was responding and was making progress implementing its action plans in order to improve the quality of care they were providing.
- Like many trusts in England, the hospital was busy and the trust had faced challenges in access and flow, especially during the winter months. Bed occupancy in the hospital had been consistently over 90% which was above the England average of 88%. In the medical division, bed occupancy was 95.5% in February 2015. It is generally accepted that when bed occupancy goes over 85% it can start to affect the quality of care provided to patients and the running of the hospital. Due to issues with patient flow, medical patients were transferred or admitted to beds that were designated for other specialities.
- The trust had a clear vision and a set of values which the vast majority of staff understood. This had been developed alongside staff and other stakeholders. There were a number of strategies in place and these all had clear goals which were measurable. All actions from the working strategies were being monitored. This allowed performance to be closely monitored.
- The trust worked on a divisional structure which was clinically led, the chief executive described how this empowered clinical staff. There was recognition however, that this was more developed in some areas than in others, and more time was needed for this structure to become embedded.
- The senior leaders in the trust had been working to increase the level of staff engagement. This was work in progress and we found evidence to suggest this was improving, but the staff survey results had been disappointing for the trust. Many staff told us they felt the organisation had changed over the past two years and was now one which had a real focus on the quality of care for patients.

We saw several areas of outstanding practice including:

- Staff in the x-ray department were able to view the electronic patient information screen held in the emergency department. This meant they knew when patients were awaiting x-ray and responded promptly, usually within 20 minutes of the request being entered into the system.
- Staff working for the local mental health trust which provides care for people with mental health problems, were able to view the electronic information screen held in the emergency department. This meant they knew when patients were awaiting review and responded promptly, usually within 60 minutes.
- Locum doctors working in the emergency department received quarterly reviews with an educational supervisor.
- The multidisciplinary huddle within the emergency department was informative and effective and valued by the team and wider trust staff.

Summary of findings

- As a pilot fixed term project, a pharmacist worked in the department to support all aspects of medicines management. Data showed this was beneficial to patients and speeded up admission processes.
- The trust had a clear vision of how its clinical environments could be made dementia friendly. They had realised this vision in the refurbishment of the discharge lounge.
- Each clinical area had its own improvement plan . This meant ward matrons and their staff were clear about the various quality and safety improvement initiatives in progress, how they would be achieved, and how they were inter-related.
- The trust had reacted positively to audit data and had embarked on a local health and social care economy project to produce and implement a dementia and delirium patient treatment pathway. Manvers ward had introduced patient based communication folders which allowed written requests for information to be made and responded to within 24 hours.

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

Action the hospital MUST take to improve

- Ensure there is appropriate and timely monitoring of deteriorating patients within the HDU department.
- Ensure ward staff are supported to identify and manage very sick or deteriorating patients in ward areas.
- Ensure that people who may lack capacity to make decisions about their care have an adequate assessment of their mental capacity, and that decisions about DNACPR are taken in line with the requirements of the Mental Capacity Act (2005).
- Ensure that an accurate record is kept for each baby, child, and young person which includes appropriate information and documents the care and treatment provided.
- Ensure all DNACPR order forms are completed accurately and in line with trust policy.
- Ensure that numbers of registered nurses meet national guidance, and meet the needs of patients at all times, including throughout the night.
- Ensure that an experienced, senior children's nurse is available during the 24-hour period to provide the necessary support to the nursing team.
- Ensure that there are sufficient numbers of staff to provide the dermatology outpatient service.
- Ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- Ensure all staff involved in caring for patients at the end of life receives adequate training in end of life care.
- Ensure the resuscitation trolleys and their equipment are checked, properly maintained, and fit for purpose in all clinical areas.
- Ensure there are robust waste management procedures in place.

Action the hospital SHOULD take to improve:

- The trust should ensure sufficient cover in the accident and emergency department to allow all staff to attend necessary training sessions.
- The trust should consider the effectiveness of signage in the emergency department reception area to advise patients when their condition requires them to proceed to the front of the queue.
- The trust should ensure safe and effective processes for the disposal of clinical and chemical waste.
- The trust should review its medical bed capacity to ensure that the majority of patients are cared for in the correct speciality bed for the duration of their hospital admission. It should also review its arrangements for the management of patients outlying in non-speciality beds to ensure the quality and safety of their care is not compromised.

Summary of findings

- The trust should review its arrangements for quality assuring Root Cause Analyses, and for monitoring the implementation and efficacy of any associated action plans to ensure that RCA's identify remedial actions that are fully implemented and evaluated.
- The trust should review its arrangements for ensuring the monitoring of in-dwelling intravenous devices in line with "Saving Lives" guidance.
- The trust should review the provision of the continuous piped oxygen and suction issue in the cardiac catheter laboratory and associated recovery areas.
- The trust should ensure that all confidential patient records in clinical areas, and confidential waste, are securely stored to minimise the risk of unauthorised access.
- The trust should review how it can provide both rehabilitation and follow up for patients who are discharged from intensive care to meet NICE guidance.
- The trust should take steps to reduce the number of patients being discharged from the critical care unit overnight.
- The providers should ensure suitable storage in the critical care unit is available so that equipment can be plugged in when being stored.
- The trust should ensure intravenous fluids are stored safely in the critical care unit.
- The trust should ensure that staff in the fracture clinic where children and young people are seen, understand their roles and individual responsibilities to prevent, identify and report abuse when providing care and treatment.
- The trust should ensure that they have written formal arrangements in place with the children and adolescent mental health team so that the needs of children and young people with mental health problems are met.
- The trust should ensure that agreed care pathways and written guidance are in place to guide staff when caring for children and young people who have mental health conditions.
- The trust should ensure there is an effective link nurse structure to enable local support and guidance in end of life care in the absence of the specialist palliative care team.
- The trust should review the hours of service provided by the specialist palliative care team to include a face-to-face specialist palliative care service from at least 9am to 5pm, seven days per week.
- The trust should consider reviewing their local and national audit activity in order to monitor the effectiveness of end of life care services and benchmark against end of life services nationally.
- The trust should review the storage of patient property following a patient's death.
- The trust should ensure a risk assessment is undertaken for those patients who are waiting within outpatient areas with no clinical oversight.
- The trust should ensure a clearly defined governance structure across the entire outpatient services. There should be more monitoring of patient outcomes and performance such as waiting times within clinics.
- The trust should ensure that there is a clear process for triaging of test results in Dermatology outpatients. by appropriately trained staff to ensure patient safety.
- The trust should review the environment within dermatology outpatients to ensure the privacy and dignity of patients.
- The trust should ensure that medical records are stored securely within outpatients.
- The trust should ensure staff leading on serious investigations working in the maternity service are appropriately trained in investigatory processes and report writing.
- The trust should strengthen the investigation of serious incidents within maternity services to include multidisciplinary involvement, the development of SMART action plans, and senior review and approval, in line with the Serious Incident Guidance, March 2015.
- The trust should ensure women who have undergone a termination of pregnancy are cared for in an area that provides them with dignity and respect.
- The trust should ensure staff working in the maternity service are given feedback on complaints received identifying themes and preventative actions.

Summary of findings

- The trust should review its complaints handling procedures to ensure that patient complaints are responded to in a timely manner. It should also ensure that staff understand the role and function of the Patient Advice and Liaison service.

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 	Overall, the urgent and emergency service was good. People were protected from abuse and avoidable harm. Reliable systems and processes were in place to promote safe care and emergency preparedness plans were in place. People's care, treatment and support achieved good outcomes for patients and were based on the best available evidence. Staff were appropriately qualified and received regular relevant training and appraisal, although some staff told us of difficulties accessing 'essential training' because of workload within the department. Staff treated people with compassion, kindness, dignity and respect. Most patients were positive about the care they received. Services were planned, organised and delivered to meet people's needs. However the department had been designed and built to accommodate a much smaller number of patients. At times staff struggled to provide responsive care because of environmental constraints. Leadership and management of the emergency department focussed on the delivery of high quality care. There was a positive team culture with excellent relationships between nursing and medical staff. Junior doctors were especially complementary about the support they received from consultants and nursing staff.
Medical care	Requires improvement 	Overall we found medical care services required improvement. This was because we identified some concerns in relation to nursing staffing at night, arrangements to identify and support patients whose condition was deteriorating, the management of confidential records and waste and below national average rates of harm-free care. There was insufficient capacity for the numbers of patients. This resulted in patients being moved around the hospital and treated in non-speciality beds where the quality of their care could be compromised. We also found that complaints were not managed in a timely manner.

Summary of findings

There were good systems to report and investigate safety incidents and systems to prevent and control infection. There were arrangements to meet the individual needs of patients including those with complex problems. Treatment generally followed current guidance, and that although outcomes for patients were sometimes less than average, action was taken to remedy this. We saw that developments were in progress to improve the care of people living with dementia and there were systems to ensure discharge from hospital was a planned event. Patients had access to most services seven days a week and were cared for by a multi-disciplinary team working in a co-ordinated way. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligations under the Mental Capacity Act.

There was an appropriate system of governance and arrangements to monitor performance as well as to escalate risks to the trust board. Staff could discuss the trust philosophy and each ward had its own strategy which staff understood. We observed a caring and positive ethos, and a culture of openness between senior managers and staff. Patients and their relatives were overwhelmingly positive about their experience of care and the kindness afforded them. We witnessed compassionate care that promoted patients' privacy and dignity. Patients were involved in their care and treatment and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

Surgery

Requires improvement

Overall we found surgical services to require improvement. Insufficient staff had attended essential training on caring for people who do not have capacity to make decisions about their treatment, and staff did not demonstrate understanding of this aspect of care. Staff did not consistently monitor patients' level of hydration where this was required. Staff did not always receive an annual performance appraisal, and uptake of appraisal was significantly lower than the trust's own target.

Summary of findings

Patients did not always receive treatment in an appropriate timescale after referral. Average lengths of stay were slightly longer than the England average. Surgical wards received a relatively high number of medical patients, for whom the medical wards did not have sufficient capacity. This impacted on the quality of care for all patients.
There were effective systems for reporting patient safety incidents and learning from them. Ward staff adhered to infection prevention and control best practice. Most equipment was well maintained and stored. Medicines were managed safely, although storage was not always suitable.
Surgical outcomes for patients were monitored and were mostly within the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements. There was good multi-disciplinary working in all the wards and departments we inspected. Staff were kind, compassionate and caring towards patients.
Patients were involved in decisions about their care options and were given enough information about their condition.
Staff demonstrated a good awareness of the trust complaints procedure and how to deal with complaints, but did not always respond to complainants within a reasonable time frame.
Surgical services were led by committed and enthusiastic staff. Governance arrangements largely identified and managed risks to quality and performance.

Critical care

Good

Overall the critical care service was good. There were areas of good practice in critical care services but there were risks posed by the cramped conditions on the ITU; the cubicles had no space to allow staff to put on appropriate protective clothing. The patients in the HDU were under the care of the consultant they were admitted under rather than the intensivists (doctors with additional training in treating critically ill patients). This led to delays in assessment and treatment.
There was a problem with patient flow through both critical care areas and patients' discharge to

the wards were often delayed due to a lack of beds. This led to the potential shortage of critical care beds. There was a higher than expected number of re-admissions to the HDU.
Guidance from professional bodies was followed as much as practicable. The critical care units had no outreach team to assist the wards in managing critically ill and deteriorating patients. There was no rehabilitation service offered for patients in ITU, including no outpatient follow up. One consultant and nurse were offering a limited service to follow up patients who contacted the unit, but this was not automatically offered to patients. There was a plan for the development of the service for the future.
Nursing staff reported excellent and responsive relationships with the medical staff in the ITU, but delays in getting patients to be reviewed in HDU. There were good examples of multidisciplinary working to ensure that patients' needs were met. Leadership of the units was supportive and effective at reducing risks to the best of their ability.

Maternity and gynaecology — **Good**

Overall, the maternity and gynaecology service was good. Although staff were confident in reporting patient safety incidents, serious incidents were not investigated thoroughly and learning from incidents was not consistently shared. The maternity department did not use a recognised method of collecting information on quality and safety so as to improve practice
Numbers of midwives did not meet nationally recommended levels and medical cover was stretched. Nursing staff were not using the 'early warning' system properly that would alert them to a patient's health deteriorating and the need to request medical review. The department did not use professionally recommended ways of measuring outcomes for patients so as to compare its performance to other similar departments.
The maternity department was clean and well organised. Equipment was available when needed and there were systems in place to manage medicines safely. Patient records were accurate and up to date. Staff were caring and respectful towards women Staff had access to professional practice guidance. Midwives were trained to deliver their

roles effectively, were supervised and supported to maintain their competencies and professional development. There was good multi-disciplinary working with a range of professionals. Staff enjoyed working in the department; they were proud of the facilities and care they provided.

Services for children and young people

Good

Overall, the services for children and young people were good. However, the trust did not provide on site paediatric consultant cover until 10pm, in line with nationally recognised standards. There were not enough experienced nurses employed over the 24-hour period to provide the necessary support to the Nightingale ward nursing team. Although risks to patients were assessed and managed, staff were not consistently monitoring the emergency resuscitation equipment and we found care records were not always accurate. Staff responsibilities for child safeguarding issues were not embedded in all of the adult outpatient areas where children and young people were seen.

Staff were caring, compassionate and respectful. There were good examples of collaborative working in the multi-disciplinary team. Staff were positive about working in the service and morale was high. There was a culture of openness, flexibility and commitment. Arrangements were in place to minimise risks to children and young people receiving care, and there was effective monitoring of quality and outcomes. The neonatal unit had implemented a developmental care approach to caring for babies.

End of life care

Requires improvement

Overall the end of life care services required improvement. While evidence based assessment, care and treatment were mostly in line with national guidance and quality standards, outcomes for end of life and palliative care patients were not always monitored. The trust was unable to identify where improvements in the service were required. Specialist palliative care was provided under a service level agreement (SLA) that had expired. Training provided by the specialist palliative care team was not consistent across the clinical areas with some staff receiving little or no training.

End of life services protected patients from avoidable harm and abuse. 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. We saw elements of good practice including the storage of patient identifiable information; clean clinical areas and good infection prevention and control practice. Patients were treated with dignity and respect, and were involved in their care. We found all staff to be compassionate and dedicated to providing good end of life care. However, we could not be assured staff had communicated effectively with those patients in the last days or hours of life in order to ensure their wishes, needs and preferences had been met.

Outpatients and diagnostic imaging — **Requires improvement**

Overall the outpatient and diagnostic imaging service required improvement. Staff reported patient safety incidents and there was evidence of learning from incidents and patient complaints. However, feedback following incidents was not consistent across all areas. There was limited risk assessment in the individual areas, and resuscitation trolleys were not consistently checked. Clinical waste in the eye centre was not disposed of securely to protect patients from possible risk of harm.

Once patients arrived at the hospital there was no measurement or recording of waiting times. The patient waiting areas were not attended by staff so patients could be in the wrong outpatient suite or would be unable to seek assistance if needed in an emergency. The dermatology clinic had low staffing levels and long waiting times for appointments. Furthermore, there were no protocols for clerical staff to follow when prioritising patients' test results.

Outpatient departments appeared visibly clean and staff used personal protective equipment, such as gloves and aprons. Patients care and treatment was delivered in line with current national standards and legislation. Outpatient services were delivered in a way that met the needs of the local population. Staff demonstrated a commitment to patient-centred care. Patients were treated with dignity and respect and spoke highly of the staff. Patient input and feedback was actively sought and

Summary of findings

several areas had established patient focus and support groups. In some areas space was limited. Certain areas within the imaging department did not have separate waiting areas for in patient and out patients and this led to potential issues with maintaining patients' privacy and dignity. This had been identified as a risk on the risk register and plans were in place to address this. Funding had been identified in the 2015/16 capital funding programme.

There were some areas that provided a proactive service to patients which included several one stop clinics providing efficient co-ordinated care. Clinical governance knowledge was limited within certain divisions of outpatients. At a local level staff felt supported by immediate line managers and clinicians. They felt listened to and able to raise concerns.

Chesterfield Royal Hospital

Detailed findings

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

Detailed findings

Contents

Background to Chesterfield Royal Hospital

Chesterfield Royal Hospital was built in the 1980s and became a foundation trust in 2005. The hospital serves five local districts with a population of approximately 441,000. There is a small ethnic minority population, with over 96% of the population belonging to a white ethnic group. Life expectancy for both men and women in two districts (Chesterfield and Bolsover) is worse than the England average.

The hospital provides 682 inpatient beds, and employs over 3,500 staff. In the year 2013-14 there were more than 71,000 inpatient admissions, and 257,000 outpatient attendances; over 67,000 patients attended the accident and emergency department.

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Improvement Director for Monitor

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The team of 40 included CQC inspection managers, inspectors and a variety of specialists; medical consultants, a surgical consultant, a consultant obstetrician, a consultant paediatrician, a consultant anaesthetist, a junior doctor, board-level nurses, modern matrons, specialist nurses, an emergency nurse manager, a paramedic, a student nurse, a physiotherapist and two experts by experience.

How we carried out this inspection

To get to the heart of the patient care experience, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the Clinical Commissioning Group, Monitor, Health Education

Detailed findings

England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch. We also held one public listening event, as well as a focus group with the Derbyshire Gypsy Liaison Group.

We carried out an announced inspection visit from 21 to 24 April 2015. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patient records of personal care and treatment.

We carried out an unannounced inspection on 2 May 2015 of some medical and surgical wards, the critical care department, and the birth centre.

Facts and data about Chesterfield Royal Hospital

Chesterfield Royal Hospital provides a full range of acute services and 24-hour accident and emergency care. The hospital provides a number of specialist children's services, including child and adolescent mental health, family therapy services, children's physiotherapy, and school nursing. Some of these are delivered in the community and our inspection of the community services for children, young people and families is reported on separately.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department at Chesterfield Royal Hospital provided consultant-led emergency care and treatment 24 hours a day, seven days a week to a population of approximately 416,000 in the Chesterfield and North Derbyshire area.

The department had a flexible number of beds up to 12, on a Clinical Decisions Unit (CDU) where patients could be admitted under an emergency department consultant for short term observation. There was an ambulatory care unit with seven bays located on the CDU.

Last year 70,378 patients, including children, attended the emergency department.

During our inspection we spoke with 23 patients, 26 relatives or carers, 50 staff and 8 non trust staff. We looked at 32 records of care and treatment. As part of our inspection we used the Short Observational Framework for inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us.

The emergency department was built in the 1980's for approximately 40,000 attendances and the trust is working with partners to plan and develop an urgent care village with capacity to accommodate the increased patient numbers.

Summary of findings

The emergency department was safe and people were protected from abuse and avoidable harm. Reliable systems and processes were in place to promote safe care and emergency preparedness plans were in place.

People's care, treatment and support achieved good outcomes for patients and were based on the best available evidence. Staff were appropriately qualified and received regular relevant training and appraisal, although some staff told us of difficulties accessing 'essential training' because of workload within the department.

Staff treated people with compassion, kindness, dignity and respect. Most patients were positive about the care they received. Services were planned, organised and delivered to meet people's needs. However the department had been designed and built to accommodate a much smaller number of patients. At times staff struggled to provide responsive care because of environmental constraints.

Leadership and management of the emergency department focussed on the delivery of high quality care. There was a positive team culture with excellent relationships between nursing and medical staff. Junior doctors were especially complementary about the support they received from consultants and nursing staff.

Urgent and emergency services

Are urgent and emergency services safe?

Good

Overall we judged the safety of the service was good.

The emergency department was safe and people were protected from abuse and avoidable harm. Lessons were learnt and improvements made when things went wrong. There were reliable systems and processes to promote safe care, including approaches to infection prevention and control and the safe management of medicines. However, there were some unsafe practices regarding the disposal of clinical and chemical waste.

Staff recognised and responded to any deterioration in a patient's health and worked with others to prevent and respond appropriately to any signs of allegations of abuse. Staffing levels were set to meet patients' needs. Effective emergency preparedness plans were in place.

Incidents

- The department had reported four serious incidents requiring investigation (SIRIs) to the Strategic Executive Information System (STEIS) between February 2014 and January 2015.There had been full investigations and learning from these incidents had been recorded and agreed actions completed.
- Staff were aware of the trust's electronic incident reporting procedure and how to use it. Security staff completed their own forms which were shared with the trust and agency nurses escalated incidents to the nurse in charge for reporting.
- Staff at all levels received feedback from incidents, verbally and via email. This was recorded in the minutes of departmental and organisational meetings as well as being discussed at staff handovers each day.
- Learning was shared and actions were taken to implement learning. For example, staff received training on a piece of equipment during our inspection following an incident the previous week.
- Mortality and morbidity meetings are used in emergency departments to review deaths and learn from them. These meetings were held at trust level and quarterly within the emergency department but were not recorded and this meant there was a risk that learning from deaths may not have been shared appropriately.
- Medical staff were aware of the Duty of Candour regulation as they had attended an educational session. This regulation requires NHS healthcare providers to be open and transparent with people about the care they receive. They were able to give us examples of when they had put this into practice.

Cleanliness, infection control and hygiene

- The department was clean and staff were aware of the current infection prevention and control guidelines.
- Adequate hand washing facilities and alcohol gel were available throughout the department.
- Staff followed hand hygiene procedures, 'bare below the elbow' guidance and wore personal protective equipment such as gloves where appropriate, so as to help prevent the spread of infection.
- At the time of our visit external clinical waste bins were left open and unlocked and chemically contaminated waste was found on the floor in split bags. This was an infection control and health and safety risk. We brought this to the attention of staff within the department who acted immediately to lock the bins and remove the contaminated waste.

Environment and equipment

- There were adequate supplies of available, accessible and suitable equipment, including resuscitation equipment. There was a schedule for regular checks of this equipment.
- There was a safe and effective system in place for the repair and maintenance of equipment.
- The paediatric resuscitation trolley in the emergency department was laid out identically to the one in the children's ward so that staff working together to treat a sick child were always familiar with the location of equipment.
- Some medical gas cylinders were stored on a public corridor at the rear of the emergency department. Some were not contained in cages and were free standing on the floor. We spoke to a member of the portering team who told us these cylinders were empty and that the store was a secondary location so as to reduce the time

spent retrieving cylinders from the primary store. However, unsecured cylinders were a potential hazard and they could have been removed by an unauthorised person.

Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately.
- Qualified nurses working in the 'see and treat' area were working under a patient group direction (PGD) for the prescription of simple pain relief. Patient group directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- A pharmacist was working in the emergency department from 9am to 5pm Monday to Friday on a trial basis over the winter period from October to April. They gave advice on dispensing and prescribing, reviewed medications prescribed by doctors, especially checking antibiotics. They reviewed patients' own medications which they bought with them to the department and completed monthly reviews of stock levels ensuring compliance with the College of Emergency Medicine (CEM) and National Institute for Health and Care Excellence (NICE) guidance. They also delivered training for PGD, conducted audits and supported learning from incidents relating to medication errors.

Records

- The department used an electronic system to create computerised records. When patients were admitted to the hospital, records were printed and passed on in hard copy format.
- We looked at 32 records of care and found that they were all completed in accordance with the trust's policy.
- Appropriate risk assessments had been completed and regular observations including early warning scores.
- Only authorised staff had access to patient records. The system was password protected. Agency staff were allocated a password which was only valid for the duration of their shift.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children. The paediatric nursing sister was the children's safeguarding lead for the emergency department.
- The hospital adult safeguarding lead attended the departmental huddle (meeting between staff at the end of a shift and those starting a shift) twice a week to share updates. Staff told us they could always contact the right people.
- The hospital electronic records system alerted staff to children presenting at the department who were at risk of abuse. There was also a system in place to ensure that children were protected should their parents attend the department as patients.
- A paediatric liaison nurse reviewed every attendance for young people under the age of 17 to ensure risks had been appropriately identified.
- There were procedures for adults and young people over the age of 16 who may be at risk of domestic abuse.
- The department monitored which staff had attended safeguarding adults and children's training. 83% of nurses were up to date with level two and 81% with level three safeguarding training.
- All junior doctors had received basic children's safeguarding training during their induction.
- Half of the medical consultants in the department were up to date with their level three children's safeguarding 3 training and the remaining 43% were due to re certify this level during 2015.
- The locum doctors working in the departments had received training in accordance with the national agreements that were in place. The trust only used locum doctors from a recognised agency who complied with these standards.

Mandatory training

- Staff received annual 'Essential Training' in mandatory topics such as infection prevention control, fire safety, resuscitation, dementia and safeguarding. Completion rates for auxiliary and nursing staff were above departmental targets but for medical staff 83% had completed the training against a target of 85%.
- Some nurses told us they were prevented from attending mandatory training as they were called back to work in the department when it was busy. If this happened, staff were booked on training for the next available and most appropriate date.

- 89% of nurses working in the emergency department were trained in the care of children and assessed using the department's own paediatric competency pack. The Platt report (1959) stipulated that children in hospital must be cared for by staff trained in caring for children. The Royal College of Nursing recommends a minimum of one children's trained nurse in each emergency department. The department had three paediatric trained nurses one of whom was the paediatric lead nurse, available to support the care of children within the department. There was also a matron trained in the care of children.
- The department monitored the numbers of staff who had undertaken paediatric life support. A total of 87% of nursing staff were trained in paediatric life support .
- All of the junior doctors had received a bespoke half day lecture and clinical skills training on paediatric resuscitation and the "unwell child" during their induction.
- All of the emergency department consultants and Associated Specialists were up to date with advanced paediatric life support.

Assessing and responding to patient risk

- Between July 2013 and October 2014 ambulance patients were assessed within the national target of 15 minutes and usually in under 10 minutes. However, staff working in this area told us that it was a challenge to complete all the required processes within the 15 minute target time.
- Staff in the department used a recognised early warning score to identify when a patient's condition was serious or deteriorating. For children, the department used a paediatric early warning score (PEWS). Staff were aware of the tools and how to escalate concerns regarding a patient. The scores were recorded on the computerised system so that all staff could see patient priority. We saw examples of care being escalated promptly when a patient's condition deteriorated.
- There was an electronic screen in the staff base area showing patient observations for stretcher cubicles which were not visible. Staff used this to assist them in recognising deteriorating patients.
- The minor injuries reception was staffed by receptionists who were aware of how to recognise an unwell patient and escalate their concerns to nursing staff. However, signs at reception could be confusing for patients as a sign advising them to wait behind the red line was next to a sign indicating that patients with chest pain should proceed to the front of the queue.
- An escalation policy and guidance for the nurse in charge of the emergency department were available.
- Between July 2013 and October 2014 patients arriving by ambulance were assessed within an average of seven minutes of arrival. This was worse than the England average of five minutes but better than the 15 minute standard.
- A receptionist was allocated to work in the "Pit Stop" area between the hours of 7am and 7pm where patients arriving by ambulance were received. This meant their details could be recorded swiftly and treatment begun promptly. At other times ambulance crews passed on patient details in the reception area. However, staff working in this area told us that it was a challenge to complete all the required processes within the 15 minute target time.
- The Care Quality Commission (CQC) A&E survey of 2014 showed that responses to questions asked of patients regarding safety were in line with England averages.

Nursing staffing

- Emergency nurse practitioners (ENP) worked in the see and treat area of the department reviewing minor injuries and illnesses between 9am and 9pm Monday to Friday.
- Two qualified nurses and one health care assistant were allocated to work in the pit stop area (where patients transported by ambulance were received) 24 hours per day.
- The department employed two matrons, 51 full time equivalent trained nurses and 19 full time equivalent health care assistants (HCAs) as well as three housekeeping staff.
- At the start of a shift nursing staff were allocated to the see and treat area, pit stop and major corridor. No nursing staff were allocated to the resuscitation room. When a patient was treated in this room a nurse was taken from the major's corridor.
- Nursing skill mix was appropriate. There were nine registered nurses per shift across the department and four health care assistants, with an additional qualified nurse and health care assistant in the see and treat area.
- Planned nursing levels were sufficient but not always achieved with trust nurses. Sickness absence and staff

vacancies meant that levels were supplemented by the use of agency nursing staff when they were available. All agency staff we spoke with had received an induction. They were also given a leaflet containing an introduction to the department and useful information.

Medical staffing

- The department employed a higher ratio of consultants and junior doctors than the England average. The ratio of middle career doctors was equivalent to the England average but the percentage of specialist registrars was significantly lower. This meant that there was a shortage of registrar grade doctors within the department. Consultants and junior doctors had to review more patients without the support of middle grade staff. This could mean patients waited longer to be seen by a doctor.
- Consultants were present in the emergency department from 7am to 10pm Monday to Friday, although they often stayed on site until midnight, and from 9am to 2pm at weekends. Outside of these times they were available on call.
- The department was funded for eight consultants and at the time of our inspection there were six consultants permanently employed and one locum consultant with a newly appointment consultant due to commence.
- The department was funded for three registrars but at the time of inspection had one locum doctor in post. Interviews were planned for middle grade doctors who would be recruited under a project for Certificate of Eligibility of Specialist Registration (CESR). CESR is a means by which doctors who have not completed an approved deanery training programme can be entered on the Specialist Register. It is a competency-based process where the trainee provides a portfolio of evidence that demonstrates their training, qualifications and experience meet the requirements of the Emergency Medicine Curriculum. Successful completion of the CESR process results in entry onto the Specialist Register and the doctor is then able to apply for emergency medicine consultant posts. This initiative could enable the department to recruit middle grade doctors at a time of national shortage.
- All doctors on shift participated in the daily huddle as a way of handing over information.

Major incident awareness and training

- The department had suitable major incident and business continuity plans in place. A consultant in the department took the lead for plans in the event of a chemical, biological, radiological or nuclear (CBRN) incident. This is one category of emergency planning.
- For security the entrance doors for ambulance patients were operated by a swipe card which ambulance staff carried with them.
- A security team was available 24 hours per day within the hospital. Reception and nursing staff told us the team responded quickly to any request for assistance and we saw an example of this during our inspection.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Overall we judged the effectiveness of the service was good.

People's care, treatment and support achieved good outcomes for patients and was based on the best available evidence, with the exception of the use of a validated risk assessment tool for pressure ulcer risk. There was a multidisciplinary approach to care and treatment and staff worked with other health care providers to assess, coordinate and plan individual patient care and treatment.

Staff were appropriately qualified and received regular relevant training and appraisal. Some staff told us of difficulties accessing 'essential training' because of workload within the department. Effective and consistent levels of care and treatment were available 24 hours a day, seven days a week despite the design and size of the department which was not fit for purpose for the number and types of patients attending.

Evidence-based care and treatment

- Clinical guidelines were available in line with National Institute for Health and Care Excellence (NICE) Guidance. These were readily accessible to staff within

the department, on the intranet and used in patient records. There was a regular programme of updates for these guidelines with each consultant having individual responsibilities for updates.

- Care and treatment pathways for stroke patients were consistent with approved guidelines. Thrombolysis (a treatment to dissolve blood clots) was delivered by the stroke team during the day and by emergency department consultants on a rota basis out of hours between 5pm and 9pm. After 9pm a medical registrar was supported by telemedicine for thrombolysis,
- The department had a robust pathway for the care of patients with sepsis. These are patients who have a severe infection which has spread via the bloodstream. There was a sepsis bag available containing relevant equipment and with guidance for staff on the exterior of the bag.
- Patients with suspected hip fractures were treated in line with best practice.
- The department was part of the East Midlands Major Trauma Network and clear protocols were in place for the receipt, treatment and transfer of patients suffering from traumatic injury.
- Ambulatory care pathways were in place and the unit, providing seven patient bays, was open from 8am to 9pm Monday to Friday and from 10am to 3pm at weekends. It was staffed by an emergency nurse practitioner (ENP), qualified nurses and a health care assistant. Patients with conditions such as cellulitis, deep vein thrombosis (DVT) and non-traumatic chest pain could be referred by their GP avoiding hospital admission in many cases.
- There was a surgical 'hot clinic' arranged with the surgical registrar so that patients could be seen the following day without requiring hospital admission.
- Patients' risk of developing pressure ulcers was assessed using a screening tool. This was not based on current best practice as it did not include a risk score. This meant that an increase in the patient's risk of pressure damage may not be recognised.

Pain relief

- Patients we spoke with had been asked about their pain and given pain relief where appropriate at regular intervals. Children were encouraged to describe their pain using pictorial expression cards.
- In the CEM renal colic audit of 2012/13 the majority of questions were within the normal range with the exception of five questions where the department performed better than the England average. For the two questions on pain relief in the CQC A&E survey of 2014 the department scored similar to the England average. These questions were about how quickly pain relief was given and whether staff did all they could to help patients with pain. In the College of Emergency Medicine (CEM) hip fracture audit of 2012/13 the department scored better than the England average for re-evaluating patient's pain.

Facilities

- The department was built in the 1980's to accommodate approximately 40,000 patient attendances. The design was not fit for purpose for the 70,000 patients currently attending. There was insufficient space for the numbers of patients resulting in patients frequently waiting on trolleys in corridor areas. Rooms and cubicles were along two narrow corridors where staff were unable to maintain clear visibility of patients. This meant that patient observation was difficult. The staff base, where nurses and doctors reviewed computer based records, ran across the corridors with open access at each end making confidential discussions difficult.
- The lack of facility for observation also created a challenge if patients wandered or decided to leave without being seen as there were multiple exits with limited visibility. In the period October 2014 to January 2015 eight patients had been reported as leaving the department without staff being made aware.
- Crowding in the department and lack of space meant that at times the temperature was difficult to control. This could be a risk to patient and staff health.
- There was a large main waiting area shared with the orthopaedic and fracture clinic. Accessible toilets were available and vending machines providing refreshments. There was adequate signage in the waiting area and an electronic screen giving details of waiting times. Information about facilities was not accessible to patients with cognitive impairments who would benefit from more pictorial information.
- Although there was a small children's play area and a separate adolescent waiting area, young children waited in the main reception with adult patients which may not

always be appropriate. The Royal College of Paediatrics and Child Health recommend that departments should have separate children's waiting and treatment areas or a reasonable compromise.
- The reception desk was fitted with a hearing loop. Patients were asked to queue behind a red line in order to promote privacy, and privacy screens were available.

Nutrition and hydration

- Staff carried out a 'comfort round' every hour where patients were offered drinks and where appropriate food, including appropriate food for those with special dietary requirements. This was recorded in their care records.

Patient outcomes

- There were regular audits of paediatric assessments to inform outcomes for children. The audit results for April 2015 showed improvement in all standards of care over the previous four months, although pain scores were only completed for 50% of the sampled records and weights obtained for 36%.
- One of the emergency department consultants was the lead for children's emergency care. The department received support from the hospital's paediatric department.
- The department participated in the College of Emergency Medicine audit programme.
- A consultant within the department took the role of audit lead and junior doctors participated in departmental audit activity.
- The College of Emergency Medicine (CEM) audit for severe sepsis and septic shock from 2013/14 showed the trust performed within the England average for nine out of 13 indicators and better than the average for the remaining four.
- In the CEM audit of fractured neck of femur from 2012/13 the department performed better than the England average for five out of 15 indicators and within the average for the remainder.
- In the CEM consultant sign off audit of 2013 the department scored better than the England average in six out of eight indicators.
- Between January 2013 and September 2014 the number of unplanned re-attendances to A&E within seven days was better than the England average and only one percent worse than the standard.

Competent staff

- Doctors told us the process for revalidation was smooth and supportive, with the hospital postgraduate centre running revalidation workshops making it easier to understand the requirements.
- Monthly teaching sessions were available within the education centre for senior doctors. Consultants reported it was sometimes difficult to attend because workloads were high within the department. However, middle grade doctors were always supported to attend (except when working nights) even if that meant employing extra medical cover in the department so they could be released.
- All middle grade doctors including locum ones met quarterly with their educational supervisor to review their development.
- Junior doctors attended weekly teaching sessions.
- An emergency nurse practitioner was clinical educator for the department, allocated 12 hours per week for this role.
- Agency nurses were given an induction to the department, including an informative induction leaflet. They also received a password for the computer system which was valid for the duration of the shift so they could work effectively.
- The departmental clinical educator was responsible for new nurse starters. They received a letter of welcome upon appointment. Once they started work they were provided with an induction pack, a competency pack for adults and one for children. Newly qualified nurses were supernumerary for eight weeks and newly appointed staff nurses for four weeks. This meant that they could shadow colleagues and learn about the department and patient care. There was also a competency pack for new health care assistants.
- Nurse training needs were reviewed annually by the clinical educator and a programme recommended to the matron. Each staff member received two days of mandatory training and one team training day. All staff were organised into teams. Some nurses reported that they were sometimes called away from training to work in the department at busy times.
- Emergency nurse practitioners received four sessions of six hours training annually. Their role was to see minor injuries and illnesses and there was no plan to expand

that role within the department. This could mean that this group of nurses had limited professional development opportunities and their skills were not always put to best use.

Multidisciplinary working

- At the beginning of the day staff attended a 9am 'huddle' to hand over general information and communicate relevant issues to the incoming team. The doctor working overnight handed over to an incoming doctor on a one to one basis at 8am. The huddle was well attended by the team including consultants, middle grade and junior doctors, nurses, health care assistants and a pharmacist with other staff such as the trust adult safeguarding lead visiting as appropriate. This handover of information was highly valued by staff who were heard to comment, "Don't start without me!"
- A medical division transfer team of one qualified nurse and a porter was available to move patients who were to be admitted. Staff in the department completed a transfer checklist which this team reviewed prior to transferring the patient. There were no telephone calls required to determine availability of beds for patients being admitted as the electronic patient update screen changed colour when a bed became available. Staff told us this saved time and was effective.
- There was good liaison between the children's inpatient team and the emergency department. A paediatric critical care group met quarterly attended by a paediatric trained anaesthetist, the emergency department paediatric consultant, lead nurse and representatives of the paediatric team. This group reviewed guidelines and treatment for sick children.
- An alcohol liaison team was available on site between 9am and 5pm.
- Mental health liaison services were available 24 hours a day from February 2015, based on site and provided by Derbyshire Healthcare Trust. This team had access to the emergency department electronic screen of patient information so they were aware when a patient was awaiting assessment. Staff told us they usually responded within 60 minutes. The department had a relatives' room which was suitable for use for mental health assessments.
- A six month trial was funded for a rapid response team with occupational therapist, physiotherapist and social care available between 9am and 5pm Monday to Friday to assess patients and get them home. They attended the department each morning to check for eligible patients. The trial was due to finish at the end of April 2015.
- There was a frailty unit within the trust where frail elderly patients could be admitted directly from the department.
- There was a tissue viability nurse and a moving and handling nurse both working 9am to 5pm Monday to Friday who could be requested to attend the department for support and advice.
- A GP out of hours service was available next to the emergency department from 6pm to 10pm Monday to Friday and from 9am to 10pm at weekends. This was provided by Derbyshire Healthcare United. Patients whose condition or illness would be suitable for treatment by a GP were referred to this service which reduced the waiting times for patients with more serious conditions.
- There was a monthly meeting with the local police. Police officers periodically shadowed a nurse within the department and nurses sometimes went out on police patrol.

Seven-day services

- The emergency department was consultant led, offering a service 24 hours a day, 36 5 days a year.
- X-ray facilities were available 24 hours per day, seven days per week, adjacent to the emergency department.

Access to information

- Staff were able to access all the information they needed to deliver effective care and treatment to patients. The department held electronic patient records.
- Patients praised the way staff communicated with each other and told us they did not have to repeat their story as they met new staff during their assessment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw during our observations that staff sought consent from patients before undertaking treatments and patient consent was recorded in the records we reviewed.
- Medical and nursing staff were aware of their responsibilities under the Mental Capacity Act 2005

Urgent and emergency services

Are urgent and emergency services caring?

Good

Overall we judged the care afforded to patients was good.

Staff treated people with compassion, kindness, dignity and respect. Most patients were positive about the care they received. Staff responded to patients' anxiety or distress with compassion and were seen to offer emotional support.

Staff involved patients in decisions about their care and their choices and preferences were, where possible, acted on. However, a few relatives told us the needs of patients had not been met. There were times when it was a challenge for staff to provide privacy because of the design of the department and crowding.

Compassionate care

- Nurses and doctors introduced themselves to patients before care or treatment. Staff closed curtains and doors to maintain patients' privacy during examinations and they knocked before entering.
- Whilst staff told us that crowding and the layout in the department made confidentiality difficult, we observed them moving patients around to ensure their privacy as far as possible within the environment.
- Between December 2013 and November 2014 friends and family test responses were lower than the England average. Low response rates are not uncommon for emergency departments.
- In the Care Quality Commission Accident and Emergency Patient Survey of 2014 the department scored similar to other emergency departments in England for levels of care. This showed that patient experiences of care were in line with current performance of care across England. However the department scored better than other trusts in response to a question about privacy at reception.
- We observed staff showing an encouraging, sensitive and supportive attitude to patients.
- Staff carried out a 'comfort round' every hour where patients were offered drinks and where appropriate food. This was recorded in their care records. Where a patient was particularly vulnerable staff increased the frequency of the 'round' to ensure that they had support during their time in the department.
- We spoke with 23 patients and 26 relatives or carers and the majority told us they had been listened to and staff respected their dignity. All patients said they had been well cared for.

Understanding and involvement of patients and those close to them

- Patients told us staff explained things as they went along. All of the patients we spoke with knew about the plan for their care and treatment. We observed consultants giving patients detailed information about their condition and addressing their concerns.
- We saw staff adapting their communication to meet the needs of patients, for example one consultant used short simple sentences to communicate with a patient with no speech but effective hearing. However, one relative told us that staff had not recognised that a patient had hearing impairment, despite being informed by relatives.
- During our observation a patient living with dementia was left alone in a cubicle despite there being a carer available in the waiting area. Upon arrival at the department a relative alerted staff to this omission.

Emotional support

- Patients told us, "I really do feel safe in here; the staff have been brilliant." "Staff are superb; they go the extra mile."
- Staff understood the impact of treatment on patients' wellbeing and social situation. For instance they ensured that one patient's missing house keys were returned to them and another patient was supported with a housing problem following bereavement.
- We observed anxious relatives being supported emotionally by staff.
- The hospital had a chaplaincy service and staff told us they could request support if necessary. However, there was only one chaplain so they may not always be available. There were on call arrangements for spiritual support for other religions and these were accessed via the hospital switchboard.

Urgent and emergency services

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

Good

Overall we judged the responsiveness of the service was good.

Services were planned, organised and delivered to meet people's needs. The department was generally meeting the four hour waiting time target for emergency departments. Systems were in place to receive, review and learn from complaints and compliments.

However the department had been designed and built to accommodate a much smaller number of patients. Staff had received one hour of training in dementia awareness and did not consistently demonstrate an understanding of the needs of this patient group. At times staff struggled to provide responsive care because of environmental constraints. Children had to wait in the main reception area along with adult patients.

Service planning and delivery to meet the needs of local people

- Over 70,000 patients attended the department each year. When it was built in the 1980s the design was to accommodate approximately 40,000 patients annually. Senior managers were aware of the challenges this created and that the facilities were not appropriate for the current attendances. The risk was entered on the divisional risk register. The trust was working with partners on funding and the design of an urgent care village to replace the current department. At the time of our inspection a funding application was ready to go to the board.
- Despite the high numbers of elderly patients, staff told us they had only received one hour of training in dementia and a junior doctor told us they had not received dementia awareness training. We observed a small number of instances where staff showed a lack of awareness of the needs of patients living with dementia. The environment did not support their ability to care for this group of patients.
- There was a frailty unit within the trust where frail elderly patients could be admitted directly from the department.
- Although there was a small children's play area and a separate adolescent waiting area, young children waited in the main reception with adult patients which may not always be appropriate. The Royal College of Paediatrics and Child Health recommend that departments should have separate children's waiting and treatment areas or a reasonable compromise.
- The department recognised the specific needs of patients with mental health illness. In partnership with Derbyshire Healthcare NHS Foundation Trust they were able to provide 24 hour access to a mental health liaison team.

Meeting people's individual needs

- A telephone interpreter service was available for patients and staff knew how to access this. The switchboard also held a list of staff who could act as interpreters.
- Patients living with dementia were seen within the department as quickly as possible. Staff placed them close to the staff base when space was available in order to observe and support them. Relatives were encouraged to support patients and the department used a "This is me" leaflet designed by the Royal College of Nursing and the Alzheimer's Society to understand the needs of patients living with dementia. On one occasion, however, we observed a patient alone, confused and calling out for help for a period of 30 minutes even though a carer was available in the waiting area.
- One nurse had the role of dignity champion to promote dignity and improve patients' experiences in the department.
- Patient information leaflets were available for a wide range of injuries and illness. Some but not all were available in different languages and formats.
- The children's play area was well equipped with toys and books for patients and there was a separate adolescent waiting area.
- The trust had a learning disabilities lead who was available to attend the department to advise on the care and treatment of patients with learning disabilities.

- One patient who had become ill on the way to an outpatient appointment told us staff had arranged for their appointment to take place in the emergency department so they did not miss it.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at A&E. Between January 2104 and January 2015 the department generally met this target. There were occasions where it dropped below and performance decreased at the end of the year. On average, performance for January to March 2015 was below the target of 95%.
- The percentage of patients leaving the department before being seen was better than the England average between January 2013 and January 2014. From January 2014 to September 2014 it was similar to the England average.
- Between January 2014 and January 2015 the percentage of patients waiting four to 12 hours from decision to admit until being admitted was better than the England average and less than five percent.
- Diagnostic tests including radiology and pathology were readily available. X rays were available promptly for patients in the emergency department, usually within 20 minutes. The x ray department staff had the same electronic display of patient information as that in the emergency department so they were able to recognise patients awaiting x ray. We observed them arriving to collect patients and returning them after x ray. Staff told us x ray department staff were very responsive to the needs of patients.
- Availability of diagnostics had been extended from 2013 to support the ambulatory care unit. Staff in this unit were able to access same day computerised tomography (CT) scans and Doppler scans until 4pm.
- Total time spent in the emergency department on average per patient was significantly longer than the England average. The reasons for this were not clear. The clinical lead for the department told us this was because of delays when patients were waiting to be admitted. However the percentage of emergency patient admissions via the emergency department waiting between four and 12 hours from the decision to admit until being admitted was significantly better that the England average.

Learning from complaints and concerns

- Learning from complaints was discussed at the quarterly senior medical teaching sessions and during the daily huddle. A trust wide feedback notice was displayed in the staff area of the department showing complaint themes.
- Systems and processes were in place to advise patients and relatives how to make a complaint. Information was displayed within the department and leaflets were available to patients.

Are urgent and emergency services well-led?

Good

Overall we judged the leadership in the service was good.

Leadership and management of the emergency department focussed on the delivery of high quality care. There was a positive team culture with excellent relationships between nursing and medical staff. Junior doctors were especially complementary about the support they received from consultants and nursing staff.

Vision and strategy for this service

- The trust's strategy was "To give the best patient care possible", supported by the "Proud to care" values. Staff within the department were aware of the strategy and supported the values.
- There was a large screen performance dashboard displayed in the staff base so that staff were aware of current and recent departmental performance.
- Staff told us about their hopes for a new urgent care village with an environment suitable for the numbers of patients and their needs. However, there was a lack of consistent understanding within the staff team about if and when this was likely to happen.

Governance, risk management and quality measurement

- Senior managers were able to identify the top risks within the department including the lack of middle grade doctors and the environment.
- The divisional clinical governance meeting met monthly, chaired by an emergency department consultant.

- Bi-monthly departmental clinical governance meetings were held. The agenda covered a range of issues including incidents, learning from complaints and national and NICE guidance. .
- One of the consultants within the department was the audit lead. Junior medical staff were encouraged and supported to participate. Findings were presented at quarterly divisional meetings.
- The trust met with East Midlands Ambulance Service monthly to discuss issues and challenges. The introduction of the pit stop area had improved ambulance waiting times.

Leadership of service

- Staff told us the Director of Nursing and Patient Care and the Medical Director were visible within the department, visiting regularly and working alongside them during busy periods. The Director of Nursing and Patient Care was thought to be approachable and willing to listen to concerns and attempt to resolve them.
- Middle grade doctors told us that consultants were supportive and approachable and there was good leadership in the department. "Leaders are in control, very approachable, give advice and review patients if we ask."

Culture within the service

- There was good team working within the department. Staff felt valued and respected by their colleagues and managers. The nursing and medical teams worked effectively together.
- Locum staff felt listened to and supported in their personal development.
- A consultant told us, "I feel very lucky to work in this department, although there are limitations with space and layout, we do the best we can. What good is a great department if the team doesn't work well together?"
- Medical students told us the staff were "brilliant", the teaching was really good and nurses were very supportive.
- Junior doctors told us there was always someone around to support their decisions and staff were very respectful especially the nursing team. Consultants provided a supportive learning environment and they were always willing to help.

Public and staff engagement

- Patient feedback forms were available in the waiting areas for patients to complete.
- Staff told us they were involved in the trust wide initiative "Let's talk care" where staff held conversations about the care they provided.
- The trust held an annual 'stars award' for staff who had been nominated in a number of different award categories.
- There was emphasis on promoting the wellbeing of staff within the department. Informal and formal debriefs were held after patient deaths and a counselling line was available to staff.

Innovation, improvement and sustainability

- Medical staff told us new ideas and innovations were encouraged and the leadership team was open to testing them where possible.
- The department had recently introduced a six month development post for Band Five staff nurses offering skills and training so they could apply for a Band Six post if one became available.
- The department was attempting to recruit middle grade doctors using the CESR programme and had a number of applicants scheduled for interview at the time of our inspection.
- During the winter period a pharmacist was working full time Monday to Friday in the emergency department. Data collected had provided evidence that this was beneficial to patients and the department had proposed three pharmacists be employed to provide 24 hour cover. Staff were positive about the presence of a pharmacist. Doctors estimated it saved them 15 minutes per patient admission.
- The emergency department pharmacist had taken part in a trial with Birmingham University considering whether pharmacists could be utilised in minor injuries units avoiding the need for a patient to see a GP or doctor.
- The sustainability of services and improvement was at threat from the risks created by the outdated facilities and environment. However there was an active plan to develop an urgent care village which would address this.

Medical care (including older people's care)

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

Information about the service

At Chesterfield Royal Hospital, medical care services were managed by the Division of Medicine and Emergency Care. Specialities included Acute and General Medicine, Gastroenterology and Hepatology, Respiratory Medicine, Cardiology, Endocrinology, Elderly Care and Stroke. The division also managed the discharge lounge. There were 30,404 admissions to medical care services at Chesterfield Royal in 2014/15, of which 56% were emergency admissions, 1% elective and 43% day cases. Most admissions (59%) were in the speciality of General Medicine.

Medical care services had a bed compliment of about 250 in-patient beds in seven wards and the Emergency Admissions Unit. In addition there were six trolley spaces in the cardiac catheter suite and seven spaces in the Cavendish suite for clinical haematology and chemotherapy. During our announced inspection we visited all the medical care areas and wards managed by the division and the discharge lounge. We visited the wards during the day, and we conducted a night visit. We carried out a weekend unannounced inspection visiting the stroke unit and Emergency Admissions Unit.

To help us understand and judge the quality of care in medical care services at Chesterfield Royal Hospital we used a variety of methods to gather evidence. We spoke with 17 doctors including nine consultants, about 40 registered nurses including ward matrons and nine healthcare assistants. We also spoke with seven Allied Health Professionals and 10 other support staff. We spoke with 25 patients and nine patients' relatives. We interviewed the Divisional Management Team. We observed care and the environment, and looked at records, including patient care records. We carried out a structured observation using the Short Observation Framework for Inspection (SOFI) methodology. This is a structured way of observing the care of people who may not be able to tell us about their experience. We looked at a wide range of documents, including audit results, action plans, policies, and management information reports.

Medical care (including older people's care)

Summary of findings

Overall we found medical care services required improvement. This is because we identified some concerns in relation to nursing staffing at night, arrangements to identify and support patients whose condition was deteriorating, the storage of medicines, the management of confidential records and waste and below national average rates of harm-free care. There was insufficient capacity for the numbers of patients. This resulted in patients being moved around the hospital and treated in non-speciality beds where the quality of their care could be compromised. We also found that complaints were not managed in a timely manner.

There were good systems to report and investigate safety incidents and systems to prevent and control infection. There were arrangements to meet the individual needs of patients including those with complex problems. Treatment generally followed current guidance, and that although outcomes for patients were sometimes less than average, action was taken to remedy this. We saw that developments were in progress to improve the care of people living with dementia and there were systems to ensure discharge from hospital was a planned event. Patients had access to most services seven days a week and were cared for by a multi-disciplinary team working in a co-ordinated way. Where patients lacked capacity to make decisions for themselves, staff acted in accordance with their obligations under the Mental Capacity Act.

There was an appropriate system of governance and arrangements to monitor performance as well as to escalate risks to the trust board. Staff could discuss the trust philosophy and each ward had its own strategy which staff understood. We observed a caring and positive ethos, and a culture of openness between senior managers and staff. Patients and their relatives were overwhelmingly positive about their experience of care and the kindness afforded them. We witnessed compassionate care that promoted patients' privacy and dignity. Patients were involved in their care and treatment and were given the right amount of information to support their decision making and patients could get the emotional support they needed.

Are medical care services safe?

Requires improvement

Overall, we judged that the safety of medical care services required improvement.

This was because potentially there were insufficient registered nurses on duty at night to meet the needs of patients. Scoring systems used to identify deteriorating patients were not always used in accordance with the trust guidance and that there was no critical care outreach service to support ward staff in the identification of these patients and their care. There were insufficient systems to ensure that medicines were stored at temperatures that kept them in optimum condition. There was inconsistency in the quality of analysis after a serious incident, and no formalised arrangements for monitoring the implementation of action points following an incident. Rates of harm free care as monitored by the national Safety Thermometer programme were usually below the England average. Confidential patient records were not always kept securely and confidential waste was not always maintained securely.

There were sufficient medical staff to treat patients safely. There was a positive culture of incident reporting and staff were aware of their responsibilities in relation to this. We found that measures for the prevention and control of infection met national guidance and that the clinical environment appeared clean and well maintained. There was sufficient equipment that was properly checked and maintained to meet patients' needs and staff were competent to use it. Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and acted according to local policies when abuse was suspected. Mandatory training in 2014 helped ensure nearly all staff had current knowledge and skills in key safety areas.

Incidents

- Trust policy stated that incidents should be reported through an electronic system that enabled incident reports to be submitted from wards and departments.

All staff we spoke with across medical care services at Chesterfield Royal Hospital were aware of the requirement to report any incidents, knew how to use the system and could demonstrate its use to us.

- Medical care services reported 2,467 incidents March 2014 – February 2015; 44% of all those in the trust. Nearly 60% were recorded as no harm events, 3.3% as moderate harm and 2 (0.08%) as severe. Care of the Elderly and General Medicine were the highest reporting specialities. The number of low harm events reported suggested that staff were reporting incidents and were confident to do so.
- In the period February 2014 – January 2015, 53 serious incidents requiring investigation (SIRI) were reported to The Strategic Executive Information System (STEIS) of which over half were grade 3 pressure ulcers (significant skin damage). About a quarter of the incidents were falls and five were infection prevention and control issues. Staff we spoke with at all levels were aware that falls and pressure ulcers were the most common incidents reported and presented the area of greatest risk.
- We found that a thorough investigation, or root cause analysis (RCA) was conducted for SIRI's. We saw examples of these and noted that they were variable in their quality. We saw good examples were the root cause was identified and that the resultant action plan reflected this. However, we saw a poor example were the root causes were not clearly identified or considered, and the action plan did not address the issues that had come to light.
- Training in root cause analysis techniques was provided and seven out of a total 37 staff that had received training were matrons, or managers from medical care services.
- We saw minutes of ward meetings and divisional governance meeting which showed safety incidents and the outcomes of their investigations were standing agenda items. Staff told us that there was learning from incidents and gave us examples of how this had occurred at local level. This showed there was feedback and learning from critical incidents.
- We spoke with the divisional management team and matron responsible for governance and concluded there were no robust arrangements for formally monitoring the implementation of action points following an incident. However, there was evidence to suggest it was done informally and we noted that action plans did not contain any information on how the efficacy of the proposed actions would be monitored and evaluated. Managers confirmed that this was not formally done. This meant that managers could not be assured that actions identified from critical incidents were carried out, or that they had had the desired effect of risk reduction or elimination.
- Morbidity and Mortality meetings were held as a trust wide forum. We saw minutes that showed medical care services were involved in these meetings and that medical patients, their management and lessons learned were scrutinised.
- We asked staff about their understanding of the new regulations concerning duty of candour. Most were aware of the concept and the underpinning notions of transparency and openness. However, we were told that not all staff had received training in the regulations or fully understood the statutory process to be followed. However, we noted that in the RCAs we viewed, clear prompts were included to ensure that process was followed, and that in these instances, it had been.

Safety thermometer

- The medical care services at Chesterfield Royal Hospital participated in the national safety thermometer scheme. Data were collected on a single day each month to indicate performance in key safety areas.
- Data for the Division of Medicine and Emergency care dated January – March 2015 showed a harm free care rate of 86%, below the national average of about 94%. In February 2015 the division reported 4.6% of patients experienced a new harm, worse that the target of 2.5% but better than the England average of 5.5%.
- Divisional figures dated February 2015 showed Venous-Thromboembolism (VTE) screening rates were above the target, although the new VTE rate was worse than the target.
- New pressure ulcers rates were worse than a target. However the incidence of Catheter Associated Urinary Tract Infections was on target.
- There were fewer falls with harm than the target rate.
- We saw that data from the safety thermometer was clearly displayed in ward areas for the public to view. Staff were aware of their performance in the safety thermometer when questioned. This meant the results were widely disseminated and understood by staff.
- Safety thermometer data was incorporated into the divisional performance dashboard which was used to provide evidence of assurance to the trust board. The

risks monitored by the safety thermometer were part of the division's governance meeting discussions. This showed that the data was used to monitor performance and to track risk trends.

- We saw the documents outlining the organisation's Reducing Catheter Associated Urinary Tract Infections initiative and saw that the use of an acronym (HOUDINI) was implemented to guide staff in the assessment of the appropriateness of a urinary catheter remaining in place. We saw this system publicised on the wards areas and saw staff using it.

Cleanliness, infection control and hygiene

- Overall we found that the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" was complied with in medical care services.
- We saw that that care bundles for indwelling intravenous devices were used for insertion and on-going care in line with the Department of Health's "Saving Lives" guidance. However these were not always fully completed. For example out of a total of 11 cannulae care bundles that we looked at on the Emergency Medical Unit, eight were undated and seven had no recording of the Visual Infusion Phlebitis score. This meant there was a risk that the early signs that an infection might not be recognised and acted upon.
- MRSA (a bacteria that is resistant to much antibiotic treatment and can cause serious infection) screening rates on admission were reported as 94.4%, worse than a target set of 100%. However, there had been no cases of MRSA blood stream infection in the year to February 2015
- There had been 33 cases of C difficile (a bacteria which causes diarrhoea) infection in the year to date February 2015 .We saw reports that showed 23 RCA's of incidences of C Difficile infection in Medicine & Emergency Care April 2014 - Feb 2015 had been carried out. Fifteen of the 23 (65%) confirmed patients in medicine with C difficile had one or more lapses in care identified as part of the RCA process.
- We observed that the environment was visibly clean, hygienic and well-maintained. Patients told us they were impressed with the standards of cleanliness. Divisional data from February 2015 showed cleaning audit scores of 96.2% better than a target of 95%. Medical wards showed a range of scores 92.3 – 99.5% in the period January – March 2015. A cleaner we spoke with explained and showed us how any deficiencies identified as part of the audit were communicated to them, and that remedial action was checked. This meant that cleaning standards were audited and the results monitored.
- We noted that there were adequate hand washing facilities in clinical areas and observed that staff generally washed their hands in line with the World Health Organisations guidance "Five moments of Hand Hygiene." We saw that there were monthly audits of hand hygiene and that the results were publically displayed in ward areas. These were generally about 90% and saw frequent examples of 100% being achieved.
- There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed that staff used it appropriately.
- Equipment shared between patients such as blood pressure monitors and commodes were usually identified as ready for use by a standard green label. All staff we spoke with were aware of the system. We observed one staff member clean equipment before it was used when a label was absent and watched staff cleaning the blood pressure machines between patients when performing a routine observation round. We saw that single patient use equipment, such as hoist slings were used, and that most clinical equipment was single use only.
- There were effective decontamination procedures for cleaning endoscopes after use.
- On some wards we visited we found that some patients were isolated for infection control reasons. These patients were nursed in single rooms and we noted that necessary precautions were clearly displayed on the doors. We observed that staff followed these precautions although we did see that the room door was not always closed. We asked nursing staff about this and they told us that sometimes the doors were left open as they patients felt too isolated. This mitigated the risk of patients' isolation but did not meet with the guidance on controlling infection
- We saw that clinical and domestic waste were appropriately segregated and that there were arrangements for the separation of high risk used linen. We observed that staff complied with these arrangements. However, we noted that on the Emergency Medical Unit, clinical waste awaiting collection was not secure.

- We observed that sharps management generally complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw that sharps containers were used appropriately and that they were dated and signed when brought into use and closed. However, on the Emergency Medical Unit we noted that used sharps boxes were not securely stored whilst awaiting collection. There was a system for auditing waste management and the report we saw noted that two out of 10 audits were overdue and one action plan was outstanding.
- Infection and Prevention Control training formed part of the trust mandatory training programme that was updated yearly. In the first quarter of 2015, 18% of all staff in medical care services had completed the required Infection Control Update. This trajectory would not ensure most people had completed training by year-end.

Environment and equipment

- We found that each clinical area had resuscitation equipment readily available. There were systems to ensure it was checked daily to ensure it was complete and ready for use. The equipment was generally checked every day; we only found a few examples of a day being missed in the last few months. However, there was confusion about recording the expiry dates of the tags which showed the equipment had not been tampered with. We spoke with the Resuscitation Officer who confirmed the expiry date should be the first of each month and that this should be the date recorded as the next check. We found this had not been the case and sometimes no date was recorded. This meant it was not clear when the seal on trolleys should be broken and the equipment checked to ensure it was in-date, complete and ready for use which may lead to checks being missed.
- Staff told us that Electrical Medical Equipment (EME) was well maintained centrally by the clinical engineering department. They said that it was very unusual for them not to be unable to access equipment when it was needed. We saw that all EME had a registration label attached which meant that the department were aware of its existence and that it was maintained in accordance with the manufacturer's recommendations. We also saw that Portable Appliance Testing (PAT) labels were attached to electrical systems showing that they had been inspected and were safe to use.
- We saw records that detailed the maintenance requirements of electrical equipment on the wards. This spread-sheet monitored compliance with these requirements and we saw that overall equipment was maintained within reasonable timescales,
- Patient Led Assessments of the Environment in 2014 showed a range of 76.2 – 100% in acute wards (including medicine) for Condition, Appearance and Maintenance.
- There was no continuous or piped oxygen or suction in the cardiac catheter laboratories and its recovery area. This posed a risk to those patients who had conscious sedation during procedures as there was no robust way of administering oxygen to more than one patient at a time. Patients who required high levels of oxygen during procedures could have experienced delays to administration due to oxygen running out.
- We visited the hospital at night and found that the entrance to the building and individual wards was secure and could only be accessed by a buzzer system. There were systems to audit security measures and the report we were supplied with noted that two out of 10 audits were overdue and four actions remained outstanding.
- We spoke with staff who explained the systems they followed when they encountered environmental problems. They told us the on-line system worked well and that the estates department responded to requests in a timely manner.
- We looked at fire-fighting equipment and noted that it all been maintained and tested. There was a system of fire risk assessments and the report we were supplied with showed one out of nine of these was overdue, and two action plans were outstanding.
- In the first quarter of 2015, 21% of all staff in medical care services had completed training in both Health and Safety and Fire and Safety Training. This trajectory would ensure most people had completed training by year-end.

Medicines

- We found that medicines were stored securely in locked cupboards and in rooms with swipe card access. We saw that keys to drug cupboards were held by appropriate staff.
- Applicable medicines were stored in dedicated medicines fridges. There was an electronic fridge and room temperature monitoring system in place. We found some staff didn't understand how the system

worked and were not clear of their responsibilities. The pharmacy department carried out regular checks of the fridges and were alerted automatically to any temperatures that were out of normal range.

- The management of controlled drugs (CD) met legal requirements. We spot-checked some medicines and found that stock balances were correct. We saw there were arrangements for ward staff to check stock balances daily and saw records of this noting that only very occasionally was a day missed.
- We observed that medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's "Standards for Medicines Management."
- New staff had their competency for drug administration checked as part of their preceptorship programme. There was also an annual updating module that was completed which also contained a knowledge check test. We saw data that showed 13 staff in medicine had successfully completed training in medicines management in 2014.
- There was a ward based pharmacy service. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatment were safe, effective and met current guidance. Clinical staff could access a pharmacist for advice when needed. We saw pharmacy technicians and pharmacist on the wards during our visit.

Records

- On the Emergency Medical Unit (EMU) we saw that confidential patients' records were stored in unlocked trolleys in the corridor. On Manvers ward we observed medical staff leaving confidential records unattended. At night on Ridgeway ward we saw confidential records unattended around the main ward entrance. This demonstrated that confidential patient records were not always kept securely.
- We found instances where confidential waste receptacles were not secure and were potentially accessible by the general public. We saw that the bin situated in the sluice room of the EMU was not secure. We also noted that confidential waste was in a black bin-bag in Manvers' ward sluice room. This was marked with a makeshift paper sign indicating "confidential waste." If this had become detached, there was potential for confidential waste being managed as ordinary waste with implications for the security of confidential and sensitive patient information.
- Ninety-three per cent of staff within the division had received Information Governance training.
- We looked at about six medical and 15 sets of nursing records and found that these were generally compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council, the professional regulatory bodies for doctors and nurses. The records we viewed were comprehensive, contemporaneous and reflected the care and treatment patients received. Patient records were readily accessible to those who needed them.
- A documentation audit dated 2014 showed that in the Division of Medicine and Emergency care overall compliance score of 95% was achieved. This showed that documentation standards were meeting local policy.
- Other records we requested in ward areas, such as duty rotas and safety information that were relevant to the running of the service could usually be produced without delay either in paper or electronic formats.

Safeguarding

- In the first quarter of 2015, 21% of staff in medical care services completed Safeguarding Children Update training and 3% had completed Safeguarding adults training. Without improvement, this training rate would not ensure that all staff received relevant training by the year end
- Staff we spoke with could name the trust safeguarding lead and told that they found them supportive and helpful.
- Staff told us that they felt confident in identifying potential abuse, and in escalating their concerns. They were able to give us examples that demonstrated their understanding and competence. For example, concerns about potential financial abuse had been identified in a patient with learning difficulties. There was evidence of appropriate escalation of the concern and the involvement of the social work team, a case conference was held and a report was documented on the electronic reporting system.
- Patients we spoke with told us they felt safe in the hospital.

Medical care (including older people's care)

Mandatory training

- There were arrangements to provide two days a year of mandatory training, which was termed Essential Training. We noted the programme covered all major risk areas relevant to staff role.
- In the Division of Medicine and Emergency Care nearly 90% of staff completed their mandatory training in 2014.
- In medical care services, in the period January 2015 – March 2015, 12% of staff of all grades completed their mandatory training; if this rate were not to improve, less than half would have completed the training by year end.
- Staff we spoke with were aware of the mandatory training they were required to undertake.

Assessing and responding to patient risk

- We found that patients were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' We watched observations of pulse and temperature being taken and noted that the technique used would ensure an accurate result.
- A two hour session on resuscitation and care of the deteriorating patient formed part of the annual mandatory training programme. Additionally, the resuscitation department provided target scenario training for specific groups, for example scenarios concerning anaphylaxis for staff in the imaging department where this event constituted a higher risk than in other departments.
- Medical care services used the National Early Warning Score (NEWS) to assist in the identification of patients at risk of deterioration. We noted on observation charts that these scores were calculated consistently and accurately. However, despite there being clear escalation protocols widely available in ward areas for staff to refer to, we found that these were not always followed. We tracked several instances of increased scoring, indicating a potential deterioration, where escalation protocols were not followed, and/or the rationale for not doing so was not clearly documented. This indicated that potential deterioration in a patient's condition was not always escalated at the earliest opportunity.
- When reporting concerns about deteriorating patients staff used a standardised format (Situation, Background, Action, Recommendation known as SBAR). We saw how the transfer document between EMU and the wards used this approach and observed its use. Staff could explain how they used the SBAR system but there were no arrangements or tools that assisted staff to do this and to record their escalation of concern clearly. This meant that the SBAR system was not auditable.
- There were no arrangements for staff to access a critical care outreach team to support and advise in the care of very sick or deteriorating patients. Ward staff did have access to the site matron team. The night staff especially felt the support these matrons provided was valuable and helped in the provision of safe care.
- We saw that patients were risk assessed in key safety areas using nationally validated tools. For example we saw the risk of pressure damage was assessed using the Waterlow score. We noted that generally when risks were identified relevant care plans which included control measures were generated. We checked a sample of these control measures and found them to be in place. We saw that risk assessments were reviewed and repeated within appropriate and recommended timescales. However, especially with falls, we did find examples where care plans had not been generated as a result of risk assessments and the organisational care bundle (known as "SLIP") had not been fully implemented.
- Risks were communicated to staff using symbol displayed on a magnetic whiteboard above each patient's bed. However, we found that the information displayed in this was not always accurate or up to date

Nursing staffing

- Nursing staffing was acknowledged as a major risk area. In common with many trusts, Chesterfield Royal experienced difficulties in recruiting appropriately qualified and experienced nurses. The trust had been proactive in meeting this challenge and had recruited from overseas and employed large numbers of overseas trained staff.
- For the 2014/15 financial year the nursing staff vacancy rate in medical care services was 6.3%
- Nursing establishments had been reviewed in 2014 using the nationally recognised "Safer Nursing Care Tool" which had led to investment in additional nursing posts. During our visit the ward areas were in the data collecting phase of a further review using this tool and

were collecting information on acuity and staff numbers for future analysis. The divisional management team assured us that they would act on the data to ensure that nursing numbers could meet demand.

- The National Institute of Health and Care Excellence has recommended minimum registered nurse patient ratios in its guidance "Safe staffing for nursing in adult inpatient wards in acute hospitals" whilst the medical wards generally met the ratio of one registered nurse to eight patients during the day, these ratios were not maintained at night. We found ratios on night shifts of one nurse to 10, 12 and 15 patients on acute wards during the 12 hour night shift.
- The overall registered nurse to bed ratio in medical care services for the period October 2014 to March 2015 was 1:7.5. However the worst ratio in this time period was 1:11.4. The average ratio for daytime (measured at 12 noon) showed that the NICE recommended ratio was achieved but the recommended ratios were not achieved at night (measured at midnight) with ranges of about one to eleven found.
- The Royal College of Nursing "Guidance on safe nurse staffing levels in the UK" (2010) noted that in 2009 registered nurses accounted for 60% of the nursing workforce on duty. In medical care services the average percentage of registered nurses as part of the total nursing staff on duty of nurses on duty was 56%, below the national average of 2009. The worst situation was found at night when they made up 51% - 56% of nursing staff on duty.
- We visited the wards at night as well as during the day and spoke to staff who, with one exception, felt there were insufficient registered nurses to meet patients' needs at night. Staff told us they thought their response to call bells was lengthier, especially during the first part of the night shift and patient falls were more prevalent although data recorded in the trust incident system did not support this perception. Night staff also told us that anti-biotic and other medicines were frequently given late. On the night we visited the nurse was still administering evening medications at 11.30pm when they were due to finish at 9pm. Night staff told us that they often felt unable to take their allocated breaks. We looked at the records for "intentional rounding" and saw that at night these rounds were often an hour or more late.
- We spoke with a senior matron who acknowledged that the move towards 12 hour shifts had been "incremental" and had not been the result of a planned strategy. They felt that insufficient consideration had been given to the fact that reducing staff numbers at around 8pm did not recognise that patients were still needing care interventions and this time, and assistance to settle for the night.
- We found that on Manvers ward and the Stroke unit, registered nurses from the ward may be required to assist in specialist, emergency procedures, further depleting the registered nurse resource on those wards for up to several hours at a time.
- We saw that the numbers of staff expected and actually on duty were displayed for every morning shift, but were not always updated for subsequent shifts.
- Staff told us that it was rare for them to be under their approved numbers of staff. We looked at the Safe Staffing Summary for February 2015. For medical wards we found less than 1% of shifts were under-filled. We also found that a small number were overfilled. This showed that actual staffing nursing numbers were in line with establishments but they did not indicate if these establishments were sufficient or met national guidance.
- Staff reported that, following an appropriate risk assessment, additional staff were hired on a shift by shift basis if individual patients required one to one care, or if patients' needs had increased. We saw a patient receiving 1:1 care in response to his complex needs and mental state.
- We found staff were available on a flexible basis and used when there were staffing shortfalls. The trust spent twice as much as their target on temporary staffing. The total number of shifts filled by agency/bank versus total number of shifts for nine medical care wards in March 2013 was 8.1%, however we noted that on four wards area this figure was around 20%. This indicated there was a reliance on flexible work force to ensure nursing numbers met agreed staffing levels.
- However, there were no robust arrangements for ward based staff to be assured of the competency of staff working for agencies. The trust had quality standards as part of its contracting framework with NHS Professionals which would ensure competency but there were no systems for this to be checked at the commencement of an assignment. Ward staff relied on the agency staff themselves being clear about their levels of competency. This presented a risk that agency staff might perform tasks for which they did not have the

requisite skills and knowledge. There was a ward induction checklist for agency staff and we saw completed examples on Manvers ward. One nursing sister we spoke with expressed concern at the skills of some agency staff and questioned if their competency was robustly assessed.

Medical staffing

- Overall, we found that there were adequate numbers of doctors at appropriate grades to meet the needs of patients. Junior doctors reported that the rotas were covered and worked well and that they received the supervision that was necessary.
- There were fewer consultants employed in medical care services and more middle grade and junior doctors than the England average. This meant the service was more dependent on more junior doctors to provide care and treatment
- The clinical director told us that they considered medical staffing one of the service's key risk areas. They told us that locum posts were used and that three new geriatric consultant posts had been created as a shortage of this staff group had a negative impact on patient management and flow.
- For the 2014/15 financial year the medical staff vacancy rate in medical care services was 11.8%.
- In the last year the locum rate was generally low for general medical specialities was 7.2% with a monthly range of 4.5 – 10.1%)
- There was a consultant presence in the Emergency Medical Unit during the day and an on call physician with appropriate skills available on call at other times. There was an appropriately senior and skilled doctor immediately available at all times.
- An audit in 2014 demonstrated that in the division, 66% of patients were reviewed by a consultant within 12 hours and the remainder within 24 hours.
- Junior doctors we spoke with told us that they found that their consultants were contactable and supportive.
- Junior doctors told us that although weekend cover was reduced, there were sufficient doctors to meet the patients' needs. They also said they were well supported by the registrar at weekends.

Major incident awareness and training

- We found that the major incident plans and business continuity policy were available on the trust intranet. We found that there was a wide variation in staff knowledge of these policies, or of their existence. Some staff knew what action was expected of them, while others felt that they could refer all issues to a senior person.
- We saw a report following a simulation exercise regarding an Ebola presentation. Whist it had mainly affected the urgent care service we noted there were implications for medical care services. Some managers in the division were not aware of the outcome of this exercise or its recommendations. This meant that the full value of such a simulation exercise was not realised.
- The trust had responded to seasonal bed pressures by the planned opening of extra capacity that was closed by the time of our visit.

Are medical care services effective?

Good

Overall we judged that medical care services were effective.

This was because we found that generally care and treatment followed national guidance. Although outcomes and measures by some national audits were below the England averages, we noted that the mangers and clinicians had acted swiftly to put improvement measures in place. Patients had access to a full-range of healthcare professionals and diagnostic facilities. Some services were provided seven days a week and others were actively moving toward this. Clinical and support staff worked collaboratively as teams to ensure patients received co-ordinated care that met their needs.

There were arrangements to ensure staff had the necessary skills, qualifications and experience to do their jobs. Staff could access up-to date information to assist them in caring for and treating patients.

Patients received adequate pain control. There were systems to ensure that patients had sufficient to eat and drink, including those with complex nutritional needs.

Where patients lacked the capacity to make their own decisions, staff acted in accordance with their legal obligations under the Mental Capacity Act, including obtaining authorisation for any deprivation of liberty.

Evidence-based care and treatment

Medical care (including older people's care)

- On the whole we found staff were aware of National Institute of Health and Care Excellence (NICE) guidance that was relevant to their work. We observed that practice was broadly compliant with guidance from the National Institute of Health and Care Excellence. We specifically looked at the requirements of guidance relating to Stroke, Diabetes in adults, Acutely Ill patients in hospital, Preventing falls in older people and IV therapy in adults in hospital.
- We were told that there was a Divisional Guidelines Group whose terms of reference were to update guidance to ensure it remained current and congruent with national guidance. However, the Clinical Director told us this group had only met once and as a consequence some updating of local guidance was required. We were supplied with a spread sheet which showed that the division had considered new guidance issued in 2014 and provided assurance that where applicable the guidance was met. Actions were planned when it was partially met.
- Clinical policies and guidance were available on the trust intranet system. Staff could locate policies when requested. We reviewed policy guidance and policies and judged they were compliant with current guidance and best practice. We noted that all local guidance that we reviewed carried a review date that was in the future. This meant policy documents were readily available, evidence-based and current.
- We saw that three key clinical guidelines, for example the anti-microbial prescribing guidelines, were available to junior doctors via mobile phone applications. This meant that that current guidance was instantly available for staff to reference.
- The endoscopy department had recently been awarded Joint Advisory Group (JAG) accreditation in February 2015. The accreditation process assesses the unit to ensure they met best practice guidelines. This meant that the endoscopy department was operating within this guidance.

Pain relief

- Patients we spoke with told us that their pain was managed well. Staff asked them about their pain and provided appropriate pain-killers when they were required. We observed staff pro-actively managing people's pain control.
- We saw that assessments of patients' pain were included in all routine sets of observations. We noted that as part of "intentional rounding" processes (where staff attend patients at set intervals to check a range of patient-centred issues) staff ensured that patients were comfortable.
- We found that there were no specialised tools in place to assess pain in those with a cognitive impairment such as a learning disability or dementia. We spoke with the leads for dementia care and they acknowledged that the management of pain in people living with dementia was an area for development.

Nutrition and hydration

- Patients and relatives we spoke with were satisfied with the quality, range and choice of food that was offered. Food that met people's special cultural and religious needs was available. There were facilities that enabled families and visitors to purchase food and beverages.
- Meal services times were generally calm and well managed, although not all wards offered patients the chance to wash their hands before eating. We saw that patients were supported to eat and drink. There was a system of observational audit for mealtimes. We saw the results of an audit undertaken on Basil ward which scored 83%.
- There was a system which identified the level of help patients required to eat and drink and this was expressed as a level 1/2/3. This classification was displayed to guide staff and ensure that the correct level of assistance was given.
- We had received information that elderly people were given inadequate assistance to drink. However, we observed that generally patients had drinks left within reach and were given assistance to drink.
- On Markham, Manvers and Basil wards we saw adaptive utensils and equipment such as plate guards, beakers, and special cutlery was available. This showed there was equipment to support patients' independence with food and drink.
- We saw that patients nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. We saw that scores were accurately recorded, and that identified risks generated care plans which were put into action, for example food charts were accurately maintained. We found that scores were reviewed within the recommended timescales.

- Compliance audits relating to MUST were completed. For example we saw audit results for Ridgeway ward dated July 2014 which showed MUST scores were completed within 24 hours admission (and 30% were completed within six hours), and 53% were reassessed weekly.
- Patients were referred to a dietition when they were at high risk with a MUST score of two or more
- We saw that there were adequate arrangements to ensure food safety. For example we found that food fridge temperatures were checked and the temperature of food was checked before service to ensure it had reached safe temperatures.
- On the stroke unit showed that there were arrangements to ensure that patients who had had a stroke were assessed promptly to ensure they had a competent swallow and were not denied food or fluid unnecessarily. On Basil ward we saw that fluid thickeners were used as planned, and that another patient received a "mashable" diet as recommended by the dietition. On our unannounced visit we found nurses had done swallow assessments and patients had dietary emergency regimes while awaiting Speech and Language Therapy (SALT) assessment. This showed there were systems to ensure people with compromised swallowing received appropriate food and nutrition.

Patient outcomes

- In the national Sentinel Stroke National Audit Programme (SSNAP), the trust achieved an overall rating of Band D (where band A in the highest and band E the lowest). This banding has been static since October 2013. 34% of teams in England achieve better results band D is largest England cohort in Sep 2014. This means the trust is performing in line with its peers.
- In the last national Heart Failure Audit reported in 2013, the trust scored below the England average in all four in-patient care measures, and in five out of seven discharge measures. We spoke with a consultant who told us that as a result of this audit result, the trust had now had in post a team of specialist heart failure nurses to provide care to patients with heart failure and to support their discharge. They were confident that the next audit would demonstrate significant improvement.
- In the last National Diabetes Inpatient Audit (NaDIA) reported in September 2013, the trust performed worse than the England average in 15 out of 20 measures. As a result of these results, the trust had developed a team of specialist diabetes nurses who were in post and addressing the underperformance identified.
- In the national Acute Myocardial Infarction Audit 2013 (which reviewed the treatment and care of patients who had suffered a heart attack), the trust scored significantly less than the England average in two out of three measures. We spoke with a consultant who explained that they had identified that blocks in the treatment pathway with a regional centre may have contributed to the situation. It was also identified that there was a lack of consultant resource when benchmarked against other providers in the region and that the recruitment of an additional consultant was well advanced. This showed the trust has responded positively to the audit findings.
- The Standardised Relative Risk (SRR) of re-admission for elective admissions to the service was 104, slightly above the benchmark value of 100. It was better than the benchmark for emergency admissions. For Stroke Medicine the relative risk of re-admission was very low.
- Patients spent less time in hospital in medical care services that the national average. For emergency admissions the average length of stay was slightly below the England average. In Stroke Medicine it was much lower at 6.1 days against an average of 12 days. Data supplied by the trust showed that in February 2015 the divisional average length of stay as 4.2 days, broadly in line with the target set of 4.1.
- Monitoring by the CQC had not identified any areas where medical care services at Chesterfield Royal Hospital would be considered a statistical outlier when compared with other hospitals.
- We found that a nurse endoscopist had received bowel scope accreditation. This meant the screening of patients aged 55 years was in line with the national screening programmes. However, we also found that due to a new IT system there was a risk that patients may be missed for surveillance. This was identified on the appropriate risk register with mitigation in place.
- We saw that individual clinical areas carried out local audits to ensure that care was in line with national and local guidance, and to inform the development of new guidance and policy. We saw that an audit "The Detection and early Management of Delirium in Older

Hospitalised patients" had been the catalyst for the development of the "Integrated Care Pathway Guidance for the Detection and management of Acute Confusion/ Delirium in Adults."

- We saw monitoring data that showed a total of 21 local or national audits had been completed, or commenced in medical care services during 2014. This monitoring data demonstrated that the audits were presented at appropriate meetings and that recommendations were made. However, we could not determine how implementation of these recommendations was ensured.

Competent staff

- All new staff attended a corporate induction programme, supplemented by a local induction. Staff we spoke with confirmed they had received adequate induction.
- We found there was a system for supporting new nursing staff, especially those that were newly qualified when they commenced work. There was a comprehensive competency based programme which they worked through with the support of a preceptor and we saw examples of these and spoke with staff who were undertaking the programme. We judged that this would ensure that staff, their managers and patients could be confident staff had the skills to carry out their jobs.
- Staff told us that there were opportunities to undertake additional study, and that the trust supported them in this.
- We saw there was a wide range of specialist nurses, for example the frail elderly team and palliative care team and noted their presence on the wards. Staff told us they felt supported by these specialists and valued their input in ensuring they were delivering competent care.
- There was a system of annual appraisal in operation. Generally staff we spoke with told us that they had received an appraisal and that they had found it useful. They told us that they had personal development plans and were supported by their managers to achieve the objectives they contained.
- Divisional data from February 2015 demonstrated that consultant appraisal rates for the preceding year stood at 70%, significantly less than the target of 90%. For other staff, year to date rates were 49.5%, behind the required trajectory of 82.5%. This meant that the division was not achieving the expected appraisal rates.
- Junior doctors we spoke with reported the trust was an excellent place for training. They told us that they had access to appropriate study leave. Other learning and training opportunities included weekly for medicine meeting and a "Grand Round" where doctors had the opportunity to discuss the clinical care of patients across a range of specialities was held each Friday
- Consultants we spoke with confirmed that had appraisals and there were systems in operation regarding revalidation of GMC registration.

Multidisciplinary working

- Wards teams had access to the full range of allied health professionals and team members described collaborative working practices.
- Medical and nursing staff of all grades described excellent working relationships between healthcare professionals. We observed that the healthcare team worked well together to provide care to patients.
- We saw that on Durrant wards all patients' notes were integrated with doctors, nurses and therapists using a single document. This meant that that all members of the team were aware of the input of others, and that care was well co-ordinated for patients and their relatives.
- We saw monitoring data that showed that 100% of referrals to therapists were responded to within the agreed response time of two working days.
- Patients with dementia were assessed by the Rapid Assessment, Interface and Discharge team (RAID). We spoke with the dementia leads who told us they felt assessment by this team was timely and contributed to the management of care and discharge. Staff on the Emergency Assessment Unit told us that they could access the advice of mental health professionals and their response to referral was prompt.
- Consultants we spoke with told us they found the input of other clinical teams and specialist nurses to be very good.

Seven-day services

- Physiotherapy offered a seven day a week service and that patients were offered a minimum of five treatment sessions per week.
- A dietition told us they offered a five day service, However, they were aware that discussions were underway to enable that to be extended to seven day working.

Medical care (including older people's care)

- Staff reported that there was seven day availability of all diagnostic services including imaging and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- On the Emergency Medical Unit we found that all new patients were reviewed every day by a consultant, including weekends.
- On the stroke unit we saw there was a telemedicine system to ensure patients could be assessed promptly out of hours. Cover was supplied on a rota basis staffed by consultants across the region. It operated using internet video-conferencing arrangements and staff demonstrated its use on our unannounced visit. This meant that there was access to a stroke consultant at all times.

Access to information

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for patients.
- We saw there were systems to ensure the transfer of information when a patient moved between wards, usually from the Emergency Medical Unit. We saw that pro-forma based on the Situation, Background, Actions, Recommendations (SBAR) model were completed and these were supplemented by a verbal handover.
- We saw that the patient flow team and site matrons routinely collected information daily to inform the management of the hospital about the flow of patients. For example we saw that information about patients in the wrong specialty beds (outliers) was collected early each morning and was widely disseminated; we saw copies displayed in ward areas.
- We saw there were adequate arrangements for nursing staff handover. We attended a 'staff huddle' and found that all relevant information regarding the care and management of patients on the ward was clearly communicated. All staff had the opportunity to ask questions and clarify plans and priorities.
- Consultants and junior doctors we spoke with told us they felt there was excellent communication between medical and nursing staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In endoscopy we saw there were arrangements for nurse-led consent which ensured that patients gave informed consent prior to their procedure.
- Patients told us that staff gained their consent before care or treatment was given, We observed health care assistants gaining patients' agreement before carrying out care.
- Staff we spoke with were generally conversant with their responsibilities as set out in the Mental Capacity Act (MCA). We saw examples of capacity assessments and best interest decisions recorded in patient notes.
- Staff we spoke with were aware of the requirements of the Deprivation of Liberties Safeguards (DoLS), although some more junior staff were less sure. We saw examples of where staff had appropriately identified that a person's liberty was being curtailed using the High Court definition of 2014. Urgent DoLS authorisations were sought and approved by an appropriate member of trust staff and that standard authorisations were sought from the relevant supervising authority. We saw that consideration was given to using the least restrictive option.
- The trust safeguarding lead and their team had responsibility for overseeing the implementation of MCA and DoLS within the hospital. From patient records we saw that they had given advice and participated in the planning for patients who lacked capacity. Staff we spoke with knew how to contact the team and told us they valued their support and advice.
- In the first quarter of 2015, 4% of clinical staff in medical care services had completed training in the MCA and no staff had completed training in DoLS. This meant that without improvement in training rates most staff would not have current training in these areas at the year-end.

Are medical care services caring?

Good

Overall we judged that the caring aspects of medical care services were good.

This was because patients and their relatives were overwhelmingly positive about their experience of care and

the kindness afforded them. We observed care that was compassionate from all grades of support and clinical staff. We also saw, and patients told us, that privacy and dignity was maintained at all times.

Patients were involved in their care and treatment and were given the right amount of information to support their decision making. We found there were arrangements to ensure patients could get the emotional support they needed.

Compassionate care

- Patients expressed a high level of satisfaction with the care and treatment provided when we spoke with them during our inspection. The quality of care was described as uniformly good throughout medical care services. Patients and their relatives commented that nothing was seen as too much trouble for staff.
- During our inspection we observed that patients were always treated with kindness and respect. Their privacy and dignity was maintained; for instance we saw that care interventions were carried out behind closed doors or curtains and staff asked before they entered.
- We carried out an observation on Basil ward using the Short Observation Framework for Inspection (SOFI) tool. We saw that out of 21 observed interactions only two were assessed as poor interactions. Eight (38%) were assessed as being of good quality and the remainder as neutral. During the observation, none of the patients studied were assessed as being in a negative mood state at any time.
- We saw some examples of exceptional care. For example, we saw that on Durrant ward, a healthcare assistant had come to the ward in their own time to support a person living with dementia.
- In the discharge lounge we saw that considerable efforts were made to preserve patients' dignity. We found that patients in nightwear were offered disposable dignity suits, that there were arrangements to ensure segregation of sexes when people were being nursed in bed, and that toilets were equipped with additional modesty curtains.
- In Patient Led Assessments of the Care environment carried out in 2014, Acute wards (which would have included some medical wards) achieved scores for Privacy, Dignity and Well-being in the range 65% – 98%
- The Friends and Family Test (FFT) response rate for medical care services were below the England average of 30.1% at 23.3%. We looked at the latest FFT scores that were available to us for nine medical wards for the period September – November 2014. The average score was 94%.
- We found staff responded promptly to request for help. From November 2014 – April 2015 the average call bell response time was two minutes and fifteen seconds.

Understanding and involvement of patients and those close to

- Patients told us that they were kept informed of their care plans, and were involved in developing these. Where appropriate, they told us they were give choices about the care and treatment options available.
- We found patients were given information to help them understand their disease and its treatment. For example we observed award pharmacist educating three patients about their medication. We noted that plain English was used and that the communication style was appropriate to the patients' needs
- We saw that the "This is Me" assessment document produced by the Alzheimer's Society was widely used to notify staff about the social history of people living with dementia and to alert staff to care preferences, and any special considerations relevant to their care. Staff we spoke with were aware that these documents were in use and told us they found them helpful. We saw that patients families had completed these documents in order to communicate their detailed knowledge of the patient.
- We saw that clinical areas displayed printed health-education literature produced by national bodies. Some of this information was general in nature whilst some was specific to the speciality of the ward. For example, literature about liver disease and associated charities and support groups was displayed on Ridgeway ward.
- Staff on Manvers ward told us about a project they had initiated to improve communication with patients. There were communication folders for each patient on the ward for patients and relatives to communicate with the medical or nursing team requesting specific information, and a response was provided within 24 hours. We saw that the project was well publicised on the ward, and we saw examples of its use.

Medical care (including older people's care)

- In the last National Diabetes Inpatient Audit, 58.8% of surveyed patients said they were able to take control of their diabetes care, higher than the national average of 54.7%.
- In the Cavendish Suite Patient Experience survey carried out in November 2013, 88.7% (55/62) of respondents stated that the doctor or pharmacist completely explained the risks and benefits of their proposed treatment to them in a way that they could understand, with the remaining 11% stating that the doctor or pharmacist explained the risks and benefits to some extent. 1005 patients said they had an opportunity to ask the doctor or pharmacist questions about their care and treatment.
- In the 2014 Diabetes Nurse Specialist Service for Inpatients survey, 48% of patients who normally self-managed their diabetes were asked if they wanted to do this in hospital. Of the negative responses, 75% said that they didn't want the chance to do so.
- In the 2014 Lung Cancer Patient Experience Survey 80% of respondents felt that, the doctor carrying out their tests explained completely the reasons in a way that they could understand.
- In the Stroke Service patient Experience Survey in 2014 85% of patients felt, they received the right amount of information on what was wrong with them; 92% felt involved in the decisions made about their care and treatment.

Emotional support

- Patients and their relatives/carers told us that the clinical staff were approachable and that they could talk to staff about their fears and anxieties.
- We found that patients could access a range of specialist nurses, for example in palliative care, stroke and diabetes care and that these staff offered appropriate support to patients and their families in relation to their psychological needs.
- There was a hospital chaplaincy service and staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- On Durrant ward we were told about a support worker from the Alzheimer's society who attended the hospital one day a week and who was able to provide practical and psychological support to people living with dementia and their families.
- In the Cavendish Suite Patient Experience survey carried out in Novembers 2013, 98.4%) of respondents felt that the staff helped to reassure them whilst they were having their treatment.
- In the 2014 Lung Cancer Patient Experience Survey, all patients stated that they were given the opportunity to have a friend or relative with them whilst their diagnosis and treatment was discussed. In the same survey, 88.9% of patients stated that they received information on the emotional support that was available and all of these found the information useful.

Are medical care services responsive?

Requires improvement

Overall we judged that the responsiveness of medical care services required improvement.

This was because there was insufficient bed capacity to meet the needs of patients. This resulted in almost half patients being moved at least once during their hospital stay. There were large numbers of patients in non-speciality beds and this had negative implications for their safe care and treatment. We also found that support for people with learning difficulties was variable, and that patients' complaints were not being handled in a timely way.

We found that there were arrangements to meet the individual needs of patients, including hard to reach groups such as travellers. We saw that considerable developments were in progress to improve the care of people living with dementia although the benefits of these were not yet fully realised. Consideration had been given to providing care close to home. We saw that there were systems to ensure discharge from hospital was planned and met the on-going health and care needs of patients.

Service planning and delivery to meet the needs of local people

- The division had designated an urgent care area for ambulatory care so to provide care closer to home and avoid unnecessary admissions. However, a consultant expressed concern that this area was not ring-fenced and had been used as extra capacity for medical inpatients in the winter. This meant there was variability in the provision of a service designed to meet the needs of local people.

Medical care (including older people's care)

- We found that extra capacity was opened (Ashover ward) to meet increased demand over the winter period and ensure local people had access to medical care services. We saw that this was a planned initiative. There was a matron and a ward sister from within the trust substantive staff in place for the duration of Ashover ward being open. This ensured professional leadership and continuity of care for patients and support for staff**.**
- We held a focus group for the travelling community who were positive about their care experiences at Chesterfield Royal Hospital. They told us that staff at the hospital understood their cultural needs and that no matter where they were in the East Midlands this was their hospital of choice. They described how the hospital understood their approaches to cleanliness and their desire as a family to be actively involved in a person's care.
- We saw that the in the discharge lounge a "Home from Hospital" service was run in partnership with the British Red Cross. This enabled patients to be transported home by the Red Cross, to be settled at home and have any immediate practical tasks such shopping or snack preparation carried out. This showed how the hospital was committed to meeting the needs of local people by working in partnership with the voluntary sector.
- On the stroke unit, an early supported discharge system was in operation which allowed patients to return to their own homes while continuing to receive treatment and therapy. Nursing and therapy staff worked on the early supported discharge team and visited patients at home for up to six weeks, with daily input if needed.
- We saw examples of usual visiting hours being varied to accommodate the needs patients and Visitors with extra-ordinary circumstances or who were very sick. We saw examples of relatives staying with a very sick patient during our night visit.

Access and flow

- Bed occupancy in the division was 95.5% (February 2015 data); considerably in excess of the figure of 85% that is recommended. This indicated a possible lack of capacity to meet demand, especially in periods of increased activity, for example during the winter.
- We found that due to issues with patient flow, medical patients were transferred or admitted to beds designated for other specialities. During the period October to December 2014 these were reported by the trust to be up to 109 per month. During our visit staff reported that a figure of between 25 and 30 at any time was usual. On the last day of our visit we saw the outlier list produced daily and noted there were 29 patients represented there. The wards the hospital have around 33 beds which so this figure represents nearly and additional ward of medical patients. This showed that medical care services were unable to care for patients within their allocated bed base. We noted that a medical ward had closed in 2014 with a reduction of about 30 beds, and that a planned relocation of a ward will result in the loss of about 12 medical beds.
- We were told that patients with whose medical needs were not particularly complex and were stable were transferred to non-specialty beds. However, we reviewed the medical records of two outlying patients and considered both inappropriate transfers due to the complexity of their needs. For example, one patient was experiencing symptoms of a gastric bleed, and we noted that a requested doctor review took four hours.
- We spoke with six medical patients who were currently cared for in surgical ward areas. Four patients told us they had been moved after 11pm and were unhappy about this. Two of these patients felt the nurses on the surgical wards did not understand their medical needs well enough
- During the period April – December 2014, 46% of patients experienced one or more ward moves. This showed that nearly half of patients were not treated in the correct speciality ward for the entirety of their stay
- We spoke with nursing and therapy staff who told us they felt that outlying patients received sub-optimal medical care. For example, they told us that doctors were difficult to contact and that consultant reviews were less likely to occur daily.
- We considered the senior leaders in the trust did not sufficiently acknowledge the scale of the problem or the risks presented. They told us they would manage the issue through more efficient patient management practices. However, staff told us the initiatives were having little or no impact.
- We were told the high number of medical patients transferred from a medical ward to a surgical ward delayed discharge as the process involving therapists and social worker had broken down. This resulted in nurses recommencing the process, including re-engaging the medical team who were more difficult to contact as they were not ward based.

Medical care (including older people's care)

- Medical care services were meeting all referral to treatment time targets (also known as the 18 week target). Medical speciality rates ranged from 99.3% to 100% compliance.
- A weekly meeting with representation from across the local health and social care economy was held to expedite discharge for those for whom it was delayed, and to identify improvements. A delayed transfer of care rate of 3.6% was reported; slightly higher than a target of 3%.
- When we looked at patients' records we saw that there was evidence of comprehensive discharge planning that commenced early during the patients' admission.
- In the 2014 Stroke Service patient Experience Survey results we saw positive feedback about the discharge planning and arrangements. For example, 89.5% of respondents stated that they felt prepared for their discharge, and 91.9% (stated that their relative/carer felt prepared for their discharge).
- We found that the organisation had invested in the upgrading of its discharge lounge facilities. We visited the lounge and the staff working there were able to explain the arrangements that were in place to ensure that comfort and safety of patients who were awaiting discharge whilst facilitating the flow of patients through the hospital. We reviewed the unit's operational policy and noted that staff were enacting its contents. Although no monitoring data was available, we heard anecdotal evidence that this facility was well used and assisted in establishing patients flow through the hospital early in the day.

Meeting people's individual needs

- We saw that patients had their needs assessed and once admitted to a ward a plan of care was devised to meet their identified needs and to minimise any risks to which they were subject. We found that care plans were clear and easy to use although navigation of nursing documentation was sometimes difficult.
- We saw that a system of "intentional rounding" had been implemented to ensure that patients' fundamental needs were met. We saw that records of kept of these care rounds and noted that generally they were carried out at the specified frequencies. However, we did note that sometimes during the night shift these records showed that these round were carried out an hour or two late.
- The trust employed a liaison nurse for learning difficulties and we met her supporting patients and staff on the wards. Nurses told us that the trust had operated a system for learning difficulty link nurses, and that resource files had been available for staff to reference. The link nurse scheme was under review as some of the staff that were part of the scheme have either left or changed roles or departments. However, staff on the wards perceived this as the service being withdrawn.
- We were told there were copies of the 'Hospital Communication Book' in the learning disability resource files on the wards. The Learning Disability Lead also provided a copy which was usually left by the bedside to assist staff in communicating with individual patients when required. We were also told that the "Traffic Light Assessment" had been in use for the past four years and that copies were available on both public and internal internet platforms for staff, patients and their carers to access.
- However, we did not see any pictorial aides for use with people with learning difficulties, nor did we see the use of a standardised communication tools (for example traffic light documents, or patient passports) that enabled community staff or family members to highlight any special needs the person with learning difficulties may have.
- However, we found that there were arrangements in the endoscopy unit that ensured that the learning disability liaison nurse identified patients with a learning disability attending the department and attended with them to ensure support appropriate to their needs was provided.
- We noted that patient assessments identified when patients had sensory deficits and this was factored into care planning. We observed specialist equipment in use to aid communication with a hearing impaired patient.
- We saw that bathrooms and lavatories were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients.
- Hospital mattresses were fit for purpose and provided protection from infection and pressure damage. Where the risk of pressure damage was particularly high, staff could access specialist dynamic mattresses to ensure patients' needs were met and they were protected.

However, staff reported that on occasions they experienced delays in receiving mattresses. We also found that at night protective heel boots were locked away on one ward so night staff could not access them.

- Staff were able to access interpreting services for people for whom English was not their first language. We saw monitoring data which showed these services were used on 84 occasions in the division between April 2014 and March 2015. Polish and British Sign Language were the languages most often requested. We did not see any patient literature displayed in languages other than English.
- We found that there were arrangements to ensure the requirement that all patients aged over 75 years were screened for dementia. We looked at the trust's monitoring figures and found that screening rates were running at almost 100%.
- Reminiscence packs were available via the library to assist in the care of people living with dementia and we saw references to these in patients' records. However, their use had not been evaluated or uptake monitored.
- We saw that an audit of the environment to assess the extent to which it could be considered dementia friendly was carried out in late 2012 using a validated tool developed by the King's Fund organisation. This had led to agreement on the principles of design for future ward upgrades to ensure they met the principles of dementia friendly design. We saw that Elizabeth ward and the discharge lounge had recently been refurbished and that these principles had been applied. For example, we saw that sanitary fittings were of contrasting colours, floors were of a matt finish and different clinical areas were identifiable by the use of different colours used at the entrances. We also found some elements applied elsewhere through medical care services, such as the use of coloured lavatory seats, but this was inconsistent. We especially noted that the environment of the ward designated as a ward specialising in the care of people living with dementia was not dementia friendly.
- Markham ward staff explained that they could access bariatric equipment when it was required, and gave an example of how they had ensured it was ready and in place before a patient was transferred to their care.
- Overall, we found that there were arrangements to ensure patients were cared for in single sex facilities and had access to single sex washing and toilet facilities.

Learning from complaints and concerns

- We noted that information on how to raise a concern or complaint was not prominently displayed in clinical areas in medical care services.
- In the division in Medicine and Emergency Care, complaints were not managed within the timescales set out in the trust policy. In February 2015, only 47.1% of complaints were managed on time, less than the target of 90.5%
- We found that although complaints were investigated, learning points identified and feedback given at ward meetings, there were no formal arrangements to track and evaluate the actions taken to resolve complaints and to implement the lessons learned.
- We heard anecdotal evidence in the absence of data from the matron with lead responsibility for complaints that the percentage of complaints re-opened was low (they estimated about 10%). This suggested that on the whole patients were satisfied with the response once they received it.

Are medical care services well-led?

Good

Overall, we judged that medical care services were well-led.

This was because all staff were aware of the trust and local service vision and strove to put this into action as part of their daily work. There were clear ward-based strategy plans.

We found there was an appropriate system of clinical governance that identified risks and underperformance in key safety areas, and the remedial actions required. The governance system used comprehensive system of metrics presented as dashboards to ensure that quality issues and trends could be readily identified. There was a divisional risk register and ward areas were expected to maintain their own risk registers through the use of the electronic incident management system. The management team acknowledged that the system for maintaining ward based risk registers was not yet fully embedded.

Staff expressed confidence in their leaders and told us they were visible and approachable, and supported them to do their jobs well. We noted that staff showed a positive attitude to their work and spoke well of the organisation and their colleagues. We saw that staff were offered

opportunities to develop their leadership skills. We found that staff and patients were engaged with the development of medical care services, and saw examples of innovative practice.

Vision and strategy for this service

- Nearly all staff we spoke with were aware of the trust vision "Proud to Care". When questioned staff could explain what this vision meant to them gave examples of how they demonstrated this vision in their work.
- Some individual wards had developed local visions or philosophies of care. Staff described to us how these had been a collaborative project involving the whole care team.
- We saw that each clinical area had its own improvement plan. These were all comprehensive documents which identified the priorities, timescales, outcome measures, enablers and barriers to success and the inter-relationships between the various strands of the plan. This was displayed for all to see and all staff we spoke with were aware of the plan, and broadly speaking its contents. We checked out the actions for the plan on Manvers ward and were assured that these actions were completed, or in progress.
- We saw minutes of meetings which showed the division maintained a 'rolling action plan'. This enabled the management team to monitor the progress of developments and responsive plans and to ensure their completion.

Governance, risk management and quality measurement

- We found that medical care services had appropriate governance structures in place. There was a monthly divisional governance meeting attended by managers and senior clinical representatives from specialities across the division. We saw minutes of these meetings.
- Assurance reports were provided by this governance meeting to the trust's Quality Delivery Group. Any issues that required it could be escalated to this group for more senior action.
- The governance meeting generated a divisional summary containing key messages which was disseminated throughout the division for information. It was expected to be discussed at matrons' meeting and ward meetings. We saw ward meeting notes which indicated that governance issues were discussed with staff. This meant that information flows from the governance meeting were robust.
- There was a matron in post with a lead role in governance and complaints management. This post holder supported ward staff and managers and played a role in ensuring consistency and quality in governance matters across the division. For example, they quality assured all RCA's before they were presented to the management team, of appropriate safety forum for sign-off.
- There was a divisional risk register and ward areas were expected to maintain their own risk registers through the use of the electronic incident management system. The management team acknowledged that the system for maintaining ward based risk registers was not yet fully embedded with the result the benefits of the system were not fully realised and not all risks being considered for incorporation to the divisional risk register.
- In discussion with staff and managers we found that there was broad consensus on the risks and challenges facing medical care services. This showed an awareness of risk issues across the service. There was a lack of clarity on how risks were evaluated, how mitigating actions were assessed for their effectiveness and what methods or data were to be used to demonstrate actual risk reduction.
- We looked at a range of action plans for the service. We noted that these actions plans did not contain any tests of efficacy, or details the end effect specified actions were intended to achieve. Therefore, it was difficult for staff to assess if the action plan had achieved the desired effects before it was closed down. Our discussions showed that although action plans were monitored for implementation, this tended to be on an informal basis. This meant that without formal mechanisms of assessing the implementation of actions and their effectiveness, there was a risk that necessary change may not occur.

Leadership of service

- All staff we spoke with told us they felt supported by their line-mangers and leaders to do their job well. This demonstrated that staff felt that there were well-led.
- Staff were aware of the role and function of key board members and could identify them. Ward staff told us

that senior nursing staff and consultants could be seen on the wards daily and that were approachable and helpful. This showed that the local and trust leadership was visible.
- We found that medical care services provided leadership development opportunities for its ward leaders. We spoke with staff who told us they were attending an externally provided leadership programme. We also spoke to staff who had attended the internal "Skills Lab" sessions which they felt had developed their management skills.

Culture within the service

- We observed that staff were positive about working for the trust, and understood the contribution they made personally to the care and treatment of patients.
- Staff we spoke with told us they felt there was a culture of openness within the organisation. For example, we saw a message from the Chief Executive encouraging staff to engage with our inspection team and to give an honest account of their achievements and challenges. A nurse we spoke with told us she considered that this was typical of the organisations' approach. They explained their interactions with the Director of Nursing and Patient Experience, and were positive about the interest they showed in their current projects. They also said they felt empowered to raise any issues or concerns.
- We were told of a personal example where a staff member wished to raise concerns about another's poor practice. They utilised the trust whistleblowing policy and told us they felt supported through the process.
- Patients acknowledged a positive and caring ethos and were overwhelmingly happy with their experience of care.
- We spoke with the Divisional Director who described the culture of consultants as positive, collaborative and pro-active with increasing involvement in clinical leadership and in quality and governance initiatives.
- The workforce was ethnically diverse with numbers of overseas-trained staff, especially nurses in post. We saw that staff were enabled to observe their cultural identity, for instance we saw nurses with covered heads. We were not told of any instances of discrimination and noted that staff from non-white British backgrounds had been promoted to senior positions.
- Divisional sickness rates had a target of 4%. Actual monthly rates September 2014 – February 2015 ranged between 6.7 and 5.1%. This showed, that despite a positive culture, this was not yet reflected in below average sickness rates.

Public and staff engagement

- We found that wards and clinical areas held ward meetings to enable staff to be informed and to contribute to the development of services. We found through our discussions with all grades of staff that staff felt informed and involved with the day to day running of the service, and its strategic direction.
- We heard that staff had attended and valued the "You Talk; We Listen" sessions provided. The divisional management team could give us examples of changes that had been made as a result of this initiative, for instance the agreement of an internal staff transfer process, and the creation of rotational posts within the division.
- Each ward displayed clearly key performance data, for example hand hygiene audit and infection rates, and staffing numbers so that patients and their visitors as well as staff could see how well the ward was performing. There were also examples displayed of how the ward had responded to both positive and negative feedback.
- We saw examples of individual specialities carrying out patients experience surveys. This meant the feedback of patients was sought and used in developing services.
- We saw that the Trust collaborated with the voluntary sector in the provision of services, for example the British Red Cross Societies Home from Hospital service and the support worker provided by the Alzheimer's Society.
- The divisional management team gave us examples of the use of patients' representatives on planning groups. For example, on the stroke development group, the Cancer Strategy Group and the Diabetes Integrated Model project group. However, there was no formal mechanism for ensuring the patient voice on all development or monitoring groups within the service.
- We saw that considerable efforts had been made to develop methodologies to collect the views of people living with dementia about their care experience. At the time of our inspection return rates were acknowledged

to be low (around 105) but were felt to be improving. We saw results dated September 2013 which showed that 25% were satisfied overall, 50% were satisfied and 25% dissatisfied.

Innovation, improvement and sustainability

- We saw examples of innovative practice as solutions to challenges faced by the service. For example, we spoke with the dementia leads and were shown draft copies of a dementia and delirium pathway which was being developed in conjunction with all partner organisations across North Derbyshire. It was part of a five year strategy with the aim of its use across the whole local health and social care economy and formed part of the Executive Boards 21st Century Workstream.
- Another example of innovation was that in order to improve the efficacy of medical ward rounds, a standard operating procedure for ward round had been developed. This was reproduced on credit-card sized aide-memoires which we observed in use.
- We saw that the division had identified a range of cost improvement plans (CIP's). We found that appropriate risk assessments had been carried out to understand their potential risks to quality and safety.
- The governance system used comprehensive system of metrics presented as dashboards to ensure that quality issues and trends could be readily identified. We found that through its clinical governance and performance review structures and processes, the divisional management team were well placed ensure that improvements needed were identified and that performance across a wide range of metrics was sustained.
- We raised our concerns about patients outlying on wards during the inspection. The trust took immediate action to review how patients were being moved and the allocation of consultants to oversee their treatment. They also implemented a system to monitor the time of day patients were asked to move wards. We were encouraged by the quick response of the trust to address the concerns we raised with them.

Surgery

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

Information about the service

The surgical division provided 181 inpatient beds across six surgical ward areas and 51 day case beds. For the in-patient services this included; the intensive therapy unit, the high dependency unit, general surgical specialties, maxillofacial services, breast surgery, vascular surgery, head and neck cancer services. Services for surgical patients were provided in outpatient consultation sessions, the pre-operative assessment unit, day surgery and inpatient wards .There were designated anaesthetic and operating theatres for the surgical directorate and an attached surgical recovery unit.

The surgical division had 12 theatres, four of which were laminar flow (this is a type of air conditioning that reduces air borne infections) and two theatres that were for emergencies on a 24/7 basis. Between July 2013 and June 2014 the trust treated 21,964 surgical patients. Fifty four per cent were day surgery cases, 15% were elective admissions and 31% were emergency admissions.

We inspected the elective admissions lounge, general surgery day surgery unit, operating theatres and recovery, six surgical wards, CSSD which is the central sterile services department and the equipment library.

During our inspection we spoke with 48 patients, eight visiting relatives and one paid care giver. We spoke with 32 staff from a range of various surgical related roles including nurses, physiotherapist, occupational therapist, health care assistants, trainee doctors and senior managers. Additionally, we spoke with members of the public at a listening event prior to the inspection. We received comments from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information about the trust.

Surgery

Summary of findings

Overall we found surgical services to require improvement. Insufficient staff had attended essential training on caring for people who do not have capacity to make decisions about their treatment, and staff did not demonstrate understanding of this aspect of care. Staff did not consistently monitor patients' level of hydration where this was required. Staff did not always receive an annual performance appraisal, and uptake of appraisal was significantly lower than the trust's own target.

Patients did not always receive treatment in an appropriate timescale after referral. Average lengths of stay were slightly longer than the England average. Surgical wards received a relatively high number of medical patients, for whom the medical wards did not have sufficient capacity. This impacted on the quality of care for all patients.

There were effective systems for reporting patient safety incidents and learning from them. Ward staff adhered to infection prevention and control best practice. Most equipment was well maintained and stored. Medicines were managed safely, although storage was not always suitable.

Surgical outcomes for patients were monitored and were mostly within the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements. There was good multi-disciplinary working in all the wards and departments we inspected. Staff were kind, compassionate and caring towards patients. Patients were involved in decisions about their care options and were given enough information about their condition.

Staff demonstrated a good awareness of the trust complaints procedure and how to deal with complaints, but did not always respond to complainants within a reasonable time frame. Surgical services were led by committed and enthusiastic staff. Governance arrangements largely identified and managed risks to quality and performance.

Are surgery services safe?

Requires improvement

Overall we judged the safety of the service required improvement.

The percentage of surgical patients with a new harm identified on the safety thermometer was higher than the trusts target. The main safety concerns related to pressure ulcer rates, although these were decreasing. We were concerned about the security of a resuscitation trolley which was positioned out of sight of staff in an area which was accessible to the public. Intravenous fluids were also stored in an area which was accessible by the public in cupboards that were not locked. There was a risk that equipment and or medicines could be tampered with.

Staff were familiar with and used the electronic system for reporting errors, incidents and near misses. Lessons learnt were shared with staff and improvements were put in place. Generally we found the day staffing levels met the planned numbers. Clinical staff monitored risks to patients and there were effective systems for infection prevention and control. Ward staff adhered to best practice with regard to infection prevention and control policies. Most equipment was well maintained and stored.

Incidents

- An electronic incident reporting system, which all staff could access was in use on all surgical wards for reporting incidents, near misses or errors. Ward staff we spoke with, including agency nurses, had a full understanding of this and were able to provide examples of how the process worked from start to finish, including where lessons learned had been shared.
- For the period February 2014 to January 2015 there were 18 serious incidents requiring investigation within the surgical division. These were all reported in ward areas, and not in theatres. Most of these were grade 3 pressure ulcers.
- Staff told us about learning from incidents. An example of this was when out of date mesh was used during surgery. This was reported via the hospitals electronic reporting system, the incident was investigated and changes made to the checking process.

- In April 2015 the trust introduced a monthly incident newsletter to inform staff and share the learnings from incidents and near misses.
- Trauma and orthopaedics reported over 40% of surgical incidents. Although the rate of incidents had decreased by 50% from June 2014 to December 2014, they had increased again by February 2015.
- Within the surgical division, morbidity and mortality (M&M) meetings were held quarterly. These meetings review patient deaths and complications, in order to develop improvements to patient safety and aid professional learning. Minutes of these meetings demonstrated that all unexpected deaths were reviewed and trends were identified.

Safety thermometer

- We reviewed the safety thermometer dashboards on the wards we inspected. The NHS Safety Thermometer is an improvement tool used for measuring, monitoring and analysing patient harms and 'harm-free' care. Each surgical ward area collected information on a range of safety measures based on individual patient risk assessments. This was clearly displayed at the entrance to every surgical ward. The results were part of the ward's performance monitoring and included such information as number of inpatient falls, number of hospital acquired pressures ulcers in each of the grading categories and number of medication administration errors. This meant patients and visitors could see how the ward was performing in relation to patient safety.
- The percentage of surgical patients with a new harm identified on the safety thermometer was 4.9% which was worse than the trust target of 2.5%. We reviewed surgical ward figures for the months April to December 2014 and found the main safety concerns related to pressure ulcer rates. The rates of pressure ulcers have decreased since May 2014, but were still worse than the trust target. In November 2014, 2.4% patients had a hospital acquired pressure ulcer against a target of 1%. The proportion of patients with a new venous thromboembolism (VTE), or blood clot, was slightly worse that the trust target of 0.5%. The proportion of patients who had suffered a fall was much better than the trust target of 0.7%

Cleanliness, Infection Control and Hygiene

- We saw ward staff complying with infection prevention and control best practice. There was access to hand washing and drying facilities on wards and a good supply of personal protective equipment, which included gloves and aprons. These items were used by staff and disposed of correctly afterwards. We observed staff wash or cleanse their hands between patient care duties and when going about their activities on wards. We saw them following best practice guidance when giving intravenous fluids and taking blood samples.
- Throughout the hospital and at the entrance to each ward, there were alcohol hand gel dispensers or hand wash facilities. An audio voice message from above the hand gel dispenser would regularly remind people to use the gel when entering and leaving the ward or hospital site.
- In the surgical ward areas, pre-assessment rooms, operating theatres and recovery, we found the standard of cleanliness to be good and saw domestic staff following guidance in regard to required cleaning standards, practices and frequency of cleaning contamination.
- The service reported no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) from November 2014 up to and including the time of our inspection.
- Patients were screened pre-operatively for MRSA and as soon as possible when admitted as an emergency. This was in line with local policy and national guidance. Patients who presented as a possible infection risk were allocated to side rooms until test results were known.
- We saw that patients who required isolation were nursed in side rooms and appropriate signage was in place to alert staff and visitors of the action to take.
- Theatre corridors were cluttered with equipment, which meant it was difficult to clean the floor. We were told this was because there was nowhere else for the equipment to be stored while the theatres were refurbished. Staff told us once the two year refurbishment was completed, there would be adequate storage space. Work on storage areas was due to commence in early May 2015.
- Staff adhered to the dress code, which was to be bare below elbow, and followed correct technical procedures for scrubbing up prior to setting up the surgical instrumentation and commencing surgery.
- Within theatres we observed there was alcohol gel on entry to anaesthetic rooms. Theatre staff were observed to adhere to best practice principles for scrubbing up

prior to surgery and for the management of surgical equipment in the operating environment. We saw that deep cleaning was undertaken in theatres every six months.
- We observed staff in all surgical areas following guidance for the safe disposal of different types of clinical and domestic waste, used sharp items such as needles, and handling soiled linen.
- Surgical staff were observed to be following the National Institute for Health and Clinical Excellence (NICE) guidelines for the prevention and treatment of surgical site infections.
- The trust reported 426 surgical site infections for the year 2014. Surgical site infection surveillance (SSIS) is mandatory for all trusts however, not all categories of surgery are required to be reported on. The trust reports on surgical site infections where knee replacement surgery has been undertaken.
- We saw that a range of equipment used by patients was checked to ensure the items were clean and appropriate for use.
- In the central sterile services department (CSSD) each specialist piece of surgical equipment had its own serial number which facilitated tracking of the equipment when in use and while it was being sterilised. We saw separate clean and dirty areas in CSSD and suitable systems for equipment to flow through without being contaminated.
- There were separate clean preparation areas and facilities for removing used instruments from the operating theatres to the hospital decontamination unit. Special sterilising equipment was tested before use and staff kept records of this.

Environment and equipment

- There were single rooms for use on each ward by patients who were particularly unwell or needed to be isolated because of infection.
- Resuscitation equipment, including emergency drugs, was readily available in all surgical areas, including theatres. A difficult airway trolley was also available in theatres. Records showed the equipment was checked daily by staff. Technical equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made.
- Theatre staff reported having sufficient equipment to undertake their roles.
- One of the resuscitation trolleys was positioned out of staff sight outside Murphy ward. This meant it could have been removed by an unauthorised person and would not have been available for staff to use in an emergency.
- We saw that clinical waste was handled appropriately and correctly labelled to ensure its safe disposal.

Medicines

- There were suitable arrangements in place for the storage and management of medicines in surgical areas, including theatres and recovery. Disposal arrangements were also in place for expired or medicines, which were no longer required.
- Medicines errors, including errors resulting in harm, were reported as part of the incident reporting process. Staff were able to discuss incidents where errors had occurred and the resulting actions that had taken place to help prevent a similar error.
- Controlled drugs on the wards and in theatres were stored appropriately and drug records were accurately completed. Emergency medicines were available for use and there was evidence these were regularly checked.
- Nursing staff confirmed that they had access to regular pharmacy advice. The pharmacists visited the wards Monday to Friday and checked prescription records and raised any queries with doctors. They also undertook checks on antibiotic prescribing and compliance with agreed protocols. These measures helped to ensure safe practice.
- Intravenous fluids were stored in cupboards between Devonshire and Barnes wards. These were not locked; staff told us the keys had been lost. This meant that the intravenous fluids were not secure and could be tampered with or taken and would therefore not be suitable or available when needed for patients. The trust rectified this following our inspection.

Records

- In general, medical and nursing records were completed appropriately. The pre-operative checklists were completed, as were records of consent. The surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. Patient records were stored securely in a notes trolley on each of the surgical wards visited.
- All the staff we spoke with were aware of their responsibilities for the safe keeping of records and

confidentiality of patient information. Throughout the wards and theatres we saw patient identifiable information was mostly stored securely. However, on two wards the interactive whiteboard behind the nurses' station which contained information concerning patients' details was easily visible to anyone standing either side of the nurses' station. This meant that patient confidentiality was not always maintained.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received appropriate training. Staff told us they were knew how to report concerns.
- Trust requirements were that it was essential for all staff to be trained to level 1 and 2 safeguarding depending on their duties. Staff that did not have a direct role with patients, such as administration and clerical staff, were required to be trained in safeguarding to level 1. Staff who were alone with patients, such as nurses and porters, must have been trained in safeguarding to level 1 and 2. Level 3 safeguarding training was for safeguarding leads.
- All theatre staff were trained in safeguarding at level 1 and over 96% at level two.

Mandatory training

- Staff completed mandatory training in a range of subjects, for example; health and safety, moving and handling, infection prevention and control, equality and diversity and basic life support. A formal system was used to monitor uptake and senior staff were seen to be proactive in prompting staff that needed to attend. More than 89% of staff in the surgical division attended mandatory training data in 2014, which was above the trust target of 85%.
- Staff we spoke with confirmed they were up to date with mandatory training which included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- Clinical staff were seen following the nationally recognised five steps to safer surgery. Staff used a document based on the World Health organisation (WHO) safety procedures to ensure each stage of the patient journey from ward through anaesthetic, operating room and recovery was managed safely. The use of this document was audited every 6 months and training undertaken if compliance fell below 90%.
- National Early Warning System (NEWS) was used for patients across the hospital to assist staff in the early recognition of a deteriorating patient. NEWS is a system that staff can use to assess whether patients are developing potentially life threatening conditions. We saw NEWS documentation was completed appropriately which meant that patients were being appropriately monitored for signs of deterioration and could be treated as necessary.
- Access to an emergency theatre was available 24 hours a day, seven days a week with a further theatre available during afternoons and evenings. Patients requiring emergency surgery were referred to the on-call anaesthetist and theatre co-ordinator by the medical staff responsible for their care.
- One patient we spoke to told us that they still had a cannula in their arm for the administration of intravenous antibiotics even though the antibiotics course had finished two days ago . We spoke to the nurse who was caring for this patient who advised they would have the cannula removed that day.
- In the operating department we observed closed-circuit television (CCTV) in operation throughout the main areas of the department, this meant the security of both patients and staff was enhanced.
- We saw an electronic theatre data system in use; this was an operating theatre management system to assist with the tasks needed to provide safe and efficient care to patients.

Nursing staffing

- Generally we found the day staffing levels met the planned numbers. Staffing levels for wards were calculated using the Safer Nursing Care Tool (SNCT) recommended by the National Institute for Health and Clinical Excellence (NICE). This tool measures the individual dependency of patients and calculates how many nurses are needed to care for them.
- A report on the nursing staffing levels to the trust board in April 2015 showed that from June 2014 to March 2015, in three out of the six surgical wards, staffing establishment was not sufficient for patient dependency. In response to this, Barnes Ward (short stay surgery) took fewer patients over the weekend and beds on an elective orthopaedic surgery ward were converted to day-case beds. In addition, staff numbers were increased on wards as required to meet patients' needs.

- Senior managers drew up proposals to reconfigure wards so as to ensure continued safe staffing and these proposals would go to the divisional management board meeting in May 2015.
- Trust data showed there was a nursing shortfall on 8.5% shifts on surgical wards during March 2015. This has decreased slightly from 9.5% in January 2015, and each month there were a greater proportion of overfilled shifts, which meant there were more staff than the calculated figure.
- On Robinson ward staffing was risk assessed weekly. The ward staffing requirements at night were; three health care assistants and two qualified staff, but there were only two health care assistants and two qualified staff on duty during our inspection. This meant the actual nursing staffing levels were not in accordance with the identified risk assessment.
- On the risk register, we saw that risk assessments were reviewed on a regular basis to ensure safe staffing levels and the appropriate skill mix . There was a high turnover rate of 12.5%, worse than the trust target of 8.4%. In December 2014 there were 12 nursing vacancies in the surgical division which was worse than the trust's target of 10. However this reflected an overall decrease in vacancies over the year from April 2014. The trust had a recruitment plan which included recruiting from abroad. They had also reviewed the recruitment process to make it quicker to fill posts.
- In theatres there was a nominated band 6 nurse on each shift for the day to day management. For night duty there were no permanent staff. A rolling rota was used, which staff told us worked well. Staff were allocated to enable two theatre lists to run throughout the night, one was a general emergency theatre and one was an obstetric theatre. There were an additional two band five scrub nurses, two band five operating department practitioners (ODP) two theatre support workers and an additional ODP who was on call.
- The skill mix on surgical areas had been considered as part of the planning rotas. There were always senior staff on duty to support junior staff, including sisters and matrons.
- Agency staff were used on the majority of surgical wards and in theatre and this was confirmed by our review of staff rotas and discussions with staff.

Surgical Staffing

- Surgical doctors, registrars and consultants from all specialities were on call to provide advice and care 24 hours a day. Doctors and registrars were available on site during the day, including at weekends, and in some cases over night. Consultants were on site during the week days and were available to attend the hospital out of hours when necessary.
- Some consultants worked an on call rota with nearby acute hospitals.
- There were high levels of locum doctors in ophthalmology at over 40%, with lower rates of 12% in anaesthetics and 9% in orthopaedics.
- The trust has three vascular consultants; assistant from a neighbouring trust was needed to cover periods of planned leave. This was on the divisional risk register so it could be monitored.
- Handover took place twice daily for all general surgical and urology patients. A separate orthopaedic handover took place between the outgoing doctors with the incoming orthopaedic team, face to face in the morning and sometimes by phone in the evening.
- A theatre meeting also took place each morning attended by the on call anaesthetic team, emergency theatre team and Consultant General surgeon on call for the day to decide the order of the emergency list.
- Medical handover for anaesthetics took place twice a day for theatres and three times a day for Intensive Care and Obstetrics.
- There were no formal protocols for deferring planned surgical operations to prioritise emergency procedures. All potential elective cancellations were discussed with senior managers– to review clinical urgency and length of wait for treatment. A weekly theatre activity planning meeting prioritised all the following week's lists.

Major incident awareness and training

- Most of the staff we spoke with were aware of the trust's major incident plan.
- In collaboration with nearby organisations and services the trust had developed an urgent care escalation and de-escalation plan.

Surgery

Are surgery services effective?

Requires improvement

Overall we rated the effectiveness of the service to require improvement.

Staff did not consistently monitor patients' level of hydration where this was required. Staff did not always receive an annual performance appraisal, and uptake of appraisal was significantly lower than the trust's own target. Low numbers of staff had attended training on caring for people who did not have capacity to make decisions about their treatment, and ward staff did not demonstrate understanding of this aspect of care.

Care and treatment were evidence based and followed recognised national guidance. Patients were asked appropriately for their consent before procedures were carried out. Pain management was effective and patients received appropriate pain relief in a timely manner. Surgical outcomes for patients were monitored and were mostly within the national average. Where outcomes were worse than the national average these had been identified and measures were in place to make improvements. There was good multi-disciplinary working in all the wards and departments we inspected.

Evidence-based care and treatment

- Pre-operative investigations and assessments and surgical procedures were carried out in accordance with National Institute for Health and Clinical Excellence (NICE) clinical guidelines and professional standards. There was a well-defined elective pathway that was followed; patients were seen up to 8 weeks before surgery. If their operation was cancelled or delayed and the next appointment date was longer than eight weeks, the pre-assessment would be repeated.
- Any potential complications identified at the pre-assessment stage were escalated to the anaesthetist. A consultant anaesthetist was available at night for urgent queries.

Pain relief

- Patients were appropriately prescribed pain relief which was administered in the recovery room after undergoing surgery. Pre-planned pain relief was also administered for orthopaedic patients.
- Staff told us there was no pain team but they could call the anaesthetist and or the clinical nurse specialist should pain be an issue for a patient.
- We asked patients if they had their pain levels assessed by staff and if they received pain relief medication as and when they required. With the exception of one patient we were told staff asked about their pain regularly. The majority of patients said their pain was managed well. Patients said they did not have to wait for tablets or pain relief medicines. We checked medication charts and found patients had been prescribed and given pain relief medicines.

Nutrition and hydration

- We reviewed 13 sets of fluid intake and output charts and found that none were complete. Eight charts only had output recorded and the remaining five sets had no record of output. This meant that patients' fluid requirements were not being monitored accurately.
- Before our inspection we received concerning information that elderly patients who had difficulty eating were not given adequate support.
- The provision of appropriate consistency fluids was an identified risk within the trust's high level risk report.
- During this inspection, we saw that all patients who required assistance with eating and drinking were identified on the wards and assisted accordingly. There were protected meal times in place on surgical wards, enabling staff to help patients with minimal interruptions.
- At lunch time we observed these patients were provided with a good level of support. We saw staff were kind and respectful when supporting patients to eat and drink and took sufficient time to enable patients to take their meals and drinks.
- Patients told us they were reasonably satisfied with the food provided at the hospital.
- Menus showed that a wide variety of diet choices were available, including, gluten-free, vegetarian, Halal, Kosher and soft diets.

Patient outcomes

Surgery

- There were no current mortality outliers relevant to surgery. This meant there had been no more deaths than expected for patients undergoing surgery.
- The trust contributed to all national surgical audits for which it was eligible. National audit data for bowel and lung cancer showed outcomes were within expected range. The trust took part in the hip fracture audit 2014. Results identified the trust performed better than the England average for 7 out of 10 indicators. Findings from the bowel cancer audit 2014 showed the trust performed better than the England average. The lung cancer audit, also in 2014, showed the trust performed well against the England average, especially in relation to multi-disciplinary team working.
- The trust reported data for mortality indicators, the summary hospital-level mortality indicator (SHMI) and hospital standardised mortality ratio (HSMR). These indicate if more patients are dying than would be expected given the characteristics of the patients treated there. The figures for the trust were as expected.
- Patient Reported Outcome Measures (PROMs) for the year to March 2014, showed that for hernia repair, joint replacements and varicose vein surgery, the proportion of patients reporting improvements was in line with the England average. The trust results showed better than average outcomes in seven of the 11 indicators.

Competent staff

- Managers were not meeting the trust's targets for providing staff with an annual performance appraisal. Up to December 2014, 37.6% of staff had had an appraisal, against a trust target of 90%, although the consultants' appraisals were significantly higher at 77%.
- All the staff we spoke with described their appraisal as a positive experience and a process that enabled them to identify their learning needs for the following year.
- Some staff told us that although training opportunities were available, it was sometimes difficult to attend because of staffing pressures on the wards.
- Most junior doctors in surgery told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns
- The majority of patients who spoke with us reported a high level of confidence in medical and nursing staff with regard to their knowledge and their skills.

Multidisciplinary working

- We found there was good multi-disciplinary (MDT) working across surgical areas.
- We observed therapy staff assisting with patient therapy sessions through encouragement of mobilisation and self-care activities. Therapy staff contributed to daily 'board' rounds which included the nurse in charge, the matron, a doctor and the bed manager. Each patient's condition and progress was discussed and their predicted date for discharge reviewed on a daily basis.
- Staff told us there was effective communication and partnership working between the teams. They met regularly to identify patients requiring visits or to discuss any changes to the care of patients.
- On Murphy ward, the elective joint replacement ward, the occupational therapists, physiotherapists and social workers were allocated to work at weekends which helped to ensure continuous rehabilitation of patients and also facilitated weekend patient discharges.
- When a patient was discharged, communication was sent electronically to their GP. This detailed the reason for admission and any investigation results and treatment undertaken.

Seven-day services

- Consultants were available on-call out of hours and would attend when required to see patients at weekends.
- Daily ward rounds were arranged for all patients. New patients were seen at weekends when necessary.
- Access to diagnostic services was available seven days a week, for example, x-rays, magnetic resonance imaging (MRI) and computerised tomography (CT) scans.
- There was an on-call pharmacist available out of hours. Pharmacy staff were available on site during the week.
- Physiotherapists and occupational therapists told us that in addition to Monday to Friday provision, physiotherapy was available at weekends to the elective patients on Murphy ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was sought in accordance with legal requirements and we saw staff recorded discussions with patients about risks, benefits and options.
- Patients we spoke with confirmed they had been given sufficient information to help them to decide to proceed

with investigations and surgical procedures. They reported they had signed a consent form prior to surgery and also verbally consented to blood tests and scans. We observed staff asking for consent both verbally and in writing. On checking patient records we saw copies of signed consent forms, all of which had been completed appropriately.

- Staff told us they were aware of, and had access to the trust policy and procedures for consent.
- Mental Capacity Assessment and Deprivation of Liberty Safeguards were included as part of mandatory training. However, most of the staff we spoke with had limited knowledge concerning mental capacity assessments. None of the nursing staff we spoke with had received training on undertaking mental capacity assessments. They told us either doctors or social workers carried out these assessments.
- Within the surgical division 762 staff were required to undertake training on the Mental Capacity Act (2005) in 2015; at the time of our inspection in April 2015, only 4% of staff had completed the training. Rates of attendance would have to increase significantly to ensure that all staff had benefited from the training by the end of the year. No staff had completed deprivation of liberty safeguards (DOLS) training within the surgical directorate. Staff we spoke with said they would refer consideration of deprivation of a patient's liberty to the hospital safeguarding team.

Are surgery services caring?

Good

Overall we judged the caring afforded to patients was good.

Staff were kind, compassionate and caring towards patients. They communicated well with patients and were attentive to patients' needs, providing support and care with courtesy and respect. Patients were involved in decisions about their care options and were given enough information about their condition. Staff provided patients and relatives with emotional and spiritual support.

Compassionate care

- Patients we spoke to were consistently positive about their experience within the surgical division. Patients told us they were treated with dignity and staff were caring. One patient told us, "Excellent is not good enough, they are all so passionate and caring"
- We observed positive interactions between staff and patients. We observed staff speaking with patients and providing care and support in a kind, calm, friendly and unhurried manner Where staff were assisting patients to move they ensured patients were covered and their clothing was in place which maintained their dignity. We saw how when one patient wished to use the toilet staff sensitively supported them and did not rush the patient. We saw one person was supported to eat. Staff were patient and communicated well with this person who appeared to have been put at ease. We spoke with the relatives of a patient who had recently undergone surgery; the relatives described the excellent support received by the nursing and medical staff. On every ward we inspected, patients were treated with compassion, dignity and empathy.
- This was confirmed in the Cancer Patient Experience Survey 2013. The trust scored highly for giving patients enough privacy and treating patients with respect and dignity.
- Friends and family test results were displayed on each ward we visited, with average scores reported from people who had commented on the service. We looked at data on individual wards, which showed that the majority of patients were 'extremely likely' or 'likely' to recommend the service to their family and friends.
- Each patient had a named nurse to ensure continuity of care and the staff had their names and role titles embroidered onto their uniforms.
- Wards were organised and included single-sex accommodation, which promoted privacy and dignity. There were no reported times when men and women were treated in the same ward bay.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt they understood their care options and were given enough information about their condition.
- Detailed information was available for patients about their procedure and what to expect. They were given contact numbers of specialist nurses to ensure they had adequate support on discharge.

Surgery

- Staff at the preoperative assessment clinic informed patients of details concerning their surgery, answered any questions and collected information about their health. All aspects of the hospital stay, operation and discharge were explained at the pre-assessment stage.
- In the Cancer Patient Experience Survey 2013 the trust scored highly for giving patients a choice of different types of treatment**. H**owever, the trust did not perform so well in the area of patients' views being taken into account by doctors and nurses when discussing treatment.

Emotional support

- Patients said that they felt able to talk to ward staff about any concerns they had, either about their care or in general.
- Clinical nurse specialist care and support for patients was available in areas including pain management, colorectal, stoma and breast.
- Staff told us the trust did not have a designated counselling service but confirmed there was access to clinical psychologists if needed. Patients also had access to the hospital chaplaincy for spiritual, religious or pastoral care.

Are surgery services responsive?

Good

Overall we judged the responsiveness of the service was good.

Patients received treatment in appropriate timescales following referral, other than in trauma, orthopaedics and ophthalmology. Where delays had been identified the trust were aware and had measures in place to address delays. Average lengths of stay were slightly longer than the England average, particularly in non-elective trauma and orthopaedics.

Staff demonstrated a good awareness of the trust complaints procedure and how to deal with complaints. There was a delay in responding to complaints and only about 50% of complainants received a response within a reasonable time frame.

Surgical wards received a relatively high number of medical patients, for whom the medical wards did not have sufficient capacity. Staff did not monitor the times that patients moved wards and therefore could not determine the scale of the impact on patients.

Service planning and delivery to meet the needs of local people

- Surgical services were available 24/7, with emergency access to operating theatres outside of normal working hours.
- The trust had an escalation policy and procedure to deal with bed availability at busy times. This gave clear guidance to staff regarding how to proceed when bed availability was an issue.
- Bed capacity meetings were held daily to monitor bed availability in the hospital; they included reviews of planned discharges to assess future bed availability.
- During times of high patient demand, elective patients were reviewed in order of priority to prevent urgent and cancer patients being cancelled.

Access and flow

- The referral to treatment time of patients admitted and treated within 18 weeks of referral was better than the national standard target of 90%. The referral to treatment time of non-admitted patients treated within 18 weeks was also better than the target of 95%. The percentage of cancer patients treated within 62 days from screening was, at 96%, better than the target of 90%.
- Trauma, orthopaedics and, ophthalmology were not meeting the target of 90% of admitted patients starting consultant-led treatment within 18 weeks. The trust told us that they were working with local area teams and commissioners in ophthalmology and orthopaedics to develop a recovery plan to improve consultant-led referral to treatment (RTT) times. There had been extra ophthalmic operations at weekends and this was planned to continue for three months.
- Patients were admitted for elective surgery by referral from their GP to relevant consultants. Patients could also be admitted via the emergency department as an emergency or as a direct admission via the GP. Elective surgery patients attended the pre-assessment clinics, where all patients expected to have a general anaesthetic procedure were seen by the pre-assessment nurse.

- Patients were assessed by the multidisciplinary team, including an anaesthetist, before admission. Patients were only admitted to the day surgery unit if they met specific criteria, including not having any high risk factors. These included for example high blood pressure, a history of heart attack in the previous year, insulin controlled diabetes and respiratory problems. This allowed staff to identify patients care needs before their operation and have plans in place for their recovery.
- The average length of stay for surgical elective patients between June 2013 and July 2014 was at 3.5 days slightly worse than the England average of 3.3 days. The average length of stay for non-elective patients at 5.7 days was worse than the England average of 5.2 days. The non-elective trauma and orthopaedic length of stay was worse than the England average at 10 days compared to the England average of 8.4 days.
- From April to December 2014 the surgical bed occupancy rate was 83%, better than the trust target of 85% above which research suggests quality of care can suffer.
- On the trust's risk register we saw that increased numbers of emergency medical patients meant that at times patients were placed on a surgical ward because medical wards had no capacity. This posed a risk to elective surgery as there would be reduced capacity on the surgical wards. Rates of elective surgery were monitored daily and at the time of our inspection 17 medical patients remained on surgical wards.
- Ward nursing staff told us they frequently had medical patients, especially during the high pressure winter months. They also expressed concern that surgical patients were moved during the night as well as the day to accommodate medical patients. This led to disruption for patients and decreased continuity of care. Staff told us even patients in vulnerable circumstances, such as those living with dementia were moved. We spoke with two surgical patients; both had been moved recently during the night. One told us they had been on three different wards since they were admitted ten days ago.
- We asked the trust for audits of surgical patient moves, but were told these were not routinely monitored. However staff were actively encouraged to record these incidents through the electronic reporting system. We reviewed surgical incidents reported from March 2014 to February 2015, but did not find any relating to patient moves.
- The numbers of cancelled operations where the patient had not been treated within 28 days had generally been low over the reporting period up to September 2014. Although this had been above the England average, from January to September 2014, this was only six patients
- The proportion of patients experiencing unnecessary delays in being able to leave hospital was low at less than 2%. Delays to discharges were reported to be related to external factors, such as community care and lack of rehabilitation beds. We were advised by nursing staff that a number of patients on the orthopaedic and trauma ward were waiting for community rehabilitation beds.
- Staff told us that delays in patient discharge also happened when there was a shortage of social care in the community. This meant that 'medically fit for discharge' patients were kept in hospital thereby occupying a bed unnecessarily.
- We observed good communication and team working around planning people's discharge from hospital. Nursing staff said discharge planning started at the time of patient admission and was multidisciplinary.

Meeting people's individual needs

- Patients told us their individual needs were met by staff and, decisions and choices had been respected. Comments included, "Sometimes they go above and beyond the call of duty." Patients who were going home confirmed they had been involved in planning their discharge planning. A discharge lounge was available for patients to use, This allowed beds to be freed up promptly for new admissions.
- There was no specialist dementia care pathway for patients living with dementia. The Trust did not have a formalised dementia strategy or policy; this was recorded on the risk register as a high risk. Most surgical staff had attended mandatory training which included a dementia awareness session. In late 2012, there was an audit of the environment to assess the extent to which it could be considered dementia friendly using a recognised method. This had led to agreement on the design for future ward upgrades to ensure they met the principles of dementia friendly premises.

- There was a lead nurse for patients with a learning disability, who could help support patients and provide resources for nursing staff.
- In March 2015, the trust board meeting heard a patient story about a patient with a learning disability. Following a visit for day case surgery which could not go ahead due to the patient's distress, staff made contact with family members to agree a personalised care plan. It was recognised that the learning disability lead nurse should become involved at an early stage to make sure an appropriate plan of care is developed.
- Staff were able to access interpreting services for people whose first language was not English. Trust data showed that these services were used on 189 occasions in the division between April 2014 and March 2015. Polish and British Sign Language were the most often used.

Learning from complaints and concerns

- Complaints were handled in line with trust policy on most wards. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at ward level and through the Assistance and Complaints Service. There was a delay in responding to complaints and in the surgical division about 61% of complainants received a response within a reasonable time.
- On Devonshire ward staff told us that some complaints raised by patients were dealt with by the ward, but were not always documented. This meant themes and trends could not be properly evaluated.
- Most staff told us they received feedback from complaints and concerns at staff meetings or through the monthly safety bulletin.

Are surgery services well-led?

Good

Overall we judged the leadership of the service was good.

Surgical services were led by committed and enthusiastic staff. Senior surgical staff demonstrated passion and responsibility for the provision of good care to their patients and to supporting staff in their roles. Leadership was regarded highly by surgical staff. Staff were aware of and understood the values of the trust and demonstrated enthusiasm and commitment to the provision of a quality service to patients. Governance arrangements identified risks and regular monitoring of these, with progress on action plans reported at directorate meetings.

Vision and strategy for this service

- The trust's vision 'Proud to care' was visible throughout the surgical division and on the trust's website. There were clear aims and objectives. The trust's values and objectives had been cascaded across the surgical wards and were visible on ward areas.
- Staff demonstrated an awareness of the vision and the values of the Trust and had a clear understanding of what these involved.
- The trust had a clinical services strategy which included the surgical division from 2014-2019. This set out the division's priority objectives over the three years up to 2017. It included a new fracture clinic, theatre refurbishment and a seven day integrated pathway working in partnership with other health and social care providers. The trust was also part of the 'Working together programme' with seven acute trusts in south and mid Yorkshire.

Governance, risk management and quality measurement

- Senior staff reported that moving to a divisional structure had been a positive move.
- The divisional governance group was a sub-group of the quality delivery group which reported to the Quality Assurance Committee . The surgical division held monthly governance meetings. We looked at the meeting minutes for October 2014 to January 2015. The group discussed issues arising from departmental governance meetings and from the trust's quality delivery group; they discussed and challenged the divisional performance report, updated on local policies, discussed learning from incidents and reviewed the divisional risk register. Complaints, audits and quality improvement projects were discussed and action taken where required, including feedback to staff about their individual practice. Items for escalation to the quality delivery group were summarised.
- Governance arrangements included discussions of serious incidents as part of the 'grand rounds' carried out. Grand rounds provide an opportunity for the multidisciplinary team to discuss cases of interest and were open to all hospital staff.

- Senior nursing staff were aware of specific issues, which had been identified on the risk register, including for example staffing levels and recruitment.
- Monthly staff meetings took place on all of the wards we inspected.

Leadership of service

- Staff were aware of their roles and responsibilities. We found there was good ward leadership and staff said they felt supported. One staff member in the operating theatre department said , " I have worked here for 20 years, the team working is really good now, I feel very supported".
- Medical and nursing staff spoke positively of each other and reported that working relationships were effective and supportive.
- A few staff reported a 'disconnect' between middle management and themselves; an example of this was the issue of movement of surgical patients to make way for medical patients had been escalated almost daily for the past few months, but there had been no feedback on this.
- Most staff from a range of surgical roles described senior managers within the surgical division as managers who were approachable, visible and committed to ensuring care delivery within surgery was patient-focussed.
- Each ward had an 'adopted Governor' who visited regularly. Staff knew the named Governor for their ward and knew they could raise any concerns with them if needed to.

Culture within the service

- Across the surgical division staff consistently told us of their commitment to provide safe and caring services and reported an open and transparent culture within the surgical division. They reported good engagement at ward level and felt they were able to raise concerns and these would be acted on.
- We met with staff in the operating theatre department, they were clearly proud of their work and the high level of care they provided to patients. They had a clear understanding of the values of the unit and the management's vision in taking the service forward.
- Trainee doctors and student nurses considered the surgical areas to provide a good experience and opportunities for learning and developing their skills.
- Within the surgical division the staff sickness rate was slightly worse than the trust's target of 4% and staff turnover levels were in line with expectations.
- Generally morale amongst the staff in the surgical division was good.

Public and Staff Engagement

- Throughout the surgical wards we saw the friends and family test results were clearly displayed on the wards with patient's feedback comments on and if there were negative comments, what had been done about these. The friends and family test for the surgical division for in-patients had response rate for surgical in-patients of 33.9%, above the trust's target of 30%.
- The staff survey for 2014 showed 71% of staff felt satisfied with the quality of work and patient care they were able to deliver and a further 92% of staff felt their role made a difference to patients.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance, which included the collection of national data, audits and learning from incidents, complaints and accidents.
- Innovative practice was encouraged and we saw examples of projects that had led to education of both staff and patients. An example of this was on Portland ward where a new education regime had been commenced for both staff and patients. The ward had an educational skeleton at the back of the ward, affectionately named 'George' by the staff. The purpose of George was to explain to patients which bone was having surgery and to refresh or teach new staff to the orthopaedic service about the different types of orthopaedic surgery and what they entailed.
- The operating theatre department was undergoing a two year improvement programme which was due for completion in 2016. Included in the improvement programme was an increase in storage area, refurbishment of theatres and the refurbishment of the staff relaxation area.

Critical care

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

Information about the service

The critical care unit at Chesterfield Royal NHS Foundation Trust consisted of an intensive therapy unit (ICU) with seven beds and a high dependency unit (HDU) with eight beds for patients over 18 years old. The unit provided level three care, that is for patients requiring one-to-one support (such as those who are ventilated), and level two beds for the care of high dependency patients. There was no outreach service to provide support for critically ill patients on other wards. The intensive therapy unit had consultant cover 24 hours a day, seven days a week.

During the inspection we visited ITU and HDU. We talked with three patients, four relatives and 25 members of staff. These included nursing staff, student nurses, junior and senior doctors, physiotherapist, pharmacist, housekeeping staff, and managers. We observed care and treatment and looked at nine care records. Before the inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Overall we judged the critical care service to be good. There were areas of good practice in critical care services but there were risks posed by the cramped conditions on the ITU; the cubicles had no space to allow staff to put on appropriate protective clothing. The patients in the HDU were under the care of the consultant they were admitted under rather than the intensivists (doctors with additional training in treating critically ill patients). This led to delays in assessment and treatment.

There was a problem with patient flow through both critical care areas and patients' discharge to the wards were often delayed due to a lack of beds. This led to the potential shortage of critical care beds. There was a higher than expected number of re-admissions to the HDU.

Guidance from professional bodies was followed as much as practicable. The critical care units had no outreach team to assist the wards in managing critically ill and deteriorating patients. There was no rehabilitation service offered for patients in ITU, including no outpatient follow up. One consultant and nurse were offering a limited service to follow up patients who contacted the unit, but this was not automatically offered to patients.

Nursing staff reported excellent and responsive relationships with the medical staff in the ITU, but delays in getting patients to be reviewed in HDU. There

Critical care

were good examples of multidisciplinary working to ensure that patients' needs were met. Leadership of the units was supportive and effective at reducing risks to the best of their ability.

Are critical care services safe?

Requires improvement

Overall we judged the safety of the service required improvement.

The HDU did not have adequate processes in place to escalate concerns about patients whose condition was deteriorating and secure a timely medical review. The patients in the HDU should have the supervision of an intensive care consultant and the nursing staff should be able to access this expertise when needed as they could in ITU. Nursing staffing numbers were such that there were not always enough clinical coordinators to support staff new to the role.

The ITU unit had effective processes to monitor and protect patients, including robust procedures for escalating concerns about deteriorating patients. The environment in both ITU and HDU was clean and hygienic. Staff complied with the trust's medicines management procedures to ensure that medicines were managed safely.

Incidents

- Staff on both critical care units knew how to use the trust's on line reporting system. They knew the types on incidents to report such as medication errors, equipment failures, admissions and discharges from the unit out of hours (between 10pm and 7am). Staff acknowledged that they received feedback about the incidents they reported.
- Clinical staff we spoke with said they were encouraged to report incidents and felt able to do so. Incidents were reported on an electronic system. The feedback and learning from incidents was shared across the unit from the matron in charge of the unit. An example of a thorough investigation or root cause analysis (RCA) and resulting action plan was seen and had been completed to a good standard. Governance meetings, attended by the ward matron, were used to discuss reported incidents and develop an action plan to prevent reoccurrences.

Critical care

- The critical care unit held mortality and morbidity meetings (these are peer review meetings to discuss mistakes occurring during the care of patients with the aim of learning from these to prevent them being repeated).
- Incidents of pressure ulcers related to the skin surrounding patient breathing tubes inserted into the neck, had led to a change in the equipment used; this has now reduced incidents to zero.

Safety thermometer

- The safety thermometer was a monthly snapshot audit of the prevalence of avoidable harms that included new pressure ulcers, catheter related urinary tract infections (UTIs), venous thromboembolism (VTE), and falls. Up-to-date safety thermometer information was clearly displayed at the entrances to both ITU and HDU. There had been no reports of catheter related blood stream infections since August 2014 which would suggest the unit had learnt from previous harm and improved pracitce.
- Pressure ulcer champions had been appointed to receive extra training and work with staff to support a reduction in avoidable harm. Training in the moving and handling of patients had also been introduced by a physiotherapist to ensure that staff had sufficient knowledge about how to reposition patients to avoid pressure ulcers.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare below the elbow' policy was adhered to. There were hand washing facilities and personal protective equipment such as gloves and aprons available. We observed that staff used gloves and aprons and changed them between patients.
- Hand washing facilities were available by each patient bed space and we saw staff and relatives using hand gels in both ITU an HDU.
- There were effective arrangements for the disposal of sharps (used needles); the boxes were accessible and close to where they were needed in order to prevent injury to staff.
- On the inspection comprehensive cleaning logs were seen and there was appropriate use of stickers to indicate that equipment had been cleaned.
- The cleanliness audits that looked at how clean the area was including beds and equipment, for February and March were over 98% which exceeded the trust target of 97%.
- Although the rate of catheter related blood stream infections was reported as 7.1% in August 2014, since that time there have been no further incidents.

Environment and equipment

- We found equipment to be clean, fit for purpose and staff told us that there was enough equipment available. The storage space, although well organised was not sufficient to accommodate the large volumes of sterile fluids that were used for patient treatment. That led to boxes of sterile fluids being stored in the corridor reducing the accessibility to the unit.
- Electrical equipment that was stored and required to be on charge was found not charging because there was insufficient space (and electrical outlets), there was a risk therefore that the appropriate equipment would not be available when needed.
- Equipment carried evidence of regular maintenance checks indicated by a signed label.
- The resuscitation trolleys were checked daily and a record of this maintained.
- In both the ITU and HDU there were two cubicles used for isolating patients with actual or suspected infections. There was no separate area outside of the cubicle but separate from the ward where staff could put on or remove protective clothing so complete isolation of patients was not possible.
- The HDU unit was of a similar size to ITU and was bright and in a good state of decorative repair. Two cubicles were available for isolating patients, but again there was no outside space to allow staff to put on protective clothing.

Medicines

- Medicines were stored in a small treatment room with no door. The cupboards (except for the one containing controlled drugs) did not have locks. Risk assessments had been completed regarding this practice. With the unit having restricted access and the high numbers of staff, they perceived the risks to security were outweighed by the ability to access medications quickly in urgent situations.

- The critical care unit had its own allocated pharmacist who worked as part of the multidisciplinary team and attended ward rounds. There was good access to medication across 24 hours.
- Some medicines require refrigeration to maintain their effectiveness. Refrigerator temperatures were not recorded, as the alarm would sound if it was out of the safe temperature range. This was discussed with the pharmacist and matron during the inspection and the memory card to record the refrigerator temperature was put into use. The refrigerator was not locked but this was included as part of the medicines risk assessment.

Records

- Patient records on both units were stored in a trolley at the end of the patient's bed. This allowed them to be accessible quickly to all clinicians who needed them. Due to the proximity of staff to patients and high levels of staff on both units there was perceived to be a small risk of records being handled inappropriately.
- On our inspection we looked at nine sets of patient records. These were up to date and in most cases demonstrated that appropriate reviews and risk assessments had been completed.
- A large proportion of the critical care template documentation was poorly photocopied and had no version control making it difficult for staff to know they were using the most up-to-date records.

Safeguarding

- The staff we spoke with could explain what safeguarding was, and could list possible types of abuse. Staff knew where to go to seek advice on safeguarding concerns and how to make a referral to the local authority safeguarding team, as they were based at the hospital. There was a high level of compliance with mandatory training on Safeguarding.

Assessing and responding to patient risk

- There was not critical care oversight for the HDU at the time of our inspection. Guidelines for the provision of intensive care services core standards state that patients need a clear and safe pathway for escalation of care from level two care to level three. In HDU nursing staff told us that it was difficult to get patients reviewed in a timely way as they remained in the care of the consultant under who they were admitted. We witnessed an example of unacceptable delays in the review and escalation of a deteriorating patient. There was no medical handover on the HDU as there was in ITU, which could lead to poor communication.
- We were concerned about the medical oversight of level two patients in the HDU. We escalated our concerns to the trust during our inspection. They took immediate action. Since the inspection they have provided information on the changes they have made which consisted of strengthening the consultant intensivist support and advice for the management of patients in HDU and those who are deteriorating in the ward. A standard operating procedure has been developed and circulated for the safe care of patients in HDU. The SOP describes the current day to day management of patients on HDU , the means for escalation and de-escalation of care and how patients in HDU and those who are deteriorating are brought to the attention of the intensivists in the hospital.

- The Medical Director has met with the intensivists and the Surgical Services Divisional management team to agree a stepped plan for establishing a combined intensivist led critical care unit by 2019. The Chief Executive, Medical Director and Director of nursing and patient care have met with the lead commissioners to discuss the gaps in the current service and to agree their support to move to a fully intensivist- led model of critical care for the organisation. This will require additional funding to recruit additional medical and nursing staff.
- The critical care unit worked to the core standards except the recommendation they should ensure patients receive care from appropriately trained Critical Care Outreach personnel. Although there was a hospital wide standardised approach to the detection of the deteriorating patient as recommended in the National Early Warning system (NEWS) guidelines, there had been no Critical Care Outreach team since 2007. Instead the trust provided an emergency medical team who provided support to the wards. Staff in the emergency medical team were all trained to nationally required standards and were all trained in advanced life support. The trust audited both cardiac arrest cases and NEWS score completion. The number of cardiac arrest per 1000 admissions has reduced since 2013. The trust links to improved use of the NEWS score and better training for staff. We found no evidence to suggest the absence

of a critical care outreach team had impacted negatively on patient care. There had been no deterioration in the trusts mortality and morbidity data which may have indicated a negative impact.
- All patients in ITU and HDU had pressure ulcer risk assessments carried out daily. Any pressure areas of concern were referred to the tissue viability nurse specialist. Risk assessment for nutrition was also carried out daily on all patients in critical care.
- Any patients who had been in ITU would be followed up by a consultant and nurse from ITU on the ward.

Nursing staffing

- Staffing met the recommended guidelines of a ratio of one nurse to one level three patient and one nurse to two level two patients. This was verified from examination of staff rotas for ITU and HDU. The staff rotas we looked at showed that staffing was a risk as the critical care unit had a high level of inexperienced and newly appointed nurses who required a period of supernumerary practice and competency assessment. The matron explained that some of the newly recruited staff would not commence their employment until September 2015.
- The senior matron for the unit, covering both IDU and HDU was a band 8a. In addition there was a band 7 matron who covered both units.
- A supernumerary clinical co-ordinator was rostered and budgeted for daily. The only exception to this would be if there was short term sickness. A clinical educator provided support to staff five days per week. Some staff told us they didn't think the clinical coordinator was always supernumery.

Medical staffing

- The ITU had 10 consultants. This enabled a consultant intensivist to be in the ITU at all times, with cover arrangements in place to allow patients to be reviewed by a consultant twice daily, seven days a week.
- In the HDU patients remained under the care of the consultant under which they were admitted. This included out of hours cover, and a daily review of all patients in HDU.

Major incident awareness and training

- There was a trust wide Business Continuity Policy in place. Contingency plans regarding loss of oxygen and suction/water were available. An escalation plan was available which directs staff to utilise Basil ward should a decant area be required or should ITU be out of commission for any reason. Although the trust has a major incident plan staff had limited knowledge of this.

Are critical care services effective?

Good

Overall we judged the effectiveness of the service was good.

Treatment and care provided followed current evidence based guidelines with the exception of a rehabilitation and follow up service for critical care patients. Multidisciplinary working was evident in both units, with good levels of seven day cover from physiotherapists and pharmacists. Staff had a good understanding of the Mental Capacity Act 2005 and how it related to their working practice. There was evidence that consent was obtained where practicable.

Competency based training and supervision was embedded across the unit and a clinical educator had just been appointed. There were a high number of readmissions to the HDU.

Evidence-based care and treatment

- Looking at patient records we found that patients' risks of venous thromboembolism, (blood clots), were assessed in line with National Institute for Health and Care Excellence (NICE) guidance.
- Although there were good examples of multidisciplinary working and access to a senior physiotherapist, there was no structured rehabilitation pathway for patients admitted to ITU as recommended in NICE guidance. The impact of this for patients is that they would not be routinely contacted by the service, but would have to request a follow up appointment to be arranged for them.
- Screening for delirium was carried out by one of the consultants on ITU, but not routinely on all patients admitted to the unit as recommended by the core standards for intensive care.
- Formal follow up clinics for patients discharged from ITU were not in place. Patients who have been in intensive

care can have lasting physical and psychological health issues which require treatment. A reactive system was in place if the patient requested a follow up appointment, contrary to the NICE guidance.

Care plans and care pathways

- Nationally recognised care bundles for the prevention of ventilation related infections, central line infections and complications were in place and their use was audited. Appropriate care plans were completed and updated daily in ITU and HDU.

Pain relief

- Patients' pain and response to pain relief treatment was monitored regularly as part of their routine observations, and was reviewed on ward rounds. There was no acute pain service in the critical care unit; however there was access to the trust pain team.

Nutrition and hydration

- The nutrition board for staff located on HDU was innovative, detailing a member of staff who would be a champion for nutrition for every day. It also had patient focused information about assistance and encouragement for eating and drinking, as well as information about volumes of fluid in glasses and jugs to enable more accurate recording.
- Staff were proactive when assessing patient's nutritional needs with risk assessments being completed on all patients. Those that could eat were given appropriate help to do so. Enteral feeding (tube feeding directly into the patient's digestive system) was started as soon as possible. Special enteral feed was always available to allow this to be started out of hours if necessary. The critical care unit had a designated dietition who attended ward rounds, in line with critical care guidelines.
- Total parenteral nutrition was prepared for patients on site and was provided by the pharmacist. Total parenteral nutrition is a way of bypassing the digestive system using a nutrient solution dripped directly into a vein.
- At mealtimes we saw patients appropriately supported with eating and drinking. Patients were offered a choice of foods and told us that the food was good.
- Patients were assessed by a speech and language therapist if required. All patients with a tracheostomy (an opening into the windpipe), were assessed to ensure they could eat safely.
- The pharmacist allocated to the unit was able to prescribe, which particularly helped with the provision of specialist intravenous feeding regimes.

Patient outcomes

- The units participated in local and national audits in order to measure their effectiveness. Where improvements had been identified, we found evidence the trust was taking action to improve outcomes for patients. For example, ventilated associated pneumonia (VAP) cases were continuously monitored and audits of care bundles take place if there is an increase in VAP rates. VAP is a type of lung infection that occurs in people who are on breathing machines in hospitals. VAP rates had deteriorated in the unit and as a result of this a quality improvement project had been implemented.
- Staff collected data on out of hour's discharges and delayed discharges. Additionally audits were carried out to ensure that evidence based care bundles were in use across the critical care unit. We were able to see the schedule for all audit activity conducted across both units and the lead for each was clearly identified.
- The data provided by the intensive care national audit and research centre (ICNARC) showed that the critical care unit was effective. The critical care unit performed in line with the England average for all indicators that are monitored by ICNARC.

Competent staff

- The junior medical staff we spoke with told us that they felt they were well supported in the ITU by consultants and that teaching was very good. Junior medical staff spoke positively about the unit, as a place to work and learn. Medical staff received induction training for both ITU and in anaesthetics.
- All the qualified Band 5 and six registered nurses worked across both the HDU and the ITU, forming part of three rotational teams
- There was always a nurse in charge of the HDU with a critical care qualification or relevant experience. In addition, the critical care matron was supernumerary and also had relevant qualifications. There was also two

senior nurses in the Surgery Divisional Senior nursing team who both had critical care qualifications and were available for additional support and advice during the day.

- The critical care unit had a number of new nurses who needed to become familiar with working in that specific environment. In response to this, the trust had supported a temporary clinical educator to facilitate the transition of the new starters within this area and allow for a robust induction programme to be delivered.
- Fifty seven per cent of staff had additional recommended post-basic qualifications in critical care, This was above the recommended guideline of 50%. There was also a rolling plan in place for staff to continue to access the modules on a yearly basis, in order to continue to support staff development.During their induction period, staff completed a period of supernumerary practice and were allocated a senior nurse as a mentor. Each qualified member of nursing staff had a competency framework document to work through, with sign off being given after observational assessment, knowledge questioning and the submission of written work. In addition to this there was a competency framework for the use of equipment which was signed off by the mentor.
- There were no critical care practitioners, who are staff with additional training in intensive care, on the critical care unit (or any staff studying towards this qualification).
- All nursing staff had an appointed mentor who carried out appraisals. The appraisal rate was recorded locally as 94%

Multidisciplinary working

- During the inspection we spoke with a physiotherapist and pharmacist, and saw a speech and language therapist, transfusion specialist, and a radiographer. Ward rounds were conducted with the multidisciplinary team including physiotherapist, pharmacist and microbiologist.
- There was a good example of multidisciplinary working with the dietition, nursing, medical and pharmacist working together to ensure nutritional requirements of patients were met in a timely way. All staff we spoke to told us that multidisciplinary working was a real feature of working in the critical care unit

Seven-day services

- The ITU unit operated over seven days, with consultant intensivist cover on site 24 hours a day seven days a week. Ward rounds took place at weekends as they did during the week.
- The high dependency unit also operated over seven days. The consultant under which the patient was admitted (or their medical team) would review their patient in HDU on a daily basis. Patients who had been under the care of the intensivists, but were in HDU would also be reviewed daily by a follow up team of a consultant and a nurse.
- Investigations and diagnostic imaging were available over seven days around the clock for critically ill patients. Pharmacists were available during the daytime at weekends, and an on call pharmacist was available outside of these hours. Medications were accessible out of hours via the site matron. There was access to physiotherapy at weekends as well as speech and language therapists.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff seeking consent from patients prior to delivering them care.
- All staff we spoke to had a good knowledge of the Mental Capacity Act. We saw an example of the correct process taken when a patient required an application for deprivation of liberty safeguards authorisation.

Mandatory training

- Mandatory training was provided to clinical staff which consisted of fire training, infection control, resuscitation (adults and children), safeguarding children, manual handling, dementia and mentorship. Trust data was kept on all mandatory training undertaken by staff; they indicated that 92.5% of medical and 92.4% of nursing staff were up to date. This exceeded the trust's target of 85% of staff completing mandatory training.

Are critical care services caring?

Good

Overall we judged the caring afforded to patients was good.

Critical care

Staff cared for patients in a compassionate manner and treated them with dignity and respect. Staff involved patients and relatives, where appropriate, in their care. Patients and relatives were given emotional support and were happy with the care received.

Compassionate care

- We observed staff caring for patients in a kind, compassionate and professional manner. We saw patients being treated with respect and dignity throughout their treatment. Nursing staff were very attentive and were always in close proximity to patients. When they provided care to patients they introduced themselves and spoke to them in kindly and respectful way.
- We saw an example of where a patient and family where given information to enable them to make treatment choices where their spiritual beliefs were fully taken into account. This interaction involved the patient, their family, consultant and nurse specialist.

Patient understanding and involvement

- Patients and their families where always involved in decisions about their care and treatment. We spoke to several relatives of patients in the ITU who told us that they had been kept well informed. Information was given in a clear and understandable way without the use of jargon. There was open visiting to the unit with the only restriction being two relatives per bedside.
- The patients' treatments were recorded in patient diaries which were completed by nursing staff and families to help improve patient memories of their stay. Patients had access to these diaries after they had left the unit. If a patient passed away, the diaries were given to families to assist in the bereavement process.

Emotional support

- The trust palliative (end of life) care team were always available to assist in the care of a dying patient in ITU. Staff told us that they regularly sought the advice of the palliative care teams. Relatives told us that staff provided support and guidance to the families of patients on the unit and were very appreciative of the rooms that were available for them to use.
- Patients from all the critical care areas could access the multi-faith chaplaincy service for support.
- Patients were not routinely offered a follow up appointment to support emotional and psychological recovery following an admission to ITU. One consultant and a nurse were able to see patients if requested to do so, but this service was not supported in business plans.

Are critical care services responsive?

Good

Overall we judged the responsiveness of the service was good.

The services were responsive to the individual needs of their patients. Staff understood how to manage complaints and were able to support people to complain if they needed to. Changes had been made in response to patient feedback.

Service planning and delivery to meet the needs of the local people

- The critical care units provided a service for patients undergoing planned or emergency surgery, as well as patients admitted to the hospital who were critically ill.

Access and flow

- The trust monitored the number of cancelled operations due to not beds being available in the HDU or ITU. Since January 2015 seven patients had been cancelled due to a lack of capacity. None of these were patients were awaiting treatment for cancer related illnesses. The trust used the post anaesthesia care unit in order to provide additional capacity and avoid cancelling surgery and had extended 24hr PACU two days per week.
- We found evidence of some patients who were ready to be discharged to the ward but were unable to transfer due to a lack of beds on the ward; this led to the patient having to remain in HDU unnecessarily. Discharge should occur not more than four hours after the decision has been made. Staff reported these delays as incidents using the trust electronic reporting system if the delay was 24 hours or more.

Discharge and transfer

Critical care

- The ICNARC Annual Quality Report 2013/14 showed that the critical care unit performed in line with the England average for all indicators relating to discharge and transfer.

Meeting people's individual needs

- We found appropriate moving and handling equipment for patients on the critical care unit. Training in moving patients safely was being given as part of a plan to reduce the number of pressure ulcers.

Patients were asked about their preferences where appropriate and these were communicated through care plans.

- The unit had sufficient skilled staff to be able to support patients who had a learning disability, mental health issues or dementia.
- There were two rooms available for relatives to use and stay in overnight if needed located on the ITU; these were pleasant and well furnished. Relatives that we spoke to were very glad of this facility.
- We saw good evidence that the spiritual needs of patients and their family were taken into consideration
- Patients who were unable to speak due to illness or breathing tube were given access to communication aids, such as paper and pen, or picture prompts. The services of an interpreter could be provided if needed.

Learning from complaints and concerns

- There were governance processes in place to investigate incidents and report findings using root cause analysis and produce an action plan from this. Staff told us that this information was fed back to them through regular meetings. Staff felt that they were aware of risks and incidents in the department.
- Patients were given information about how to make a complaint if they needed this. There were a low number of complaints about critical care. We did not see any information on display about making a complaint.
- Complaints had been received about the level of noise in the critical care unit and this was being investigated in order to improve this for patients.

Are critical care services well-led?

Good

Overall we judged the leadership of the service were good.

There was supportive leadership on the critical care units but some recent movement had left staff feeling very unsettled. Medical leadership was strong. There was a vision for the critical care unit and plans were in place for its development, but not all staff were not aware what this was.

The number of vacancies and recruitment of new staff to posts had diluted the pool of experienced nurses although there were plans in place to mitigate this risk. The governance arrangements had been strengthened and the processes were good. More time was needed to embed the processes to ensure all staff were engaged with the governance process.

Vision and strategy for this service

- The Clinical Services Strategy 2014-2019 included plans for Critical Care development and we saw plans had been presented to the leadership team. The staff we spoke with had little knowledge of this strategy.
- There were a number of vacancies for nursing posts, now mostly filled but this had meant that there were new nursing staff who required a period of induction and training before assessment of competence. This dilution of experienced staff appeared on the risk register for the surgical division. Action was in place to mitigate this risk such as an increase in the clinical work undertaken by the nurse educator and the nurse who managed the ICNARC data.
- The critical care unit held regular governance meetings where incidents and risks were discussed; ward meetings followed these to update staff on action plans and performance.
- There was a governance system in place but we found this still needed further development. Not all staff were engaged with the process and were contributing to it. The risk management process had undergone a review and improvements had been made to strengthen this. we found the structures were in place but more time was needed to become embedded within the service with staff at all levels.

Critical care

Leadership of service

- There had been some recent changes to the matrons within the service and this had left some staff feeling unsettled about the future leadership arrangements. There was one senior matron in place and another band 7 matron to provide leadership across both units.
- Medical leadership of the ICU was strong.

Culture within the service

- We found a supportive and open culture, with nursing, multidisciplinary and medical staff felt able to raise concerns about incidents, poor care and safeguarding. Staff told us that the unit matron was very visible, supportive and staff felt happy to discuss any issues.

Public and staff engagement

- Staff told us that they felt engaged and actively encouraged to develop, they were proud to work in the unit. The staff said they were happy to contribute suggestions about the way the unit is run, and that their input was valued.
- There were good examples of where feedback to the unit had resulted in change, such as report of high noise levels at night.

Innovation, improvement and sustainability

- The patient focused nutrition board was innovative and the daily nutrition champion was identified daily in hand over to ensure patients had appropriate support.

Maternity and gynaecology

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

Information about the service

Maternity and Gynaecology services at Chesterfield Royal Hospital Foundation Trust were part of the Women and Children's Division. From July 2013 to June 2014 there were 2,725 babies born, averaging 227 per month.

The maternity service consisted of community midwives, an antenatal department including outpatient clinics, pregnancy assessment centre, birthing centre and a combined antenatal and post natal ward with 17 beds which included two en-suite side rooms. There was one designated maternity theatre within the main hospital theatre complex.

Community based midwifes were employed by the hospital and worked at community locations with placements at the birthing centre to maintain clinical competencies. Hospital based midwives were employed with integrated contracts which ensured that they all had the opportunity to work in a range of the maternity services, including community, to ensure that they maintained competencies in all speciality areas.

The Women's Health Unit saw outpatients, daycase surgery, early pregnancy and unplanned gynaecology referrals. Gynaecology inpatients requiring inpatient care following surgery were admitted to Barnes Ward in the Surgical Division, where appropriately trained staff were based. During our inspection we spoke with 48 staff including senior managers, consultants and junior doctors, including those gaining experience as part of their general practitioner training, matrons, midwives, health care assistants, ward clerks and domestic staff. We also spoke with 17 patients and 12 visitors.

Maternity and gynaecology

Summary of findings

Although staff were confident in reporting patient safety incidents, serious incidents were not investigated thoroughly and learning from incidents was not consistently shared. There were also limited systems in place to ensure learning from complaints. The maternity department did not use a recognised method of collecting information on quality and safety so as to improve practice.

Numbers of midwives did not meet nationally recommended levels but were in line with other neighbouring trusts.. Nursing staff were using an 'early warning' system to alert them to a patient's health deteriorating and the need to request medical review. The department did not use professionally recommended ways of measuring outcomes for patients so as to compare its performance to other similar departments.

The maternity department was clean and well organised. Equipment was available when needed and there were systems in place to manage medicines safely. Patient records were accurate and up to date. Staff were caring and respectful, although there was limited emotional support for women planning to have, and following, a termination of pregnancy. Staff had access to professional practice guidance. Midwives were trained to deliver their roles effectively, were supervised and supported to maintain their competencies and professional development. There was good multi-disciplinary working with a range of professionals. Staff enjoyed working in the department; they were proud of the facilities and care they provided.

Are maternity and gynaecology services safe?

Requires improvement

Overall we judged the safety of the maternity and gynaecology service required improvement.

Although staff were confident in reporting patient safety incidents, the process for investigating serious incidents and learning from these needed strengthening. The trust responded to this straight away.

A maternity dashboard was used to capture data to monitor quality and safety, however it was not the tool issued by the Royal College which captured additional data to monitor quality.

Numbers of midwives did not meet nationally recommended levels although they were in line with other neighbouring trusts.. The maternity department was clean and well organised. Equipment was available when needed and there were systems in place to manage medicines safely. Patient records were accurate and up to date.

Incidents

- There was an electronic incident reporting system which staff informed us they were confident in using. We were shown an example of an incident that had been reported the day prior to our inspection. The reporter had received an automatic email acknowledging receipt of the report. Staff were unable to describe what happened to the report following submission and were not aware of any process or forums for sharing and learning as an outcome of reported incidents.
- For the period February 2014 to January 2015, 533 incidents had been reported including thirteen serious incidents. A serious incident is when serious harm or death has occurred to a patient, visitor or member of staff or an adverse event causes disruption or suspension of a service.
- A band seven midwife recalled an incident which related to the documentation of reduced fetal movements. Changes had taken place in response to the investigation which included the introduction of clear criteria for staff to review all recent attendances documented in an individual's notes.

- We read two serious incident reports and identified concerns about the quality of the investigatory process. There was a uni-disciplinary approach to investigations, with poor root cause analysis (RCA), weak action plans and little dissemination of the lessons learnt. RCA is the process used to uncover the root cause of an incident. The investigations were looked at did not reflect the National Patient Safety Agency (NPSA) guidelines for best practice in incident investigation. The Obstetrics and Gynaecology team took immediate steps to address this, with the implementation of a new written 'Process for Undertaking Root Cause Analysis Investigations' and 'RCA Investigation Log'.
- An interim Band 7 midwife had protected management time to ensure risk management was a priority. Their role included individual discussions with staff, giving feedback at meetings and populating the maternity newsletter. They were in the process of recruiting to a substantive governance midwife at the time of our inspection.
- We discussed the two serious incident investigations with a senior manager who acknowledged the team's findings and stated that the comments would be taken to the next governance group meeting in May 2015.
- Band five and six midwives were asked how they were informed about incidents and lessons learnt and whether they attended divisional governance meetings. They told us governance meetings were for senior members of staff and that information was shared through the maternity service newsletter. Staff we spoke with were unable to recall a change in practice following a serious incident from the last twelve months.
- A maternity newsletter issued each month was displayed on notice boards throughout the department. This included information about incidents, policies and other general information. There was no monitoring to indicate who had read this communication. Staff told us that they were emailed the newsletter or it could be accessed on the ward notice board.
- We reviewed three Obstetrics & Gynaecology governance group summary sheets for November 2014, December 2014 and January 2015. There was an agenda item for investigations and a brief summary of the incidents being presented. The summary sheet did not include action plans or lessons learnt.
- The 'Maternity Incident Quarterly Report' outlined all incidents reported and was available to all staff through the hospital intranet.
- There was a general understanding of 'duty of candour'. Staff told us that they would inform patients and carers should an incident occur and that such conversations would be recorded within the patient's medical or maternity notes. Staff showed us documented evidence in a patient's notes that the patient had been informed and an apology offered following an incident.

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetrics and Gynaecology in October 2014. It allows maternity teams to take a temperature check on harm and report on women who have experienced harm free care. The recommended key areas of harm included are perineal and or abdominal trauma, post-partum haemorrhage, infection, separation from baby & psychological safety, APGAR score of 6 or less at 5 minutes of birth.. The APGAR score is an assessment of overall new-born well-being. There was no evidence that the maternity safety thermometer was being used to monitor quality. A maternity dashboard was used to capture data to monitor quality and safety, it captured perineal trauma, however the other maternity safety thermometer key indicators of harm were not quantified.

Environment and equipment

- The maternity department appeared in good order throughout. The birth centre was purpose built and staff had been involved in its design. All areas within the department including out patients, pregnancy assessment, women's health and the pre/postnatal ward appeared clean and well ordered. The corridors were uncluttered providing unobstructed flow for patients, staff and equipment throughout the department.
- Equipment, sterile packs, linen and stores were all stored in designated cupboards with easy access from the corridor. Key pad access was in place for all items that required secure storage. Labelling was clear and there was no evidence of floor level storage.
- Staff told us that equipment was always available when needed and that faulty equipment was reported and repaired quickly.

- We observed that the adult resuscitation trolley was not easily accessible; it was stored behind other trolleys, within a store cupboard. Emergency access would therefore be delayed. This was highlighted to a senior member of staff who explained that this had not been an issue to date and that the other trolleys stored within the area were in more frequent urgent use. This remained a risk for the department.
- We looked at that resuscitation and emergency trolleys within the birthing centre and noted that they were recorded as checked daily and all associated products were in date.
- The pregnancy assessment centre' for women attending with suspected complications during pregnancy did not have resuscitation equipment for mother or baby. If needed equipment would need to be collected from the nearby antenatal and postnatal ward which would delay treatment and increase risk to mother and baby.
- Fridges for temperature sensitive medicines were unlocked but placed in locked rooms with key code access. A senior member of staff told us that this was quicker than searching for keys when drugs were required for emergency use. Temperature checks were carried out and recorded daily and we were told monitored centrally..
- Access to all areas within the maternity department and the Women's Health Unit was by intercom request

Cleanliness, infection control and hygiene

- The department appeared clean and domestic staff were employed specifically for individual areas. The trust had a deep cleaning team who attended on request following discharge of a known infectious patient or where large amounts of body products were present. Staff reported that access to this service was usually within two hours and available 24 hours a day.
- We saw that staff of all disciplines were bare below the elbow as per infection control policy. Good hand washing techniques were observed by all disciplines throughout the inspection period.
- Hand cleansing stations were clearly visible at the entry to all departments and cleansing gel readily available for all staff and visitors.
- Beds were cleaned after use and labelled indicating the date and time they were cleaned. Other equipment was cleaned after use and prior to storage, but was not labelled. This was highlighted to a senior member of staff who told us that staff always cleaned the equipment and it was visually checked prior to use. This did not meet infection control recommendations.
- Birthing pools were cleaned by domestic staff after use. We didn't find the pools to be unclean, but there was no indication that a pool had been cleaned and was ready for use. Pool cleanliness was checked as part of the Cleaning for Credits audits which were compliant. A decontamination system was implemented following the inspection and once the birthing pools were cleaned and decontaminated there would be a signed and dated record to evidence the cleaning.
- There was a regular daily flush programme for the birthing pools, running the water to ensure that infective organisms such as legionella were not present.
- On the postnatal ward there were knitted breasts and cloth dolls which were used as teaching aids. We asked staff how these items were cleaned. The staff told us that they had not sought the advice from the infection control team to ascertain if a cleaning regime was required. We were told these were replaced with cleanable substitutes following the inspection

Medicines

- Medicines were stored and administered appropriately according to drug management policy. All of the prescription cards we looked at were clearly written, dated and signed.
- Controlled drug records were checked on the women's health unit, antenatal and postnatal ward. All were stored in accordance with legal and policy requirements. The record books for controlled drugs require the signature of two registered professionals. The books were consistently signed by two individuals at each use.

Records

- Women who used the maternity services were provided with their own set of care records. The records included community midwifery information and recorded antenatal checks, scans and screening tests, such as for Downs Syndrome. These records were brought into the hospital by the women on admission or when attending clinics and were updated accordingly.

- All patient records were found to be stored securely, and organised in a logical systematic way to enable easy access to all required information.
- Nine handheld maternity notes were reviewed and not all documentation demonstrated best practice. Crossing out was not timed, dated or signed. Best practice 'National Midwifery Council and the Royal College of Nursing Record keeping paper 2012' states that in the case of needing to alter a record the original entry must remain visible and the new entry must be signed, timed and dated.

Safeguarding

- The trust had a named midwife for safeguarding who also had responsibility for alcohol and substance abuse. Midwives asked were able to name the safeguarding lead and said they would not hesitate to make contact for advice or escalation.
- Social vulnerability was assessed at booking and throughout the ante-natal period. Safeguarding referrals were made by community and hospital midwives. We were shown evidence that this took place in the medical records.
- Safeguarding training was included in the three day mandatory training programme undertaken by all midwives within the division.
- In December 2014 records showed that only 63% of staff within the division had attended safeguarding training within the previous twelve months. The trust target for attendance is 100%. There was a clear plan to meet the target within 2015/2016.
- There was a published series of dates for 2015/2016 for staff to access mandatory training, including safeguarding. All staff had been allocated attendance dates. Non-attendance triggered a letter to the individual and further non-attendance would trigger disciplinary action. No disciplinary action had been taken at the time of the inspection.
- There was a baby abduction policy and baby tagging on the maternity in-patient ward, birth centre and neonatal unit. The arrangements were tested in 2014.

Assessing and responding to patient risk

- Low risk women in pregnancy were assessed on admission to ensure their level of risk had not changed and they required a different level of care, for example, by medical staff instead of midwife led care.
- Nine sets of records were reviewed for routine venous thromboembolism assessment and Waterlow and / or Plymouth score where appropriate and it was noted that these were not consistently completed. Waterlow and Plymouth scoring are tools used to assess patient risk of pressure ulcer development. The Plymouth score is a tool specifically designed for maternity patients.
- We reviewed four sets of notes and found cannula risk assessment forms which had not been signed indicating that the cannula had been removed. One of the sets included three assessment forms for cannula risk and none were signed to identify that the cannula had been removed.
- We reviewed patient observation charts and identified that enhanced observation or intervention was not initiated appropriately. The maternity early warning score (MEWS) is a tool to identify deteriorating patients through numerical scoring of the observations taken, for example blood pressure, pulse, respiratory rate. A rising score triggers a range of responses from increased frequency of observations to urgent review by the medical team. Two MEWS charts were found to have scores which triggered a need for medical review that had not been acted upon. However on further review other charts were found to have been completed and escalated correctly.
- Women who had had a general anaesthetic were transferred from theatre to post-operative recovery unit before being taken into the birthing centre.
- A two bedded bay called the Maternity Observation Unit (MOU) was situated directly in front of the staff midwifery station so that there was good observation of the patients. If a patient required high dependency level 2 care they would be transferred to the trusts HDU or Intensive therapy unit (ITU). When patients were fit to be discharged from HDU or ITU, they were located in the MOU. Although these patients would be well enough to return to the general post natal ward, the MOU had an increased level of care and could support the woman with "rooming in" with her baby. It is well known that the quality of "rooming in" is crucial to maternal and neonatal wellbeing especially following a period of separation Examples of patients who are commonly cared for in the MOU are women with eclampsia who need frequent observations; women who have had a major post partum haemorrhage (PPH).

- All midwifery staff receive a specific maternity mandatory training day which covers subjects such as Sepsis and MEWS; PPH and Major Obstetric Haemorrhage (MOH); Eclampsia; Maternal Collapse as well as the recognised obstetric emergency drills. This training is required annually.
- There was a procedure in place to evacuate patients from the birth pool in case of emergency.,
- There was a dedicated 'red phone' on the birth centre for community midwives to contact the centre in an emergency.

Midwifery staffing

- Nationally approved guidance recommends that in order to ensure a safe service, There should be sufficient midwives to provide one to one care during established labour and a midwife to local birth ratio of 1:28. Chesterfield Royal Hospital had increased its establishment of band five and six midwives in recent years to reach a ratio of 1:30 which was not in line with national recommendations. However, this ratio was comparable with other maternity services across the region. In addition, there was a supernumery midwife on duty on every shift who could support where the need was greatest. The supernumery midwife was not included in the midwife to birth ratio. The maternity department had 97 whole time equivalent band five, six and seven midwives and seven band seven matrons and specialist roles.
- Staff told us that they were able to provide one to one care. We were informed that the co-ordinator role within the birthing centre was always supernumerary (not allocated a woman to care for) which enabled them to coordinate the Labour ward and be available to support staff. The establishment had taken this into account with 5.4 WTE midwives at Band 7 level who undertook this role. The 5.4 wte was also removed from the midwife to birth ratio calculations to support this. The rota was planned with the coordinator having supernumerary status. There were occasions when the supernumery midwife had to support other team members. There was a standard operating procedure in place which described the escalation process for times of both high activity and also short notice absence of other staff members. The staffing position is monitored 4 hourly on a daily basis and the matrons complete a staff variance database. The escalation policy is used often and we were told it worked exceptionally well. In practice, by the nature of maternity services, acuity and activity can fluctuate over the day (hence the 4 hourly monitoring). If activity/acuity is higher and needs input for a few hours then the supernumerary coordinator may help out with care. During periods of higher activity/acuity, additional staff are sourced from across the midwifery services.
- Community midwife caseloads were in line with the national average of 1 to 96.
- The divisional management team monitor vacancy rates. The maternity service did not use agency midwifery or nursing staff.
- The Supervisor of Midwife to midwife ratio was approximately 1 to 22. There were two student supervisors in training and on appointment of these posts, the ratio would reduce to 1 to 17. There was 24 hour access to a Supervisor of Midwives.

Medical staffing

- Medical staff at the time of the inspection consisted of eight consultants, six registrars, two speciality doctors, eight GP trainees & one junior doctor. The divisional risk register identified potential harm to maternity and gynaecology patients due to junior doctor vacancies; this resulted in increased use of locum doctors. There is a recognised national and local shortage of junior doctors for maternity services. The trust were working with the Deanery to increase training placements.
- The 'Obstetrics and Gynaecology Quality Governance group' had reviewed medical staffing in February 2015 and junior doctor recruitment was kept on the risk register graded as high It was also agreed to request additional funding for one consultant post at the trust transformation Meeting in February. This funding had not been finalised at the time of the inspection.
- There was 48 hours of dedicated consultant cover for the birthing centre but this did not meet the safer childbirth standard of 60 hours presence for total annual births of 2500-4000. There was a plan to increase this to 60 hours of dedicated cover following the additional recruitment of two consultants. One post had been approved and the other was awaiting board approval. Out of hours consultants were available to be called from home.

- Dedicated obstetric anaesthetic cover was available between 8am and 6pm Monday to Friday. Out of these hours the on call team wold be contacted.

Major incident awareness and training

- Staff were aware of and could demonstrate access to the major incident policy. The maternity service told us that they were aware of the escalation guideline for episodes of high activity and staff shortages. The service had not experienced any suspension of services during the last year.

Mandatory training

- A senior Midwife was responsible for updating the maternity training database. They were in the process of increasing the training programme from two to three days to incorporate a wider range of essential knowledge and skills specific to midwives.
- All staff we spoke to within the maternity and women's health unit told us that they were either up to date with training or that they had the designated days allocated for them to attend. During the last 12 months 74% of staff had attend the maternity mandatory training. Staff who had not yet attended had been allocated dates to attend.
- The content of maternity specific essential training is reviewed annually to incorporate education/ training needs identified from incidents and complaints. A recognised training simulator was used in training and live skills drills.

Are maternity and gynaecology services effective?

Good

Overall, we rated the effectives of the maternity and gynaecology service as good.

Staff working within the maternity and gynaecology service had access to professional guidance to enable them to provide care which reflected current best practice. Midwives had been trained to deliver their roles effectively, were supervised and supported to maintain their competencies and professional development. There was good multi-disciplinary working; pain relief was well managed and there was dedicated support from the allied health professionals.

Evidence-based care and treatment

- Policies and guidelines were posted on the intranet and were easily accessible by all members of staff with a current access password. We observed a junior doctor accessing the intranet to find a specific guideline; it was a very easy process to follow with guidelines clearly identifiable.
- We viewed six guidelines relating to maternity and gynaecology which were found to be based on current best practice, were in date and had clearly identified review dates.
- Women were given a choice as to place of birth, at home, midwifery led, or consultant led care as appropriate according to their level of risk. Care was seen to be provided in line with Royal College Obstetricians and Gynaecologists (RCOG) guidelines including Safer Childbirth: minimum standards for the organisation and delivery of care in labour.

Care plans and pathways

- We reviewed nine sets of maternal medical records; we found there was daily documentation of medical reviews and care plans where appropriate for high risk women.
- Midwives documented daily within patients records but there was not a formalised care plan page. This meant that a midwife would not be able to assimilate from the records any specific care required by the mother and baby. It was not clear within the notes of discharged patients that the plan of care was complete.
- We were told by a birthing centre coordinator that Fresh Eyes (this is where another member of staff reviewed a Cardiotocograph (CTG) to check that an assessment of the foetal heart is accurate) was embedded within birthing centre practice and was being performed at the required intervals. Staff told us that they reviewed the CTG hourly and then asked a midwife or registrar to perform 'Fresh Eyes'. The patient records reviewed did not reflect this. When 'Fresh Eyes' was completed the explanations of findings within the patient notes were not clear.

- We reviewed six sets of Gynaecology medical records in the women's health unit and all of the relevant proformas were completed. There were plans of care documented by the medical staff and nursing staff.
- There was a care pathway in place for a bereaved woman and the support that can be offered to her and her family. Part of this care pathway included care of the baby and how to discuss issues in relation to aspects of choice around undertaking a post mortem, sensitive arrangements with regards to the funeral.
- The HSA1 consent forms (the consent form used for termination of pregnancy) requires two medical practitioners to consent prior to a termination of pregnancy. We found these were completed appropriately and documented consent for the sensitive disposal of tissue was obtained.

Pain relief

- Women were given a choice of pain relief and provided with non-pharmacological options such as aromatherapy and the use of a birthing pool.
- Epidural pain relief was available on request and the waiting time for this was within an acceptable 30 minute timeframe. All patients having epidural pain relief during the period of inspection met the 30 minute timescale.
- We observed a patient requesting pain relief following gynaecological surgery which was provided promptly. Women spoken to on the surgical wards post gynaecological surgery reported no problems in accessing pain relief in a timely manner.

Nutrition and hydration

- All patients had access, where applicable, to water jugs and were regularly offered other refreshments. Patients told us that the food was on the whole nice and that there was a varied choice with special diets catered for within the menu choices.
- Women had access to a cooked meal (microwaved) post-delivery of their baby or an option of a snack box should they prefer (sandwiches).
- The maternity department had UNICEF Baby Friendly status which was reaccredited in February 2015. .
- Breast feeding rates were recorded and there was a breast feeding initiation rate of 88%, falling to 64% on discharge from the hospital. The trust was meeting the required standard in the National Neonatal Audit Programme for babies receiving any of their mothers milk.
- Five patients told us there was a lack of knowledgeable support for breastfeeding. Staff on the maternity ward told us the health care support workers discussed infant feeding prior to discharge. There were no dedicated support workers or voluntary workers that came into the hospital to support women with breast feeding. The trust did contract with a peer support service which women were referred to on discharge home.
- We were told that all women were asked their preference of feeding choice for their babies prior to the birth. All women were given a leaflet about feeding (breast and formula) at at 34 weeks gestation. National guidance recommends that women are not asked their proposed method of feeding until after the first skin to skin contact following the birth.
- We were given a copy of the discharge information pack which included information on formula and breast feeding. This was given to all women irrespective of their feeding choice. Maternity health care assistants discussed the feeding information with the women and the midwives discussed the other discharge information.
- All postnatal women on the ward were asked to complete a feeding chart. This included; length of time at the breast or volume of formula milk taken. this was not in accordance with promoting responsive feeding. Feeding charts are useful for women to complete if there are problems with feeding, but are not required for women/babies who are feeding well.
- Women who had chosen to formula feed were asked to bring in their own formula milk. The ward taught women on how to make up feeds safely in a designated room. Ready-made formula was available for mothers who had not brought their own.

Patient outcomes

- Patient outcome data was collected and a dashboard was used. The Royal College of Obstetrics and Gynaecology recommend this data is collected alongside parameters to allow the trust to identify good practice or areas of risk. This meant the unit was not comparing itself against other units and it was therefore difficult for the trust to see if outcomes for patients were

better, worse or about the same. A risk rated 'Maternity Dashboard', is not a statutory requirement but is nationally accepted as best practice for monitoring safety, quality and outcomes.

- There were no maternity outliers at the time of our inspection. Outliers are areas of care and treatment that when compared with data from other similar trusts are outside of what would be expected. There was no evidence of any risks when looking at the trusts rates for maternal readmissions, emergency caesarean section, elective (planned) caesarean section, neonatal readmission rates and puerperal sepsis and other puerperal infections.
- The trust did not use the 11 Royal College of Obstetricians and Gynaecologists (RCOG) indicators set out in the 'Patterns of Maternity Care in English NHS Hospitals' to help develop and improve pathways available to women. We were not able to identify any evidence that statistics were benchmarked against national targets and standards.
- The trust submitted a maternity minimum dataset to their commissioners on a quarterly basis. Performance was also monitored through monthly maternity statistics. The Women's and Children's Governance Committee recently discussed a revised template for the maternity dashboard. They plan to further develop the measures and outcomes monitored to enhance their performance data monitoring.
- The trust performed in line with national standards in the National Neonatal Audit Programme (NNAP) for three indicators were close to meeting the other two standards..

Competent staff

- Staff of all grades told us that they were up to date with appraisals and supervision. They were very positive about the appraisal process and had agreed objectives. Those who were due an appraisal had dates arranged in their diaries.
- To enable midwives to maintain their competencies in all elements of their profession they spent three months at a time in different areas of maternity services, including community and hospital placements.
- Newly qualified midwives worked through a comprehensive competency package. This included all the essential clinical skills required as a midwife and other specific skills such as the insertion of an intravenous cannula and perineal stitching. Newly qualified midwives told us that it took one to two years to complete and they are awarded a band six grade (promotion) on completion.
- Midwives told us that once they had achieved all their competencies they were scheduled to attend Nottingham University to complete a mentorship training programme to enable them to sign off student midwives competencies.
- Women who were low birthing risk were offered early six hour discharge; this was achievable because of the number of midwives qualified to perform New-born Infant Physical Examination (NIPE). The examination is required to be completed within seventy two hours of the baby's birth to give an early indication of the baby's health and physical condition. Having midwives trained to perform this examination enabled the birthing centre to meet a woman's choice for early discharge and reduced the need for an extended hospital stay.
- All midwives participated in live skills and drills (simulated emergencies) and weekly cardiotocograph (CTG) meetings to evaluate high risk cases.
- Midwives selected audits that they wanted to facilitate. A senior member of staff gave an example of an audit of electronic record keeping and how the findings had changed practice. This audit had also provided information to support the temporary cessation of implementing an electronic monitoring system which the trust had purchased.
- A midwife had the lead for maternity and gynaecology bereavement support; one of the priorities of this role was staff education and a plan was currently in development for later 2015. Sessions on the practical aspects of bereavement were included in the midwifery-specific essential training every two years. This training was delivered in 2014/15 by the Birth Centre Matron and all staff have had bereavement training or an update in the last year.
- The trust had a team approach to infant feedking. This was to help all midwives to be completent in all areas of practice. In order to ensure staff were up to date on best practice in these areas, sessions were included on the mandatory midwifery training courses.
- Both a bereavement and diabetes lead midwife were in place.

Multidisciplinary working

Maternity and gynaecology

- The staff reported good multi-disciplinary (MDT) working, stating that there was MDT handovers on the Labour ward twice a day. We witnessed effective handovers in the birthing centre and the ante-natal and post-natal ward.

Seven-day services

- There was out of hours' medical cover at night and over the weekends, made up of on site availability for weekday nights and an on-call system for the weekend.
- Junior doctors working within obstetrics were expected to work in the hospital's Emergency Department (ED) during periods of high activity and when the trust was at risk of breeching their ED four hour target. We were assured by midwives and senior medical staff that they returned to the maternity department as a priority if required. We spoke to junior and senior medical staff regarding this arrangement and they did not feel that there was any compromise to the safety of the service.
- Physiotherapists did not work seven days. At weekends urgent referrals were made via the hospital on call physiotherapy system.
- There was a dedicated theatre team during daytime hours which was used for elective caesarean sections and obstetric emergencies. Out of hours a dedicated theatre was on standby with availability within the maximum 30 minute timeframe. A second emergency theatre was available for general emergencies .We were informed that priority would be given to any obstetric emergency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by staff that training was in place for Consent, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We were shown a programme of published dates for mandatory training which included MCA and DoLS. This programme had been devised to ensure that all staff received the appropriate level of training in this subject. Attendance would be monitored through annual staff appraisals.
- Midwives were aware of the mandatory training programme and most had planned attendance dates. The midwives we spoke with could not explain MCA and DoLS comprehensively, and told us they would refer to the adult safeguarding lead. This lack of awareness was a risk, particularly out of hours when the adult safeguarding lead was not at work. However, the staff working in the Women's Health Unit (WHU) could explain MCA and DoLS and demonstrated evidence of good practice.
- We observed in the medical records that consent forms were completed for operative procedures.

Are maternity and gynaecology services caring?

Good

Overall we rated the maternity and gynaecology service to be good.

Staff in the maternity and gynaecology department were caring and compassionate. Families and visitors were treated with respect and fathers were allowed to stay in hospital with their partners. A facility to support bereaved families was comfortable and fit for purpose with good arrangements for both the parents and extended family.

The physical layout of the ward meant women who had undergone a termination of pregnancy were not always treated as sensitively as possible.

Compassionate care

- We observed compassionate and considerate care provided to all women, families and their visitors and patients said they felt well cared for.
- Partners were welcome to stay following delivery of the baby, facilitating further support for the mother and baby. We spoke to four fathers who had remained with their partners following the birth of the babies and all said that they had been made welcome and encouraged to be involved to a level that they felt comfortable. They were all pleased to be able to stay on the ward if they wished but did not feel pressured to do so.
- We spoke with nine mothers who told us that the care was very good and that they felt safe at all times. They also stated it was good that their partners could stay with them after the birth of the baby. Most patients and relatives spoken with were happy with the attitude of staff; although patients did express a concern about the attitude of a member of staff.

Maternity and gynaecology

- Friends and Family Test scores for the period December 2013 to November 2014 showed a varied experience of maternity services across the reporting period. However during the period September 2014 to December 2014 there was overall improvement in all areas and 100% of respondents recommended the trust to family and friends
- The 'Friends and Family Test' antenatal scores were generally above the England average with 100% of patients recommending the trust for four out of 12 months during 2014/15. Postnatal scores for the 'Friends and Family Test' were above the England average for nine months in the period between December 2013 – March 2014.
- The postnatal community provision 'Friends and Family Test' fell from 100% for December 2013 – March 2014, to 67% in June 2014. Since then the score had improved to above the England average for three out of the five months.
- Patients dignity was maintained in all areas. Curtains were used within the four bedded patient bays which maintained privacy. Staff were observed announcing their presence prior accessing patient bed areas or rooms.
- Throughout the inspection we observed good practices for maintaining privacy and dignity. The maternity service was proud to have been awarded a 'Bronze Award for Dignity and Privacy' in 2014 by the local authority. This is valid for two years.
- The women's health (Gynaecology) unit was working towards the Bronze Award for Dignity and Privacy.

Understanding and involvement of patients and those close to them

- Partners were actively encouraged to stay during and after the birth of their baby
- A bereavement room was available on the birthing centre for families who had suffered the death of a baby prior, during or immediately following birth. This was sensitively decorated and furnished.
- The mortuary was able to facilitate viewing of the babies by bringing them to the bereavement room whenever requested.

Emotional support

- Staff told us that they provided a Birth Afterthoughts service for women who expressed concerns about their birthing experience or for women who required specific emotional support following the birth of their baby.
- We were able to observe a patient attending clinic for consultation with a nurse and consultant. Good practice was observed with effective communication and informed consent obtained.

Are maternity and gynaecology services responsive?

Good

Overall, we rated the responsiveness of the maternity and gynaecology service as good.

The service met the needs of the local population and waiting times were within required timeframes. The birthing centre were able to facilitate six hour post-delivery discharges due to a high percentage of midwifes being competent in new-born infant health checks.

The physical layout of the ward meant women who had undergone a termination of pregnancy were not always treated as sensitively as possible

The maternity department had taken part in a very successful pilot to support women who were overweight to achieve weight loss by linking in with a locally based national slimming club. There systems in place to learn from complaints but staff were less clear about any examples of learning.

Service planning and delivery to meet the needs of local people

- The maternity and gynaecology division served the population of north Derbyshire. There were 2700 babies born each year. There had been no occasions where the service had to be suspended due to lack of capacity.
- There was choice available for where women gave birth to their babies and a wide range of facilities available to support their choice. This included home delivery or hospital delivery with birthing pools, birthing chairs and home from home environments.
- Chesterfield Royal Hospital was a pilot site for obesity in pregnancy project that provided vouchers for 'Slimming World' for women who met a referral criteria. The pilot

study had evaluated very well and there was positive life changing stories from the women. Charitable funds had paid for this service which had been fully utilised and all funds allocated. However, it was hoped to recommence the scheme in 2015 when further funding may be available.

Access and flow

- There were eight consultant led rooms and a two bedded room to observe high risk cases which were all well-equipped. There were four midwifery led beds for low risk women.
- We were informed that the referral to first appointment within maternity met the national standard of before the 12th week of pregnancy. This was confirmed by women we spoke to on the post-natal ward who said that from visiting their general practitioner they saw a midwife quickly and that they were able to easily contact a midwife, if required, throughout their pregnancy.
- Women attending the pregnancy assessment centre when experiencing problems, such as reduced fetal movements, were seen and assessed promptly. Prior to the inspection we were informed that women experienced up to a four hour wait to be seen in this area. During our inspection this was not evident with women being seen on arrival. The midwife in charge informed us that assessment would be within 15 minutes and admission if required would be prioritised according to clinical need. We were shown the admission book which clearly documented time of arrival and time seen which confirmed this.
- Waiting times for gynaecology patients were within nationally set timeframes. Ninety five per cent of patients met the referral to treatment time of 18 weeks, and 93% of oncology patients were seen within two weeks.
- Women referred for termination of pregnancy were seen and treated within two weeks which met national guidance.

Discharge and transfer

- The birthing centre was able to facilitate rapid discharge home, six hours post-delivery of their baby, seven days a week, due to the high number of midwives who were trained and competent to undertake baby heath checks prior to discharge.

Meeting people's individual needs

- The trust performed better than other similar trusts for the time taken to respond to the call button at the patient's bedside.
- There was a room in the birthing centre used for families who were experiencing bereavement. It was sympathetically decorated, comfortably furnished and allowed families to spend time together with their baby without interruption.
- Staff were aware of the learning disabilities liaison nurse and the safeguarding midwife, who both provide advice and support for people in vulnerable circumstances, as well as for their families and carers. They also supported people who lacked capacity to make decisions about their care.
- There was a specialist midwife with responsibility for complex care relating to alcohol abuse, drug abuse, safeguarding, and teenage pregnancy. Staff told us that they would refer women if required.
- For patients who did not have English as a first language, language line was used and all staff we spoke with knew how to access the service. One member of staff told us that they also used picture cards when understanding was limited or the patient had a learning disability.
- There were pathways of care in place for midwives and obstetricians to follow on referral to the perinatal mental health service. This was a commissioned service following a pilot in 2013.
- A midwife had the lead for maternity and gynaecology bereavement support and there was a pathway in place.
- The trust had a female genital mutilation policy in place. The subject was included in the mandatory safeguarding update as well as in perineal repair training and updates.
- Following late termination of pregnancy (after thirteen weeks gestation) patients who stayed overnight in hospital were cared for in side rooms adjacent to the maternity ward. At night the doors between the wards were left open so that midwives could provide support to the surgical nurse caring for these patients. A senior member of staff in the women's health unit told us that patients could hear the babies cry on the ward and that

this upset those patients who had had a termination of pregnancy. There was no action plan in place to mitigate the emotional trauma that this could have on patients.

- Women attending their consultation for a termination of pregnancy had their psychological needs assessed by the gynaecology nurse and the consultant. If they felt that the patient required further support they were provided with a leaflet to self-refer to a counselling service.

Learning from complaints and concerns

- Maternity and Gynaecology receive consistently low number of formal complaints with only 1% of the 807 complaints received by the trust being attributed to this service.
- Staff of all levels said that they would try and were empowered to achieve local resolution when a complaint was made to them verbally.
- Complaints feedback was included in the 2014 essential training programme for all staff. This used real anonymised complaints. Learning from complaints was also included in the maternity newsletter and patient comments were on display on the wards. Complaints were a standing agenda item on the Obstetrics and Gynaecology governance meeting's agenda. There was limited evidence of sharing and learning from complaints when we spoke with staff.

Are maternity and gynaecology services well-led?

Good

Overall we found the leadership in the maternity and gynaecology service was good.

There was a divisional governance and risk management system in place. There was evidence of changes being identified as a result of learning, although the staff we spoke with during the inspection struggled to articulate this to us.

There was a strategy for future developments but staff were not familiar with this

Staff enjoyed working in the department; they were proud of the facilities and care they provided.

Vision and strategy for this service

- There was a trust wide clinical strategy which included the maternity and gynaecology service. Staff were not able to articulate the strategy when we asked them about it. We were told the strategy had been communicated to all staff. The divisional director produced a quarterly newsletter that communicated key matters, including service development to staff.
- The service had an improvement plan in place. In addition, there was a programme in place called Choices. The teams received support from a team of staff who supported them through change, innovation and improvement. There were two projects underway as part of this programme; extended opening times and weekend service provision for the ante-natal clinic and assessing the option of a Community Midwifery Support Worker

Governance, risk management and quality measurement

- There was an established Obstetrics and Gynaecology Quality Governance Group which met monthly. The set agenda covered themes under headings reflective of the Care Quality Commission's domains Safe, Caring, Responsive, Effective and Well Led.
- All actions arising within quality governance meetings were recorded via a separate rolling action plan rather than within minutes. The action log included an identified responsible lead and due date for each action. The minutes of the Obs/Gynae Quality Governance Group Meeting from Thursday 4 December 2014 and Thursday 08 January 2015, included a review of the rolling action plan. Outcomes of the meeting were published within the divisional newsletter. Despite this, the ward staff we spoke with were not able to give examples of governance issues discussed.
- The departmental risk register was managed through the electronic reporting system.
- Staff sickness levels were monitored on a monthly basis for each staff group.
- The trust suspended its implementation of the new electronic intrapartum patient record system in January 2015 because of the clinical risk identified following an audit of records. this meant the trust had used a review of practice, assessed the risk and put in mitigating actions to control the risk until further solutions could be found.

- There was a clinical audit plan for maternity and gynaecology services. This was reviewed annually and delivery was monitored through the divisional quality governance meetings.

Leadership

- There was a lack of clear communication between senior management and staff working within the department. This meant that staff on the 'shop floor' did not have any information about future developments within the service. Staff we spoke with were not able to tell us of any plans for the division or the trust.
- Senior managers expressed pride in the workforce and what they were achieving. Staff told us they could raise concerns to senior members of the team.
- The trusts 'let's talk care program' had identified that staff did not know who the trust senior managers were. We were informed that there were plans to commence executive walk rounds to raise the profile of management within the department and to offer an opportunity for staff to meet and talk to senior managers on a regular basis.

Culture within the service

- As an outcome of the new divisional structure there was limited communication with junior members of staff in the planning and development of the service. All information appeared to be through the divisional newsletter which although covering a wide range of topics did not provide staff with an insight into managerial decisions or quality outcomes.
- All the staff we spoke with commented that they enjoyed working in the service; many had been there all of their career and said they had no intention of moving on. Midwives working within the maternity department stated that they were happy working at the hospital and were proud of the good facilities provided for patients

Public and staff engagement

- The family and friends test had provided a mixed response over the last twelve months with an improving picture over the last three months with 100% recommendation of the trust to family and friends
- There was a North Derbyshire Maternity liaison committee in place which met quarterly to discuss all matters related to the local maternity services. Women who are users of the service attend and engage with these meetings.
- The trust board hear patient stories at every meeting. A recent patient story was from a patient about her experiences of care following the loss of her baby and her experiences of care from the trust.
- The trust had an audit by the Local Supervising Midwifery Advisor in October 2014 and patients attended an event to share their experiences of care by the service.

Innovation, improvement and sustainability

- A key innovation was a pilot project working with women who had a high body mass index (BMI) providing them with vouchers to attend a local national slimming club. This had been very well accepted and had some very successful outcomes with women losing weight and sustaining a healthy lifestyle. Funding is supported through trust charitable funds and there were no plans to discontinue these arrangements.
- The Trust participates in a programme to incentivise breast feeding in areas of low prevalence.
- The 'Don't shake the baby' DVD is shown to all parents prior to discharge from hospital and at home to parents who have had a home birth.
- Three midwives in the unit were involved in research and development.

Services for children and young people

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

Information about the service

Children's services at Chesterfield Royal Hospital included a 20 bedded children's inpatient ward called Nightingale ward. Nightingale ward had six day beds and two high dependency beds. Children's outpatient services were located in The Den, a dedicated children's outpatient area.

A 14 cot level two neonatal unit was located at the hospital. Three cots were designated critical care cots, and the rest provided special care. However, we were told that the neonatal unit was currently operating a maximum of ten cots due to staffing shortfalls.

The neonatal service provided a full range of medical services required by infants born at 27 weeks gestation and above. Babies who were born under 27 weeks gestation, required surgery or had cardiac problems were stabilised and transferred to other hospitals.

During our inspection of children's services at Chesterfield Royal Hospital we visited the neonatal unit, the children's outpatients department and Nightingale ward. We also visited two adult outpatient areas, the fracture clinic and the orthoptic clinic to ascertain whether the clinics provided for children and young people met their needs. We spoke with 18 medical staff, 19 trained nursing staff, 11 members of the multi-disciplinary team, 16 children, 27 parents and one carer.

Summary of findings

The trust did not achieve standards six and eight as set out by the Royal College of Paediatrics and Child Health (RCPCH) 'Facing the Future Standards for Paediatric Services' (April 2011). This was because the service had eight paediatric consultants rather than the recommended ten consultants required to provide the acute on-call support for the service. This had therefore resulted in a shortfall of paediatric consultant cover on site from 5pm until 9am the next morning.

The trust did not follow Royal College of Nursing best practice guidance (2013) in relation to nurse staffing levels for general children's wards. This was because there were insufficient experienced band six nurses employed over the 24-hour period to provide the necessary support to the Nightingale ward nursing team.

Although, risks to patients were assessed and managed, staff had not consistently monitored the emergency resuscitation equipment. We also found gaps in record keeping in 14 care records. Staff responsibilities for child safeguarding issues were not embedded in all of the adult outpatient areas where children and young people were seen.

Staff were caring, compassionate and respectful. There were good examples of collaborative working in the multi-disciplinary team. Staff were positive about working in the service and morale was high. There was a culture of openness, flexibility and commitment.

Services for children and young people

Arrangements were in place to minimise risks to children and young people receiving care, and there was effective monitoring of quality and outcomes. The neonatal unit had implemented a developmental care approach to caring for babies.

Are services for children and young people safe?

Requires improvement

Overall we judged the safety of the service required improvement .

There was not always a senior member of nursing staff available in the hospital to offer advice and support in relation to the care of children and young people. Records were not always complete and accurate, and the system to check essential equipment was not effective. There was no written guidance on how to manage risks for those children and young people who presented with mental health concerns. Staff responsibilities for child safeguarding issues were not embedded in all of the adult outpatient areas where children and young people were seen.

However, the service had systems in place which provided safeguards for the service overall. These systems were corroborated by the staff we spoke with who confirmed their involvement in and the effectiveness of these systems, for example, incident and risk management, safeguarding, mandatory training and staffing. We saw that an ethos of learning was in place throughout the service.

Incidents

- Systems were in place to ensure that incidents were reported, investigated and learnt from. . Incidents, complaints and significant events had been discussed at forums such as the ward meetings, staff ongoing training sessions and clinical governance meetings.
- Discussions with most staff confirmed that they were aware of how to report incidents and had received feedback and learning. Two staff told us how the nursing handover process had changed following an incident. The outcome resulted in staff attending bedside nursing handovers as well as taped nursing handovers.
- Between February 2014 and January 2015 two serious incidents had been reported. We reviewed the trust investigation report and action plan into one of these incidents which showed that the incident had been investigated and learnt from. The action plan also confirmed that the outcome of the investigation had been shared with the family.

- National safety alerts were received at ward level and had been actioned as appropriate.
- Since August 2014 the children's service had been a pilot site for the paediatric safety thermometer in association with 16 other NHS trusts. Information had been captured in six areas, including pain and the early warning signs of deterioration. The audits results showed that where concerns had been identified, escalation had taken place and measures taken. For example, when a child was in pain, pain intervention had been delivered.
- Bi-monthly paediatric mortality meetings took place. Separate mortality meetings took place for paediatrics and neonates. Neonatal mortality was discussed at the quarterly network mortality meetings and at the child death overview panel. Staff told us and we saw that learning from these meetings had been shared with clinical staff through emails and displayed on staff notice boards.
- Some of the clinical staff we spoke with about the 'Duty of Candour' demonstrated knowledge of what this new regulation involved. However, we observed that junior medical staff were not aware of this new regulation. The 'Duty of Candour' states that providers must be open and honest with patients and other relevant persons when things go wrong with care and treatment.

Cleanliness, infection control and hygiene

- The infection prevention and control service was led by the executive nurse, who was supported by a nurse consultant and 'link' staff located in the clinical areas. Staff told us that they could easily contact the infection control team which meant appropriate professional advice was available.
- The areas we visited had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance and wall mounted hand gels.
- Good infection control practices were observed. For example, we observed a doctor using aseptic technique whilst undertaking an insertion of a cannula in a baby. Staff were observed using personal protective equipment such as gloves and aprons when undertaking tasks.
- Infection control audits had been completed in 2014, for example, hand hygiene and bare below the elbow audits. The 'Divisional Clinical Governance Feedback Report (February 2015)' identified that the neonatal unit hand hygiene audit scored 100% compliance; whilst Nightingale ward scored 84% compliance. We saw minutes which confirmed that the ward matron had taken action regarding this non-compliance.
- The bare below the elbows audits (February 2015) confirmed that the neonatal unit and Nightingale ward had achieved 100% compliance.
- Staff had received infection prevention and control training as part of their annual essential training programme. Trust training statistics confirmed that 92.5% nursing staff in acute paediatrics and 94.1% of paediatric medical staff had completed infection control training in 2014.

Environment and equipment

- We saw equipment suitable for babies, children and young people in all clinical areas.
- We undertook random checks on the resuscitation equipment. On Nightingale ward the resuscitation trolley was unlocked. We questioned the matron about this practice and asked whether a risk assessment had been completed. We were told that a risk assessment had not been completed. We reviewed the other resuscitation trolleys throughout the service and saw they were locked.
- On Nightingale ward we found two boxes of drugs that were not stored securely in the resuscitation trolley. We found three pieces of essential equipment without 'use by' dates. This meant that staff could not be sure the equipment was sterile and safe to use. One of these was replaced later the same day. The records of daily checks of the equipment did not identify that the dates were missing.
- The baby transport incubator on the neonatal unit did not have an identified checklist of equipment checks.
- The transfer bag attached to the transport incubator had one piece of essential equipment missing and some equipment undated. We also found other pieces of unchecked equipment. The matron removed the transport bag and told us that they had asked a member of staff to replace any equipment which required replacement.
- We were told that information technology system problems had affected children's hearing services which could have delayed hearing assessments due to data loss. However, we were told that to-date no child's

hearing assessments had been delayed. We saw that these risks had been identified on the 'Women and Children's Division' open risks register dated 20 February 2015. The current risk was identified as a high risk.

- A yearly ligature point survey had been undertaken on Nightingale ward by the trust health and safety lead. This was to ensure that the environment was safe for children and young people who may try to harm themselves. We were also told that oxygen and suction points would be removed from the wall and bedside curtains would remain drawn.
- The matron told us that the children's service was developing a checklist of potential risks to look out for. When agreed this checklist would be used by staff to initially assess individual children's risks. We were told that currently, the service had no written guidance on how to manage risks for those children and young people who presented with mental health concerns.

Medicines

- The trust policy for safe management of medicines was in line with National Institute for Health and Care Excellence (NICE) guidance.
- Additional guidance included medicine specific leaflets. We saw that staff used local trust protocols when administering medication for babies, children and young people.
- Medicines management was good. For example, medicines were stored in locked cupboards; the nurse in charge carried the controlled drug keys which were separate from the ward keys. We reviewed five drug charts and no gaps were seen against the entries.
- Daily checks of the temperature of the drug fridges had taken place; we saw records of checks confirming this on Nightingale ward and the neonatal unit. However, on the neonatal unit we observed that there was no temperature range identified on the documentation for staff to refer to should drug fridge temperatures fall outside of recommended ranges.
- Nursing staff within the neonatal service had completed a yearly competency assessment and two yearly medication administration papers.
- Doctors' induction programmes included a 30 minute training programme on paediatric prescribing. One junior doctor told us that they had received teaching on prescribing by the paediatrician and pharmacist.
- We were told that children's medicines to take home were available within an hour of being ordered.

Records

- We reviewed 23 sets of medical and nursing notes and observed shortfalls in record keeping in nearly two thirds. For example, the paediatric early warning score (PEWS) charts completed for one young person over 13 years of age did not identify the frequency of reviews required, whilst on two other PEWS charts the PEWS score had not been added up correctly.
- Children's care plans were pre-printed, standardised plans, although some had been individualised. In five of the seven care plans we reviewed on Nightingale ward not all domains had been completed; not all care plans were dated or identified aims and goals. This meant information was missing and this could subsequently impact on the care received by the child.
- Whilst observing a ward round on Nightingale ward we reviewed one set of notes which showed that the discussion with the parents although documented, was not detailed. The doctor following completion of the record had not identified their general medical council (GMC) registration number against their signature.
- We also saw that some of the following information had been omitted from another eight sets of notes; the doctors GMC number, the rank of the doctor and / or the printed name of the doctor. The standard is that entries are signed, then the name is printed, GMC number recorded and rank of the doctor identified.
- We were told that ward notes audits had been completed in January 2015 as part of the trust audit programme. We saw some feedback in the 'Paediatric Bi-monthly News Sheet April & May 2015'.
- A neonatal records audit took place in January 2015. The outcome of the audit showed there were seven areas which required improvement. For example, the 24 hour fluid balance charts had not always been completed. The resulting action plan showed that each area had been addressed and we saw that a re-audit was planned for six months. The audit had also been discussed at the March 2015 paediatric audit meeting and three actions agreed. The trust had identified that there was no additional update regarding these actions since the March 2015 paediatric audit meeting. The outcome of these records audits had been shared with staff as part of their mandatory training.

- Staff told us that nurse's handover tapes and medical staff handover sheets had not been kept. This meant there was not an audit trail should queries be raised about specific handover sessions.
- Lone workers completed hearing screens at the weekends would contact the neonatal unit to tell them when they arrive, what time they are expected to leave and when they finally leave. This information is documented in a file on the neonatal unit. We reviewed this file and found that some entries were missing.

Safeguarding

- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide. The director of nursing and patient care was the trust executive lead for safeguarding. The trust did not have an identified non-executive director for children.
- Staff told us that they had effective working relations with the local children's safeguarding team and demonstrated a knowledge of what to do and who to contact should a concern be raised.
- An annual trust children's and young people's safeguarding report was presented at trust board.
- We found a potential gap in child safeguarding practice when we visited the adult fracture clinic to look at the facilities and care provided for children and young people. The staff informed us that they did not see it as their responsibility to refer to the children's safeguarding team; instead, they referred them to the child's consultant. The paediatric matron was informed of this practice and told us that they would investigate.
- NICE safeguarding guidance recommends that qualified staff are trained to a level three standard in safeguarding. We were told that of the 101 staff requiring level three training 83% had completed this. Nursing staff had completed safeguarding training as part of the mandatory rolling programme. Three junior doctors told us that they had received safeguarding awareness (level one) training during their trust induction. Two other doctors told us they had completed either level two or level three safeguarding training in previous employment but as yet had not completed additional updates, despite ongoing training sessions being available.
- The trust met the statutory requirements in relation to 'Disclosure and Barring Service (DBS)' checks. All staff employed at the trust undergo a DBS check prior to employment, and those working with children undergo an enhanced level of assessment.
- Infant protection plans for neonates had been flagged up on the perinatal alert register. The named midwife writes a protection plan for any antenatal safeguarding issues identified. A copy of this protection plan was put into the baby's notes once the baby had been delivered. Risks were then discussed at weekly meetings with the safeguarding team.
- A new electronic alert system had been implemented for children and young people with known safeguarding plans.

Mandatory training

- We talked with members of staff of all grades, and confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting , paediatric resuscitation, health and safety, medicines management and information governance.
- The trust's training figures for 2014 confirmed that 94.1% of medical staff and 92.5% of staff in acute paediatrics had completed this training.

Assessing and responding to patient risk

- The trust had identified guidelines and protocols to assess and monitor in real time, and react to changes in risk level. 'EMBRACE' the paediatric and neonatal network worked with the trust when children and neonates required transfer to other hospitals. The acute children's service had two high dependency beds and should a child require high dependency care this would be identified in advance, for example, a child requiring surgery.
- Trust wide the 'paediatric early warning score' (PEWS) was a system used to monitor children and to ensure early detection of deterioration. Staff said that they felt that the current PEWS chart did not reflect the condition of the child. However, staff said they would escalate concerns to medical staff. We reviewed seven paediatric early warning score observation charts and found these had been completed. The matron told us that the current PEWS chart was due to be reviewed as part of the trust audit plan in June 2015.

- Risks to babies on the neonatal unit were identified during their initial assessment and identified within care plans. These risks were reviewed twice daily and the outcome of each review documented. We reviewed five babies' notes, plus, observed a new baby's admission to the neonatal unit. We saw this in practice in the form of a risk assessment which took place during the baby's admission and completed evaluations and updated care plans in five other babies' notes.
- The 'Paediatric Resus Training – Division Summary – 01/04/2014 to 31/03/2015' training statistics identified that 227 (82.55%) staff had completed this training.
- Critically ill children were cared for on Nightingale ward or on the post anaesthetic care unit (PACU2). The paediatric matron told us that all of the nursing staff had completed 'Care of the critically ill child' training provided by EMBRACE which is the paediatric network. We saw a training register which showed a total of ten nursing staff had completed care of the critically ill child training in 2015. The matron told us that the 2014 training register captured the dates of training attendance for the remaining staff. We asked to see this register and were told that the information had not been kept. We were also told that three nursing staff had completed the six month paediatric high dependency course at Sheffield Children's Hospital.
- We found no written evidence confirming PACU2 staff's completion of paediatric competencies in the care of the critically ill child. We discussed this with the head of nursing and paediatric clinical director and were told that when a child was admitted to the PACU2 a paediatrician would always be present to monitor that child's condition. This meant there was appropriate clinical support available to monitor the critically ill child.

Nursing staffing

- Nursing and medical staff across the services told us that there had been shortfalls in staffing. Nightingale ward had 2.4 'whole time equivalent' band five vacancies. Where there were shortfalls on shifts bank nursing staff would be used from NHS Professionals and were mostly covered by existing staff.
- Neonatal and paediatric staffing concerns had been identified on the 'Women and Children's Division' open risks register dated 20 February 2015. This meant the risks had been escalated to trust board level.
- To mitigate these risks we saw that a number of actions had been identified and completed. For example, the matron told us that patient dependencies had informed staffing numbers and that they were available to support the paediatric ward during Monday to Friday. There had also been investment agreed by the board of directors on the 28 April 2014 to recruit substantive nurses up to agreed staffing levels. Staff we spoke with confirmed that this recruitment drive had taken place and that they had no concerns now about staffing levels.
- The Den which is the children's outpatient department had a full staffing establishment.
- Best practice staffing guidance had not been fully implemented within the children's services as senior nurse cover at band six was not always present on every shift on Nightingale ward. We reviewed two nursing staff rotas with the paediatric matron. The rotas showed that band six nurses had not been allocated to work night duty on both rotas and not all day duty shifts had been covered. Between the 27 October 2014 and 23 November 2014 there were 6.5 days without band six nursing cover. This shortfall increased to 8.5 days between 22 December 2014 and 18 January 2015.
- We looked to see what band six nursing cover was on shift on the 22 April 2015 (the first day of our inspection). We saw that band five children's trained nurses and two healthcare assistants were rostered for the day and night shifts. This meant that experienced, competent band six nursing provision was not available to support staff 24 hours a day seven days a week.
- Monitoring of staffing levels against patient dependencies had commenced two years ago. Auditing took place three times a day for a month against the 'Royal College of Nursing (RCN) staffing standards'. The February 2015 staffing report included details of the June and September 2014 audit outcomes and showed between 62 – 97% compliance had been achieved against the RCN staffing standards over these time periods. It was noted that compliance had improved (85 – 97%) between September 2014 and February 2015.
- The neonatal acuity tool was measured against 'British Association of Perinatal Medicine Guidelines (2011)'. This was recorded within the unit's information system and benchmarked against other local providers. This information informs managers how many staff should be rostered for each shift. We were told that an e-rostering system produced duty rotas and band six

staff nurses were rostered to work every shift. We reviewed the duty rotas for November 2014 and February 2015 which confirmed band six staff presence on every day and night shift. The staff we spoke with told us that staffing and skill mix levels were safe.

Medical staffing

- The trust did not achieve standards six and eight as set out by the Royal College of Paediatrics and Child Health (RCPCH). This was because the service had eight paediatric consultants rather than the recommended ten consultants required to provide the acute on-call support for the service. Paediatric consultant presence was from 9am – 5pm. This shortfall of consultants resulted in a shortfall of consultant cover on site from 5pm until 9am the next morning. We were told there was no plan in place to identify how this cover would be achieved.
- One consultant was on maternity leave and was due to return to work in January 2016. The lead clinician confirmed that not all consultant staff worked full time hours. The Trust has a head count of 12 consultants, eight working across acute and community paediatrics and four working in community paediatrics only .
- To mitigate the risks there was always a middle grade or more senior registrar on site; locum consultants were used and permanent consultant staff identified on the out of hours rota. A consultant post had been advertised and interviews were due to take place. Following the inspection we were told that a consultant had been appointed and would start employment at the trust from October 2015.
- One consultant identified concerns about the difficulties recruiting consultants, middle grade doctors and locums. However, when locums had been used continuity had been good. Recruitment from India through the RCPCH medical training initiative scheme was ongoing.
- Consultant staff were supported by one associate specialist, one specialist doctor and five specialist registrars. Five junior doctors and five GP trainees also worked within the service. In addition to this two specialist registrars are employed to cover one vacancy and leave.
- Two anaesthetic consultants have a paediatric interest. We were told that there was always an anaesthetic consultant or intensivist available out of hours to provide anaesthetic advice and support for children's services.
- We observed one paediatric handover and saw that they were thorough; records of doctors' attendance were documented. Medical staff told us that teaching took place at handover sessions three times a day; two sessions were consultant led. We were told that a post ward round handover also took place.
- The neonatal lead consultant completes between two to three ward rounds weekly and the middle grade registrar on week one undertakes a joint round.
- We asked what out of hours support the service provided and were told that on-call staff at consultant level was 'tight' because of the current paediatric vacancies. We were told that the 'hot week' consultant covered the neonatal unit during the day time when the neonatal consultant was not there.

Major incident awareness and training

- The trust had a business continuity plan (undated) which ensured that critical services could be delivered in exceptional circumstances.
- A trust major incident policy (2015) was in place. This policy identified what measures would be put into place should a major incident require paediatric expertise.
- The neonatal unit had contingency planning in place for when the neonatal unit was at full capacity or in bad weather conditions. Escalation guidelines were also included in this document.

Are services for children and young people effective?

Good

Overall we rated the effectiveness of the service as good.

The service provided effective services to the local population. Multi-disciplinary team working had resulted in positive outcomes for children. Most services provided evidenced based care, although some clinical guidelines were past their review dates.

Most staff had received an annual performance appraisal. Staff told us they were well supported and generally

received relevant professional development. However, we were told that there was not at least one nurse per shift in each clinical area trained in advanced paediatric life support or European paediatric life support and junior doctor's competencies had not been formally signed off.

Audits had informed practice, and introduced changes to improve outcomes for children and young people. The neonatal service had achieved a stage three UNICEF Baby Friendly accreditation.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care. Neonatal unit guidelines were linked to the network guidelines. Staff told us evidenced based practice such as early ventilation techniques had been adopted and network guidelines adapted for local use, for example, in the use of high flow oxygen.
- Medical staff confirmed the use of evidence based guidelines and said that guidelines from NHS trusts in Nottingham or Sheffield had been used where there was no local guideline in place.
- We reviewed a selection of medical guidelines and observed that some required review as they were out of date. Some were over a year past their review by date.
- The sudden infant death guidelines (2011) were out of date in that they did not follow coroner's guidance in the emergency department. We did not see guidance about making contact with the police and for the parents not to be left alone with the deceased child.
- Updated and new policy guidance was communicated through the 'Paediatric Bi-monthly News Sheet' (April & May 2015).
- The neonatal consultant lead said the neonatal consultants had no time within their current role to take on clinical lead responsibilities.
- The neonatal unit had an electronic ear placed in the high dependency area whose function was to monitor noise levels. Where noise levels were too high the ear's colour would change. 'Whispering Wednesdays' had also been introduced, when noise levels were kept to a minimum.

Pain relief

- Babies, children and young people had access to a range of pain relief. If babies were unsettled or appeared to be in pain, this observation would be discussed with the doctor to determine whether pain relief was needed to settle the baby.
- The trust did not have a paediatric pain management team. Staff from Nightingale ward led acute pain management. Children with chronic pain were supported by an anaesthetist who had an interest in this area. Specific pain protocols and patient controlled pain relief guidelines were in place. Additional support for chronic pain management was provided through Sheffield Children's Hospital.
- Children's pain scores were incorporated in four of the patient early warning sign charts that we reviewed.

Nutrition and hydration

- A variety of food choices were available to children.
- Seven children's records were reviewed to ascertain the type of nutritional assessments which had taken place. Two children had formal nutritional assessments completed by a dietition. Five other care plans included a generalised nutritional component which had not been completed.
- Stage three Baby Friendly accreditation (16 October 2013) had been achieved. Stage three involves parents' experiences. The Baby Friendly initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding'.
- Staff were aware of relatively low breastfeeding rates for babies in the neonatal unit which, we were told by staff was a cultural issue. In response, staff had promoted breastfeeding. The trust performed in line with national standards in the National Neonatal Audit Programme (NNAP) for three indicators were close to meeting the other two standards..

Patient outcomes

- A paediatrician was the audit programme lead. A yearly audit plan was in place and audit presentations took place on Monday afternoons every two months.
- The trust's audit dashboard identified a list of the audits that had been completed in children's services and the progress they had made against them. We reviewed two audits and their associated action plans; those relating

to paediatric epilepsy and neonatal jaundice. We found that lessons had been learnt and that progress had been made in improving care for children with these conditions.

- Information we saw which related to the epilepsy audit identified the outcome against the previous audit had not been fully achieved against all the issues identified. For example, only 27.3% of children had received input from a paediatrician with expertise in epilepsy by one year. The recent audit showed an improvement at 80% and actions confirmed that additional epilepsy clinics had been set up temporarily to achieve a 100% target. These actions showed that progress had been made.
- Information from audits were fed back to staff in the 'Paediatric Bi-monthly News Sheet April & May 2015'. The ongoing audits identified were, sepsis, fluid balance and compliance with the new surgical policy.
- Minutes from the November 2014 and January 2015 monthly paediatric and children and adolescent mental health service (CAMHS) quality governance meetings confirmed that patient outcomes and clinical effectiveness issues had been discussed and improvements noted. Quality, safety and performance were also identified on the report.

Competent staff

- Formal processes were in place to ensure staff had received mandatory, role specific training and an annual appraisal. Four nursing staff told us they had received yearly appraisals and training specific to their needs.
- The trust provided details of staff appraisal rates from April 2014 to March 2015. The figures include an adjustment for long term sickness. The proportion of staff who had received an appraisal in 2014 were between 70 to 90%. We also received confirmation that all except two of the consultant and associate specialist staff had undergone appraisals in 2014.
- The paediatric equipment training lead said that external companies provided 'train the trainer' sessions to maintain staff competencies on equipment. Staff completed an annual equipment update as part of their local training. One staff member showed us their completed and verified equipment competency training file.
- Medical and nursing staff confirmed attendance and satisfaction with their corporate and local inductions. Locum doctors received an induction pack.
- The paediatric critical care network had visited the trust on three occasions in 2014 to provide simulation training. There had been two simulation training events which had been provided through the neonatal network on two occasions in 2014 - 15. An unannounced baby abduction simulation had taken place in April 2015.
- The paediatric matron said they had completed the advanced paediatric life support training course and 28 out of 32 nursing staff had completed paediatric intermediate life support (PILS) training. Completion of PILS training was also confirmed by the staff we spoke with.
- In PACU2 the five staff we spoke with said they had not completed paediatric resuscitation training. However, we later spoke with the management team who told us that operating department and recovery staff had completed an annual rolling programme which included a three hour resuscitation update and theatre specific simulation training.
- Junior doctors' competencies had not been formally signed off. For example, junior doctors would be shown how to carry out a neonatal examination and basic new-born life-support at induction but were not observed afterwards to ensure true competence.
- Medical staff confirmed attendance at paediatric and neonatal basic life support training sessions. They told us they had also attended teaching sessions three times a week during ward rounds and at medical handover sessions.
- Staff had received clinical supervision sessions. Each area had designated nurse clinical supervisors who had completed clinical supervision training to allow them to run clinical supervision sessions. Staff either had group clinical supervision or individual clinical supervision. Clinical supervision dates had been identified in both paediatric and neonatal clinical areas.

Multidisciplinary working

- Staff identified there were effective working relationships between children and adolescent health services (CAMHS) professionals and the paediatricians. CAMHS professionals visited Nightingale ward daily when a child with mental health concerns had been admitted.
- Staff described examples of partnership working and we saw examples documented in children's records. For example, we saw that CAMHS weekly meetings had taken place. Changes in the child's care included

changes to their diet plan and the agreed activities for the next week. The minutes of multidisciplinary team discussions were seen for one child covering a month period.
- Transition pathways were in place for diabetic patients.
- Representatives from the children's service had met with the children's network, 'EMBRACE' twice yearly at the paediatric critical care meeting. The paediatric critical care meeting minutes dated 22 January 2015 confirmed joint working arrangements and discussions had taken place.
- The head of nursing said they had met with other paediatric managers and providers to develop practice and improving children's outcomes, for example, the trust was involved in the paediatric safety thermometer pilot.
- When a baby was due to go home on oxygen paediatric community nurses liaised with neonatal staff as part of the baby's discharge planning process. Following the baby's discharge the neonatal and paediatric community nurses completed a joint home visit.

Seven-day services

- Twenty-four hour paediatric and neonatal consultant support was in place. The consultant rotas provided details of which paediatricians to contact that week. Medical and nursing staff said they could access consultants out of hours and described the consultant team as supportive.
- Staff said they could access out-of-hours investigations, for example, imaging and urgent laboratory tests. We were also told that pharmacy access and support was available.

Access to information

- Weekly multi-disciplinary handover meetings took place to discuss babies currently receiving support. Members of the team involved in this meeting included the matron or nurse in charge, the health visitor liaison person, a physiotherapist and the safeguarding midwife.
- Staff had received some training in children and adolescent mental health issues. One member of staff said they now felt more informed of CAMHS conditions and able to care for this vulnerable patient group.
- All safeguarding referrals of children and young people were discussed at weekly meetings attended by members of the multi-disciplinary team. The learning disabilities nurse also told us that where there was a need they would provide support to young people.
- We observed as part of one post-operative child's journey that their parents received a discharge letter and discharge information including who to contact if they were worried. A discharge checklist had also been completed and signed by the discharge nurse.

Consent

- Staff were informed of the consent process and had received training in the Mental Capacity Act.
- Staff explained that the consent process was completed by surgeons for children requiring surgery and that written consent had been obtained prior to children and babies receiving blood transfusions whilst verbal consent would be obtained for the use of a dummy.
- We observed as part of one preoperative child's journey that both the surgeon and anaesthetist explained the procedure, checked the parents and child's understanding of the procedure and confirmed that written consent had been obtained.

Are services for children and young people caring?

Good

Overall we rated the care in the service as good.

Children, young people and their parents said they had received compassionate care with good emotional support. Parents and young people said they were fully informed and had been involved in decisions relating to their treatment and care.

Facilities for both parents and children were satisfactory and support had been provided by the multi-disciplinary team during the child's admission and in preparation for their discharge home. Additional measures such as parent craft and parental support were also available.

Compassionate care

Services for children and young people

- Throughout our inspection we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers.
- Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- We spoke with 27 parents of children using the service who told us they had been happy with the care and support they and their children had received.

Understanding and involvement of patients and those close to them

- We spoke with 16 children, 27 parents and one carer about their experiences. They told us that they had been involved in and were happy with the care and treatment their children had received.
- A wide selection of information was displayed which could be accessed by young people and their parents. The parents we spoke with told us they had been given sufficient information and training to care for their child's needs. We saw this in action when we attended the paediatric consultants ward round. The paediatrician answered the parent's questions and ensured that the asthma plan was individualised to the child's needs prior to being agreed.
- Staff told us that prior to a babies discharge home on oxygen their parents would complete a teaching programme to enable them to care for their baby.

Emotional support

- The mental health needs of mothers were re-evaluated regularly, demonstrating that appropriate emotional support was in place for both mother and baby.
- Clinical nurse specialists in diabetes and child protection were available for children, young people, parents, carers and staff to access for support and explanations where needed.
- Primary and secondary school teacher support was available for five mornings a week.
- The school room was also used as a day room for adolescent patients when school sessions were not in progress.
- There were newly decorated, secure play areas both inside and outside of the building. Three play specialists worked on a shift system within the unit and also provided occasional weekend cover.
- The hospital had a yearly memorial service for parents and families of children and babies who had died. We saw a copy of the programme of the last memorial service which had taken place on the 12 April 2015. We were told that these parents and families had also been given the option of attending 'talking therapy' sessions and an appointment with the paediatrician and matron to help them with their grieving process.
- Parents from the neonatal unit could access parent craft and parents support groups. This was a new initiative planned to take place every two to three months. We saw meeting dates for 2015 identified.

Are services for children and young people responsive?

Good

Overall we judged the responsiveness of the service to be good.

The children's, young people and families' service were responsive and generally met children's needs. The service had good support from specialist centres such as Sheffield Children's Hospital.

Patients generally had good access to services. Children were seen in some adult out patient clinics and generally their needs were accommodated well. The fracture clinic needed further development to ensure children's needs were met.

Service planning and delivery to meet the needs of local people

- We were told of a recent pilot where funding had been agreed from November 2014 – March 2015. This funding was for the temporary employment of additional staff. We saw that CAMHS health provision had recently been discussed at the 'Quality Assurance Committee' (30 March 2015).

Access and flow

- Neonatal and children's services generally provided good access to its services. Children with long term conditions had open access to the paediatric ward. The ward had a folder detailing children and young people who required open access and their notes were kept on the ward.

Services for children and young people

- The waits for the child development centre (CDC) had increased to 14 weeks which was within the 18 week target. The reason for this increase was due to insufficient consultant availability and long waits to see a psychologist. The impact meant that a child could have a yearlong wait for a full multi-disciplinary team (MDT) assessment for autism. To reduce the backlog of CDC patients the consultants had worked one weekend where they had seen over 100 patients.
- Staff told us that children who attended outpatients may have to wait for two to three weeks for blood samples to be taken. However, on occasion these children were referred to and seen on Nightingale ward which meant that blood samples could be taken immediately. The head of nursing told us that to-date no actions had been taken to resolve this issue.
- We were told that a pilot GP rapid access clinic had been set up on Nightingale ward. This was where some children and young people had been seen by a GP, rather than in the emergency department. Staff told us that the pilot had worked well and was due to finish on the 1 May 2015. When Nightingale ward was at full capacity GP referrals were then seen in the emergency department.
- Paediatric epilepsy service provision was identified as a risk on the 'Women and Children's Division' open risks register dated 20 February 2015. The risk was identified through the divisional leadership team and governance systems in late 2014. There was insufficient clinic capacity and insufficient medical and nursing staffing. The service had an action plan which related to these risks and identified monitoring was in place. We saw the latest action plan (23 Feb 15 update – version 2) which confirmed that two actions had been completed.
- The adult orthoptic clinic was seen to provide for children's and young people's needs.

Meeting people's individual needs

- There was good care of children and young people with mental health problems on Nightingale ward. The children and parents we spoke with confirmed involvement when planning and agreeing their care. Care plans were up to date and appropriate for the child.
- However, we were made aware of an incident where one child who had required mental health support following their admission did not have immediate support through the CAMHS team. We saw the completed incident form and noted that actions and learning points had been identified. The matron told us that an outcome from this incident had resulted in the current development of a risk list tool which staff would complete at the child's admission. This tool was in development.
- Staff had received training sessions in equality and diversity and safeguarding to inform their clinical practice and decision making.
- Access to interpreters or language line could be arranged so that staff were fully informed of children's, young peoples and their family's needs.
- We saw examples of where children's needs had been met. For example, one child had a shared care arrangement with the community and acute teams in relation to the administration of intravenous antibiotics.
- Individualised pre-assessments took place for children undergoing ear, nose and throat procedures.
- Arrangements were in place for adolescents with diabetes and cystic fibrosis who were moving to adult services. Two diabetic nurses were based on the ward and worked closely with children, their families, medical and nursing staff.

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Assistance and Complaints Service or the trust complaints department. Some of the parents we spoke with confirmed they knew how to access this service.
- One parent said that they had no complaints about the service. Staff confirmed feedback from managers had been given following complaints investigations had been completed. We saw complaints feedback given via the 'Paediatric Bi-monthly News Sheet April & May 2015'.

Are services for children and young people well-led?

Good

Clinical strategies and priorities were in place against which were action plans and progress updates.

Services for children and young people

A clear leadership structure was in place in the women's and children's service. Individual management of the different areas providing services to babies, children, young people and families were well led.

However, an experienced band six nurse was not always present throughout the 24-hour period to provide the necessary support to the nursing team on Nightingale ward.

Governance processes and known clinical risks had been monitored. Public and staff engagement processes captured feedback from both groups.

Two staff from the neonatal unit introduced the developmental care approach to the neonatal unit to improve care for babies using this service. This had been well received by both parents and staff and the change is now embedded in practice.

Vision and strategy for this service

- Both the children's and neonatal services had clearly defined clinical strategies and priorities in place which had been devised in line with the organisational five year plan. The trust provided us with updates against each strategy action plan which identified progress made.
- The trust vision and values was displayed on noticeboards in locations throughout the services we visited. The staff we spoke with were aware of the trust's value statement 'Proud to care'.

Governance, risk management and quality measurement

- A divisional quality governance structure was identified within the women's and children's division.
- Monthly discussions of risk and quality had taken place at a number of forums. Initial discussions took place at the paediatric clinical governance group and were escalated to the divisional governance group. Escalation to trust board was through the quality delivery group or hospital leadership team. We were told that issues identified as high risk (risk levels of 12 and above) were discussed at the monthly trust board meeting.
- We reviewed four sets of minutes from the 'Paediatric and CAMHS Quality Governance Meetings' held from October 2014 to January 2015. We saw that agenda items included, trust risk register, root cause analysis action plan updates, policies / guidelines, audit, incidents and complaints. We also saw that a quarterly complaints report and quality assurance plans had been discussed.
- Quality and governance information updates had been communicated in team meetings and information displayed on governance information boards in the clinical areas. The information provided included learning from neonatal mortality 2014 and guidance dated 23 January 2015 on recording patient results. Information about current risks had also been given to staff through the 'Paediatric Bi-monthly News Sheet April & May 2015'.
- The service had a performance dashboard and local risk registers which are monitored monthly.
- We were told that part of the trust quality assurance strategy included patient safety walkabouts. We asked staff whether they had seen any of the executive team undertake these walkabouts and were given a mixture of responses from staff.

Leadership of service

- A nursing leadership structure was in place and described by staff as supportive.
- Best practice staffing guidance had not been fully implemented within the children's services. This was because senior nurse cover at band six had not been present at all times during the 24-hour period to provide the necessary support to the nursing team on Nightingale ward. To mitigate this risk the matron told us that they were available to support the paediatric ward Monday to Friday.
- A new clinical lead had been in post four months and we were told that medical leadership was good.
- Staff leadership development opportunities were confirmed by nursing staff and managers.

Culture within the service

- There was a culture of openness, flexibility and willingness among all the teams and staff we met. Staff spoke positively about the service they provided and we saw that morale was good.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other agencies involved in the delivery of children's health services.

- One staff member told us that should they need to raise a concern they felt confident and supported to do so. We were also told us that concerns could also be reported through a dedicated phone number.

Public and staff engagement

- Satisfaction surveys had been carried out from January 2014 to March 2015 within the acute children's service. Staff told us that parents, adolescents and children had completed satisfaction surveys. We saw the survey action plans displayed in the children's ward.
- The NHS England 'Neonatal Survey 2014' which showed that most of the trusts ratings were either within the top 20% of trusts or the intermediate 60% of trusts. The 2014 survey of parents' experiences of neonatal care involved 72 NHS trusts and 88 hospital neonatal units in England.
- The neonatal unit satisfaction survey action plan with updates identified (October 2014 to December 2014) was displayed in the neonatal unit.
- Staff told us that feedback cards had been introduced in April 2015 for parents and young people. These cards were seen to be available in The Den.
- We saw 'Tops and Pants' feedback from parents and children displayed on Nightingale ward. Tops comments described what was working well, whilst pants' comments identified what needed to improve. There was no negative feedback displayed.
- A children's focus group had been introduced. The first meeting took place on Nightingale ward before Easter with previous patients and those inpatients who wanted to be involved. Discussions at the first meeting were based on the NHS initiative 'The Fifteen Steps Challenge'. This initiative helps staff, patients, service users and others to work together to identify improvements that can enhance the patient experience. We were not told what the outcome of this meeting had identified.
- Nursing staff said they felt valued and had been involved in the development of the unit through the 'Let's Talk Care' initiative. Information about incidents and complaints had been communicated at monthly staff meetings and at the rolling programme. No concerns were raised about the service from staff.

Innovation, improvement and sustainability

- Two staff from the neonatal unit had travelled to America to observe the neonatal development care program. Following this visit information and training was provided to staff to enable them to introduce the developmental care approach. We were told that this had been well received by both staff and parents and that the change was embedded in practice. For example, the use of boundaries and swaddling on admission to the unit was introduced to reduce the baby's stress. The lights were kept low and noise to a minimum over the cot / incubator. Parents and staff within the unit received training to identify when the baby is showing signs of distress or instability so that comfort measures are used to enable the baby to regain stability. Part of this process involves the parents in writing their baby's care plans with staff.

End of life care

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

Information about the service

Chesterfield Royal Hospital provided end of life care throughout the trust. Patients with palliative or end of life care needs were nursed on general wards throughout the hospital.

End of life and palliative care services were provided as part of the medicine and emergency care division of the trust and, were supported by the mortuary, chaplain and, bereavement services.

The trust had a service level agreement with a local hospice for four band seven palliative, clinical nurse specialists who worked from Monday to Friday 8.30am to 4.30pm, excluding bank holidays. The trust employed three palliative medicine consultants. One consultant was based at Chesterfield Royal Hospital; the other two Consultants were based at a nearby hospice and, one specialist registrar who worked Monday to Friday 9am to 5pm, excluding bank holidays. There was also a rota of consultants and specialist registrars on call 24/7. These were shared with neighbouring organisations to provide telephone advice and in exception, face to face visits.

We visited eight wards where end of life care was provided, the bereavement centre, the chaplain and the mortuary. During our inspection we spoke with three patients, two relatives and 26 staff, including staff nurses, ward sisters, matrons, the specialist palliative care team, porters, a reverend, a junior doctor, a senior doctor, mortuary staff and the bereavement staff. We observed interactions between patients, their relatives and staff, considered the environment, and looked at 31 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and six medical and nursing care records. Before our inspection, we reviewed performance information from, and about, the hospital.

End of life care

Summary of findings

End of life services protected patients from avoidable harm and abuse. 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. We saw elements of good practice including the storage of patient identifiable information; clean clinical areas and good infection prevention and control practice.

While evidence based assessment, care and treatment were mostly in line with national guidance and quality standards, outcomes for end of life and palliative care patients were not always monitored. The trust was not always able to identify where improvements in the service were required. Specialist palliative care was provided under a service level agreement (SLA) that had expired. Training provided by the specialist palliative care team was not consistently accessed across the clinical areas with some staff receiving little or no training.

Patients were treated with dignity and respect, and were involved in their care. We found all staff to be compassionate and dedicated to providing good end of life care. However, we could not be assured staff had communicated effectively with those patients in the last days or hours of life in order to ensure their wishes, needs and preferences had been met.

Are end of life care services safe?

Good

Overall we found end of life services at this trust were safe. Patients were protected from avoidable harm and abuse.

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

Arrangements to minimise risks to patients were in place with measures to prevent falls, malnutrition and pressure ulcers and the early identification of a deteriorating patient through the use of an early warning system. We saw elements of good practice including the storage of patient identifiable information; clean clinical areas and good infection prevention and control practice. However, we were concerned about the storage of patient property in the bereavement office.

Incidents

- Incidents were reported through the trust's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. However nursing staff told us there were very few reported incidents relating to end of life care and could not recall the last time they had raised an incident.
- The mortuary staff had raised ten patient safety incidents between August 2014 and March 2015. One incident, involving tissue damage to a deceased body, had been reported to the Human Tissue Authority. The HTA is a regulator set up in 2005 to regulate organisations that remove, store and use human tissue. We saw where a root cause analysis investigation was in progress following this incident. Mortuary staff told us this was an isolated incident and if learning was identified this would be shared amongst the mortuary team through email and team meetings. Following this incident we were told the relative of the deceased had been contacted, an explanation was given in addition to an apology on behalf of the trust.

Cleanliness, infection control and hygiene

End of life care

- Mortuary staff were aware of procedures for the management, storage and disposal of clinical waste, environmental cleanliness and prevention of healthcare acquired infection guidance. We observed staff using personal protective equipment appropriately.
- The trust had a policy for dealing with the body of a patient who had been or was suspected of suffering from an infectious disease. Nursing and porter staff were aware of this policy and followed procedures to ensure their protection when having contact with the deceased patient's body. This included the use of personal protective equipment when dealing with the body and, the use of a body bag for the storage and transportation of the deceased patient.
- As part of the last offices procedure, (the process involved when preparing the body for transfer to the mortuary), nursing staff would complete a 'last offices checklist'. Information contained within the checklist would alert any member of staff, dealing with a deceased patient, to a possible infection.
- Bereavement services raised concerns with us regarding the storage of patient property following a patient's death. Currently, the bereavement officers would collect patients' property from the relevant wards in preparation for meeting with the relatives. We saw where this property was stored in a cabinet in the bereavement office. Bereavement officers told us the cabinet would often be full and property would 'overspill' onto the office floor. Frequently property bags contained soiled items of clothing or bags could not be sealed properly due to larger items such as walking sticks. Soiled property created an unpleasant odour and at times this meant windows and doors had to be kept open. If relatives requested an item from the property, for example, house keys, the bereavement officers would have to retrieve these from amongst the other property. Trust policy required patient property that was soiled or infected, to be put into a disposable laundry bag before putting into another bag. Bereavement officers told us this was rarely the case nor were they informed when the patient had a known infection.

Environment and equipment

- The trust used syringe pumps for end of life patients who required a continuous infusion to control their pain. Syringe driver equipment met the requirements of the Medicines & Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication, because the syringe drivers used were tamperproof and had the recommended alarm features.

Medicines

- We reviewed six medical and nursing case notes of those patients identified as being in the last hours or days of life. We saw where anticipatory medications, medications prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea and vomiting and breathlessness), were prescribed appropriately.

Records

- Management of medical notes had been identified as a high risk on the divisional risk register, with a large quantity of patient medical records insecurely stored and unsupervised. During our inspection we saw where medical notes for end of life patients were stored securely in lockable cabinets.
- We reviewed the medical and nursing notes for six patients who were receiving end of life care. Notes were accurate, complete, legible and up to date.

Safeguarding

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. Most staff were aware of who the safeguarding lead for the trust was. None of the staff we spoke with could recall a recent safeguarding incident regarding an end of life care patient.

Assessing and responding to patient risk

- We reviewed the nursing notes of six patients identified as being in the last hours or days of life. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools. For example, the risk of developing pressure damage was assessed using the Waterlow Scale. Risk assessments for patients were completed appropriately and reviewed at the required frequency to minimise risk.

End of life care

- Staff used an early warning system to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores were used to monitor patients and initiated calls to the emergency medical team when required.

Nursing staffing

- There were no dedicated 'end of life' beds at the trust. Patients requiring end of life care were nursed on general medical and surgical wards. Many staff we spoke with, on these wards, told us of periods of understaffing especially at night. However, staff told us they would give priority to the care of those patients in the last hours or days of life.
- At the time of our inspection, there were no link nurses for end of life care on any of the wards we inspected. Link nurses could share relevant end of life information and enable two-way communication between the specialist teams and nurses in the clinical area. All the staff we spoke with, both nursing and medical, felt it would be useful to have an end of life link nurse on the clinical areas to increase awareness of end of life and palliative care. On one ward the matron told us they planned to induct a band six ward sister into the role of end of life champion in order to provide support and training in end of life care.

Medical staffing

- Three palliative care consultants and, a specialist registrar were available Monday to Friday, 9am to 5pm. There was also a rota of consultants and specialist registrars on call 24 hours a day, seven days a week. This rota was shared with neighbouring organisations to provide telephone advice and face to face visits where required.
- Nursing and medical staff told us they had good access to medical support Monday to Friday, and indicated there was a strong presence by the palliative care consultant. However, some nursing staff told us it was, at times, difficult to contact a doctor out of hours.

Mandatory training

- End of life/palliative care training was not included as part of the trust's mandatory training programme. However the end of life lead for the trust told us there were plans for training to be included in the trust corporate induction and essential training programme and this would be delivered across all staff groups. We saw where this action had been identified in the trust National Care of the Dying Audit action plan with a completion date of March 2015. However, from the information received from the trust following our inspection we could not see where this training had been included in the corporate induction and essential training programme.
- The plan was that end of life corporate and essential training would be delivered via e-learning but due to delays with the development of the trust e-learning platform they were still in the development stage of the programme. The original implementation date was March 2015 but the trust now anticipated there would be a further four month delay before this was live.

Major incident awareness and training

- The trust had a major incident plan which was supported by individual action cards and specific, linked contingency plans. Whilst the trust was not a designated disaster mortuary (DDM) the use of the mortuary was identified in the trust major incident plan. Mortuary staff told us were there a significant increase in the mortality rate of the victims from an incident who were being treated within the hospital, the on call mortuary technician would have to request for the provision of a response/resilience storage area. This would be a temporary holding area prior to the deceased being moved to the DDM.
- Chaplaincy services alongside the trust bereavement officers had also been identified in the trust's major incident plan.

Are end of life care services effective?

Requires improvement

End of life care at this trust required improvement. Patients were at risk of not always receiving effective care and treatment.

Outcomes for end of life and palliative care patients were not always monitored and as such the trust was unable to identify where improvements in the service may be required. Training in end of life care was not consistent across the clinical areas with some staff receiving little or no training

End of life care

Whilst most staff reported a good access to specialist palliative care, the team were not available 24/7. Where additional support and guidance were needed this would be via an 'on-call' rota of medical staff and not always be face to face. Local audits demonstrated poor compliance with the implementation of the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders. Of the forms we sampled we found that nearly 20% were not fully completed.

In response to the 2013 review of the Liverpool Care Pathway (LCP) the trust had developed a number of resources that guided and supported staff to care for patients, and those close to them, at the end of life. Evidence based assessment, care and treatment were mostly delivered in line with national guidance and NICE quality standards.

Evidence-based care and treatment

- End of life care at this trust mostly followed the National Institute for Health and Care Excellence (NICE) Quality Standard relating to best practice in end of life care for adults. Where the service was not meeting the guidelines we saw where the trust had identified this in their three year end of life care strategy. For example, statement 10: People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night. The trust had identified this as a shortfall and plans were in place to work with commissioners and a local hospice to establish a seven day service for end of life patients.
- A review of six medical and nursing records showed symptom control for end of life patients had been managed in accordance with the relevant NICE Quality Standard. This defines clinical best practice for the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- In response to the trust's performance in the National Care of the Dying Audit May 2014 the trust had developed an action plan with 17 actions identified. We reviewed the action plan and found 11 actions had been completed by March 2015. Where actions had not been completed for example, end of life corporate and essential training, a plan was in place with an expected completion date of four months.
- Between April and December 2014, 877 patients had been referred to the specialist palliative care team. Of these, three quarters had a cancer diagnosis. Our discussions with the palliative care team and trust lead for end of life care suggested, despite good relationships with all ward teams and consultants, those patients with a non-cancer diagnosis were often not identified as requiring end of life and palliative care support.
- The trust did not audit the percentage of patients seen by the palliative care team within 24 hours. Information received before our inspection stated that urgent cases were seen the same day and non-urgent within 48 hours of referral. Nursing staff we spoke with said most patients were seen by the palliative care team in a timely manner. We reviewed six patient case notes and saw, in five out of six cases the patient had been seen the same day as referral and, the sixth patient had been seen within 48 hours.

Care plans and pathways

- The trust had taken action in response to the 2013 review of the Liverpool Care Pathway (LCP). The trust had developed a number of resources that guided and supported staff to care for patients, and those close to them, at the end of life. A 'care of the patient in the last days of life' policy was also available to staff. This policy described how the trust would deliver care and treatment to patients in the last days of their life and was in line with the recommendations published by the Leadership Alliance for the Care of Dying People (2014).
- Dedicated 'last days of life' (LaDOL) care plans for patients believed to be dying, were used to communicate care and treatment. We looked at six LaDOL care plans during our inspection. Care plans were patient centred and included essential care such as; hygiene, symptom management, nutrition and hydration and communication.
- For guidance and support each clinical area had an end of life resource folder. This included guidance for completing relevant end of life documentation, communication and recognising dying. Nursing staff told us they found this folder useful.

Pain relief

- Local audits to assess the effectiveness of treating and managing pain were not undertaken by the trust. However results from the National Care of the Dying

Audit 2014 demonstrated where the trust had achieved the organisational key performance indicator 5: Clinical protocols for the prescription of medications for the five key symptoms at the end of life.

- As part of the trust's 'recently bereaved' questionnaire family and friends were asked how they felt about the overall support given to their friend or relative with regards to pain relief. Results from the August to November 2014 survey showed 83% of family and friends felt the support was either good or excellent. The remaining 17% responded as 'does not apply/don't know'.
- We spoke with three patients who had been identified as being in the last 12 months of their life. All three patients told us their pain had been managed appropriately by the medical and nursing staff.

Nutrition and hydration

- The trust had participated in the National Care of the Dying Audit (May 2014). The results showed that the trust performed better than the England average for; assessing the patient's ability to take oral nutrition, following recognition that the patient was expected to die in the coming hours or days (73% compared to the England average of 59%) and; worse than the England average for assessing the patient's need for clinically assisted (artificial) nutrition (CAN), following recognition that the patient was expected to die in the coming hours or days (32% compared to the England average of 45%).
- We saw where the trust had identified; assessing the patient's need for CAN within their National Care of the Dying Audit action plan and wards now had an end of life resource file that included information and guidance on CAN.
- We reviewed six nursing records for patients in the last days of life. We saw that patients were screened for malnutrition and the risk of malnutrition on admission to hospital using the malnutrition universal screening tool (MUST). Where interventions were required we saw these documented on the last days of life patient daily record.

Patient outcomes

- The trust had taken part in the National Care of the Dying Audit May 2014. The Trust performed better or the same as the England average for six out of the seven organisational key performance indicators (KPI) and, better than the England average for six out of ten clinical indicators. The Trust scored particularly well for KPI 10: a review of the care after death (98% compared to England average of 59%) and KPI 2: professional's discussion with the patient and their relative/friends regarding their recognition that the patient is dying (85% compared to England average of 75%).
- During our inspection we found the trust was not contributing data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set. By examining the data trusts can identify unmet need and develop services to support robust palliative and end of life care. We discussed this with the named member of the trust board responsible for end of life care who told us data for the MDS was usually submitted by a local hospice. However, due to information technology issues data had not been submitted for 2013/14. These issues had now been resolved and data for 2014/15 had been submitted..

Competent staff

- Most nursing staff told us they had received training to enable them to safely administer medications via an ambulatory syringe driver. This was a new piece of equipment and staff had only undertaken the training in the past 12 months. Date supplied following our inspection demonstrated that 66 staff had completed this training by 23 April 2015. The specialist palliative care team provided 'point of care' education to individual ward based staff on an ongoing basis, during visits to see their patients. Ad hoc informal training was also provided on request. In addition, a member of the palliative care nursing team was seconded into an end of life education role, funded by the trust, for one day per week to provide training to larger staff groups.
- Porters did not receive training around palliative and end of life care. We discussed this with the end of life lead nurse for the trust who told us there were plans to include this in the trust corporate Induction and

essential training. We spoke with two porters. Both felt end of life training would be useful especially for the younger, newly appointed staff who may not have had any experience of end of life patients either through work or in their personal lives.

- Some nursing staff in the clinical areas told us they had received ad hoc training around palliative and end of life care. This was provided at ward level by the specialist palliative care team. However, four band five staff nurses told us they had received no end of life training since working at the trust.
- On one ward, nursing staff told us they cared for a large proportion of patients who were either in the last 12 months or last days of life. The ward matron told us it was important therefore, that staff were competent to deliver care to those patients. We saw from the ward training records where 11 out of 30 registered nurses had completed a post registration course in palliative care.
- The specialist palliative care, nursing and medical team provided end of life care training sessions for junior doctors at induction and as part of their ongoing training programme. Most medical staff we spoke with told us they had received some end of life training during their induction to the trust however, felt there was a need for additional ongoing training.

Multidisciplinary working

- All patients known to palliative care services were identified using an alert system. This meant that palliative care services were able to respond very quickly once a patient arrived at the hospital. However, not all staff were able to access this system. The trust did not have a robust process in place to record and share patients' care preferences and key details about their care at the end of their life. A scheme designed by an out of hours GP service, commissioned by the surrounding counties, allowed staff working in the emergency department and emergency medical unit to view patient wishes, preferences and plans of care. The specialist palliative care team visited the emergency management unit (EMU) daily Monday to Friday, to identify new patients and those already known to the team.
- End of life patients on the ward areas could be referred at any time to the specialist palliative care team (SPCT). Nursing staff told us this was commonly on ward rounds; at multidisciplinary team meetings and via other specialist nurses.
- During our inspection we observed a ward multidisciplinary team (MDT) meeting. This included the matron, the ward sister, the patients named nurse, a physiotherapist and the patient's doctor. We saw where each patient's condition and progress was discussed including mental capacity, best interest decisions and deprivation of liberty safeguards. Where an end of life patient had been identified the MDT discussed what communication had already taken place with the patient and/or their relatives.
- Following a peer review of the colorectal cancer service in 2013/14 as part of the NHS England national peer review programme, the reviewers highlighted there was excellent specialist palliative care support and engagement with the multidisciplinary team. The national peer review programme is a quality assurance programme that is aimed at reviewing clinical teams and services to determine their compliance against national measures, as well as the assessment of quality aspects of clinical care and treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed six medical and nursing records of patients in the last days of life. We saw consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. Patients were supported to make decisions and where appropriate, their mental capacity was mostly assessed and recorded.
- We saw one patient receiving end of life care whilst being deprived of their liberty. We saw that the deprivation of liberty safeguards and orders by the court of protection authorising deprivation of a person's liberty were used appropriately.
- Patients admitted to adult wards at the trust who were deemed to be at risk of cardiac arrest were assessed within 24 hours of admission. Where a decision was taken that a 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) order was appropriate then a DNACPR form was completed and placed at the front of the patient records. A trust wide audit of DNACPR forms

End of life care

dated January 2015 showed the percentage of forms that were complete was 10% (n=12/123) compared with 52% (n=40/77) of cases in in September 2014 and 62% (n=48/77) of cases in June 2014. Fifty nine percent of patients were deemed not to have capacity to contribute to the decision regarding DNACPR but of these only 24% of forms showed evidence that a capacity assessment had been completed.

- During our inspection we reviewed 31 DNACPR forms across ten clinical areas. Our review showed 25 out of 31 DNACPR forms had been fully completed and included an assessment of the patient's capacity to consent to the DNACPR where required. Approximately 20% of the forms we looked at were incomplete. They did not indicate where discussion had taken place with the patient and did not contain mental capacity assessments where a patient was recorded as lacking capacity to consent.

Seven-day services

- The specialist palliative care nursing team were employed by a local hospice and worked for the trust under a service level agreement (SLA). The nursing team provided advice and face to face visits Monday to Friday, 8.30am to 4.30pm.
- Bereavement services were open Monday and Tuesday 9am to 4pm, Wednesday 9am to 3.30pm and, Thursday and Friday 9am to 3pm.
- The Mortuary was staffed from 8am to 4pm Monday to Friday, excluding bank holidays. An out of hours service was available for cases under investigation by the Police/Home Office, special preparation of bodies for identification purposes and tissue retrievals.
- Porters provided out of hours cover for viewing arrangements, which was normally from 4 to 8pm Monday to Friday, all day Saturday, Sunday and during bank holidays.
- The mortuary provided a service to both the hospital and the local Coroner and acted as the public mortuary for North East Derbyshire.

Are end of life care services caring?

Good

End of life services at this trust were caring. Patients were supported, treated with dignity and respect, and were involved in their care. All the patients and relatives we talked with spoke positively about the care they had received.

Compassionate care

- We spoke with three patients and two relatives during our inspection. Feedback was continually positive about the way staff treated patients receiving end of life care. One visitor told us their relative was being well looked after and they could not fault the care being delivered. Another patient, identified as being in the last 12 months of life, told us staff had ensured they were able to have a side room. This had been particularly helpful because the patient had visual problems and needed to spend their time in a darkened room.
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Medical and nursing staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- In order to improve the services for patients in their last days of life and their friends and/or relatives, questionnaires were handed out to recently bereaved friends and relatives to ask them a number of questions about their experience and that of their loved one. The trust's latest results dated August to November 2014 were mostly positive with 85% of family and friends responding that their friend or relative was always treated with respect and dignity by hospital doctors and nurses.
- Mortuary services demonstrated an understanding and respect of patients' cultural and religious needs. We saw where there were facilities within the mortuary for washing the body for religious and cultural reasons. Mortuary staff also told us that relatives of the deceased were given the opportunity to dress the body if they had requested to do so.

End of life care

- In order to preserve the dignity and confidentiality of deceased bariatric patients, these patients were transported to the mortuary on their beds. Once prepared for collection by the nursing staff, the body was covered by another sheet draped over the bed.
- The bereavement service supported the trust to provide a sensitive and specialised service when a patient died. The bereavement service were involved in the immediate period following death and provided practical help and information to deceased relatives. In addition, the bereavement service officers supported the process to obtain consent for a hospital post mortem examination.

Patient understanding and involvement

- The trust had participated in the National Care of the Dying Audit in May 2014. The results showed that the trust was identified as being better than the national average in relation to health professional's discussions with both the patient and their relatives/friends regarding their recognition that the patient was dying. The survey also identified the trust as being significantly better than the national average for communication regarding the patient's plan of care for the dying phase.
- As part of the trust's 'recently bereaved' questionnaire dated August to November 2014, 85% of family and friends said they felt they and the patient were involved in decisions about their loved one's care as much as they wanted to be.
- We spoke with three patients during our inspection. All had been identified as being in the last 12 months of their life. All three patients spoke positively about the care they had received at the trust. They felt staff had explained their care and treatment to them in a way they could understand.
- Where relatives were present at the time of death the ward staff would explain that the bereavement service would contact them the next working day. Ward staff would also provide them with a hospital information leaflet 'What to do after a death?' and a card detailing the contact information for the bereavement service.

Emotional support

- Ward, nursing and medical teams offered emotional support in addition to the palliative care team. The trust also had a chaplaincy service and a clinical psychologist, if required. Support for carers, family and friends were provided by the chaplaincy and bereavement services.
- We spoke with two relatives and three patients during our inspection. All the people we spoke with told us they felt emotionally supported by all the staff involved in their care.
- The viewing of deceased patients was carried out in the viewing room of the mortuary. Arrangements for the viewing were made directly with the mortuary staff by the ward or department staff concerned. This ensured that a time could be agreed for the viewing to take place. Mortuary staff told us every effort was made to ensure the viewing room was arranged sensitively. We saw where the viewing room was non-denominational and did not have any religious articles.
- During normal working hours viewings took place between the hours of 11am and 3pm. This allowed time for the morning post mortem examinations to take place. The viewing room was not sound proof and noises from the fridge room and post mortem room may be heard. Mortuary staff told us it was possible to make ad-hoc viewing arrangement with relatives and if relatives arrived unannounced they would be treated sympathetically and every effort would be made to facilitate the viewing of the deceased.

Are end of life care services responsive?

Requires improvement

Overall we rated the responsiveness of the service to require improvement.

End of life care was not always responsive to patient's needs. The identification of patients in the last hours or days of life needed development. Staff were not demonstrating how they were having discussions with patients or their family about their priorities for their care. The trust did not audit 'preferred place of care' or 'preferred place of death'. There was a fast track' discharge policy in place but it did not specify how soon patients should be discharged to their preferred place of care or death. 'fast track' discharges usually took up to 48 hours to arrange.

End of life care

There was not auditing of the length of time patients were waiting for a 'fast track' discharge and were unable therefore, to identify and address potential delays in the process.

Service planning and delivery to meet the needs of local people

- There were no dedicated end of life beds at the trust; we were told the trust worked closely with an independent registered hospice that ensured end of life care support was available 24 hours a day.
- All the nursing staff we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. On the emergency management unit (EMU) the sister told us of occasions where a bay would be 'closed off' and used to accommodate a patient in the last hours of life and their family, although this was not always possible and dependent upon the patient capacity on the unit. A visitor told us they had been offered a side room for their relative but had declined.
- Facilities were available for relatives to stay close by. Relatives were offered the use of a relatives' room however, most nursing staff told us, where patients were nursed in a side room, relatives were able to stay in the room with them and folded beds were available for the relatives comfort.
- Nursing staff told us there were no visiting time restrictions for family and friends visiting a patient in the last days or hours of life. This allowed family and friends un-limited time with the patient.

Access and flow

- The trust used a form called 'Recognising dying' to identify patients who may be in the last hours or days of life. Guidance to support the completion of this document suggested the health professional discuss the patient's priorities for their care with the patient and/or their family. For example, where their preferred place of death was. We looked at five 'recognising dying' forms for patients who had been recognised as dying, but this information was not documented.
- The trust did not audit 'preferred place of care' or 'preferred place of death'. We discussed this with the end of life lead nurse for the trust who told us they were aware this information was not consistently documented as part of the patient's plan of care and that 'preferred place of care/death' was on the trust audit plan for 2015/16.
- As part of the trust's 'recently bereaved' questionnaire family and friends were asked if their friend or relative ever stated where they would have liked to die; only 17% of family and friends responded that their relative stated where they would like to die.

Discharge and transfer

- For those patients with a rapidly deteriorating condition and likely to be entering the terminal phase of their illness the trust had a 'fast track' discharge policy. This facilitated a rapid discharge where possible, for patients who had identified their preferred place of care. The 'fast track' policy did not specify how soon patients should be discharged to their preferred place of care or death. Nursing staff told us 'fast track' discharges usually took up to 48 hours to arrange. Where delays in discharge had been identified staff told us this was largely due to the patient's locality and obtaining equipment. The trust did not audit the length of time patients were waiting for a 'fast track' discharge and were unable therefore, to identify and address potential delays in the process.
- The trust had an 'older person's team'. This was made up of a matron and four registered nurses. The team saw all patients over the age of 75 and facilitated complex discharges. Nursing staff on the EMU told us the team were frequently involved in the complex discharges of palliative care patients and more commonly those patients with a non-cancer diagnosis.

Meeting people's individual needs

- Bereavement packs included written information for bereaved family and friends and were available through the bereavement service. However, staff were unable to tell us if this information could be translated for people whose first language was not English.
- The trust had participated in the National Care of the Dying Audit (May 2014). The results showed that the trust was identified as performing significantly better than the national average (63% compared to national average of 21%) in relation to discussions with patients

regarding their spiritual needs and, (55% compared to national average of 23%) in relation to discussions with the nominated relative/friend regarding the patient's spiritual needs.

- A chaplain was available within end of life services to ensure that the spiritual needs of dying patients and those close to them were met. The chaplain told us they had facilities to provide emergency marriages within the trust and told us of a marriage they had conducted recently at the patient's bedside.
- We found the chaplaincy service to be responsive to patients and relative's needs. The chaplain told us relatives were encouraged to submit prayer requests through the chapel. Where possible the chaplain, through the information contained within the prayer request, was able to determine the location of the individual patient and visit to offer support to the patient and their family.
- We visited the chapel of rest during our inspection. Although it was non-denominational religious articles were available depending on the individual's religious beliefs.

Learning from complaints and concerns

- Staff told us there had been very few complaints relating to end of life care services. Information received from the trust following our inspection showed there were five complaints currently under investigation relating to end of life care. These had been received by the trust in the three months preceding our inspection. Three related to poor communication and the remaining two related to the clinical care delivered.
- We discussed complaints with the lead nurse for end of life care. They told us they were keen to learn from complaints and gave an example where a complaint was taken to the trust board of directors' public meeting in November 2014. We were also told where several actions were taken following this complaint. Actions included; the bereaved family meeting with the ward staff to discuss the family's perception of the staffs' attitude towards them during the last days of their relatives life, and the effect this had had on them; amending the last days of life policy to ensure that communication with the coroner was made in a timely manner and using this complaint as an educational tool for end of life staff training.

Are end of life care services well-led?

Requires improvement

Overall we rated the leadership of the service to require improvement.

There was a three-year strategy outlining the trust's plans to improve care and services in end of life care led by a named member of the trust board. However, this had not been widely communicated across staff groups and we found there were very few audits and quality measures in place to monitor the effectiveness of this strategy.

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.

Vision and strategy for this service

- The trust had an end of life strategy for 2015 to 2018. The strategy outlined the trust's plans to improve care and services in end of life care and reflected the trust's 'proud to care values' of compassion, achievement, respect and environment. The end of life strategy had well–defined objectives that aligned to the 'five priorities for care of the dying person' as recommended by the Leadership Alliance (2014).
- The trust had an end of life strategy group, where key members of the service met quarterly to discuss issues and developments around end of life care. There was a multidisciplinary attendance at these meetings including; the end of life lead nurse, a senior matron, the palliative care consultant, specialist palliative care nurses from the local hospice, the dementia care matron and the clinical skills matron. Minutes from these meetings demonstrated where 'standing' items were discussed. For example, DNACPR forms, the end of life strategy and policy, complaints and the bereavement questionnaire results.
- Whilst most staff we spoke with were unaware of the trusts 'proud to care' values and behaviours, we did see where staff demonstrated the trust values and behaviours through their practice. All the staff we spoke with were passionate and committed to ensuring end of life patients received the care and treatment they needed.

End of life care

Governance, risk management and quality measurement

- The quality, risks and performance issues within end of life care were monitored through the medicine and emergency care division governance framework.
- We identified two risks on the risk register relating to end of life care; the end of life care strategy was rated as a moderate risk. The end of life strategy had not been widely communicated across the trust. The trust therefore, could not give assurance that staff and stakeholders had sufficient understanding to support the delivery of the trust's end of life care objectives.

Leadership of service

- There was a lead executive director for end of life care. There was strong leadership and vision for the service. However, whilst improvements had clearly been made and a strategy developed, there was little evidence that the quality of care was being effectively monitored.
- All the staff we spoke with were aware of the various support mechanisms available to deliver good end of life care and gave examples of the specialist palliative care team, chaplaincy, the mortuary and bereavement services and the porter service. Most medical and nursing staff we spoke with were aware of the end of life lead for the trust and could recall recent visits, by them, to their clinical areas.

Culture within the service

- Most staff told us they loved working at the trust. They felt there was good training opportunities and career progression. One member of staff said: "it's a privilege to work here".
- Throughout all areas delivering end of life care, staff consistently told us of their commitment to provide safe and caring services. Overall we saw good morale amongst staff and staff spoke positively about the care they delivered. Generally staff felt listened to and involved in changes within the trust.

Public and staff engagement

- In order to improve the services the trust provided to patients in their last days of life and their friends and/or relatives, questionnaires were handed out to recently bereaved friends and relatives to ask them a number of questions about their experience and that of their loved one. A palliative care nurse told us a formal action plan would be drawn up every 6 months; the next was due to be developed by 21 May 2015 and would be a topic on the trust's next end of life care strategy meeting. Also, as an interim measure, key points from the survey results were fed back to ward matrons and were discussed at the professional standards group in February 2015.

Innovation, improvement and sustainability

- The specialist palliative care team and trust end of life lead acknowledged that there was a lot of work to be done to improve end of life care services throughout the trust. We saw where significant progress had been made following the care of the dying audit (2014) however; there were very few audits and quality measures in place to monitor the effectiveness of end of life care in order to benchmark against end of life services nationally.
- In each clinical area we saw where staff had access to a palliative care resource folder. This provided staff with support and guidance when providing end of life care.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients services at Chesterfield Royal Hospital consisted of eight outpatient suites covering a wide range of specialities including audiology, general surgery, urology, ear nose & throat (ENT), maxillofacial surgery and orthodontics, dermatology, medical outpatients, physiotherapy, pain management, orthopaedics and ophthalmology. The trust's services were split between four divisions - clinical specialist services, medicine and emergency care, surgical specialties and women and children's services. Most outpatient services fell within the surgical division.

There was a reception area at the main entrance of the hospital for outpatient suites one to four. Patients for the remaining clinics such as audiology, urology, general surgical outpatients, ENT, maxillofacial, orthodontics, dermatology and medical outpatients were checked in at the clinics own individual reception areas.

Ophthalmic clinics were situated within the eye centre which had its own reception. The majority of outpatient services were only available Monday to Friday with a variety of clinic times. However, there were some evening and Saturday clinics to meet demand, such as ophthalmic services.

The diagnostic imaging services included routine x-rays, magnetic resonance imaging (MRI), nuclear radiology, computerised tomography (CT), ultrasound scans and breast imaging service. Diagnostic imaging services were available seven days a week. The trust had a total of 243,498 appointments between July 2013 and June 2014.

As part of our inspection we visited all outpatient suites and the medical records department. We observed patients' care and their treatment and spoke with 28 patients, eight relatives and 73 staff. These included senior and junior medical staff, nursing staff (registered and non-registered), managers, physiotherapists, pharmacists, radiographers and domestic staff. We also reviewed performance information provided by the hospital.

Outpatients and diagnostic imaging

Summary of findings

Staff reported patient safety incidents and there was evidence of learning from incidents and patient complaints. However, feedback following incidents was not consistent across all areas. There was limited risk assessment in the individual areas, and resuscitation trolleys were not consistently checked. Clinical waste in the eye centre was not disposed of securely to protect patients from possible risk of harm. Temperatures in areas where medicines were stored were not monitored consistently.

Once patients arrived at the hospital there was no measurement or recording of waiting times. The patient waiting areas were not attended by staff so patients could be in the wrong outpatient suite or would be unable to seek assistance if needed in an emergency. The dermatology clinic had low staffing levels and long waiting times for appointments. Furthermore, there were no protocols for clerical staff to follow when prioritising patients' test results.

Outpatient departments appeared visibly clean and staff used personal protective equipment, such as gloves and aprons. Patients care and treatment was delivered in line with current national standards and legislation. Outpatient services were delivered in a way that met the needs of the local population. Staff demonstrated a commitment to patient-centred care. Patients were treated with dignity and respect and spoke highly of the staff. Patient input and feedback was actively sought and several areas had established patient focus and support groups. In some areas space was limited. Certain areas within the imaging department did not have separate waiting areas for in patient and out patients and this led to potential issues with maintaining patients' privacy and dignity.

There were some areas that provided a proactive service to patients which included several one stop clinics providing efficient co-ordinated care. Clinical governance knowledge was limited within certain divisions of outpatients. At a local level staff felt supported by immediate line managers and clinicians. They felt listened to and able to raise concerns.

Are outpatient and diagnostic imaging services safe?

Requires improvement

Overall we rated the safety in the service to require improvement

Although patient safety incidents were reported, staff did not always receive feedback and information regarding lessons learnt and changes to practice. Clinical waste in the eye centre was not always managed safely and staff did not consistently check emergency equipment as required. Patients were directed to wait in outpatient areas without staff in attendance, which meant they were not always in the right location and were unable to seek assistance if needed. Temperature recording in areas where medicines were stored was not robust.

Medical records were readily available for outpatient clinics, but records were not securely stored in all areas. Staff adhered to policies in relation to infection control and endoscopic equipment was decontaminated in line with national guidance.

Incidents

- There was an electronic system for reporting patient safety incidents. Staff were aware of the process and how to report incidents. However staff reported that feedback was variable across the service, with staff in some areas stating that feedback did not occur or was unlikely. This meant that there was a potential risk that similar incidents could reoccur.
- There were changes to practice resulting from incidents within the eye centre. Lessons learnt were discussed and communicated at team meetings. An example of this was a recent incident involving a wrong patient identity number that had been entered into the ophthalmic imaging system. This was identified, reported and investigated and a standard operating procedure (SOP) was produced to reduce the risk of reoccurrence.
- There had been four serious incidents in diagnostic imaging reported between June 2014 and January 2015. Three related to diagnostic imaging, specifically CT scanning incidents and one related to slips, trips and falls. These incidents had been investigated and

reported appropriately including notification to external regulatory bodies where necessary. Staff were aware of learning which included plans to set up an alert on the system to highlight if a patient had received a recent x-ray. This would reduce the risk of overexposure from unnecessary repetition of a procedure. However this was not yet implemented and a timeframe was unspecified.

Cleanliness, infection control and hygiene

- The outpatient suites were visibly clean and uncluttered however there was a lack of senior nursing oversight of cleaning regimes. For example, when we asked when specific cleaning occurred and curtains were exchanged, several matrons at local level within the outpatients suites could not give details and told us the domestic supervisors were responsible for this.
- Staff adhered to trust policies and guidance on the use of personal protective equipment (PPE), and to 'bare below the elbow' guidance, so as to help prevent the spread of infection. There was adequate provision of gloves, aprons and visors throughout.
- Single use equipment was available and seen to be used and discarded within the clinical areas. Couches and equipment were wiped with disinfectant wipes between patients.
- Equipment was decontaminated in line with national guidance. Audit paperwork was fully completed to allow traceability.
- Clinical waste management was poor within the eye centre. There were information signs displayed for correct disposal of waste, but full clinical bags were not secured with identifiable cable ties. Clinical waste was removed by the domestic staff each day and placed into larger clinical waste bins which were then collected by porters. These containers were stored behind the eye centre building, an area which was easily accessible to the public. Furthermore, the containers were not locked to prevent potential risk of harm or contamination to the public.
- Within outpatient suite 6 the dirty utility room had some clean items, such as clean sharps boxes and Entonox, stored on the floor which meant there was an increased infection risk and potential safety risk to staff handling cylinders from the floor.

Environment and equipment

- Staff, within the outpatient areas, carried out daily checks of resuscitation trolleys and emergency equipment. However, these checks were not consistent across the various suites which meant that there was a risk that emergency equipment was not being maintained and safe for immediate use. Checks were also sporadic within diagnostic imaging with gaps occurring midweek as well as at a weekend. From the beginning of 2015, there were three days in January, March and April and six in February when checks had not been recorded. The defibrillator had been serviced, but there was no stated expiry date which meant that there was no assurance that service maintenance would take place at the correct time..
- All radiation premises had secure access. In MRI there were safety notices on the doors into the suite which stipulated safety measures such as restrictions with regard to loose metal.

Medicines

- The pharmacy service was situated in suite 1 and provided a seven day service for the trust. There was a partitioned area of two booths, to promote privacy, where pharmacy staff could give individual one to one medication advice to patients. Pharmacy also operated a bleep system, where patients were provided with a bleep to be contacted when prescriptions were ready.
- In the pain clinic, hospital prescription pads were held securely in a locked cupboard and handed out during clinic. However these were not logged in and out and therefore it could not be assured that all prescription pads were accounted for at the end of each clinic.
- In diagnostic imaging, the restocking and rotation of contrast medium, which is a substance used in radiography to improve the quality of an image, was undertaken twice a week by the housekeeping team. Stock was reviewed and in date. Amount and dose of contrast medium administered to patients was recorded onto the computerised information system.
- There was a dedicated radiopharmacy provision for nuclear medicine. The dispensing room was grade C standard which meant it was suitably designed to the expected level for preparation and dispensing, in accordance with the Ionising Radiations Regulations 1999 (IRR99) and the Medicines Act regarding safety of radiopharmaceuticals. Staff were monitored for levels of exposure via an approved finger dose monitoring system.

Outpatients and diagnostic imaging

Records

- Patient records were held within the onsite medical records library. Notes were prepared ahead of clinics and delivered to the suites the day before by medical records staff. There was a computer tracking system which could log patient records into and out of the medical records department however there was no system to book receipt of the notes within the outpatient suites. This meant there was not a complete tracking system when notes went missing.
- When patient records could not be found then temporary notes were provided and a comment was made on the tracking system for medical records staff to collate at a later point once original notes had been found.
- Management of medical notes was recorded as a high risk in the divisional risk register. Following an information governance check compliance issues were identified within one medical outpatients suite and one surgical outpatients suite with regard to medical records storage and supervision In the majority of outpatient areas we observed medical notes secured within locked cupboards. There were bespoke cupboards designed for storage of records within the eye centre.
- During clinic times the notes were with members of the nursing team or held within the clinic room. However in the pain clinic (outpatient suite 6) there were notes left within an unlocked office where patients had access to the corridor. In suite 4 the notes trolley was left open and unattended. We brought this to the attention of the nurses and the trolley was closed.
- The dermatology clinic was one area where workload and staffing had increased, without an increase in administration support. There was only one administrative member of staff who was supporting up to six consultants within that specialty. This had been raised with the immediate line manager however no action had been taken or feedback provided to the team.
- Clinical filing backlog had been identified as a high risk under the surgical specialties on the divisional risk register.

Safeguarding

- The Trust has a safeguarding policy available on the trust's intranet and staff confirmed that they had undergone safeguarding training. Data for outpatient and diagnostic imaging combined in the first quarter of the year, January - March 2015, showed that 20% of staff had completed the safeguarding children update. Seven percent had completed the adult safeguarding update. The trust target is 100% therefore an improvement to this training rate would be required to ensure all staff had completed by the end of the year.
- Staff, both in outpatients and diagnostic imaging, were able to explain clearly their role with regard to safeguarding and what actions they would to take to raise concerns for a vulnerable patient. There was an example given where a safeguarding referral was made by a member of staff to the appropriate authority and that local service provision was arranged to reduce safeguarding risks.
- The trust had a policy whereby chaperones were provided when requested or required. However this was not clearly embedded across the outpatient suites and there had not been any formal training regarding chaperoning. In some areas staff informed us that this was available if patients requested it, but was not actively promoted. Therefore we could not be assured that a chaperone would be provided to all patients who required one. One member of nursing staff stated that in dermatology a chaperone could not always be provided as at times there was only one nurse for the clinic.

Assessing and responding to patient risk

- There were waiting areas where patients could not be seen by any nursing staff which meant that if a patient's condition deteriorated this would not be recognised promptly. When nurses were assisting in clinics and doors were closed for consultation, patients were alone in the waiting areas. This was observed during inspection and patients stated that they "could sometimes be left for a long time".
- A call bell system was not available in any of the adult or children's waiting areas. The only way to summon assistance would be to shout or actively seek out a member of staff. This meant that there was an increased risk of a delay should a patient require urgent attention.
- When dermatology test results were received from the laboratory, they were triaged by clerical staff into urgent and non-urgent before being reviewed by the consultants. There had been no additional training given to enable non-clinical staff to understand or prioritise these results. Furthermore, there was no

written triage guidance provided for administration staff to undertake this. This meant there was a risk to patient safety should an urgent test result review be delayed if triaged incorrectly.

Nursing staffing

- There were sufficient nurse staffing levels in most areas with bank (temporary) staff utilised where necessary and staff turnover within the outpatient service was minimal. We reviewed the staffing rotas in medical and surgical outpatients for a three month period and saw that appropriate levels of staff were maintained.
- There were adequate nursing and allied health professional staff within the diagnostic imaging department.

Medical staffing

- There were sufficient numbers of medical staff to cover the outpatients' service. Most clinics were consultant led. There were some specialty clinics ran by specialist nurses such as haematology, dermatology, urology and ophthalmology.
- The haematology service was run by four consultants. The consultant workforce was in line with national guidance however there were no middle grade supporting staff which increased the consultant workload.
- There is a national recognition of a shortage of radiologists, and the Trust had entered into a split post arrangement with another provider to support vascular interventional radiology. Staff reported this was working well."

Major incident awareness and training

- The Trust had a major incident plan in place which included actions staff should take. There were hard copies of the incident plan within the individual outpatient suites, including the central radiographers' station in the clinical imaging department, with individual action cards for each department.
- Staff confirmed verbally that they were aware of the major incident procedure and when we asked, were able to find the information they needed, quickly.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not rate the effectives of the service.

Care and treatment were evidence based and followed recognised national guidance. There was evidence that regular audit took place within the diagnostic imaging department.

The number of patients seen as a follow up against the number of new patient's rate was similar to the England average from July 2013 to June 2014. Additional clinics, such as ophthalmology, were run at weekends when required to ensure that waiting lists were kept within national targets.

Patient outcomes were not monitored and it was difficult to determine who had oversight of the outpatient department generally to monitor and report on patient outcomes.

Staff training was encouraged and adapted to the requirements of the specific specialty and there were opportunities for further training. Annual staff appraisals were in place but were not consistent across all areas.

Evidence-based care and treatment

- Staff followed the National Institute for Health and Care Excellence (NICE) guidelines such as those for treatment of erectile dysfunction and prostate assessment. There had recently been a change in practice in response to recent guidance for prostatic cancer.
- There was a nominated clinical supervisor within urology and a nurse consultant also attended as a nurse advisor on the NICE panel for prostatic cancer. Patient outcomes for cancer patients were collected however there was little evidence of records of clinical outcomes for other patient groups.
- The urology service had links with hospitals in Sheffield and Derby as they were nominated as the tertiary (secondary referral) centres locally. Weekly video links were arranged during multi-disciplinary team (MDT) meetings to share information and training.
- The audiology service was provided across North Derbyshire from 13 sites and staff were proud of the service provided. During an ENT consultation the

audiometry results were available via the trust's intranet enabling the clinician to review them at the time of consultation and make a booking for operation, should it be required.

- Nursing staff informed us that the acupuncture service, which had consisted of four clinics a week with approximately sixty patients, had been discontinued. Staff believed that this had been a beneficial service to patients for pain relief but funding had been removed. There had been no audit as to the clinical effectiveness of acupuncture and those patients that had been receiving acupuncture previously had their treatment changed to medication to manage pain.
- IRMER guidelines (Ionising Radiation Medical Exposure Regulations 2000) were available on the Trust intranet and were reviewed every two years or in response to national update. These regulations ensure that the use of X-rays are in the patients best interest and give clear definition to those who refer, take or make a clinical decision that radiographs are required for diagnosis.
- There were trained radiation protection supervisors (RPS) in all modalities within imaging. They had regular weekly contact with the radiation protection advisor (RPA) based in a different NHS trust. Room dosage recordings were checked and recorded daily with more detailed checks occurring every seven weeks as part of a rolling programme which was within national guidelines.
- Staff were aware of the reporting thresholds for radiation dosage and the process for raising concerns and seeking advice. The department had active dose management processes in place including documented Dose Reference Levels (DRL) for all examinations. Any variation was discussed with the radiation protection advisor (RPA).
- Policies and procedures within the radiology department were up to date. There was a system in place to ensure these were maintained. Policies were noted to include, date of issue, date of last review and date of next review due with named person responsible.
- There was a list of referrers and permitted procedures held in the central radiology area. Requests were checked by radiographers and any procedures which required higher than average exposure levels were verified by radiologists. This provided assurance that requests for X-ray, CT, nuclear medicine or other radiation diagnostic tests were made in accordance with IRMER. The requests were checked by radiographers and any procedures which lay outside the written guidelines were discussed with radiologists.
- A number of audits took place within the radiology department. Examples of recent audit included the lead shields used to protect body areas. The audit looked at positioning and sizing of the shields for children. As a result the sizes were re-aged and the positioning diagram changed to ensure patient safety was maintained. A lumbar spine audit considered exposure factors and had resulted in changed settings which achieved a reduction in dose to the patient whilst maintaining image quality. Findings were presented at the team lunch time meetings.

Patient outcomes

- The number of patients seen as a follow up against the number of new patients' rate was similar to the England average from July 2013 to June 1014.
- It was difficult to determine the responsibility of the management team and who had oversight of the outpatient department generally to monitor and report on patient outcomes.

Competent staff

- Staff told us the trust strived to support staff in education and development. We saw local training organised specific to the requirements of the specialty, for example within urology staff had received bladder scanning training.
- One audiologist had received training and competence in Rational Immotive Behavioural Therapy (RIBT) which assists patients to accept hearing loss over a period of time.
- Within the eye centre there was a corporate and local induction for new staff with competencies to complete. One staff member was currently enrolled onto the Ophthalmic Science Vision Diploma which is a three year course. It was hoped that this would become available as modules so that more staff could access the learning.
- The nursing team in outpatient suite one had compiled a clinical information file as a tool for new staff and bank staff. This had information regarding the individual clinics in the area with useful contact numbers. Staff felt this was a valuable resource.

- Annual staff appraisal was not consistent across the outpatient service. Staff appraisal was monitored within each individual area but this varied across all areas. 34 out of 39 staff within the eye department had received an appraisal between January and March 2015, and all staff within outpatient suite 2, with the exception of 1 person on maternity leave, had received an appraisal in the last twelve months. However this was not the case in dermatology where one member of staff stated they had not received an appraisal for two years.

Seven-day services

- Most clinics took place during weekdays only, however Saturday clinics had just begun within the eye centre for patients with diabetic macular oedema and evening clinics for age related macular degeneration.
- Pharmacy provision was a seven day service with electronic prescriptions available for most clinics, dermatology being the exception.
- The imaging department provided seven day services in CT, MRI, Ultrasound and plain film.

Access to Information

- Throughout the outpatient suites there were patient information leaflets readily available within waiting areas and consulting rooms and these were kept stocked by the nursing team. Reordering of leaflets was undertaken by the patient information and support assistant for the Trust who provided support to all patients from diagnosis onwards.
- The orthodontist polyclinic within suite 2 had two screens at each patient chair which enabled clinicians to show visual images to patients and parents of "before" and "after" treatment. The system included an anonymised data base of over 5000 examples. Staff stated they felt that this enabled truly informed consent and facilitated a more active engagement with the patients for continuing adherence to treatment regimes.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff gained consent from patients before carrying out procedures. We saw consent for surgery being obtained during an ENT (Ear, Nose and Throat) consultation. The consent form was completed with an explanation of the procedure given by the consultant including benefits and potential risks. The form was then signed and dated by both the consultant and patient. This meant that the patient was fully informed and had the opportunity to ask questions and clarify any points prior to surgery. We reviewed three sets of notes where consent was completed appropriately; a stamp for informed consent was in use as a visual prompt and nurses were required to sign the stamp once consent had been gained. Several patients told us that they had received clear information prior and throughout their treatment.
- At the time of our inspection, the trust had not yet formalised its dementia strategy or policy which was identified as a high risk on the trust's risk register. Dementia awareness, communication and training was delivered on a Trust wide basis via corporate induction and the essential training programme and data showed 87.2% had completed "seeing the me" training.
- None of the suites were dementia friendly environments, for example all waiting areas and consulting room doors looked the same.
- The trust had a dual consent process in place for all interventional imaging procedures. The first part of the form is completed by the referring clinician. The second part and confirmation of consent is completed by the radiologist performing the procedure.
- Radiographers undertook patient safety checks prior to procedures. These included a three point patient identification check (name, date of birth and first line of address), patient understanding and awareness of procedure and a last menstrual period check for female patients. This was in accordance with local policy and IRMER (Ionising Radiation Medical Exposure Regulations 2000).
- The nominated Radiation Protection Advisor for the Trust liaised with the RPA at the Radiology Physics department at Sheffield Teaching Hospitals NHS Foundation Trust to ensure that paediatric protocols were in line with current practice.

Mandatory training

- Mandatory training for all staff included health and safety, fire safety, infection control, safeguarding children and adults, equality and diversity and information governance. This was delivered by face to face training, paper based and E learning.
- Mandatory training compliance was inconsistent across the services. In outpatient suite 1 & 2 information regarding staff compliance was readily available, local managers had oversight of staff status of training

compliance and staff attendance was planned. Elsewhere, such as the eye centre, this was not readily available at a local level and we were informed that human resources collated the information.
- Mandatory training data provided from the Trust was not broken down to individual outpatient suites. Data for 2014 for outpatient and diagnostic imaging combined showed that 94.4% of staff had completed essential mandatory training.

Diagnostic Imaging

- Staff appraisals within the radiology department included evidence of completed mandatory training. The clinical administrator maintained an appraisal and mandatory training list.

Are outpatient and diagnostic imaging services caring?

Good

Overall, we rated the care in the service to be good.

Patients were treated with compassion, dignity and respect. Services were patient centred meaning that patients were treated holistically rather than as a condition. Support from staff extended to help with welfare and disability benefits.

There were several areas within the outpatient service that had proactively established patient centred care such as the nationally recognised prostate cancer support group for men and the focus group for ophthalmic patients. There were some areas where the environment was not ideal leading to potential issues with maintaining a patient's privacy and dignity.

Compassionate care

- There were several teams within outpatients and diagnostic imaging services that provided patient centred care. Patients we spoke with said they were treated as an individual rather than a condition. These included the audiology department where the focus was on the patient as a whole and "not just a pair of ears" and the anticoagulant clinic where patients described the service as "outstanding". Staff had good rapport with the patients. One patient we spoke with used a wheelchair and said she felt respected and was "not talked down to". Staff made proper introductions, treated her as opposed to her condition and organised weekly appointments which were adaptable to her needs.
- Relatives and patients informed us that staff treated them with care and compassion. Nurses in the haematology clinic provided patients with hot and cold drinks whilst they were waiting.
- Patients stated that they were always asked before students were allowed to be present during appointments.
- Compliment cards were available within the eye centre for patients to complete. These were shared with the individual staff member concerned and displayed in the staff room. Patients in most outpatient suites were treated with dignity and respect.
- Details of conversations held within clinic rooms could not be overheard externally. A patient and relative told us, "privacy and dignity are respected like you wouldn't believe". The phlebotomy department had large cubicles giving privacy for patients, however, in dermatology, two patients were separated by curtains in a small room. This provided no privacy as both were talking about their problems which could be overheard.

Understanding and involvement of patients and those close to them

- Patients provided feedback by way of comment boxes and the friends and family test (FFT) surveys. Data from FFT in March 2015 showed that the percentage of patients that would recommend the services to family or friends was 97.7% for medical outpatients, 96.9% for surgical outpatients and 100% for pain clinic.
- The prostate cancer service was nurse led and had an active support group for men. The team had written a paper on the way of working they had devised, which was nationally known as the "Chesterfield Model". The clinic had received visits from both Macmillan cancer support and other hospital trusts from across the UK to find out more about the support group.
- Staff ran a patient focus group in the eye centre. This met quarterly and had six patient representatives who shared their experiences of the service. Minutes from these focus groups were displayed within the departments' communication folder and were also included in information used by the central governance team.

Outpatients and diagnostic imaging

- Patients within medical outpatients stated that they had the option to telephone the clinic directly for advice and that their questions were answered and explained well.
- The phlebotomy department was a small and organised unit with an ample waiting area, large cubicles giving privacy for patients, and minimal waiting times.

Emotional

- Within the outpatient suite one there was a quiet room available for private conversations with distressed patients.
- A patient information and support assistant provided a five day service that provided non-clinical support to patients. This encompassed information and support regarding diagnosis and cancer treatments but also extended to welfare information and support with disability entitlements such as benefits and "blue badge" provision. Information was available in various formats including written, visual and electronic for patients who may be unable to read and write.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Overall we rated the responsiveness of the service to require improvement.

Most clinics were only open during normal working hours, Monday to Friday, although some started earlier or ran later to be flexible for patients. Diagnostic imaging provide a seven day service and the eye centre run Saturday clinics. Managers in some outpatient suites did not manage their own clinic lists or have oversight of patient attendance levels. Staff did not monitor patients' waiting times once they had arrived at clinics and did not provide information for patients on how long they might have to wait. There were no reception desks in outpatient suites one to four. This was confusing for patients and they sometimes were waiting in the wrong area. Patient appointments were either booked by telephone or sent via letter and there were no opportunities to book by text or email, for example.

There were some areas that provided a proactive service to patients. These included several one stop clinics providing efficient co-ordinated care such as the Breast clinic, urology clinic, audiology clinic, the phlebotomy department and electronic prescribing in the majority of clinics, dermatology being the exception.

Service planning and delivery to meet the needs of local people

- At a local level, in each outpatient suite, activity figures were unknown. There were no regular meetings with performance and planning managers and no local ownership of the waiting lists. This meant there was no oversight of any impact to patients care and treatment. Most Matrons confirmed that they arranged additional clinics when they were informed by the performance management team that there was a requirement.
- There were several one stop services on offer across various specialties. These were where diagnosis and treatment took place at the same time if appropriate and improved efficiency and the patient experience. For example there was a urology one stop service for patients with prostate cancer with nurse led clinics starting at 7am and a one stop audiology clinic for patients with tinnitus.
- The pharmacy led anticoagulant clinic included an electronic prescribing system provided by pharmacists. All patients received a standard anticoagulation booklet in line with recognised best practice. For patient convenience repeat appointments were scheduled at each visit.
- The staff within the anticoagulant clinic had also produced an informative video for patients as an alternative information source.

Access and flow

- The trust's performance was similar to or better than the England average for referral to treatment time.
- The trust's performance was similar to or better than the England average for both the 31 and 62 day targets for referral to treatment.
- The trust's performance was similar to or better than the England average for 'did not attend' (DNA) rates.
- Most patients attending the phlebotomy service were 'drop in' patients without a pre booked appointment. There was a small number of booked patients and a limited GP service. The average wait was around five minutes; at very busy times this was extended to 20 minutes however patients and staff stated that this was very unusual.

Outpatients and diagnostic imaging

- Within the eye centre there were one stop clinics for people with cataracts and age related macular degeneration (AMD). Patients were seen by the nurses, their vision assessed and appropriate eye drops administered. They were then seen by the doctors. Patients with AMD received injections to treat their condition on the same day. Patients who were to undergo cataract surgery, had their consent obtained, were given information and an operation date was arranged prior to leaving.
- The availability of regular scheduled appointments for treatments within the eye centre was limited. The planning and performance team were notified regarding patients that could not be seen within the correct time frame. There was a rapid access clinic which only booked two weeks in advance and this was used at times when there was difficulty rebooking.
- Telephone appointments were standard with limited opportunity for alternative methods such as text or email. Within outpatient suite 5 administration staff were currently looking into actions that would help improve DNA rates. This included sending appointment letters rather than relying on telephone appointments. Staff had suggested a text message reminder service may be beneficial however they had been informed that the IT system would not support this.
- Waiting times for each clinic were generally displayed on white boards by the clinic staff. Staff stated that they would update the boards throughout the day and also verbally announce any delays to attempt to keep patients informed. However we were not assured that during busy periods this would be an effective method of keeping patients informed. Patient feedback was mixed; some told us they were kept informed of waiting times, whilst others stated that they weren't.
- Waiting time for appointments within the pain clinic was a concern for patients we spoke with. New patients had to wait for approximately 6 weeks for an appointment. There was a nine month wait for patients requiring a follow up. Appointments were allocated in ten minute sessions and patients told us they often waited up to 1.5 hours to be seen and then felt ten minutes was too short to discuss everything fully.
- There was a development plan in the pain management service. Staff had been involved with several ideas such as an administration mapping exercise to review the non-clinical service, review of clinic times to provide more patient choice and group sessions for patients. Staff were not able to tell us when these planned changes would start.
- The haematology service was overbooked. Space was limited with only three consulting rooms and a small waiting area. Staff informed us that at busy times there were up to 77 patients and "standing room only" in the waiting area. Appointments were allocated in ten minute sessions, with up to five patients allocated to the same time. This meant several patients were waiting to be seen at the same time. Subsequently this could have a detrimental effect for other clinics if patients had been sent for blood tests prior to consultation. There were plans for relocation to a new building which was planned to open in October 2016.
- The Mammography service had a system to track patients to provide efficient patient appointments within the national two week target. Patients suspected of having cancer received a one week follow up appointment with a surgeon. There was a system in place which gave patients the option to receive results via telephone. This was more convenient for the patients and reduced the need for an additional follow up appointment.
- There was a second CT scanner which was close to the emergency department enabling a quick transfer for emergency scans. The facility had separate waiting areas for in patient and out patients and separate reporting area which maintained patients' privacy and dignity.
- A recent significant demand for prostate MRI had led to pressures on the service, which had been identified on the risk register. The imaging and urology team had worked together to stratify the referral pathways enabling consistent service provision.

Meeting people's individual needs

- The trust had a reception in its main entrance area for outpatient suites one to four. There were no reception desks or formal meet and greet areas within these individual outpatient suites. This led to confusion for patients with them getting lost. Patients often had to seek out staff to ensure they were in the correct place. We observed three patients needing assistance within five minutes of arrival in outpatient suite 1. Patients

being seen in audiology, urology, general surgical outpatients, ENT, maxillofacial, orthodontics, dermatology and medical outpatients were checked in at the reception areas in the individual clinic.

- Each suite held numerous clinic specialties and had separate waiting areas for each of these however demarcation of this was not always clear. We were informed by nursing staff that during busy periods each area may need to merge, with for example urology patients sitting in the general surgery or audiology area which added to confusion for patients
- Chairs were all standard seating, which meant that some patients who were elderly, frail or had joint replacements were at risk of discomfort and difficulty with mobility.
- Within therapy services physiotherapy opening hours had been extended to provide more availability. Clinics ran until 6.30pm on a Monday and 6pm on a Tuesday. Joint appointments were also available for patients requiring physiotherapy and occupational therapy. This had a positive impact on waiting times for physiotherapy and occupational therapy. All were, at the time of our inspection, reporting a three week wait in comparison to some other clinics which had 4-6 week waits.
- The physiotherapy clinic provided a walking aid assessment and provision service for patients from the emergency department. This was a Monday to Friday service, during evenings and weekends this was undertaken by the emergency department staff who had been trained by physiotherapists.
- Access to audiology rooms for larger patients was identified as an issue. In response there was a contingency room in ENT that could be used for hearing treatments and could accommodate wheelchairs designed for larger patients. Within the eye centre the door from reception through into the waiting area, and most corridors were too narrow to allow access for a wider wheelchair.
- There was a range of interpreters available throughout the trust and an interpreter was prearranged where possible to attend appointments. There was also a telephone help line that staff could access to help with language communication problems.
- Children only clinics within dermatology occurred once a month, but children also attend the general clinic. There was no paediatric trained dermatology nurse within the department.
- The lack of a separate waiting area for outpatients and inpatients attending the ultrasound and CT2 departments was noted as a risk at local and trust level. Patients brought to the department in their hospital beds and in chairs had to be left in the waiting area in full view of other patients and visitors. Imaging staff liaised with ward staff and porters to facilitate timely arrival for in-patients. Wherever possible patients were brought to the department immediately before their appointment time to minimise distress and waiting times. To help maintain patients' privacy and dignity, staff ensured patients were fully covered with gowns and blankets.
- Nurse escorts were not always in attendance but the radiology department had some imaging assistants to accompany patients whilst in the department when required. Resources have been identified within the 2015/16 capital plan to address the waiting area issue within the departmental configuration.

Learning from complaints and concerns

- Feedback cards were available within the eye centre for patients to comment anonymously and these were then collected and collated each month by the matron. Changes had been made as a result. For example, it had been commented that there was no appropriate seating area for adolescents. This had been addressed with a sofa area in the second waiting area (sub wait 2) which provided a separate area with age appropriate information and magazines.
- In some outpatient departments white boards were used to convey, "You said, we listened," comments and actions undertaken. For example in medical outpatients a television had recently been ordered in response to patient feedback.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Overall, we rated the leadership in the outpatient service to require improvement. It was difficult to determine the

responsibility of the management team and who had oversight of the services to ensure national targets were met There was little knowledge, even amongst senior staff, of the number of cancelled clinics or the number of patients waiting to be seen. There was no robust management of risk within the outpatient services however there was within diagnostic imaging

Clinical leadership at a local level was good. Support and leadership was given with clinicians, matrons and senior staff working alongside junior staff. Staff in both outpatients and diagnostic imaging felt listened to and well supported by their immediate line managers. Staff were aware of the trust vision and values.

Vision and strategy for this service

- Staff we spoke with were aware of and understood the vision and values of the trust. Staff identified the "proud to care" initiative to look after patients and the six "c's" - care, compassion, competence, communication, commitment and courage, details of which were displayed within several outpatient suites. Nursing staff were clear about their role and behaviours that would achieve these values.

Governance, risk management and quality measurement

- The accountability for managing outpatients and their respective performance is delegated to the four clinically led divisions. The divisional director and their management teams have responsibility for oversight and management of performance for outpatient services within their clinical remit. The governance structure was clearly defined within the clinical specialist services division however clinical governance knowledge was limited within certain divisions of outpatients and staff we spoke to were unable to confirm the governance structure.
- There was no ownership of risk management within the various individual outpatient suites. For example staff verbally identified the lack of a reception area within the separate suites one to four as a risk but there had been no formal risk assessment completed and the issue was not on the trust risk register.
- Staff told us that non-clinical risk was picked up by the patient safety team however no evidence was seen to confirm this and no monitoring undertaken within each area which meant we could not be assured that there was a robust system in place to ensure risks were identified, reviewed and actions taken.
- Some nursing staff stated that results from complaints and outcomes from governance meeting were dealt with at a higher level and no feedback was received.
- It was difficult to determine the responsibility of the management team and who had oversight of the services to ensure national targets were met. Monthly integrated performance reports were in place at board level however we could not determine how the communication flowed from board to services at a local level.

For example, although booking office staff coded and recorded reasons for session cancellations, nursing and administrative staff did not know if these figures were analysed and who would take responsibility for this.

- There was a clear quality governance structure in place within the clinical specialist services division. At department level this encompassed radiology, pathology, pharmacy and therapies. This governance group met monthly and reported to the Quality governance board at divisional level which then subsequently reported to the quality delivery group and quality assurance committee.
- There was a comprehensive quality assurance system in place for testing of the equipment both within the department and externally such as mobile units and theatre equipment. Tests were conducted by a team of radiographers on a six weekly cycle using recognised methods (Sheffield test tool and dose meters). Yearly RPA reports were in place.

Leadership of service

- The senior team were visible within the service. We were informed that there was an executive walk about that occurred once a month and that both the chief executive and finance director had visited the outpatient departments. Staff were also aware that the chief executive had a blog which can be accessed online or via email.
- At a local level staff stated they were supported by their individual line managers. Managers had an open door policy in most of the outpatient suites and regular one to one meetings happened. Staff also felt very supported by the consultants.

Outpatients and diagnostic imaging

Culture within the service

- Staff informed us that they felt there was an open, supportive and transparent culture within the trust. Staff felt confident that they could raise concerns without fear of reprisal and were aware of the whistle blowing policy.

Public and staff engagement

- "Let's Talk Care" workshops had been attended by staff throughout the outpatients and diagnostic imaging services. Staff were positive about the experience but were largely unsure of what the next steps would be.

Innovation, improvement and sustainability

- One consultant within the Orthodontic service was due to chair the World Orthodontic conference. This was supported by the senior hospital management and the entire department (nine staff) were scheduled to attend alongside the consultant for the three day conference.
- Significant investment has been made by the trust to enter into a regional Picture Archive and Communication System (PACS) and Radiology Information System (RIS) as part of the East Midlands Radiology Project with a commencement date of May 2016. This collaborative project will provide the hardware infrastructure to support the delivery of regional radiology networking.

Outstanding practice and areas for improvement

Outstanding practice

- Staff in the x-ray department were able to view the electronic patient information screen held in the emergency department. This meant they knew when patients were awaiting x-ray and responded promptly, usually within 20 minutes of the request being entered into the system.
- Staff working for the local mental health trust which provides care for people with mental health problems, were able to view the electronic information screen held in the emergency department. This meant they knew when patients were awaiting review and responded promptly, usually within 60 minutes.
- Locum doctors working in the emergency department received quarterly reviews with an educational supervisor.
- The multidisciplinary huddle within the emergency department was informative and effective and valued by the team and wider trust staff.
- As a pilot fixed term project, a pharmacist worked in the department to support all aspects of medicines management. Data showed this was beneficial to patients and speeded up admission processes.
- The trust had a clear vision of how its clinical environments could be made dementia friendly. They had realised this vision in the refurbishment of the discharge lounge.
- Each clinical area had its own improvement plan . This meant ward matrons and their staff were clear about the various quality and safety improvement initiatives in progress, how they would be achieved, and how they were inter-related.
- The trust had reacted positively to audit data and had embarked on a local health and social care economy project to produce and implement a dementia and delirium patient treatment pathway. Manvers ward had introduced patient based communication folders which allowed written requests for information to be made and responded to within 24 hours.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital SHOULD take to improve

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person must ensure care and treatment is provided in a safe way. Ensure there is appropriate and timely monitoring of deteriorating patients within the HDU department. Ensure ward staff are supported to identify and manage very sick or deteriorating patients in ward areas.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person must ensure that care and treatment of service users must only be provided with the consent of relevant people. People who may lack capacity to make decisions about their care must have an adequate assessment of their mental capacity. Decisions about DNACPR must be taken in line with the requirements of the Mental Capacity Act (2005).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person must ensure an accurate complete and contemporaneous record for each service user.

This section is primarily information for the provider

Requirement notices

Ensure that an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.

Ensure all DNACPR order forms are completed accurately and in line with trust policy.