Care Quality Commission

Sherwood Forest Hospitals NHS Foundation Trust

Kings Mill 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	Inadequate
Urgent and emergency services	Inadequate
Medical care (including older people's care)	Inadequate
Surgery	Good
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Sherwood Forest Hospitals NHS Foundation Trust was formed in 2001, and achieved foundation status in 2007. Sherwood Forest Hospitals is the main acute hospital trust for the local population, providing care for people across north and mid-Nottinghamshire, as well as parts of Derbyshire and Lincolnshire. The trust employs 4,300 members of staff working across the hospital sites.

King's Mill Hospital in Sutton-in-Ashfield is the main acute hospital site. It provides over 550 inpatient beds (more than half in single-occupancy en-suite rooms), 13 operating theatres, and a 24 hour emergency department. Each year there are more than 45,000 inpatient admissions and 36,000 day case patients; 100,000 patients attend the emergency department, around 3,500 babies are delivered, and more than 390,000 people attend outpatient and therapy appointments in the King's Treatment Centre.

In February 2013, the trust was identified as being one of the 14 healthcare providers in England which had higher than expected mortality rates. This led to the trust being reviewed by Professor Sir Bruce Keogh, NHS Medical Director for England. This review in July 2013 led to the trust being placed in special measures by Monitor, the independent regulator of NHS foundation trusts.

We inspected the trust in April 2014 and gave an overall rating of 'Requires Improvement.' We judged the provider was not meeting seven out of 16 essential standards of quality and safety.

We carried out an announced inspection visit from 16 to 19 June 2015 and three unannounced visits on 7, 9 and 30 June 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.

Overall, this trust was rated as inadequate. We identified significant concerns in safety and leadership of the trust. We found that effectiveness and responsiveness required improvement but the caring was good.

Our key findings were as follows:

- Staff were kind and caring and treated people with dignity and respect, but there were some instances where improvements were required. A greater emphasis was needed on providing care that was based on people's individual needs rather than as tasks.
- Overall the hospital was clean, hygienic and well maintained. There had been 54 cases of clostridium difficile (c. diff) infections in 2014/2015. C diff is an infective bacteria that causes diarrhoea, and can make patients very ill. This was worse than the national average and above the trust's target, which was a total of 48 cases per year. Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections MRSA rates for the hospital were low with one case recorded between 2014 and 2015. Routine screening of patients for MRSA was completed with further screening repeated after 21 days.
- Nursing and midwifery staffing had increased since 2013 and it had been a focus of the Executive Director of Nursing. Midwifery staffing levels were almost meeting the national recommended levels of 1:28. Planned nurse staffing levels were in accordance with national guidance of one registered nurse for every eight patients.
- There was an escalation process in place if staffing levels did not meet the planned levels, but staff didn't always feel this resulted in a change. We saw some occasions where patients were not able to receive their assessed level of care due to shortages of healthcare assistant staff.
- In May 2015 there were 94.89 whole time equivalent (ETE) registered nurse vacancies. This was a high risk on the trusts risk register. A recruitment programme was ongoing and changes had been made to speed up the recruitment process. Oversees recruitment had taken place.
- There were medical staffing vacancies and there was a high use of locum medical staff.

Summary of findings

- Patients pain was well managed and women in labour received a choice of pain relief. Patients at the end of life were given adequate pain relief and anticipatory prescribing was used to manage symptoms.
- Monitoring by the Care Quality Commission had identified areas where medical care was considered a statistical outlier when compared with other hospitals. The trust reported on their mortality indicators using the Summary Hospital- level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR). These indicate if more patients are dying than would be expected. The data for the trust was higher than would be expected and its overall level of HSMR was 120.67. This had been reported to the trust board and it was one of the trusts top three objectives for improvement.
- We were concerned about the hospitals performance in relation to the management of people with sepsis. There have been longstanding concerns about the management of patients with sepsis. This is a severe infection which spreads in the bloodstream. In 2010 and 2012 we raised mortality outlier alerts with the trust, when information showed there were a higher number of deaths than expected for patients with sepsis. The trust had identified a third mortality outlier for patients with sepsis in the period April 2014 to January 2015. Our analysis of the data from April 2014 to February 2015 found 88 deaths of patients with a diagnosis of "unspecified septicaemia" compared with an expected number of 58. The death rate for patients with this diagnosis was 32%, almost twice as much as the England rate of 17%.
- The trust participated in a range of national audits and outcomes varied. Outcomes for women in labour were good, although the trust was significantly higher for induced births. They did not understand the reason for this high rate.
- Like many trusts in England, their hospitals were busy. Bed occupancy rates were high and were consistently above 90% which was above the England average of 88%. It is generally accepted that when occupancy rates rise above 85%, this can affect the quality of care and the orderly running of the hospital. There were initiatives in place to reduce bed occupancy and improve the flow of patients through the hospital. Delayed discharges were a problem across the trust.
- The trust were not meeting the national targets set regarding patients access to treatment and they had failed to meet the 18 week target for access to treatment. The trust were however meeting the standard for patients being admitted, referred or discharged from the A&E department within four hours.
- There was a vision and strategy for the trust but staff were not able to articulate this to us. The priority for the organisation was to come out of special measures.
- Staff generally felt they were well supported at their ward or department level.

We saw several areas of outstanding practice including:

- There was some innovative work taking place at King's Mill Hospital where the trust had developed a new changing facility for patients with complex disabilities. The facility offered a large changing area that would meet the needs of patients with profound disabilities.
- Staff went out of their way to meet the needs of their patients on the critical care unit. Some patients could be moved on their beds out of the critical care unit to an outdoor area. Staff told us they tried to do this when possible as patients appreciated being outside and away from the unit. Staff had been able to allow visiting by patients' pet dogs in this way.

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

Importantly, the trust must:

- Ensure all staff receive training in safeguarding children and vulnerable adults. The training must be at an appropriate level for the role and responsibilities of individual staff.
- Ensure staff are appropriately trained to provide the care and support needed by patients at risk of self-harm.
- Ensure staff receive effective and appropriate guidance and training about the assessment and treatment of sepsis.
- Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.
- Ensure all patients in the emergency department are able to summon help if they need it.

Summary of findings

- Ensure all patients over the age of 75 have a cognitive assessment when arriving in the emergency department.
- Ensure learning from complaints is shared with staff in the emergency department which leads to improvement in care.
- Ensure the governance framework in the emergency department clearly identifies risks, responsibilities and actions required to manage those risks within a stated timeframe.
- Ensure systems and processes are effective in identifying where quality and safety are being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to outpatient appointment issues.
- Ensure any remedial actions taken to address outpatient appointment issues are regularly audited to give assurances improvement has taken place.
- Ensure patients in the critical care unit are routinely and properly assessed for delirium.
- Ensure the provision of level two critical care on Ward 43 includes nursing staffing levels in line with the 'Core Standards for Intensive Care Units' published by the Intensive Care Society and the commissioners expectations.
- Ensure patients requiring critical care at level two on Ward 43 are cared for by appropriately trained staff in line with the 'Core Standards for Intensive Care Units' published by the Intensive Care Society.
- Ensure staff delivering end of life care receive suitable training and development.
- Ensure all patients at the end of life receive care and treatment in line with current local and national guidance and evidence based best practice.
- Ensure the quality of the service provided by the specialist palliative care team is monitored to ensure the service is meeting the needs of patients throughout the trust.
- Ensure risks for end of life care services are specifically identified, and effectively monitored and reviewed with appropriate action taken.
- Ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in all clinical areas in the children's and young people's service.
- Ensure that medication is monitored, in date and fit for purpose in all clinical areas of the children's and young people's service.
- Ensure emergency lifesaving equipment in the maternity service is checked regularly and consistently to ensure it is safe to use and properly maintained.
- Ensure staff have the appropriate competence and skills to provide the required care and treatment to women using the maternity and gynaecology service. Specifically, women who are acutely ill or who are recovering from a general or local anaesthetic.
- Ensure patients in the medical care wards receive person-centred care and treatment to meet their needs and reflect their personal preferences, including patients living with dementia and those with a learning disability.
- Ensure all staff working in the medical care service receive appropriate supervision, appraisal and training to enable them to fulfil the requirements of their role.
- Ensure patients in the medical wards are treated with dignity and respect at all times.
- Ensure sufficient provision of hand gel dispensers within the emergency department.
- Ensure adequate provision of defibrillators and cardiac monitoring equipment within the emergency department.

In addition the trust should:

- Ensure there are effective and consistent systems for learning from incidents to be shared across the trust at all locations.
- Ensure there are sufficient computers available for staff use in the ambulatory care area of the emergency department.
- Ensure there is appropriate signage and information in the emergency department and that this is available and accessible to all people using the service.
- Ensure the process for diagnosis of fractures and how learning is analysed and shared within the emergency department reduces the impact of missed diagnosis on patients.

Summary of findings

- Improve the time taken for the transfer of patient care from ambulance staff to emergency department staff.
- Ensure clinical leadership in the emergency department is delivered at a consistently high standard 24 hours a day, seven days a week.
- Ensure patient records are available when patients attend outpatient and diagnostic imaging clinic appointments.
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- Ensure systems and processes are operated effectively to minimise delays for patients in outpatient clinics.
- Ensure there is a review the hours of service provided by the specialist palliative care team to consider a face to face service available seven days a week.
- Ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients.
- Ensure that medical consultant staffing for the children's and young people's service is in line with Royal College of Paediatrics and Child Health (RCPCH) standards.
- Ensure acute paediatric clinical guidelines are reviewed and follow best practice guidance.
- Ensure that the paediatric allergy clinic meets the 18 week referral to treatment target.
- Ensure that all nursing and medical staff in the children's and young people's service receive a minimum of yearly appraisals.
- Ensure controlled drugs are checked twice a day on the maternity ward, in line with the trust's policy.
- Ensure that staff in the maternity service follow the trust hand hygiene policy.
- Ensure that workforce requirements are analysed in terms of what women using the service need, rather than what midwives do.
- Ensure accurate data is collected regarding the use of steroid medication for pregnant women at risk of early labour.
- Ensure information and guidance about how to complain is available and accessible to patients and visitors in the maternity service.
- Ensure appropriate care and treatment pathways are developed for women using the pregnancy day care unit.
- Ensure that midwife visits to mothers with new-born babies are in line with current National Institute for Health and Care Excellence (NICE) guidance.
- Actively seek and record women's views and preferences regarding one to one care and postnatal visits by midwives
- Ensure cardiotocograph documentation follows current local and national guidance.
- Consider appointing a designated bereavement midwife and a diabetic specialist midwife.
- Ensure all staff in the maternity and gynaecology service understand their role and responsibilities regarding the Deprivation of Liberty Safeguards.
- Provide a home from home environment for giving birth for women at low risk of complications.
- Ensure women attending the termination of pregnancy clinic are seen by a diploma level qualified counsellor.
- Ensure there is a designated consultant to take the lead for fetal medicine and the pregnancy day care unit.
- Ensure there are sufficient operating theatre facilities and time dedicated for planned caesarean section operations.
- Review the protocols for how long women remain in hospital after giving birth and consider changes to improve access to the maternity service.
- Ensure staff in the maternity and gynaecology service understand and comply with the trust's policy regarding interpreter and translation services.
- Ensure that all identified risks in the maternity service are regularly reviewed and added to the trust risk register where appropriate.
- Ensure maternity information leaflets are easily available in languages other than English.
- Consider the development of a maternity services liaison committee.
- Ensure systems are operated effectively to reduce delays in transfer from theatre recovery to the surgical wards.
- Review the use of theatres to improve flow and reduce delays between surgical cases.
- Ensure the delays in orthopaedic surgery caused by limited access to a skilled periprosthetic consultant are monitored and reviewed and appropriate measures put in place to mitigate risk.

Summary of findings

- Ensure that staff practices on the medical care wards are in line with trust policy and current legislation regarding the prevention and control of infection.

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	Inadequate 	We rated the urgent and emergency service as inadequate. The emergency department did not always protect people from avoidable harm. A quarter of patients with sepsis, or potentially life threatening blood poisoning, did not receive safe and timely treatment for their infection. Some equipment was missing, insufficient or inappropriate. Patients did not have access to call bells in some areas of the department, and did not have means of summoning assistance. Medical staffing levels were insufficient at times and there was a heavy reliance on locum doctors which could affect the quality of care for patients. Some patient groups did not always receive responsive care. The department had consistently failed to meet the four hour waiting time target since 2013, although improvements had been made and sustained from February 2015 onwards. Patients waited longer than the recommended time to be handed over from the care of ambulance staff to hospital staff. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was limited evidence of wider learning from events or action taken to improve safety. The leadership, management and governance of the department did not always assure the delivery of high quality person-centred care. Although risks and quality measures were regularly reviewed, responsibilities were not always clear and risks were not always understood and managed. Clinical leadership was not consistent. There was no strategy underpinned by detailed, realistic objectives and plans. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action was not taken to manage them. There were some reliable systems to promote safe care and treatment including approaches to infection prevention control and the maintenance and repair of equipment. People's care, treatment and support were based on the best available

Summary of findings

evidence. Staff were mostly appropriately qualified and worked well together to provide effective care. Staff treated people with kindness, compassion, dignity and respect. Most patients were positive about their care. There was a positive culture of teamwork among staff who were individually committed to meeting the needs of patients and proud of their team.

Medical care (including older people's care)

Inadequate

We rated the medical care at the hospital as inadequate.

Safety was not a sufficient priority. When serious incidents were investigated there was a lack of systematic learning across the division. Patients being treated for sepsis, a severe infection which spreads in the bloodstream, were not always assessed and treated in line with good practice. There were high clostridium difficile (c. diff) infection rates and when patients required isolation, the correct procedures were not always followed. Equipment was readily available but storage space was insufficient.

At weekends patients were not routinely reviewed by a consultant. Ward staffing levels were mostly maintained at planned levels however, where the care needs of patients increased, there were not always enough staff to provide safe care and meet patients' needs. There were high levels of nursing and medical staff vacancies throughout the hospital. Staff did not all have an annual appraisal and nurses did not receive clinical supervision. Patients' care and treatment did not always follow national guidance or meet quality standards. Where patients required intensive staff support to maintain their safety this was not clearly documented and arrangements varied.

Many patients were positive about the quality of care, but sometimes people's privacy and dignity were compromised. At times staff focused on the task rather than the individual patient. We saw a medical ward where male and female patients were sharing the same bed bay and staff were not aware of the guidance on mixed-sex accommodation. We did not see ward staff using care pathways for patients living with dementia and with a learning disability.

Summary of findings

There were significant delays in discharging medically fit patients and bed occupancy rates were consistently high. Unacceptably high numbers of patients were moved at least once during their inpatient stay. However, there were initiatives in place to address these concerns and referral to treatment times were being met. Governance structures were in place but risks were not always identified or well managed.

Surgery

Good

We rated the surgical services as good.
Arrangements to minimise risks to patients were in place with a full range of risk assessments on admission, and the early identification of patient deterioration following a surgical procedure. However, in the 12 months April 2014 to March 2015, two thirds of patients with sepsis, a potentially life-threatening condition triggered by infection, did not receive safe and timely treatment.
Care and treatment was planned and delivered in line with national guidance and NICE (National Institute of Clinical Excellence) quality standards. Patient outcomes were generally in line with or better than the England average, although some standards were not being met. Some allied health professional support was only available four days a week, which resulted in delays in patients receiving assessments and treatment.
People's individual needs and preferences were considered when planning care. The service achieved the required referral to treatment time (RTT) of 18 weeks and cancellation rates had been improved by 50% over the last twelve months.
There was good leadership at departmental level. Staff were enthusiastic and supportive of each other. There was a good governance structure with regular, well attended meetings, with sharing and learning from incidents and complaints. However, there was a lack of clear vision and strategy for the future development of surgical services.

Critical care

Requires improvement

We rated the critical care service as requires improvement.
Patients were at risk of increased harm and not receiving effective care and treatment. Current evidence based guidance and standards were not always followed. Patients were not routinely assessed for delirium. Daily ward rounds did not

Summary of findings

always support or promote effective multidisciplinary working. Physiotherapy was not available for all patients at weekends. The critical outreach team was not available 24 hours a day, despite a demonstrated need for this.
The proportion of nursing staff attending mandatory training was well below the target of 90% for most of the required topics. Staff lacked awareness of the requirements of the Duty of Candour regulation. There was a lack of strategic overview and planning of critical care services Risks were not always identified and issues were not always dealt with in a timely way.
Patients were treated with kindness, dignity and respect. Patients and relatives were positive about how they were cared for and supported. Staff spent time with patients and relatives to ensure they understood the care and treatment and were involved in making decisions. Staff understood and fulfilled their responsibilities to report concerns and safety incidents. Lessons were learned and action was taken to improve safety. Cleanliness and infection control measures were generally appropriate and effective. The environment and equipment were mostly properly checked and maintained. Staffing levels in the critical care unit were in line with national standards.

Maternity and gynaecology

Requires improvement

We rated the maternity and gynaecology service as requires improvement.
Patients were not always protected from the risk of avoidable harm. Staff did not check essential lifesaving equipment as often as they should. Staff did not carry out routine patient observations as often as they were required to and when findings indicated a risk to a patient's health, the right actions were not always taken. Midwives were delivering post-operative care without the required formal training and competency assessments. Medicines were managed safely in the hospital but community midwives did not have effective systems in place.
Women using the maternity service did not always receive care based on the maternity service's guidelines and national guidance. Women stayed on the ward after giving birth for up to five days and there were no plans to work differently to reduce

the time women stayed in hospital. Women did not have a choice to give birth in a midwifery led, home from home environment. Caesarean section rates and natural birth rates were better than the national averages. Patients' pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding. Patients were positive about the care they had received. Staff were kind and thoughtful. Women and their partners felt involved with their care were happy with explanations that were given to them.

Although staff demonstrated a strong desire to develop the service, patients and the public were not involved in service development and women did not have the opportunity to express choices about postnatal care. Women and their families did not know how to make a complaint and staff were not aware of departmental complaints. Services were arranged to meet some people's individual needs, with specialist support staff people with complex conditions and wheelchair accessible premises.

There were established local governance arrangements, but the department was not integrated into divisional and organisational governance and risk management. Identified risks to patients and service delivery were not being managed through a risk reporting process. The department's initial response to the national recommendations of an important review of maternity services was incomplete and lacked clarity.

Services for children and young people

Good

We rated the children and young peoples service as good.

Although risks to patients were assessed and managed, staff had not consistently monitored the emergency resuscitation equipment. Medication monitoring practices were not effective as we found some out of date medications.

Patients received evidenced based care and there was good multi-disciplinary working between the children's services and the child and adolescent

mental health team. However, there was no written guidance on how to manage risks for children and young people who presented with mental health concerns.
In adult outpatient clinics staff tried to accommodate children's needs, but the clinic environments were not child friendly, and some patients had excessive waiting times. Staff in adult outpatient areas where children and young people were seen had not received adequate child safeguarding training.
Staff were caring, compassionate and respectful. Staff were positive about working in the service and 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.

End of life care

Requires improvement

We rated the end of life care services as requires improvement.
Staff knew how to report incidents but there was little evidence that learning from incidents and near misses was shared throughout the organisation. We were not assured that all incidents were reported as they should be. There were few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust and to benchmark against end of life care services nationally.
An executive lead had been identified at board level, but there was a lack of engagement and commitment on behalf of the trust to invest in adequate resources so that a quality end of life care service could be sustained. There was no service level agreement for the specialist palliative care team from a local hospice who were commissioned to provide specialist support within the trust. This meant the trust had no protection from this service being withdrawn.
The end of life care team acknowledged there was a lot of work that needed to be done and improvements were underway. The operational lead nurse had worked hard to improve the quality of end of life care.

Summary of findings

Outpatients and diagnostic imaging

Inadequate

We rated the outpatients service as inadequate. People using the service were at high risk of avoidable harm. A significant number of reported incidents had not been systematically and routinely reviewed or assessed for severity of harm caused to patients. Learning from incidents was not always shared with staff. Not all staff had received training about reporting incidents.

A significant number of patients were overdue a follow up appointment or had no record of their previous attendance and therefore it was not clear if they had received essential treatment. The trust's response to this issue was not sufficiently timely or effective.

There were some notable gaps in the completion of staff mandatory training, putting patients at an increased risk of harm. Staff were aware of the need to ensure patients gave appropriate consent for their care, though not all staff had received relevant training.

The time waited by patients from referral to treatment was worse than the England average and below the expected standard. When attending clinics, some patients experienced long delays for their appointments. Despite historical problems with the administration of outpatient services, there remained many practical problems. Some teams were staffed by agency staff only, with limited training, induction and support.

The leadership, governance and culture did not always support the delivery of high quality care. Attendance at divisional governance meetings was inconsistent. The divisional risk register did not show who held responsibility for each risk and timescales for action were not always included. Although staff felt supported at a local level, they felt there was a disconnect between the trust and divisional senior management teams and themselves. Staff morale had deteriorated in individual teams.

Outpatient clinics and diagnostic imaging areas were clean and equipment was properly maintained. Medicines were safely managed. There were sufficient nursing, medical and other staff to meet patients' needs but there was no method for assessing if the numbers and skill mix of staff was appropriate. There was effective multidisciplinary

Summary of findings

working for patient care. Most patients spoke positively about how they had been treated. We observed patients were treated with kindness, dignity, and compassion when receiving care and treatment.

Kings Mill 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 Kings Mill Hospital

Sherwood Forest Hospitals NHS Foundation Trust was formed in 2001, and achieved foundation status in 2007. Sherwood Forest Hospitals is the main acute hospital trust for the local population, providing care for people across north and mid-Nottinghamshire, as well as parts of Derbyshire and Lincolnshire. The trust employs 4,300 members of staff working across the hospital sites.

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King's Mill Hospital is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

In February 2013, the trust was identified as being one of the 14 healthcare providers in England which had higher than expected mortality rates. This led to the trust being reviewed by Professor Sir Bruce Keogh, NHS Medical Director for England. This review in July 2013 led to the trust being placed in special measures by Monitor, the independent regulator of NHS foundation trusts.

We inspected the trust in April 2014 and rated Kings Mill Hospital as 'Requires Improvement.' In summary this was because of:

- Ineffective organisational learning from incidents
- Inadequate systems to maintain and repair equipment
- Unsafe medicines storage
- Failure to recognise deteriorating patients
- Inconsistent record keeping
- High infection rates
- Insufficient staff levels at night
- Poor risk assessments and care pathways
- Unsafe discharges
- Not meeting the majority of referral to treatment times
- Poor management of outpatient appointments in some areas
- Limited staff engagement in service development
- Ineffective governance and risk management

Detailed findings

We judged the provider was not meeting seven out of 16 essential standards of quality and safety at Kings Mill Hospital, namely:

1. Care and Welfare of people who use the service
2. Assessing and monitoring the quality of service provision
3. Medicines management
4. Safety and suitability of equipment
5. Keeping accurate and secure records
6. Having sufficient and suitably qualified staff
7. Supporting workers

Our inspection team

Our inspection team was led by:

Chair: Dr Nigel Acheson, Regional Medical Director, NHS England

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The inspection team comprised 20 members of CQC staff, 30 specialist advisers and three experts by experience who have experience of or who care for people using healthcare services. CQC members included the deputy chief inspector of hospitals, two heads of hospitals inspection, four inspection managers, a pharmacy manager and 12 inspectors. Our specialist advisers included: heads of governance and patient safety, specialist nurses, medical consultants, and anaesthetist, a histopathologist, a junior doctor, allied health professionals and clinical managers.

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 England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We carried out an announced inspection visit from 16 to 19 June 2015 and three unannounced visits on 7, 9 and 30 June 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 support services, ward areas, and outpatient services. We observed how people were being cared for, talked with patients, carers, visitors and relatives, and reviewed patient records of personal care and treatment.

Facts and data about Kings Mill Hospital

King's Mill Hospital is located in Ashfield District, which was ranked in the fifth (most deprived) quintile in the English Indices of Deprivation 2010. Other bordering districts were ranked as equally deprived. The catchment population is predominantly white (over 97%) and slightly older than the national average. The catchment population is expected to grow more slowly than the national average. By contrast, the over 80s are growing at or above the national rate of around 3% per annum.

Detailed findings

Over the last ten years, Sherwood Forest Hospitals carried out a £320 million modernisation and extensive reconstruction of the existing site. The first major new building, the diagnostic treatment centre, opened in April 2008, with a phased relocation of wards starting in early 2009. Maternity Services, including neonatal and the Sherwood Birthing Unit, relocated from their previous accommodation to the new Women's & Children's Services building in 2013. The private finance initiative (PFI) used to fund the modernisation has proved very costly and in 2013/14 the trust's deficit was over £21m.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department at Kings Mill Hospital provided consultant-led emergency care and treatment 24 hours a day, seven days a week. A separate waiting and treatment area was available for children between 9am and 9pm. The department saw 133,632 patients in 2014, and 17,000 of these were children. The department was a designated trauma unit within the East Midlands regional trauma network.

During our inspection we spoke with 22 patients and 14 relatives, 51 staff and 12 non-trust staff. We looked at 32 patient records. 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. We also reviewed information from comment cards that were completed in the waiting area.

Summary of findings

The service was inadequate overall.

The emergency department did not always protect people from avoidable harm. A quarter of patients with sepsis, or potentially life threatening blood poisoning, did not receive safe and timely treatment for their infection. Some equipment was missing, insufficient or inappropriate. Patients did not have access to call bells in some areas of the department, and did not have means of summoning assistance. Medical staffing levels were insufficient at times and there was a heavy reliance on locum doctors which could affect the quality of care for patients.

Some patient groups did not always receive responsive care. The department had consistently failed to meet the four hour waiting time target since 2013, although improvements had been made and sustained from February 2015 onwards. Patients waited longer than the recommended time to be handed over from the care of ambulance staff to hospital staff.

When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was limited evidence of wider learning from events or action taken to improve safety. The leadership, management and governance of the department did not always assure the delivery of high quality person-centred care. Although risks and quality measures were regularly reviewed, responsibilities were not always clear and risks were not always understood

Urgent and emergency services

and managed. Clinical leadership was not consistent. There was no strategy underpinned by detailed, realistic objectives and plans. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action was not taken to manage them.

There were some reliable systems to promote safe care and treatment including approaches to infection prevention control and the maintenance and repair of equipment. People's care, treatment and support were based on the best available evidence. Staff were mostly appropriately qualified and worked well together to provide effective care. Staff treated people with kindness, compassion, dignity and respect. Most patients were positive about their care. There was a positive culture of teamwork among staff who were individually committed to meeting the needs of patients and proud of their team.

Are urgent and emergency services safe?

Inadequate

The safety of the service was inadequate. People using the service were at high risk of avoidable harm.

Half of all patients did not receive an initial assessment within the target time of 15 minutes from arrival. A quarter of patients with sepsis, or blood poisoning, did not receive safe and timely treatment for their infection. Some equipment was missing, insufficient or inappropriate. Patients did not have access to call bells in some areas of the department, and did not have means of summoning assistance. When concerns were raised or things went wrong, the approach to reviewing and investigating causes was insufficient. There was limited evidence of wider learning from events or action taken to improve safety. Not enough staff had attended specialised children's safeguarding training and other areas of mandatory training.

Nursing staffing levels were acceptable, but staff told us and we saw they struggled to cope at busy times. Medical staffing levels were insufficient at times and there was a heavy reliance on locum doctors which could affect the quality of care for patients. There were some reliable systems to promote safe care and treatment. These included approaches to incident reporting, infection prevention control, medicines management and maintenance and repair of equipment. Most records were accurately and comprehensively completed. Effective emergency preparedness plans were in place.

Incidents

- The department reported two serious incidents requiring investigation (SIRIs) to the Strategic Executive Information System between March 2014 and February 2015. We requested the serious investigation reports from these incidents and saw there had been full investigations. Learning from incidents had been recorded along with agreed actions.
- Staff were aware of the trust's electronic reporting procedure and knew how to report incidents. Feedback from incidents within the department was shared with staff via notice boards, emails and the morning handover meeting. Staff were able to give us examples

of changes in practice as a result of incidents. For example, qualified rather than unqualified nurses escorted children being admitted from the emergency department to the paediatric ward following concerns raised.

- Staff were not aware of learning from wider incidents within the trust. For example they were not aware of policies relating to patients at risk of self-harm and had not received any relevant training. These were two recommendations made to the trust following a serious incident in another department in March 2014 which staff were also unaware of.
- Thirteen of the 80 complaints received by the emergency department between October 2014 and March 2015, specifically related to undiagnosed fractures in the emergency department. Missed fractures was an agenda item at the speciality clinical governance meeting The minutes from the February 2015 meeting recorded, "Seven missed fractures but had we taken into account that patient numbers had increased, missed fractures would increase because of this." There was no evidence of analysis or actions to address this risk.
- Monthly speciality clinical governance meetings included mortality and morbidity reviews for adults and children. The paediatric lead consultant told us mortality and morbidity meetings for paediatric cases were also held monthly.
- The leaders of the service were aware of the requirements of the Duty of Candour Regulation, introduced in November 2014 for all NHS Trusts. It is a legal requirement for providers of health care to act in an open and transparent way with people using services. The regulation sets out specific requirements providers must follow when things go wrong with care and treatment.

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 were available in the department, although there was a lack of alcohol gel dispensers when moving between areas of the department. This meant that relatives and visitors were unlikely to clean their hands on arrival.
- We observed good practice such as staff following hand hygiene, 'bare below the elbow' guidance and wearing personal protective equipment such as gloves and aprons, whilst delivering care.
- Clinical waste was generally managed according to trust policy. During our unannounced visit, however, we saw a large sharps bin in the resuscitation area was overflowing. Sharps bins are plastic containers used for the safe disposal of needles and other contaminated sharp objects. We also observed blood soiled waste and used gloves in a household waste bin.
- Trust infection control nurses carried out regular audits in the department.
- There were three rooms available for patients who needed to be isolated because of infection risk.

Environment and equipment

- There were no patient call bells in cubicles in the 'majors' area of the department. We checked with staff and they confirmed this. These cubicles were out of the line of sight of the nurses' station. Some staff told us they advised patients how to summon help and other staff told us they tried not to put vulnerable patients in this area. However the lack of call bells meant that patients were not able to summon help if they needed it and during our inspection we heard several patients shouting for assistance and at least one patient vomiting alone in a cubicle. During our unannounced inspection one patient pushed the cardiac arrest staff call button believing it to be a patient call bell. This brought the emergency resuscitation team running to the cubicle.
- Some curtain rails within the department were not collapsible. In 2007 the Department of Health issued an alert to NHS trusts requiring action to reduce potential suicide risks relating to patients using curtain rails from which to hang themselves. Curtain rails within the department were not all collapsible, and therefore posed a risk. The trust had carried out a ligature risk assessment in 2013 which we reviewed. The department had access to a safe ligature knife following the risk assessment and so some steps had been taken to minimise risk.
- There were often no trolleys to transfer patient onto from the ambulance stretchers. This meant that patients could spend longer than necessary on stretchers designed for short periods of use.
- There were two defibrillators for six bays in the resuscitation area with another one in the designated paediatric bay and one in the majors area. There was a potential that these were not enough for the numbers of patients in the department.

- On two occasions during our inspection we saw patients having cardiac monitoring on a defibrillator because there were not enough monitors in the department. This meant that there was not enough cardiac monitoring equipment and life saving equipment may not have been available if a patient went into cardiac arrest.
- There was a lack of computers for staff to use in the triage area. We observed staff interrupting clinical activity to share a computer.
- There was a safe and effective system in place for the maintenance and repair of equipment.

Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately. However, during an unannounced inspection we found two prescription pads in an unlocked treatment room in an area accessible to patients. We brought this to the attention of the senior nurse who immediately locked them away
- Qualified nurses were working under a patient group direction (PGD) for the prescription of simple pain relief, eye drops, respiratory medicine and antihistamines. 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. We saw copies of these PGDs which were all correctly completed and authorised.

Records

- The department used a mixture of electronic and paper patient records. We looked at 32 patient records and found that they were generally completed in line with trust policy. The exception was the documentation of care for patients with sepsis, for example one set of patient notes did not record when antibiotics were given to a patient.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children. The department had a system to flag patients who were vulnerable or at risk, for example of domestic violence. This meant staff were able to respond appropriately and discreetly.
- The paediatric lead nurse was also the paediatric safeguarding lead for the department at the time of our inspection. Paediatric safeguarding meetings were held fortnightly and attended by the trust safeguarding specialist nurse, the paediatric lead nurse and the paediatric lead consultant. There were no minutes for these meetings but the paediatric lead consultant told us the recent trust appointment of a specialist nurse for safeguarding children would create capacity for notes to be taken.
- Only half of the staff in the department had completed paediatric level three safeguarding training. Four out of eight consultants had completed the training, one needed to update their training in July and three had not attended at all. This meant that some staff may not be aware of risks to keeping children safe.

Mandatory training

- All staff were required to complete emergency life support training updates every two years. Fifty four per cent of nursing staff had completed advanced life support training (ALS), 49% had completed the European paediatric life support training and 81% paediatric intermediate life support. All medical staff had completed adult and paediatric life support training.
- Staff completed training in mandatory topics such as information governance. Completion rates ranged from 11% to 100% depending on the topic and the staff group against a target of 90%. This meant that some mandatory training completion levels were unsatisfactory.

Assessing and responding to patient risk

- Patients being treated for sepsis, a severe infection which has spread via the bloodstream, were not always treated in line with the trust pathway. The key immediate interventions that increase survival comprise the 'sepsis six bundle.' This has been shown to be associated with significant mortality reductions when applied within the first hour. There is strong evidence that swift delivery of 'basic' aspects of care prevents much more extensive treatment.
- In six out of seven records we looked at, no urinary output was measured which was part of the pathway. In one case out of seven, antibiotics were not administered until after blood tests returned and in one case out of seven blood tests were not ordered. These

concerns had previously been identified in the Royal College of Emergency Medicine (CEM) audit of sepsis in the department in 2013 with 11 out of 26 patients having no urinary output recorded.

- The department's audit of compliance with the pathway between 2014 and 2015 indicated 75% compliance. Minutes of the department's clinical governance meeting in March 2015 reported sepsis compliance at 65%. The minutes of the clinical governance meeting did not record any understanding of what the issues were and there were no actions noted to reduce the risk to patients.
- The trust provided us with information after our inspection which showed 66% compliance with the sepsis treatment bundle in the emergency department during 2014/2015. This meant that at least a quarter of patients with sepsis did not receive appropriate treatment. One of the serious incidents reported by the trust involved a failure to follow the sepsis protocol.
- The median time to initial assessment for patients arriving by ambulance was better than the England average for four out of five months between October 2014 and February 2015. However, for all patients arriving in the department only approximately 50% had received an initial assessment within the target time of 15 minutes between April 2014 and May 2015. This meant that half of patients were not assessed promptly on arrival in the department.
- Between April 2013 and October 2014 all patients received treatment within the target time of 60 minutes from arrival.
- Children arriving at the emergency department were seen first by receptionists and then directed to the children's area between 9am and 10pm. Outside of these times they were required to wait in the main adult waiting area. In the case of an obvious emergency the receptionist would summon the assistance of a nurse.
- There were two reception staff on duty during the day and one at night time.
- Staff in the department used a recognised early warning score to show when a patient's condition was serious or deteriorating. For children, the department used a paediatric observation priority score (POPS). Staff were aware of the tools and how to escalate concerns regarding a patient.
- There was an escalation policy in place for the department and the children's area and some staff told us it was effectively used. We saw this during our inspection when there were a large number of patients in the department for long periods because of the lack of beds in the hospital. Staff from other areas were working in the department to review patients and keep them safe.

Nursing staffing

- The department was fully staffed to their own established numbers with no nurse vacancies. These numbers were not based on a robust assessment of nursing needs. Sickness absence was consistently around only one percent. At the time of our visit the emergency department matron was completing the Royal College of Nursing baseline assessment of emergency staffing (BEST). This tool enables a department to highlight any disparity between nursing workload and staffing. Nursing staff told us and we saw they struggled to cope at busy times.
- Eight advanced nurse practitioners (ANPs) worked in shifts from 8am to midnight. There were plans to recruit four more ANPs so that there were enough staff to provide 24 hour cover.
- Nursing handovers took place at each shift change on a one to one basis. At busy times this was difficult to manage as staff were not available when required. As evening shifts had a staggered finish the departmental handover only took place in the mornings. Important information for staff was also displayed on a communications board in the staff base and in a communications folder which staff signed after reading.
- The department had a nurse lead for the care of children. This nurse was the only paediatric trained nurse in the department. This meant the department did not comply with best practice guidance which requires a minimum of one children's trained nurse per shift. Staff working in the children's area had a minimum of two years nursing experience and 89% of nurses working in the emergency department had completed competency assessments to enable them to treat children. This was done as part of a two day course where training was delivered in topics such as treating the sick child, epilepsy, diabetes and common injuries in children. One nurse and one emergency nurse practitioner were allocated to work in this area supported by one health care assistant.
- There were no nurses specifically allocated to the ambulatory care area in the department, where medical care was provided on an outpatient basis, nor were

nurses allocated to cover certain cubicles or bays. Nurses took over a patient's care as they became available and worked on a 'task allocation system' rather than patient allocation system. This sometimes led to delays in patients receiving treatment. We observed one patient was two hours overdue for intravenous fluids when they were dehydrated.

Medical staffing

- The department was funded for 11 consultants and at the time of our inspection there were 6.8 whole time equivalent posts filled. This meant that there was a shortage of senior doctors to make decisions and give advice as well as to support less experienced medical staff.
- The department employed a higher ratio of middle grade doctors than the England average and a lower ratio of registrars and junior doctors. The ratio of consultants was similar to the England average.
- Between Mar 2014 and March 2015 average monthly medical ad hoc locum usage was 48%.This meant that up to half of all middle grade doctors may not be familiar with the department or other staff which could affect their ability to deal swiftly and appropriately with patients.
- Overnight there were two middle grade doctors and two junior doctors in the department. Staff told us they were concerned about medical staffing levels overnight because of the heavy reliance on locum doctors and because there were some middle grade gaps which were not filled leaving the department short of doctors. We looked at rotas and saw evidence of this. One senior nurse described medical cover as 'diluted' and other staff told us they were fearful of asking locum medical staff for advice as they were not familiar with their clinical ability.
- Consultants were present in the department from 8am to 10:30pm Monday to Friday although they stayed later if required, and from 9am to 6pm at weekends. This meant guaranteed consultant presence was for 14.5 hours per day during the week and nine hours at weekends, not the recommended 16 hours per day, seven days a week. Outside of these times a consultant was available on call for advice. Consultants would only come into the department out of hours for specific situations set out on a list available to staff.
- One consultant took the lead in the care of children within the department. There was no doctor allocated to work specifically in the children's area when it was open.
- The department had the recommended minimum of one specialist registrar doctor (StR 4) available 24 hours a day.
- All medical staff had completed adult and paediatric life support training.
- There was a morning handover meeting each day at 9am. This was attended by nursing and medical staff and led by the consultant in charge for the day. Information was shared about changes or learning from incidents. As the area available for this meeting was small, it was difficult for all staff to hear and participate in the meeting.

Major incident awareness and training

- The department had suitable major incident plans in place. During our inspection staff discussed the Ebola risk and told us about their plans for dealing with a Middle East respiratory system (MERS) outbreak. Staff in the department participated in major and chemical incident training every 18 months.
- The departmental major incident lead had spent time with the local ambulance Hazardous Area Response Team (HART) to understand their major incident capability. Joint training had taken place recently with the fire service, ambulance trust and the police.
- The security office was based within the department and staff were available 24 hours a day. Reception staff told us there were panic alarm buttons within the department and they felt safe at all times.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

The effectiveness of the service was good.

People's care, treatment and support was based on the best available evidence. Patients received pain relief and nutrition effectively.

Urgent and emergency services

Staff were appropriately qualified and received regular, relevant training and appraisal. Staff, teams and services worked well together to provide effective care and treatment and they had access to the information they required to do so.

Some of the departmental facilities required improvement.

Evidence-based care and treatment

- Clinical guidelines for treatment were available on the intranet and pathways for different conditions were displayed within the department. The trust intranet linked to the website of the National Institute for Clinical Excellence (NICE) where staff could check guidance and nationally recognised standards.
- Most patients received care and treatment which was consistent with the clinical standards for emergency departments published by the College of Emergency Medicine (CEM).
- There was no audit schedule or activity at departmental level. All audits were prompted by the trust audit programme or external requirements.
- Care and treatment pathways for stroke patients were consistent with approved guidelines. Thrombolysis (a treatment to dissolve blood clots) was available 24 hours a day, seven days a week.
- Patients with suspected hip fractures were treated in line with best practice.
- Ambulatory care pathways were in place.

Pain relief

- Patients we spoke with had been asked about their pain and given pain relief where appropriate at regular intervals.

Facilities

- The ambulatory care area within the majors department had limited facilities. Staff shared one computer. As the emergency department children's area was usually open between 9am and 10pm, approximately a quarter of children attending were seen in the adult emergency area. These waiting and treatment areas were not visually or audibly separate and this may not always be appropriate for children. The Royal College of Paediatrics and Child Health recommend separate children's waiting and treatment areas or a reasonable compromise.

Nutrition and hydration

- Staff carried out a 'comfort round' every hour where patients were offered a drink. We observed staff carrying out these comfort rounds and patients' records included this information. Patients told us that they had been offered food and drinks after their initial assessment.

Patient outcomes

- Between January 2013 and September 2014 the number of unplanned re-attendances to A&E within seven days was better than the England average but worse than the national standard.
- During May 2015 the department had participated in three Royal College of Emergency Medicine (CEM) audits; initial management of the fitting child, assessing for cognitive impairment in older people and mental health in the ED. There was an action plan for the audit of initial management of the fitting child where results showed good documentation but a lack of written information given to the patient when they were discharged. Other action plans were in development because these audit results had only just been published.
- A peer review visit in January 2015 for the regional trauma network assessed the department's compliance with rehabilitation measures at 60%. This was because there was no rehabilitation coordinator in post and the repatriation process for patients was not embedded in routine practice. The score for definitive care measures was 80%. The department had not submitted data on all eligible patients to the trauma audit and research network (TARN) for the required national audit. Results for reception and resuscitation measures were at 92%. Improvement actions had been identified and plans were in place to address concerns. The review identified some good practice around auditing of trauma calls and training for all staff groups.
- Audit activity was prompted by the trust wide plan or national audit requirements. There was no local audit plan.

Competent staff

- For the period July 2014 – April 2015 87% of nurses, 82% of health care assistants and 83% of administrative and clerical staff had received an appraisal.
- There was a practice and service development lead within the department. All staff told us they were highly effective and that learning and development activities

were readily available. Staff felt supported in their learning and told us they were given plenty of development opportunities. One nurse told us they had received more teaching in this department than anywhere else in their entire career to date.
- Housekeeping staff were invited to attend some clinical training for example trauma training so they were able to recognise equipment and be familiar with procedures.
- Doctors told us there were no issues with their revalidation.

Multidisciplinary working

- We saw effective working with theatre staff, physiotherapists and radiographers when they were in the department. Physiotherapists visited the department three times daily to check if they were needed and would respond if called upon within 20 minutes. Staff from the X-ray department attended the emergency department to carry out diagnostic tests for patients in the resuscitation area. This meant they did not need to be moved.
- Porters were available 24 hours a day. At least one porter was permanently based in the department.
- There was good liaison between the paediatric department and the children's emergency area.
- A rapid response liaison psychiatry (RRLP) team based on the hospital site but employed by another trust were available to support patients and provide initial assessments. Staff told us they responded promptly to requests for assistance, usually within 15 minutes.
- The Profiling risk, integrated self-management team (PRISM) was an initiative funded by the Clinical Commissioning Group (CCG). Two former community nurses worked in the emergency department between 8am and 8pm to support patients to avoid admission to hospital. They liaised with community services to put appropriate support in place to allow vulnerable elderly patients to return home rather than be admitted to hospital.
- A police officer in the department with a patient told us staff worked well with them to accommodate them to do their job.
- During our inspection the department experienced a high demand for services. We observed a team from the medical division completing a ward round in A&E to support the team with managing patients.
- Senior managers told us about a weekly multidisciplinary trauma project team meeting which was attended by medical representatives from the emergency department. Actions were logged from these meetings.
- Senior staff participated in meetings of the north Nottinghamshire urgent care working group with representatives from the commissioners and other health and social care providers.
- A recent visit by Health Education East Midlands had raised concerns about working relationships between emergency department clinicians and other clinical departments within the hospital. An action plan was in the early stages of development and a further visit was planned for the autumn to assess progress.
- Discharge letters were automatically generated for GPs when patients were sent home so that their care could be followed up in the community.

Seven-day services

- The emergency department was consultant led, offering a service 24 hours a day, 365 days a year.
- Consultants were present in the department from 8am to 10:30pm Monday to Friday although they stayed later if required, and from 9am to 6pm at weekends. Outside of these times a consultant was available on call for advice.
- X-ray and scanning 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. The department held a mixture of electronic and paper patient records.
- At discharge and transfer all relevant patient information was available and shared appropriately for their on-going care.
- The electronic system used by staff to manage information about patients was effective and updated by the flow coordinator. The department also maintained a manually updated visual display of patient status in the staff base area, so staff always had access to the information they required for the care and treatment of patients.

Urgent and emergency services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw 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. Ninety-six per cent of nursing staff had completed training but we were unable to find out how many of the medical staff had received training in the Mental Capacity Act 2005.

Are urgent and emergency services caring?

Good

The care provided to patients using this service was good.

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

Staff involved patients in decisions about their care and treatment, however sometimes the views of relatives were not requested or taken into consideration.

Compassionate care

- Nurses and doctors generally introduced themselves to patients before care or treatment. We observed porters also introducing themselves.
- In the Care Quality Commission Accident and Emergency Patient Survey of 2014 the department scored similar to other emergency departments in England for all levels of care. This showed that patient experiences of care were in line with current performance across England.
- Patients told us staff were welcoming and professional. Relatives of one patient told us, "What they are doing now isn't being put on for your benefit. They are always kind like this".
- Staff pulled curtains around bays and closed doors to individual cubicles to maintain patients' privacy and dignity during examination or treatment. However, conversations and treatments in the ambulatory area could be overheard in the waiting area, even with curtains closed.
- Staff were kind and considerate to relatives as well as patients. One example was during our inspection a patient's relative had lost her handbag. It had been handed in at the staff base and we saw at least three staff checking that it had been returned to her. On another occasion when the department was especially busy we saw a porter find a chair for a relative so they could sit with the patient.

Understanding and involvement of patients and those close to them

- Patients told us that reception staff were helpful and informative and made sure they knew about what to expect.
- We observed staff taking time to listen to confused patients and those close to them even when the department was very busy.
- During our observations we heard medical and nursing staff explaining care and treatment to patients and those close to them. However we observed some interactions where the relatives' views were not requested or taken into consideration.
- Many patients expressed frustration at the delays they experienced moving to the wards because of the lack of beds. One patient had waited more than 16 hours to be admitted to a ward but told us they knew staff were doing their best for them.

Emotional support

- We observed staff showing genuine concern for patients and relatives who were distressed or anxious.
- There was a chaplaincy service available within the hospital and staff told us the chaplain would attend the department if requested to support patients and families. The chaplain told us they tried to visit the department twice a week to offer support. When required they were able to contact representatives of other faiths within the local community to attend and offer support.

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

Urgent and emergency services

(for example, to feedback?)

Requires improvement

The responsiveness of the service required improvement.

Mostly services were planned, organised and delivered to meet people's needs but some patient groups did not always receive responsive care. Staff did not prioritise treating people with a learning disability or living with dementia, and dementia screening fell well below expected levels.

Patients waited longer than the recommended time to be handed over from the care of ambulance staff to hospital staff, and were experiencing long waits in the department. Although the department had consistently failed to meet the four hour waiting time target since 2013, improvements had been made and sustained from February 2015 onwards.

Systems were in place to receive and review complaints within the department but not to learn from them and from those received in the wider trust.

Service planning and delivery to meet the needs of local people

- Signage in the department was minimal, often above eye level and at times confusing. The signs from the road described an A&E department but the very large sign above the door read Emergency Care. One patient told us they had spent 10 minutes searching for the A&E department before realising it was differently named.
- Information about facilities was not accessible to patients for whom English was not their first language, or to patients with cognitive impairments who would benefit from pictorial information.
- The department had two rooms available for relatives to use. They were located in a quiet area with comfortable seating and magazines available.
- The department had a separate children's area which was open from 9am to 9pm. At the time of our inspection the team were trying to extend the opening hours until 10pm, however this was not always possible if the adult department was busy and staff were required there.
- We saw staff responding well to patients with mental health conditions
- Staff told us that they had identified they needed to gather more data on mental health concerns and alcohol misuse amongst children. They had also identified there were no guidelines for staff relating to children who had drunk alcohol.

Meeting people's individual needs

- The department did not prioritise the treatment of patients with a learning disability or those living with dementia, which is considered best practice to reduce their anxiety.
- The reducing harm team within the hospital could be available to sit with patients living with dementia who may have needed extra support. Staff told us they recognised that the department could be a scary place for these patients.
- Results from the CEM audit 'assessing for cognitive impairment in older people' 2014-15 showed that the department made a cognitive assessment in 15% of patients over the age of 75. This meant that patients living with dementia may not have been identified and appropriately supported in hospital.
- There was a trust link nurse available to advise and support staff caring for adult patients with learning disabilities.
- Staff had access to translation and interpreting services. Information leaflets were available in the department and some were translated into languages appropriate for the local community. None were available in other formats such as large print or braille.

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 October 2014 and January 2015 the department had failed to meet the standard and was generally performing below the England average. However, between March and early June 2015 the department met the national standard for 13 out of 14 weeks. Senior managers told us this was as a result of a trust wide approach to patient flow within the hospital. It was too early to measure whether this was a sustainable improvement.
- Between April 2014 and January 2015 the percentage of patients waiting four to twelve hours from decision to admit until being admitted was highly variable but at times significantly worse than the England average. In

the period January to March 2015, 15 patients waited over 12 hours from the decision to admit until being admitted which represented less than one per cent of all admissions.

- The percentage of patients leaving the department before being seen was better than the England average between April 2014 and September 2014.
- During the period November 2013 to March 2014, 1,160 patients waited over 30 minutes to be accepted by the department from an ambulance. This figure put the department in the worst 25% of trusts for delayed handover in the 2013/14 winter period. During our inspection the trust was experiencing a busy period and some patients waited over an hour to be transferred from the care of ambulance staff to department staff.
- Total time spent in the emergency department on average per patient was higher than the England average for 20 out of 21 months by between four and 23 minutes. This was often because there were no free beds in the hospital for patients waiting to be admitted.
- The department employed a flow coordinator 24 hours per day, seven days per week, who was responsible for managing the patient's journey through the department. They ensured that all relevant information was entered onto the electronic patient management system and where necessary they booked inpatient beds for those patients being admitted to the hospital.

Learning from complaints and concerns

- Systems and processes were in place to advise patients and relatives how to make a complaint. Information about how to make a complaint was displayed in the department. Staff were aware of their responsibilities to support patients wishing to formally complain. Complaints were managed within the department by the senior team. They were reviewed at the clinical governance meetings and themes were displayed and shared via email to staff and at the morning handover meeting. These themes did not include any learning. The minutes from the clinical governance meeting of January 2015 recorded, "Although there had been seven complaints in December, there had also been lots of compliments." No analysis or actions were recorded.
- Staff told us they did not receive information or learning from complaints in the wider trust.

Are urgent and emergency services well-led?

Inadequate

The management of this service was inadequate.

The leadership, management and governance of the department did not always assure the delivery of high quality person-centred care. Although risks and quality measures were regularly reviewed, responsibilities were not always clear and risks were not always understood and managed. Senior clinical leadership was not consistent.

There was no strategy underpinned by detailed, realistic objectives and plans. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action was not taken to manage them.

The newly appointed head of service was highly regarded. There was a positive culture of teamwork among staff who were individually committed to meeting the needs of patients and proud of their team.

Vision and strategy for this service

- Staff were aware there was a vision to create a 'single front door' where patients could be directed either to primary care services or to the appropriate area of the emergency department. Some staff had been consulted about these plans.
- There was no urgent and emergency care published strategy or vision. However the week before our inspection the recently appointed clinical director for medicine and emergency care had given a presentation to the trust clinical assembly entitled 'future hospital vision'.
- The trust's 'quality for all' values were displayed and staff were familiar with them.

Governance, risk management and quality measurement

- Monthly clinical governance meetings were held in the department, chaired by a consultant. All staff were invited to attend and encouraged to review the minutes of the meeting. In practice attendees were mostly senior

staff. At these meetings staff reviewed governance, risk and quality measures for example clinical audits, the department's performance against the four hour standard and patient compliments and complaints.

- We reviewed the minutes of these meetings from June 2014 to May 2015. Actions were not always identified and recorded. Responsibility for an action was not always allocated to an individual with timeframes and there was no evidence of systematic review of these actions at subsequent meetings. There was some evidence of risks being escalated to the monthly divisional quality governance meetings.
- The divisional risk register recorded three risks to the emergency department. These related to failure to meet the four hour standard, an increased usage of agency medical staff and delays in transfer for mental health patients. It did not include risks to patients from a lack of call bells or equipment, lack of compliance with the sepsis six care bundle, shortage of emergency department consultants or missed fractures.
- We asked the department for copies of CEM audits and action plans from 2014 and 2013 relating to sepsis, paracetamol overdose and consultant sign-off. They told us there was a new audit lead in the department. They were able to provide two out of three of these audits but told us they were unable to locate any action plans relating to CEM audits within the past 18 months. This meant that actions may not have been taken to review and manage identified risks.
- Staff were not aware of policies relating to managing patients who self-harm and they had not received any relevant training. These were two recommendations from the investigation into a serious incident on a ward in March 2014. Staff we spoke with were unaware of the incident and any learning from it.

Leadership of service

- The recently appointed head of service was highly respected and all staff told us they were supportive and effective. Staff told us where changes were necessary they implemented them and they had a real focus on patient care.
- The new head of service was a nurse. There was no consultant lead within the department. The previous lead had recently been promoted to a divisional role. Staff told us the lead consultant role had been advertised but as there was no protected time allocated for this there had been no applicants.
- Staff told us that consultants were approachable and supportive, although at times they were under significant pressure in the evening and weekends when patient numbers were high and middle grade doctors were locum staff. At these times staff told us it was difficult to get consultant support because of the workload.
- Some consultants struggled with the pressure of the situation and were perceived by staff as less supportive in managing patients as a result. During our inspection a consultant opted to carry out a minor procedure in the 'minors' area while the team were dealing with a particularly busy spell with many sick patients in the department. The nurse in charge did not know where the consultant was and staff were left without senior clinical guidance and support. Some middle grade doctors told us they believed the consultant had gone home.
- Earlier this year, health education east midlands (HEEM) and the general medical council (GMC) visited the hospital and raised concerns about out of hours support for junior doctors in the emergency department, workforce planning, consistency in the role of lead consultant and clinical supervision. The trust has already addressed some of these concerns.

Culture within the service

- There was a positive culture of team working within the department which staff were proud of. Departmental staff worked hard to deliver patient centred care and demonstrated genuine concern for even the most challenging of patients.
- The department had no difficulty in recruiting nurses who told us they had chosen to work there. Nurses, doctors and support staff told us about the supportive nature of the department, how everyone worked hard to meet the needs of patients and how proud they were of their colleagues.

Public and staff engagement

- Reception staff told us there were plans to move to a single front door with the service shared with the primary care centre but they had not been consulted about the changes or the design of the new area. Nursing and medical staff told us they had been asked for their views.
- Staff had been invited to take part in the 2014 national NHS staff survey.

Urgent and emergency services

- Since our inspection of April 2014 the department had introduced noticeboards in a staff corridor where information about performance, learning and improvements were displayed.
- Volunteers were recruited to assist in the emergency department with tasks such as providing food and drinks to patients, restocking non clinical areas and helping patients and their relatives find their way around.

Innovation, improvement and sustainability

- At the time of our visit the emergency department matron was completing the Royal College of Nursing baseline assessment of emergency staffing (BEST). This tool enables a department to highlight any disparity between nursing workload and staffing.
- From April 2015 a consultant from the paediatric department began working in the children's emergency area for three days a week to support with the review of patients and improve links between the two departments. At the time of our inspection it was too early to evaluate the impact of this initiative.

Medical care (including older people's care)

Overall **Inadequate**

Information about the service

At King's Mill Hospital medical care services were managed by the Division of Emergency Care and Medicine. There were 16 medical wards; these included an emergency assessment unit, cardiology, haematology, gastroenterology, stroke care, respiratory care, care of the elderly wards, a short stay ward and a discharge ward.

Linked to the hospital's accident and emergency department was a Clinical Decisions Unit (CDU), and the emergency admission unit (EAU) ward, with 56 beds provided. Overall, the hospital's medical care service had 352 beds.

There were 20,335 admissions to medical care services at King's Mill Hospital in 2014/15, of which 61% were emergency admissions, 3% elective and 36% day cases. Most admissions (58%) were in the speciality of general medicine.

During our inspection, we visited 12 wards, the Clinical Decisions Unit (CDU) and the Emergency Assessment Unit (EAU), and spoke with 66 patients/relatives, and 97 staff. We also looked at the care plans and associated records of 43 people. We carried out observations using the Short Observation Framework for Inspection (SOFI) to gain insight into the experiences of patients who may not be able to express this for themselves. We carried out unannounced visits before and after our inspection, on 7, 8 and 30 June 2015.

Summary of findings

The service was inadequate overall.

Safety was not a sufficient priority. When serious incidents were investigated there was a lack of systematic learning across the division. Patients being treated for sepsis, a severe infection which spreads in the bloodstream, were not always assessed and treated in line with good practice. There were high clostridium difficile (c. diff) infection rates and when patients required isolation, the correct procedures were not always followed. Equipment was readily available but storage space was insufficient.

At weekends patients were not routinely reviewed by a consultant. Ward staffing levels were mostly maintained at planned levels however, where the care needs of patients increased, there were not always enough staff to provide safe care and meet patients' needs. There were high levels of nursing and medical staff vacancies throughout the hospital. Staff did not all have an annual appraisal and nurses did not receive clinical supervision. Patients' care and treatment did not always follow national guidance or meet quality standards. Where patients required intensive staff support to maintain their safety this was not clearly documented and arrangements varied.

Many patients were positive about the quality of care, but sometimes people's privacy and dignity were compromised. At times staff focused on the task rather than the individual patient. We saw a medical ward where male and female patients were sharing the same bed bay and staff were not aware of the guidance on mixed-sex accommodation. We did not see ward staff using care pathways for patients living with dementia and with a learning disability.

There were significant delays in discharging medically fit patients and bed occupancy rates were consistently high. Unacceptably high numbers of patients were moved at least once during their inpatient stay.

Medical care (including older people's care)

However, there were initiatives in place to address these concerns and referral to treatment times were being met. Governance structures were in place but risks were not always identified or well managed.

Surgery

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

Information about the service

Sherwood Forest Hospitals NHS Foundation Trust provides surgical services at Kings Mill Hospital as part of the planned care and surgery division.

The planned care and surgery division provides 106 inpatient beds across four wards. This includes the emergency surgical assessment unit, the trauma assessment unit, general surgery, urology, breast surgery, vascular surgery, trauma and orthopaedics, and head and neck surgery. A further 18 beds were available in the day case unit.

Between July 2013 and June 2014, there were 18,200 episodes of care. Of these, 53% were day case procedures, 14% were elective (planned admissions) and, 33% were non-elective (emergency) admissions.

During our inspection we visited the surgical assessment unit, day case unit, four surgical wards, operating theatres, and met with staff providing allied health services within surgery. We spoke with 20 patients and four visiting relatives. We spoke with 56 staff from management, medical, nursing, allied health professionals, administration, and housekeeping roles. In addition we carried out a short observational framework for inspection (SOFI) which helps us gain insight into the experience of patients who are unable to express this for themselves.

Summary of findings

The service was good overall.

Arrangements to minimise risks to patients were in place with a full range of risk assessments on admission, and the early identification of patient deterioration following a surgical procedure. However, in the 12 months April 2014 to March 2015, two thirds of patients with sepsis, a potentially life-threatening condition triggered by infection, did not receive safe and timely treatment. Although nurse vacancy levels were minimal on the wards, in theatres there was a 3.98% vacancy rate. There were three surgical consultant vacancies for which there were development roles identified to fill these positions.

Care and treatment was planned and delivered in line with national guidance and NICE (National Institute of Clinical Excellence) quality standards. Patient outcomes were generally in line with or better than the England average, although some standards were not being met. Some allied health professional support was only available four days a week, which resulted in delays in patients receiving assessments and treatment.

People's individual needs and preferences were considered when planning care. The service achieved the required referral to treatment time (RTT) of 18 weeks and cancellation rates had been improved by 50% over the last twelve months.

There was good leadership at departmental level. Staff were enthusiastic and supportive of each other. There

Surgery

was a good governance structure with regular, well attended meetings, with sharing and learning from incidents and complaints. However, there was a lack of clear vision and strategy for the future development of surgical services.

Are surgery services safe?

Requires improvement

The safety of this service required improvement.

There was an increased risk of harm to patients. Two thirds of patients with sepsis, a potentially life-threatening condition triggered by infection, did not receive safe and timely treatment. Although nurse vacancy levels were minimal on the wards, in theatres there was a 38% vacancy rate. There were three surgical consultant vacancies for which there was development roles identified to fill these positions.

Staff had a good awareness of the process for identifying and recording patient safety incidents, and could identify where lessons had been learnt, and changes in practice implemented. Arrangements to minimise risks to patients were in place with a full range of risk assessments on admission, and the early identification of patient deterioration following a surgical procedure.

There were good infection prevention and control practices and medicines were managed safely. Patient records were stored securely to maintain confidentiality and kept up to date. Staff were competent and suitably trained to deliver care in line with the trust's policies and procedures.

Incidents

- Staff were aware of the incident reporting process and told us they were confident in using the trust's electronic incident reporting system.
- Between June 2014 and February 2015 six serious incidents had occurred within surgery. These included four falls with harm, one pressure ulcer development and one incident of Methicillin-resistant Staphylococcus aureus (MRSA).
- We reviewed three serious incident reports and found them to reflect the national patient safety agency (NPSA) guidelines for incident investigation and action planning.
- Staff gave us examples of medicine errors that had been reported as incidents, and as a result changes to practice were made. They told us that duty of candour had been observed. The duty of candour regulation came into force in November 2014. It intends to ensure

providers are open and transparent with patients and sets out specific requirements that providers must follow when things go wrong with care and treatment. These include informing people about the incident, providing reasonable support, providing truthful information, and issuing an apology.

- We observed team handovers within the surgical division which included information sharing about departmental and trust wide incidents.
- Clinical Governance meetings took place monthly and minutes demonstrated meetings were well attended. The minutes included discussions and learning outcomes from incidents.
- The surgical division mortality and morbidity meeting was combined with the clinical governance meeting and we saw that individual deaths were discussed.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring, and analysing patient harm and 'harm free' care. All five surgical wards inspected had the safety thermometer data on display; this meant that staff and the public could see how the ward was performing in relation to patient safety. Information on display included required and actual staffing levels, infection rates, patient falls, pressure ulcers, and patient harm.
- We reviewed the safety thermometer data for five wards between March 2015 and May 2015. Harm free care for this period was good at 98%.

Cleanliness, infection control and hygiene

- All of the theatres and surgical wards we visited at Kings Mill Hospital appeared clean, well maintained, and all corridors were unobstructed. Store rooms were tidy, equipment was clearly labelled and there was no storage at floor level. NHS guidance recommends equipment should never be stored on the floor.
- Staff carried out best practice infection prevention and control procedures. Staff were 'bare below the elbow' and we saw that they washed their hands or used hand sanitising gel between patients. There was access to hand washing facilities and a supply of personal protective equipment, including gloves and aprons.
- We observed staff in theatres follow correct technical procedures for scrubbing up prior to commencing surgery.
- Staff monitored infection rates and we were shown how an identified infection control problem had resulted in an action to improve infection control techniques when caring for a patient in isolation. This included a series of posters displaying the correct procedures and protection required.
- There had been four surgical site infections in the previous six months; two were within orthopaedics, and two within gynaecology.
- There were effective procedures to dispose of clinical waste, to ensure environmental cleanliness, and to prevent healthcare acquired infections.
- Instruments used in theatres were cleaned and decontaminated safely. The trust had an on-site hospital sterilisation and disinfection unit. Staff told us there was rarely a problem relating to the supply of instruments in time for planned surgery.

Environment and equipment

- Emergency resuscitation equipment, including portable cardiac defibrillator and suction units, were regularly checked in accordance with trust's policy and were signed off daily as being correct. We looked at resuscitation trolleys in all of the surgical ward and theatre areas and they were clean, in good order, and a label indicated all contents were within date. Resuscitation trolleys were stored in visible, easily accessible areas.
- Emergency equipment was readily available for those patients with suspected sepsis. Sepsis is a complication of infection and is potentially life-threatening.
- Monitoring and anaesthetic equipment, including difficult intubation trolleys were well laid out and met the Association of Anaesthetists of Great Britain and Ireland (AAGBI) standards.
- The medical electronic department, based on site, was responsible for the servicing and maintenance of equipment. Technicians visited throughout the week and were contactable by telephone for urgent repairs. Staff told us that there was rarely a problem getting equipment repaired. Portable Appliance Testing (PAT) stickers were in place demonstrating when equipment was next due to be serviced.
- Theatre recovery was spacious with twelve trolley bays. All bays were large enough to accommodate beds.
- All wards complied with single gender accommodation including separate washing and toilet facilities.

Surgery

Medicines

- Kings Mill Hospital used a comprehensive prescription and medication administration record chart for patients which ensured safe administration of medicines. Medicine interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the medicines records for 13 patients on two wards. We saw appropriate arrangements were in place for recording the administration of medicines. Records were clear and fully completed. Records showed patients were given their medicines when they needed them, and any reasons for not giving medicines were recorded. This meant patients were receiving their medicines as prescribed. If patients were allergic to any medicines this was recorded on their prescription chart.
- Medicines, including those requiring cool storage, and controlled drugs, were stored appropriately. Controlled drugs have strict legal controls on how they are stored and supplied
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- The pharmacy team visited all wards daily. We saw that pharmacy staff checked the medicines patients were taking on admission were correctly prescribed, that records were up to date, and the medicines were prescribed safely.
- The day case surgery unit held a stock of regular 'take home' medicines to support timely discharge. This was monitored by pharmacists.

Records

- Nursing and Medical staff we spoke with told us they had completed their information governance training as part of mandatory training, and were aware of the requirement to maintain patient confidentiality at all times.
- Patient records were kept in trolleys which were stored in rooms accessible by key code only.
- On the day case unit patient record trolleys were stored in covered trolleys adjacent to the central nurses' station; we were told that this area was staffed at all times.
- Medical and nursing records reviewed were found to be comprehensive and most were legible and signed by staff although not always using capitals and signature for clarity.

Safeguarding

- We saw safeguarding information displayed on communication boards in the surgical wards and theatre departments.
- There was a good awareness of adult safeguarding and staff we spoke with said they would report any concerns to a senior member of staff on duty.
- Staff told us they had completed safeguarding training and that they could access further information and guidance on the intranet if needed. Trust data indicated that 95% of staff within the surgical division had completed adult safeguarding. The trust target was 100%.
- A learning disability nurse (LDN) employed by the trust and based at Kings Mill Hospital provided additional advice and support regarding vulnerable patients attending for surgical procedures.

Mandatory training

- Staff working within the surgical division at Kings Mill hospital were either up to date with, or had dates to attend mandatory training. Mandatory training included information governance, basic life support, the Mental Capacity Act, safeguarding, mentorship, manual handling, and infection control.
- Information received from the trust showed the overall attendance for mandatory training to be between 86-100% for staff across the surgical division, the trust target for attendance was 90%.
- We saw that individual areas maintained a record at local level. For example, mandatory training compliance within theatres had an overall score of 90%.
- Medical staff compliance with mandatory training averaged 80% with an overall target of 90%. However, we were told that not all medical staff were included within the trust's electronic staff records (ESR) and therefore data did not always fully reflect the situation.
- There was an induction programme for new employees which took place over six days.

Assessing and responding to patient risk

- In theatres staff followed the 'five steps to safer surgery'. This is an adaption of the World Health Organisation

(WHO) surgical safety checklist, which included a team brief prior to each operating list, sign in prior to anaesthesia, a stop moment before surgery commenced, sign out before staff left the theatre, and a debrief on completion of the operating list. The WHO checklist is a core set of safety checks which help improve performance at key times in surgery.

- Performance against the five steps to safer surgery was audited twice a year. Results were discussed at the theatre management group and shared within the surgical division. Results demonstrated where performance had improved over the last five years. Audit results for February 2015 showed compliance at 'sign in', 'time out' and 'sign out' to average 99 %. Results for the 'briefing' and 'debriefing' showed 98% compliance in May 2015.
- Staff followed the National Institute for Health and Care Excellence (NICE) guidance on managing acutely ill patients. Patients' physiological observations were recorded using an electronic tablet which enabled results to be monitored remotely by senior nursing and medical staff. The system automatically applied a score to the physiological observations recorded. The score indicated a required action, from repeat observations to urgent clinical review. We looked at tablets on the surgical wards and observed that raised scores were acted upon appropriately and in a timely manner.
- We saw that risk assessments on admission to surgical wards had been completed. These included anaesthetic risk and fasting times, venous thrombolytic embolism (VTE), Methicillin-resistant Staphylococcus aureus (MRSA) screening, Waterlow score (pressure ulcer risk), falls risk, bed rail assessment, and mental capacity assessments (MCA).
- Sepsis is a common and potentially life-threatening condition triggered by an infection. Early recognition and treatment of sepsis is key to improving outcomes. The trust used the sepsis six bundle to detect and treat sepsis. This has been shown to be associated with significant mortality reductions when applied within the first hour. The trust's audits for 2014/15 showed that only 9 out of 26 surgical patients with sepsis (35%) received treatment according to trust protocol. This was significantly worse than the target of 95% by March 2015, and was worse than the trust wide compliance of 55%. Although there were better rates of compliance with key components of the bundle, providing intravenous fluids at 58% and providing intravenous antibiotics at 63%, this meant that many acutely ill patients were not receiving the treatment they required.

Nursing staffing

- Nursing skill mix was measured for one month, twice a year, to make sure there were sufficient staff of an appropriate skill mix to enable effective care to be delivered. Ward managers worked a range of shifts including night shifts.
- Nurse staffing levels had been reviewed following an external inspection in 2013, and a ratio of one qualified nurse to six patients during the day and one to eight at night had been agreed. This had been achieved on the surgical wards with no vacancies reported. Two staffing rotas were checked and levels reflected the agreed ratio. Where there were shortfalls due to sickness, actions had been put in place with bank or agency nurses requested to fill gaps.
- There were staff shortages within theatre and the surgical admissions unit. Data provided indicated vacancies of 3.98% with an on-going recruitment programme in place. Theatres were able to request staff from Newark Hospital where possible, and utilise operating department practitioners to support theatre recovery at times of peak activity. Other shortages were managed through the use of agency or bank staff.
- We were told that agency nurses were employed from a list of reputable agencies and that each agency nurse completed a competency check on first employment by the trust. This was described as a 'yellow card'. Requests for external agency staff required approval at matron level.

Surgical staffing

- The medical staffing skill mix was within six per cent of the England average for the four categories of staff: consultant, middle career, registrar and junior.
- There were three surgical consultant vacancies; however we were told there was senior staff succession planning (a process for identifying and developing internal people with the potential to fill key roles) was underway which reduced the risks. Medical cover for the general surgery / urology ward consisted of one specialist consultant, one registrar and two junior doctors during the day, and one registrar with one junior doctor at night.

- Medical staff shortages were managed through the use of locum staff. Data indicated between October 2014 and March 2015 locum medical cover was highest in ear, nose and throat (20%), ophthalmology (18%), and trauma and orthopaedics (12%).
- Staff told us there were no delays in accessing medical support when needed.

Major incident awareness and training

- Major incident training was included in mandatory training.
- Policies and procedures were available on the hospital intranet.

Are surgery services effective?

Good

The effectiveness of the service was good.

Care and treatment was planned and delivered in line with national guidance and NICE (National Institute of Clinical Excellence) quality standards.

The pain management team were proactive, providing acute and chronic pain services and advice to the surgical division and across the trust. Patient nutrition and hydration was in line with best practice, and care plans were evaluated and revised throughout the patient's hospital stay. Multi-disciplinary team working was evident across the surgical division.

Patient outcomes were generally in line with or better than the England average, although some standards were not being met. Some allied health professional support was only available four days a week, which resulted in delays in patients receiving assessments and treatment.

Evidence-based care and treatment

- Patients' needs were assessed, planned, and delivered in line with National Institute for Health and Care Excellence (NICE) quality standards using evidence-based guidance and best practice. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and venous thromboembolism.
- A hand held electronic tablet system was in use for the recording and monitoring of patients' physiological observations, for example heart rate, blood pressure, temperature and respiratory rate. This enabled rapid communication between health professionals regarding a patient's condition, highlighting any indicators of deterioration.
- We observed the application of fasting guidelines, post-operative nausea and vomiting, and safe discharge from theatre recovery. Documentation of the application of these guidelines was evident in patients' medical notes.
- Anaesthetic provision followed the Association of Anaesthetists of Great Britain and Ireland guidelines, and Royal College of Anaesthetists guidance.
- Within theatres a regular monthly audit of nine quality standards which included pre-operative fasting, and post-operative nausea and vomiting was completed. Ten sets of medical notes were randomly selected. Results were shared at governance meetings and displayed on the department communication board.
- Guidelines for the identification and treatment of sepsis were available. Sepsis is a potentially life threatening complication of infection. Staff within the surgical division were aware of the policy for rapid commencement of the sepsis six bundle and were able to describe when they would use the guidelines. The bundle provides a six stage process for identifying potential sepsis and implementing early treatment.
- The pain management team followed the British association of pain management guidelines.
- Nutrition and hydration provision at ward level was delivered in line with national guidance and NICE quality standards.

Pain relief

- There was a proactive pain management team that provided both acute and chronic pain management to all specialities across the trust. The team included a senior pain specialist and a clinical psychologist.
- The team offered advice on a range of pain management methods which included complementary therapies such as acupuncture and psychotherapy.
- Pain assessment within the trust was based on a verbal rating score of naught to three. Staff also used a behavioural pain assessment scale (BPAS). This helped nursing staff assess pain in patient's limited communication or those patients living with dementia.
- Patient Group Directives (PGD) were in place to enable suitably trained nurses from the pain team to prescribe pain relieving medication and to support discharges.

- The pain team offered an advice service to the pre-operative assessment clinic and to specialists as required. We were given an example of how, following advice on pain management, a patient's discharge was earlier than expected.

Nutrition and hydration

- We saw that patients were screened and supported for their nutritional and hydration needs in line with evidence based practice. The malnutrition universal screening tool (MUST) was used on admission to assess patients' nutritional risks, and as a result appropriate care planning was initiated. Care plans were seen to be evaluated and revised throughout the patients' stay.
- Staff told us they had good access to dietetic support. Urgent dietetic advice was accessed through an on call system. Routine referrals were seen within a maximum of 48 working hours.
- We saw specialist pathways which included nutritional guidance being used on a ward for patients following bowel surgery.
- Meals provided were varied and met a variety of dietary needs. Patient's told us that the choice was good and that chefs frequently visited the wards for feedback.
- Hot food was delivered chilled and reheated at ward level. Hotel services staff were trained in safe reheating of chilled food and food hygiene certificates were on display. Regular snacks and drinks were available, and snack boxes were provided for those returning from surgery outside of normal meal times.
- There was a red tray system for patients needing assistance. The red tray system alerted nursing staff to those patients who were at risk of malnutrition, or those patients requiring assistance with their meals.
- A protected mealtime system was clearly advertised. Protected mealtime allowed patients to eat without being interrupted, meaning staff were available to offer patients assistance where required.
- We looked at six fluid and food charts for the previous five days which were correctly completed. We saw that the patients' fluid and food intake for that day had been recorded appropriately.
- Nursing staff followed guidance on fasting prior to surgery based on best practice guidance from the Royal College of Nursing (2005). Recommended fasting times pre-operatively were monitored closely and adjusted if operating delays occurred.

Patient outcomes

- The planned care and surgery division contributed to the 2014 bowel cancer audit. Results indicated the trust had performed better than the England average in three key areas; discussion by the multidisciplinary team; seen by a clinical nurse specialist; and reporting of the computerised tomography (CT) scan.
- The hip fracture audit 2014 included data from Kings Mill Hospital. The hospital performed better than the England average in five out of seven indicators, with performance in two indicators being significantly better than the England average. The rate of pre-operative assessment by a geriatrician was significantly worse than the England average (1.6% in comparison to the England average of 51.6%). However this was being addressed with increased orthogeriatrician input into the trauma care pathway for elderly patients.
- We reviewed information on comparative surgeon outcomes submitted to the National Joint Registry (NJR). Data submitted from April 2013 to July 2014 demonstrated that the 90 day mortality rate following knee and hip surgery for this trust, based on the type of patients seen, was better than the national average.
- The number of patients who had unplanned re-admission to hospital for the top three surgical specialties, indicated that in both elective and non-elective general surgery, and elective trauma and orthopaedics there were less re-admissions than expected when compared with the England average. In elective urology, re-admissions were similar to the England average. However, for non-elective trauma and orthopaedics, and urology, there were more re-admissions than the England average.
- Patient Reported Outcome Measures (PROMs) for the period April 2013 to March 2014 indicated an improvement in outcomes for groin hernia and knee replacement surgery with the trust performing better than the England average. Improvements were similar to the England average.
- The average length of stay for hip fracture patients was reported as longer than the national average at 25 days in 2014 (national average 19 days). Sixty six per cent of bowel surgery patients remained in hospital for greater than five days which was slightly better than the national average of 69%.

Competent staff

- Staff were supported to deliver effective care and treatment through the appraisal process. Data provided by the trust showed that 92% of qualified and non-qualified staff within the surgical division had received an appraisal within the last 12 months. This was in line with the trust's target of 90%.
- Mandatory training was provided and additional role specific training was available at the manager's discretion. Staff told us that they could apply to attend training, but approval was dependant on the availability of funding.
- Junior pharmacists employed within the surgical division received three months direct supervision and weekly meetings with a line manager. Staff told us that the junior pharmacist development role was well supported.
- Speech and language therapy (SALT), dietetic, and pain management teams provided training to all new staff on the induction programme.
- The pain team also provided monthly study days for clinical staff to attend which covered pain assessment and management.
- Within theatres new staff were allocated two mentors to ensure support was provided on every shift. A departmental induction pack was in use, and competencies were signed off by qualified mentors. For newly qualified staff this was in addition to their preceptorship programme.

Multidisciplinary working

- Multidisciplinary (MDT) working was evident across the surgical division with board rounds attended by doctors, nurses, and allied health professionals. Board rounds are an opportunity for the MDT to discuss the daily plans for patients.
- There were also monthly multidisciplinary meetings which were well attended. These were an opportunity to discuss patient treatment pathways, audits, and outcomes. Case studies were also presented at these meetings for learning.

Seven-day services

- SALT and dietetics services had three staff each working three days per week, providing cover Monday to Thursday. This resulted in delays in seeing patients after referrals were made. A revised rota was being developed to be able to provide services over five days with effect from July 2015. The SALT and dietetic teams reported an increase in referrals; this meant a decrease in the amount of time they were able to spend with an individual patient.
- Access to surgical services was available seven days a week and provided on going 24-hour care for elective surgical patients. Specialist emergency surgery was dependant on the availability of suitably skilled surgeons, for example, we saw a patient's operation was planned to take place five days after sustaining a periprosthetic fracture (a bone fracture next to a previously inserted joint replacement). This was due to the unavailability of a suitably skilled orthopaedic surgeon.

Access to information

- Staff were able to access information required to assess, plan, and deliver care to patients. Protocols and guidelines were easily accessible via the hospital intranet, and those we viewed were current with planned review dates.
- Information was readily available for staff on communication boards and information folders. Staff were able to access information including care pathways or care bundles to support them in planning care for patients. A care bundle is a structured way of improving the care of patients using a set of evidence-based practices that have been proven to improve outcomes.
- Nutritional displays were seen including 'three steps to thirst' supported by the diabetic society which helps staff and patients recognise thirst as opposed to hunger, preventing dehydration.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.
- We observed verbal consent being requested for routine interventions such as taking blood pressure. We reviewed six surgical consent forms and found that these were completed and included evidence of risks being discussed, and all forms were signed by the patient and consultant.

Surgery

- The staff we spoke with had a good understanding of the Mental Capacity Act (MCA) and had received training for MCA at level two. Level two MCA training is for staff who have direct contact with adult patients.

Are surgery services caring?

Good

The care provided to patients using this service was good.

Surgical services at Kings Mill Hospital were caring. Patients gave positive feedback about the care and treatment received whilst in the hospital. We observed interactions between patients, visitors, and staff, and found them to be positive, responsive, and compassionate.

Compassionate care

- We spoke with 20 patients and four visitors. Comments received were positive about the care provided, stating that they were treated with respect at all times, felt safe, and that the staff were caring and compassionate. However a few patients did report delays in responding to call bells, long waiting times for analgesia, and low standards of basic nursing care. We witnessed some call bells not being answered for up to ten minutes.
- Feedback from patients who had used surgical services at this hospital was collected using the Friends and Family Test (FFT). The FFT is an important feedback tool that enables people who use NHS services the opportunity to provide feedback on their experience. From December 2013 to November 2014 the average response rate for the surgical inpatient wards (excluding the emergency surgical assessment unit) was 34%, this was better than the hospital wide response rate of 28%, and the England average response rate of 32%. In the six months prior to our inspection the average response scores for the surgical wards indicated that 90% of patients would recommend the wards to their friends and family if they needed similar care or treatment.
- We observed staff actively involved in conversations with patients.

Understanding and involvement of patients and those close to them

- We undertook a Short Observational Framework for Inspection (SOFI) on ward 31. This is a tool which records interactions between patients and carers. We observed positive and caring interactions which demonstrated a respect for patients and their privacy. Good hand hygiene practices were seen, explanations for interventions were given, and consent was gained before carrying out personal care.
- Generally patients reported that they were involved in decisions about their care although two patients said, “They treat you like you’re stupid”.
- Visitors spoken to said they were pleased with the care being provided and that information was available and clear.

Emotional support

- There was a multi-faith chapel available to staff, patients and visitors. This was open 24 hours. A chaplaincy service was also available. Religious service times were available on the wards.
- Bereavement information was available on the wards.
- Specialist nurses were available for advice and support, for example, there was a learning disabilities nurse and a pain management team which included a psychologist.

Are surgery services responsive?

Good

The responsiveness of this service was good.

People’s individual needs and preferences were considered when planning care in order to meet the needs of all patients and in particular those with special needs or physical difficulties.

Bed occupancy within the surgical wards was in line with similar services across the country. The service achieved the required referral to treatment time (RTT) of 18 weeks and cancellation rates had been improved by 50% over the last twelve months. Patients who were cancelled by the trust were wherever possible provided with a revised surgery date within 28 days.

There was an identified delay in referral to treatment by dieticians and speech and language specialists who were working with the local commissioners to increase provision of these services and reduce waiting times.

Surgery

Service planning and delivery to meet the needs of local people

- The surgical day case unit included direct access to designated day case theatres. There were 16 trolleys and 12 reclining chairs divided between two areas, providing separate areas for males and females. Additionally, there was a ward area with 12 beds and six en-suite side rooms.
- Vulnerable adults and those with special needs or disabilities were offered additional support by nursing staff. Carers or relatives were allowed to accompany patients wherever possible.
- The day case surgical area had a designated area where vulnerable patients could be accompanied by a carer during their stay.
- A learning disability nurse (LDN) could be contacted. Staff told us that the LDN usually knew of impending admissions and would provide advice in advance.
- Improved theatre use had taken place during the twelve months before our visit with cancellation rates reduced by 50%. This had been supported by the employment of a theatre transformation manager who had improved planning and scheduling.
- An agreement involving both speech and language therapists and dieticians was being renegotiated with the local commissioners, based on activity and referral levels. The aim was to increase the provision of these services and reduce waiting times.

Access and flow

- Bed occupancy within surgery between November 2014 and April 2015 averaged 90% which is above the recommended upper level of 85%.
- The national standard is for 90% of admitted patients to start consultant-led treatment within 18 weeks of referral. Between April 2013 and November 2014 referral to treatment time (RTT) was similar to, or better than, the national standard in six out of eight specialties. However, trauma and orthopaedics at 86 % and oral surgery at 87% were performing below the 90% standard. Between December 2014 and May 2015 trust performance against the national standard had declined absolutely and in comparison with the England average
- Based on patient activity the trust had identified the top three specialties as trauma and orthopaedics, general surgery and urology. From June 2013 to July 2014 the average length of stay (LOS) for these three specialties, was similar to the England average for both elective and non-elective admissions.
- From October 2013 to September 2014 a total of six patients had their operation cancelled and were not treated within 28 days. With the exception of April to June 2014, the percentage of patients whose operations were cancelled and not treated within 28 days was lower than the England average.
- Theatre usage at this hospital was reported to be 74% across all specialties for April 2015. Usage throughout the year leading up to April 2015 was between 62% and 91%.
- Between April 2014 and May 2015 there were 292 occasions where operations were cancelled on the day for non-clinical reason, the highest number of cancellations occurring in general surgery. Trust wide there were 315 operations cancelled on the day, the main reason being documented as 'list overrun'.
- A task and finish group to improve theatre efficiency had been established. The group's purpose was to reduce cancellations by 50% through improved listing of patients. One improvement area identified was to have one patient waiting in the anaesthetic room whilst another patient's surgery is completed. This was shown to reduce the period of time in theatre when there was no activity by 30 minutes.
- Kings Mill Hospital used a 'golden patient' concept to promote patient flow. This involved moving a low risk, straight forward patient, to the beginning of an operating list. Their operation could start, while discussions between the surgeon and anaesthetist took place regarding the clinical condition of another patient which might otherwise have caused delays.
- We observed an unacceptable delay in surgical treatment for an elderly patient with a particular type of fracture. This was due to the lack of availability of a specialist surgeon. There was no flexibility to enable the patient to be added to an existing operating list. This meant the patient had to wait five days for the next available slot for surgery. Although ward staff had not raised this as an incident, we considered this to be a risk for the frail patient, and escalated it to the clinical lead, but they were unable to alter the situation.

- Staff we spoke with told us an area of concern was waiting times for patients in recovery to be allocated a post-operative ward bed. Delays occurred on a daily basis, mostly in the afternoon, delays averaged 30 minutes but could be up to four hours.
- The clinical lead within trauma and orthopaedics told us of improvements being made to the department with the aim of improving patient flow and outcomes. Positive changes that had taken place included shorter waiting times for trauma patients to go to theatre, tighter controls on fasting times to avoid unnecessary prolonged fasting, and the introduction of the 'golden patient 'concept.

Meeting people's individual needs

- Allied health professionals (AHP) including speech and language therapists and dieticians told us that delays in therapy occurred when patients were transferred between wards due to poor communication. AHPs told us that not all of them had access to the trust email.
- One to one care was always provided for post-operative patients in theatre recovery and we observed this in practice. Where nurse shortages occurred operating department practitioners were rostered into recovery.

Learning from complaints and concerns

- Staff told us they were encouraged by their department managers to aim, where possible, for local resolution to avoid a concern escalating to a formal complaint. One health care assistant (HCA) gave us an example of a patient being unhappy about the food available. The HCA arranged for a different meal to be collected from the hospital restaurant. Ward staff told us that they would always do their best to deal with any concerns a patient or visitor had.
- A Patient advice and liaison service (PALS) was available at Kings Mill hospital. Information was clearly visible in the form of posters and 'how to complain' leaflets, although this was not seen to be available in languages other than English.
- We asked patients on the ward if they knew how to make a complaint should they wish to do so. They said that they would talk to the ward sister if they had a problem.

Are surgery services well-led?

Good

The leadership of this service as good.

There was mostly good leadership at departmental level. Staff were enthusiastic and supportive of each other. There was a good governance structure with regular, well attended meetings, with sharing and learning from incidents and complaints. However, risks were not always managed effectively. There was a lack of clear vision and strategy for the future development of surgical services at senior level, and a lack of communication between senior management and divisional staff.

Vision and strategy for this service

- Managers we spoke with did not tell us of any long term vision or strategy for the surgical division.
- There was an action plan at trust level which included improved communication with staff regarding incidents and complaints. This had been achieved through the introduction of the communication board. Additionally, medicines storage and administration, previously identified as a problem, was found to be good within the surgical division.

Governance, risk management and quality measurement

- There was effective governance and quality monitoring within the surgical division. Monthly governance meetings were well attended and included incidents, complaints, and risk and audit outcomes within the agenda.
- The planned care and surgery divisional risk register included risks specific to surgical specialities, but did not identify sepsis. This meant that risks associated with sepsis were not always effectively managed.
- The communication boards which were evident in all departments were used daily for information sharing. All of the staff spoken to recognised the importance of the daily communication board meetings and made every effort to be present. The shift leader was responsible for calling the team together for these meetings.
- Discussions with middle management showed there was an awareness of the main risks and challenges for the surgical division. This included theatre use, accuracy

of data collected and staffing shortages within theatre. There was also an awareness of the need to provide increased support to Newark Hospital, and to assess which surgical services could be transferred to maintain activity at Newark Hospital and provide Kings Mill Hospital with increased capacity.

Leadership of service

- There was strong leadership at departmental level within the Planned Care and Surgery division.
- Staff reported good feedback from their line managers and told us they felt well supported.
- There were established communication processes in place at departmental level with daily information sharing at the communication board. This included day to day departmental information, updates on incidents, complaints, and any alerts issued.
- Staff told us they felt detached from senior trust management who visited occasionally but did not communicate about long term strategy.
- Staff told us they liked working at Kings Mill hospital and were proud of the modern facilities.

Culture within the service

- Within the surgical division staff consistently told us of their commitment to provide safe and caring services. Overall we saw a positive attitude to working within the hospital. Generally staff felt listened to and involved in changes at departmental level but distanced from senior management.
- Staff said they were concerned about being in 'special measures' as this did not reflect the commitment of the staff who worked hard to provide a good service. (Hospitals judged to be not providing good and safe care to patients are placed in special measures and provided with support to improve).

Staff and Public engagement

- Staff spoken to within the surgical division told us that they would be comfortable about raising concerns with their line manager.
- Family and Friends test results showed a better than average response rate with one ward achieving an average of a 45% response rate with 90% of respondents saying they would recommend the trust to family and friends.
- On the whole staff were positive about working for the trust

Innovation, improvement and sustainability

- We saw that communication at ward level was given a high priority. The communication board system was embedded, and all staff recognised the purpose of regular gatherings to share information.
- A clinical lead was reviewing ways of working within trauma and orthopaedics in order to improve patient flow and outcomes.
- A theatre transformation lead was actively implementing changes to improve theatre use.

Critical care

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

Information about the service

Sherwood Forest Hospitals NHS Foundation trust provided critical care at King's Mill Hospital. There was a critical care unit (CCU) with provision for up to 13 patients. The CCU provided critical care at levels two and three as defined by the Intensive Care Society. Level two patients are those requiring more detailed observation or intervention including support for a single failing organ system, or post-operative care and those 'stepping down' from higher levels of care. Level three patients are those requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multi-organ failure.

Critical care at level two was also provided for patients requiring respiratory support in four high dependency beds located on Ward 43. The care of these patients was managed by medical consultants and so is reported on in the 'Medical care' section of this report.

The CCU provided care for patients aged 16 or over. Critical care for children and young people was provided by neighbouring NHS trusts. There was a critical care outreach team providing care and treatment for acutely ill patients throughout the hospital. The team was managed from the CCU and was available seven days a week, though not 24 hours a day. The critical care outreach team responded to around 350 calls per month.

The critical care service was part of the Mid Trent Critical Care Network.

We visited the CCU and the high dependency beds on Ward 43. We spoke with five patients and nine relatives of patients. We spoke with 31 staff in total including nurses, doctors, therapists, health care assistants and ancillary staff.

We previously inspected critical care at King's Mill Hospital in April 2014 and rated the service as good overall.

Critical care

Summary of findings

This service required improvement overall.

Patients were at risk of increased harm and not receiving effective care and treatment. Current evidence based guidance and standards were not always followed. Patients were not routinely assessed for delirium. Daily ward rounds did not always support effective multidisciplinary working. Physiotherapy was not available for all patients at weekends. The critical outreach team was not available 24 hours a day, despite a demonstrated need for this.

The proportion of nursing staff attending mandatory training was well below the target of 90% for most of the required topics. Staff lacked awareness of the requirements of the Duty of Candour regulation. There was a lack of strategic overview and planning of critical care services. Risks were not always identified and issues were not always dealt with in a timely way.

Patients were treated with kindness, dignity and respect. Patients and relatives were positive about how they were cared for and supported. Staff spent time with patients and relatives to ensure they understood the care and treatment and were involved in making decisions. Staff understood and fulfilled their responsibilities to report concerns and safety incidents. Lessons were learned and action was taken to improve safety. Cleanliness and infection control measures were generally appropriate and effective. The environment and equipment were mostly properly checked and maintained. Staffing levels in the critical care unit were in line with national standards.

Are critical care services safe?

Requires improvement

The safety of this service required improvement.

There was an increased risk of harm to patients using the service. The critical care outreach team was available every day, but did not provide a 24 hour service. There was a demonstrated need for increasing the availability of the outreach service but this had not been addressed. The proportion of nursing staff attending mandatory training was well below the target of 90% for most of the required topics. Staff lacked awareness of the requirements of the Duty of Candour regulation.

Staff understood and fulfilled their responsibilities to report concerns and safety incidents. Lessons were learned and action was taken to improve safety. Cleanliness and infection control measures were generally appropriate and effective. The environment and equipment were mostly properly checked and maintained. Staffing levels in the critical care unit were in line with national standards.

Incidents

- There were 129 incidents reported between 1 January and 17 May 2015. Delayed discharge of patients from the critical care unit made up the largest group of incidents. Other incidents included pressure ulcers, staff accidents and staff shortages. Incidents were reviewed and appropriately investigated.
- Staff understood their responsibilities to raise concerns and to record and report safety incidents. Staff knew how to use the trust's electronic reporting system.
- Information and learning from incidents was displayed on staff notice boards. Feedback and learning from incidents was also discussed at team meetings and clinical governance meetings.
- There were regular mortality and morbidity meetings to share learning from the deaths of patients in CCU. The meetings were attended by doctors, nurses and therapists working in critical care.
- An example of learning and action taken in response to an incident was when two patients were found to have the same strain of infection in invasive lines (special tubes inserted into veins or arteries). Investigation showed the infection was probably due to cross

infection caused by inadequate hand washing. The action taken was to install a scrub sink in CCU and to include scrub hand washing prior to insertion of venous and arterial lines. (Scrub hand washing is a systematic and thorough procedure that ensures hands are as clean as possible).

- Nurses, doctors and managers we spoke with were aware of the Duty of Candour regulation, but generally lacked awareness of the full requirements of the legislation. It is a legal requirement for providers of health care to act in an open and transparent way with people using services. The regulation sets out specific requirements providers must follow when things go wrong with care and treatment.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter, and blood clots or venous thromboembolism (VTE).
- The safety thermometer data for the CCU for December 2013 to December 2014 showed there had been few avoidable harms, with no falls, one pressure ulcer and three urinary tract infections in patients with catheters.
- The safety thermometer information for the CCU was displayed for staff but was not available for patients and visitors to see.

Cleanliness, infection control and hygiene

- Compliance with key trust policies, such as hand hygiene, use of personal protective equipment, and isolation of patients was monitored through quarterly audits. The CCU had a high rate of compliance with the policies, for example demonstrating 100% compliance with hand hygiene for every audit in 2014 / 2015.
- We saw that staff adhered to trust policies and good practice in infection control, such as bare below the elbow and effective hand hygiene. Each bed space was suitably equipped including hand wash sinks, disposable gloves and aprons, and anti-bacterial hand gel.
- There was a low incidence of infection in the CCU. In the six month period from December 2014 to May 2015 there were five incidents of infection. There were no incidents of methicillin resistant staphylococcus aureus (MRSA) infection.
- As there was a lack of storage space, supplies of bags of fluid were stored on a wooden pallet in an unused bed space. The wooden pallet could not be effectively cleaned and so presented a risk regarding infection prevention and control.
- There were two rooms available in the CCU for patients who were an infection risk. The rooms did not meet the current standards for proper isolation measures. This had been identified as a risk and discussed by the clinical governance group.

Environment and equipment

- The CCU was spacious with sufficient room for the equipment required in each bed space. The unit was in two halves as the original unit had been extended. Both areas were used for level two and level three patients. There was direct access into the theatre and recovery area from the CCU.
- There was insufficient general storage space, as noted at our previous inspection in April 2014. Empty bed spaces were used for storage of equipment and other items but there was no suitable shelving or racks. This meant that items could be difficult to find and the areas were not easy to clean. Plans had been made to address this issue but no action had been taken.
- The facilities for linen storage were identified by the trust as not fit for purpose. Linen was stored on two trolleys. Staff told us there were times when they ran out of bed linen, particularly over busy weekends. Plans had been discussed to address this but no action taken.
- Equipment was mostly suitably clean and maintained in working order, including electrical safety checks. One exception was a portable ultrasound machine that had not been properly cleaned before being stored.
- There was an effective system for reporting repairs and maintenance required. We saw that repairs were dealt with promptly. Staff told us that equipment in the CCU was treated as a priority for repairs and maintenance.
- Suitable resuscitation equipment was available and daily checks were recorded.
- There was a bag of equipment for use when patients were transferred to another CCU. Staff told us the bag was not used very often because of the low number of transfers and also because there were other sources of the same equipment. There was no indication of what the contents of the bag should be. We found two disposable syringes in the bag were out of date, meaning they were no longer fit for use. There were no

records of checks of the bag and staff were not aware of any system in place to ensure the contents of the bag were regularly checked. There was a risk that essential equipment would be unavailable or unusable when needed.

Medicines

- Storage of medicines was mostly appropriate and secure. The newer part of the CCU had locked cupboards in each bed space to store medicines for individual patients. Each of these cupboards had a 24 hour supply of medicines for an individual patient. The older part did not have the bedside cupboards and so the medicines needed for each 24 hours for all patients were stored together in a drug trolley. The drug trolley had trays containing the medicines, some of which were loose ampoules and strips of tablets. It was possible these loose items could be knocked from one tray to another within the trolley, increasing the risk of medicine administration errors.
- Intravenous fluids were stored in an unused bed bay on open shelves. This did not meet current guidance that intravenous fluids should be stored in a locked room with restricted access. However this was a low risk given the restricted access to the CCU and the high number of staff always around.
- Medicines requiring refrigeration were kept securely in locked fridges. There were records showing the fridge temperatures had been checked daily and were within a correct range.
- There were accurate records of the administration of medicines to individual patients, including controlled drugs.
- Patient allergies were recorded on their medication administration record.
- Antibiotics had start, stop and review dates on the patient's medicines administration record. There were local microbiology protocols in use for the administration of antibiotics.

Records

- We looked at five patient records in the CCU. Records were all paper based. Records of current care and treatment were kept at the patient's bed so they were easily accessible for staff.
- Patients' medical records were transferred with them to the CCU when they were admitted from a ward or from theatres.
- Patient records included patient assessments and plans of care and treatment. There were detailed records for each day including reviews of bodily systems, pain and sedation, medication reviews, infection or sepsis status, and the current plan of care.
- Charts for recording patient observations and administering medication were kept up to date.
- Audit data for the Intensive Care National Audit and Research Centre (ICNARC) was recorded in admission and transfer records.
- The patient administration system was used to record where patients were located within the hospital. We found during our visit that a patient was discharged from the emergency department to be admitted to the CCU but there were no beds available. The patient was safely cared for in the theatre recovery area until a bed was available, but during this period was not entered on the patient administration system. This meant it could be difficult to track the patient's whereabouts and data normally obtained on admission to the CCU would not be collected in a timely way.

Safeguarding

- Staff we spoke with understood their responsibilities regarding safeguarding vulnerable adults. They knew how to report any concerns or allegations of abuse.
- Trust training data showed that all nurses had attended annual training about safeguarding adults and children. There were no figures available for medical and allied health professionals.

Mandatory training

- Trust training data showed that insufficient nursing staff had attended mandatory training except for safeguarding, health and safety and the Mental Capacity Act.
- There were 14 other topics where the proportion of staff who had attended was well below the target of 90%. For example, 71% of nursing staff had completed moving and handling training, 57% had completed fire safety training, and 29% had completed information governance training. Figures were not available for medical staff, administrative staff and allied health professionals.

Assessing and responding to patient risk

- Early warning scores were used throughout the trust to monitor patients and identify when their condition may

be deteriorating. Early warning scores have been developed to enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points. The trust's observation policy included guidance for staff about when and how the critical care outreach team should be informed and involved in the patient's care.

- The criteria for calling the critical care outreach team were defined according to the patient's early warning scores. The outreach team attending included specific staff according to the level of risk and the patient's individual needs.
- The outreach team was available seven days a week, from 7.45am to 8.45pm, so was not a 24 hour service. Out of hours cover during the night was provided in part by the night team leaders, but full outreach cover was not available. National guidance recommends that there should be a dedicated critical care outreach team available 24 hours a day. This standard now forms part of the specification for commissioning adult critical care services and is also the expectation of the local critical care network.
- A report produced by members of the critical care outreach team in April 2015 showed the results and analysis of daily audits carried out April 2014 to March 2015. The report demonstrated the need for increasing the availability of the outreach team, including providing a 24 hour service, but had not resulted in any additional resources.
- Risk assessments were carried out including pressure ulcer risk and the risks associated with moving and handling the patient. Individual patient risks were reviewed at least daily and risk assessments were reviewed and kept up to date.
- Patient observations were taken and recorded at the required frequency including ventilator observations. Appropriate action was taken in response to changes in observations.
- During our visit, we found one patient's admission was delayed by more than four hours due to a lack of beds in the CCU. The patient was safely cared for in the theatre recovery area until a bed was available. This was in line with the trust's critical care operational policy.

Nursing staffing in the critical care unit

- The planned nursing staffing for each shift in the CCU was eight registered nurses and a health care assistant plus an additional registered nurse acting as a shift coordinator. The staffing allowed for one to one nursing of level three patients and one nurse for every two level two patients. This met the 'Core Standards for Intensive Care Units' published by the Intensive Care Society (ICS). The staffing was adjusted according to demand as the numbers of level two and three patients could change frequently.
- Nursing staffing levels were monitored against the planned levels. Actual staffing levels usually met or exceeded planned levels. Shortfalls in staffing were met by using in-house bank staff or external agency staff. In-house staff were always contacted first for any cover required and agency staff were used as a last resort.
- The use of agency nurses was low, ranging between nil and 5% over the period March 2014 to April 2015. Staff told us the process for obtaining permission to use agency staff was long and complicated. This could lead to delays in booking nurses and caused frustration and additional stress for staff.
- Nurses and health care assistants were sometimes moved to other wards where there were gaps in staffing. Staff said they accepted the need for this sometimes but felt frustrated at being moved. They said they were able to return to the CCU if another patient was admitted.
- Nurses who were shift leaders started work 15 minutes before the shift starting time to receive a handover from the previous shift leader. Other staff then received a handover of information about each patient at their bedside. Handovers observed were thorough and unhurried.

Medical staffing

- Medical staffing in the CCU met the ICS standards. There were eight consultants in intensive care medicine providing 24 hour cover, seven days a week.
- The consultants led the care of patients in the CCU. The consultant to patient ratio met the ICS standards as it did not fall below 1:15 at any time
- Nurses and junior doctors in the CCU told us that advice and support from consultants was readily available, including out of hours.
- An intensive care consultant was the designated clinical lead for the critical care service.

Major incident awareness and training

Critical care

- There was a business continuity plan covering a range of possible events, such as fire, power failure, loss of IT and communication systems, and extreme weather conditions. Not all staff were aware of the plan, though knew they could find it on the trust's intranet if needed.
- Major incident planning was included in the business continuity plan and there was a trust wide major incident plan. Staff were familiar with how the chain of command worked in the trust for major incidents.

Are critical care services effective?

Requires improvement

The effectiveness of this service required improvement.

Patients were at risk of not receiving effective care and treatment because current evidence based guidance and standards were not always followed. Patients in the CCU were not routinely screened for delirium. Daily ward rounds did not support effective multidisciplinary working. Physiotherapy was not routinely available for all CCU patients at weekends.

Patients in the CCU were cared for by competent staff with relevant qualifications and experience. The critical care unit performed within expected ranges in the national annual audit of critical care services. The critical care outreach team provided support for acutely ill patients throughout the hospital and for patients recently discharged from the critical care unit.

Evidence-based care and treatment

- The assessment of patients' needs and their planned care were not always in line with national standards and guidelines.
- Patients in the CCU were not properly assessed for delirium. Delirium is an acute medical condition and a common occurrence in critical care units. Patients with delirium are likely to spend longer in hospital and have an increased risk of long term cognitive impairment or death. Current guidance is that patients in critical care units should have daily assessment for delirium using a recognised tool, such as the 'Confusion Assessment Method for the Intensive Care Unit'. There was no delirium screening tool in use in the CCU. It was planned that this would be added to the patient care and treatment chart. However, there was no firm date for this to be put into practice.
- The critical care outreach team responded to calls for care and support of deteriorating patients on the wards. The composition and function of the team was in line with evidence based research and national guidance, such as from the National Institute for Health and Care Excellence, (NICE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- There was a standardised handover procedure for patients discharged from the CCU to the wards. A CCU nurse accompanied the patient to the ward and gave a formal written and verbal handover. This included information such as a summary of the patient's care and treatment in the CCU, a plan for on-going treatment, and any follow up requirements. This met the ICS standards.
- Patients transferred to the wards from the CCU were followed up by the critical care outreach team. This was in line with the national ICS standards.
- Local audits were carried out including audits of care bundles used, such as the care of ventilated patients. Other audits underway included an audit of compliance with the patient rehabilitation pathway and an audit of accidental extubation (removal of breathing tube). Audits were discussed at clinical governance meetings.

Pain relief

- Pain relief and sedation for patients was recorded and reviewed daily. The patient's response was monitored and changes were made as necessary.
- Relatives told us that staff responded quickly if a patient appeared to be in pain or distress.

Nutrition and hydration

- Dieticians and speech and language therapists were employed and provided through a service level agreement with another NHS trust. Staff told us that there were no problems in getting advice and support from a dietician or speech and language therapist.
- We saw from patient records that patients were routinely seen by a dietician for assessment and monitoring of their nutritional needs. Patients who were unable to eat or drink orally were fed artificially to ensure adequate nutrition.

Critical care

Patient outcomes

- The critical care service engaged, participated and contributed in the Mid Trent Critical Care Network. This included audit activity and regular benchmarking against other critical care services in the region.
- The critical care service took part in national audits, such as the National Cardiac Arrest Audit and the Tracheostomy Audit carried out by NCEPOD. This meant the outcomes for patients using the critical care service could be measured against outcomes achieved by similar services.
- The CCU participated in the national annual audit of critical care services by the Intensive Care National Audit and Research Centre (ICNARC). For the 2013 / 2014 audit the CCU performed within expected ranges for all of the 11 quality indicators used. This included hospital mortality rates and the unplanned readmission rate within 48 hours of discharge.

Competent staff

- Newly appointed nurses had an induction to their role in the CCU and were supernumerary for at least four weeks. They had identified mentors on all shifts and worked through a competency framework.
- There was a dedicated clinical nurse educator responsible for coordinating the education, training and continuing professional development framework for critical care nursing staff. This met the ICS standards.
- Nearly all nursing and support staff working in the CCU had received an annual appraisal in the last 12 months.
- There were 64 nurses working in the CCU and 31 of these had a post registration award in critical care nursing. Another two nurses were currently working towards this. This met the standard required of 50% of nurses having the award.
- There was an interim matron who had been in post for approximately two months. Although the matron was an experienced nurse, they did not meet the requirements of the ICS standards. The lead nurse with overall responsibility for the nursing elements of the service should be an experienced critical care nurse in possession of a post-registration award in critical care nursing. Recruitment to the matron's post was in progress.
- Physiotherapists told us they had in-house training and updates at their weekly meetings, for example, presentations by the children's physiotherapists and the lymphoedema team.
- Nurses were supported to undertake relevant training or to look at practice in other trusts. The critical care nurse consultant had been supported to complete a doctorate. A nurse told us about visiting another trust to look at improving practice around weaning patients from ventilators (machines used to assist or replace spontaneous breathing).
- The critical care outreach team provided education and training in acute and critical care skills to staff across the trust. However, the increase in demand for the team had resulted in less time available for training other staff.

Multidisciplinary working

- The multidisciplinary team included nursing and medical staff, physiotherapists, dietician and speech and language therapists, microbiologist, and pharmacist. Physiotherapists, dieticians and speech and language therapists did not routinely attend ward rounds. The daily ward rounds were not always attended by the senior nurse on duty (the supernumerary clinical coordinator). The ward rounds did not meet the ICS standards and did not promote multidisciplinary working. The ICS standard is that consultant led multidisciplinary clinical ward rounds must happen every day in the CCU with input from nursing, microbiology, pharmacy and physiotherapy.
- The dieticians and speech and language therapists were provided by another trust. Staff told us there were no problems in getting these therapists to visit patients in the CCU.
- Patients discharged from the CCU onto wards were followed up by the critical care outreach team.

Seven-day services

- Consultants provided seven day cover and carried out daily ward rounds every day including weekends.
- There was always a consultant on call out of hours. Nurses and doctors told us they were always able to get advice and support from a consultant.
- Diagnostic imaging was available on call outside normal working hours.
- The critical care outreach team was available seven days a week, but not 24 hours a day. Physiotherapy was not a seven day service. Physiotherapists were on-call at

weekends and routinely visited patients in CCU requiring respiratory physiotherapy at weekends. Depending on workload, physiotherapists were sometimes able to see other patients in the CCU at weekends.

Access to information

- Records of patient observations, assessments, care and treatment were kept at the patient's bed. This ensured that staff had easy access to the information they needed and could update the records as and when necessary.
- There was a formal handover document for patients transferred from the CCU to the wards. This included information such as a summary of the patient's care and treatment in the CCU, a plan for on-going treatment, and any follow up requirements. This met the ICS standards.
- Staff had access to computers in the CCU for policies, guidance and communication with other staff.

Consent and Mental Capacity Act

- Nursing and medical staff understood their responsibilities regarding consent and the Mental Capacity Act. We saw that decisions were taken in the patient's best interests if they did not have the capacity to make a decision. Relatives were fully involved in decisions where the patient lacked capacity.
- Deprivation of Liberty Safeguards (DoLS) were considered as part of patients' care. DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty in a hospital. Nurses were clear that any kind of restraint should be a last resort, for the shortest possible time, and use the least restrictive option.

Are critical care services caring?

Good

The care provided to patients using this service was good.

Patients were treated with kindness, dignity and respect. Patients and relatives were positive about how they were cared for and supported. Staff spent time with patients and relatives to ensure they understood the care and treatment and were involved in making decisions.

Compassionate care

- We spoke with four patients and eight relatives of patients. They were all positive regarding the care provided. One relative said, "They've all been so kind and the nurse today has been particularly compassionate. That's what you need when you're here and it's what you want for the person you love who they're caring for."
- We observed staff caring for patients with kindness, compassion and respect.
- Another relative said, "They've respected our privacy when I want to say goodnight to him and that's really important for both of us."
- A relative completed one of our comment cards: "I cannot find one negative thing to say about the staff in ICU or the care they are giving my husband. Even though he is so heavily sedated that he is aware of nothing they always tell him exactly what they are doing to him and why they need to do it."
- We saw that curtains were used around bed spaces to provide privacy for patients. The CCU and the four beds on Ward 43 were mixed sex, accommodating male and female patients in the same areas. This was necessary and acceptable when providing critical care. When patients were ready for discharge from the CCU and no longer needing critical care additional screens could be used to provide privacy. Patients in Ward 43 could be moved to single sex areas on the ward when they no longer required critical care.
- Some patients could be moved on their beds out of the CCU to an outdoor area, (though unfortunately this was an area where bins were stored). Staff told us they tried to do this when possible as patients appreciated being outside and away from the unit, despite the unattractive area. Staff had been able to allow visiting by patients' pet dogs in this way.

Understanding and involvement of patients and those close to them

- Patients and relatives told us they were kept involved and up to date with the care and treatment of the patient. They said the staff took time to make sure the patients and relatives understood the care and treatment and the options available.
- We saw in patient records where doctors had noted their discussions with relatives. The notes showed the questions asked by relatives and the answers given.

Critical care

Emotional support

- Patient diaries were used in the CCU. The diaries were completed by staff and relatives so that patients had a record of what happened during their stay in the CCU when they were discharged. This helped them understand and come to terms with the physical and psychological effects of a stay in the CCU.
- Relatives told us they were well supported by staff when visiting. One relative said, "We get lots of reassurance from staff – and plenty of cups of tea!" Relatives could stay overnight if this was necessary. They used recliner chairs as there were no beds available for them in or near the CCU.
- The hospital chaplain visited the CCU regularly and also on request to provide support.
- When patients were discharged to a ward from the CCU they were followed up by staff from the critical care outreach team. This was to support the patient with their recovery and also to support the ward staff to meet the patient's needs.
- Patients discharged home from the CCU could contact the critical care nurse consultant directly if they had any concerns or questions.
- Patients attending the follow up clinics could be referred for psychological support and counselling if this would be beneficial for them.

Are critical care services responsive?

Requires improvement

The responsiveness of this service required improvement.

The service did not always meet the needs of patients. Bed occupancy in the CCU was consistently above the national average, often significantly higher. This indicated the provision of critical care may not be sufficient. The number of planned operations cancelled because of lack of a CCU bed had increased. Delays in patients being discharged from CCU were worse than the England average.

Admissions to the CCU were usually timely and there were safe alternative arrangements if a bed was not available. Patients were followed up by the critical care outreach team when discharged from the CCU.

Service planning and delivery to meet the needs of local people

- The CCU had provision for up to 13 patients. The commissioning of critical care in the CCU was based on the previous year's actual provision, rather than a fixed number of level two and level three beds. The current commissioned provision was based on approximately 33% level three patients and 66% level two patients. This translated to four beds for level three patients and eight beds for level two patients.
- The CCU worked with the Mid Trent Critical Care Network in managing peaks of demand for critical care beds in the local region. Bed availability was reported daily so that patients could be appropriately directed or transferred where there was a bed available.
- The critical care outreach team provided a service every day, though not covering 24 hours. Use of the teams had increased following the introduction of the early warning score system in 2013. Before the use of the early warning scores the teams had an average of 150 calls per month. This had risen to around 350 calls per month in April 2015. Staffing in the team had been increased to meet this demand.
- Follow up clinics were provided for patients discharged from the CCU. All patients who were on a ventilator for more than 48 hours were invited to a follow up clinic. Other patients were also offered appointments if it was felt they would benefit. The clinics were held every two weeks. Patients could be referred to other services if necessary, such as psychology or physiotherapy.
- There were two quiet rooms available for relatives to use. Relatives could stay overnight using recliner chairs in these rooms. There was a small outdoor courtyard for relatives to use.
- The facilities and premises were generally suitable for the critical care services being delivered. There were plans to look at improving and expanding the facilities.

Meeting people's individual needs

- Staff told us they knew how to get support with language interpretation and translation, though they said this was not often needed.
- There was a specialist learning disabilities nurse who was notified of all admissions of patients with a learning disability. The nurse provided support for patients, relatives and staff in meeting the individual needs of patients with a learning disability. Staff in the CCU said they had been supported by the learning disabilities nurse when necessary.

- Patients were not routinely screened for dementia in the CCU. Staff said this was because this had usually been carried out before the patient was admitted to the CCU.
- Information was provided for patients and their visitors about the CCU and what to expect. This included a display of photographs and information in the visitors waiting area and a series of booklets.

Access and flow

- Most admissions to the CCU, nearly 90%, were unplanned. Other admissions followed planned surgery or the return of patients from other critical care units where they had been for specialist care.
- Bed occupancy in the CCU was above the national average for all except one month between January 2014 and April 2015. The national average was around 85%. Bed occupancy in most months was significantly above the national average, ranging from around 93% to just over 146%. Persistent bed occupancy of more than 70% may indicate insufficient critical care provision.
- The number of planned operations cancelled due to a lack of CCU beds had increased from 15 in April to March 2014/2013 to 25 between April 2014 and March 2015. Following discussion at clinical governance meetings, the procedure for booking CCU beds for patients requiring this after planned operations was under review.
- The decision to admit to the CCU was made by an intensive care consultant together with the consultant or doctors already caring for the patient.
- Patients should be admitted to the CCU within four hours of the decision that this is required. We asked the trust what percentage of patients was admitted within the four hour target. They told us they did not currently collect this data in a way they were sure was reliable. They said they were now intending to introduce measures to capture this information accurately.
- The time of the decision to admit patients to the CCU was noted in patients' records. In four of the five records we looked at there was no delay in admitting the patient to CCU.
- Patients were seen and reviewed by an intensive care consultant within 12 hours of admission to the CCU, in line with the 'Core Standards for Intensive Care Units' published by the Intensive Care Society (ICS).
- Patients should be discharged from the CCU within four hours of the decision being taken that they are ready for discharge. The number of patients experiencing delays in discharge from the CCU was worse than average. This was identified on the divisional risk register with action planned to mitigate the risk. However, the action plan lacked detail and the risk had not been reviewed within the timescale. There was a service improvement group led by a critical care consultant looking at delays in patients being discharged from the CCU. They were in the process of carrying out an audit of delayed discharges looking at the reasons for the delays. This was providing more detail and context than the standard data provided to ICNARC and to the local critical care network.
- Patients were only discharged to a suitable ward. For example, there were specific wards with staff who had the right skills to care for a patient with a tracheostomy, (an opening created in the patient's windpipe to help them to breathe). Staff told us patients would be kept in the CCU rather than discharged to an unsuitable ward, even if this meant a delay.
- Patients should not be discharged from the CCU between 10pm and 7am if at all possible. Discharges during the night have been associated with an excess mortality and patients find it unpleasant to be moved from CCU to a ward outside of normal working hours. Staff told us they avoided out of hours discharges whenever possible and we saw there was a low rate of this in 2014 / 2015.
- Delays in discharge and discharges between 10pm and 7am were reported as adverse incidents, and were investigated.
- Very few patients were transferred out of the CCU for non-clinical reasons, (that is, patients moved to a critical care unit in another hospital due to lack of beds. Clinical reasons would be for different specialist care, such as treatment for patients with severe burns). Current evidence and guidance indicates that patients transferred to other critical care units for the same type and level of care spend longer in hospital overall and have poorer outcomes.
- There was a low rate of patients readmitted to the CCU. A low rate of readmissions indicates that patients were discharged at an appropriate point in their treatment and with suitable support.

Learning from complaints and concerns

- There were low numbers of complaints about the critical care service. Complaints and concerns were

discussed at monthly clinical governance meetings. Action to address concerns and make improvements was planned and followed up at subsequent meetings. One example was changes made in response to a complaint about end of life care in the CCU.

Are critical care services well-led?

Requires improvement

The leadership of this service required improvement.

The leadership and governance of the service did not always support the delivery of high quality person-centred care. There was a lack of strategic overview and planning of critical care services. Risks were not always identified and issues were not always dealt with in a timely way.

Leadership of the service was not always clear and effective, although nursing and medical staff spoke positively of local leadership within the CCU. Staff felt well supported by colleagues, and described effective team working.

Vision and strategy for this service

- There was no critical care delivery group in the trust. It was recommended by the Department of Health in 2000 that NHS trusts should develop a strategic group for critical care to ensure the needs of critically ill patients are being met and planned for. We were told there had been a critical care delivery group but this had not been operational for approximately 18 months. The divisional managers acknowledged that there was a need for a strategic group. Without this there was a lack of strategic overview and planning of critical care services.
- The critical outreach team had produced an annual report of the service in March 2015. This was presented to other staff groups in the trust by the critical care nurse consultant and was well received. However, plans for service improvement projects identified in the report had not advanced.

Governance, risk management and quality measurement

- There were monthly clinical governance meetings that included discussion of patient safety, patient experience and feedback, national and local guidance, and current and new risks. Actions were decided and were followed up at subsequent meetings. An example of this was the work being carried out to audit delayed discharges of patients from the CCU and examine the reasons for delays
- Identified risks were noted in the divisional risk register. Risks with a score of 15 or more were added to the trust's significant risks register which was reviewed monthly by the Risk Management Committee and the executive team.
- There were two current risks in the divisional risk register relating to the critical care service: delays to patient discharges from CCU, and the lack of storage space within the unit. Both risks had been recently reviewed and neither scored above 15.
- The action plan to reduce the risk of delayed discharges from CCU lacked detail. The actions included, "Inpatients beds for patients to be identified as a priority", but there were no details of who would manage or monitor this. The risk was last reviewed on 2 June 2015 but there was no date for the next review.
- The lack of storage space was noted during our previous inspection in April 2014. . It was noted on the risk register, "Score reduced 20/05/2015 as actions implemented." However, it was not clear what action had been taken as the storage arrangements had not changed since our last inspection. The risk was last reviewed on 21 May 2015 but there was no date for the next review.
- The risk register did not include risks identified by staff: the lack of a 24 hour critical care outreach team and the high rate of bed occupancy in the CCU.
- The lack of delirium screening had been discussed at clinical governance meetings and work was in progress to identify and implement a suitable screening tool. There were no firm plans for when the delirium screening would start.

Leadership of service

- The nursing leadership in the CCU did not meet the 'Core Standards for Intensive Care Units' published by the Intensive Care Society (ICS). The lead nurse with overall responsibility for the nursing elements of the service should be an experienced critical care nurse in possession of a post-registration award in critical care nursing. The interim matron, although an experienced nurse and manager, did not have the relevant critical care experience or qualification. Recruitment to the matron post was in progress.

Critical care

- Most staff spoke positively of the support from managers within the CCU. This included the ward manager, a nurse consultant, a nurse educator, and the interim matron.
- The ward manager had been supported by the trust to complete a nationally recognised leadership programme.

Culture within the service

- Staff told us they were frustrated by the complicated process for obtaining permission to use agency staff. They felt they were not trusted to make appropriate assessment of the staffing situation and request suitable staff.
- Nursing and medical staff described positive and effective working relationships in the critical care service. Staff told us they were proud of the team work and said staff were always willing to help and support their colleagues.
- Nurses told us they had good support from medical and other nursing staff when there were difficult times, such as patient deaths or serious incidents.

Public engagement

- Patients were asked to complete a questionnaire on discharge from the CCU. This had only started in April 2015 and the responses were still being collected and analysed.
- Thank you cards from patients and relatives were displayed. During our visit we saw relatives and a patient returning to the CCU to thank staff.

Staff engagement

- Most staff felt they could bring ideas for improvements to the service and they would be listened to.
- Nurses, therapists and health care assistants used a 'clocking-in' system that calculated their working hours. There was a general dislike of this system. Staff felt their goodwill and loyalty had been affected as the system did not allow flexibility. This meant that staff were sometimes unwilling to work additional shifts or to stay on when needed at the end of shifts.

Innovation, improvement and sustainability

- The current critical care outreach provision was from 7.45am until 8.45pm every day. After this time, calls were responded to by the night team leader. The nurse consultant for critical care was collecting data on calls for critical care outreach during the night. The data showed there was a demand during the night and the nurse consultant was planning to put a business case for an increase in the hours of operation of the critical care outreach team.
- There was an upgrade planned to the electronic system used for monitoring early warning scores. This would allow the system to send automatic calls to the critical care outreach team when a patient's scores indicated the need for an urgent response. It was identified that this was likely to mean an increase in calls to the outreach team. The critical care nurse consultant was looking at how this could be managed and considering support that could be provided by other staff for some patients rather than the outreach team.

Maternity and gynaecology

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

Information about the service

The maternity unit at King's Mill Hospital included the pregnancy day care unit, antenatal clinic, maternity ward (antenatal and postnatal), the Sherwood Birthing Unit and the neonatal unit. The Sherwood Women's Centre at Newark Hospital provided comprehensive facilities for antenatal and postnatal care, including ultrasound. The birthing unit provided care to women during pregnancy, labour and after giving birth. There were three triage bays (where women were assessed to determine if they were in established labour), nine birthing rooms, two high dependency rooms, a pool room, a bereavement room and two theatre suites. The maternity ward had 32 beds, and four of the 14 side rooms were used for induction of labour. This area of the maternity ward had an adjoining corridor to the birthing unit to allow easy access for emergency cases.

Four community midwifery teams provided maternity services in partnership with general practitioners and health visitors.

The total number of births from April 2014 to March 2015 was 3429, which was a 4% rise from the previous year. The hospital had one of the highest normal births and home birth rates in the country.

The gynaecology service offered inpatient ward, day care and early pregnancy assessment unit facilities. They cared for women with gynaecological problems and early pregnancy issues or miscarriage. A team of gynaecologists were supported by gynaecology nurses, general nurses and support workers.

During our inspection we visited all the ward areas and departments relevant to the service. We spoke with 28 women, 4 relatives, and 57 members of staff, and we reviewed 29 medical records.

Maternity and gynaecology

Summary of findings

This service required improvement overall.

Patients were not always protected from the risk of avoidable harm. Staff did not check essential lifesaving equipment as often as they should. Staff did not carry out routine patient observations as often as they were required to and when findings indicated a risk to a patient's health, the right actions were not always taken. Midwives were delivering post-operative care without the required formal training and competency assessments. Medicines were managed safely in the hospital but community midwives did not have effective systems in place.

Women using the maternity service did not always receive care based on the maternity service's guidelines and national guidance. Women stayed on the ward after giving birth for up to five days and there were no plans to work differently to reduce the time women stayed in hospital. Women did not have a choice to give birth in a midwifery led, home from home environment.

Caesarean section rates and natural birth rates were better than the national averages. Patients' pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding. Patients were positive about the care they had received. Staff were kind and thoughtful. Women and their partners felt involved with their care were happy with explanations that were given to them.

Although staff demonstrated a strong desire to develop the service, patients and the public were not involved in service development and women did not have the opportunity to express choices about postnatal care. Women and their families did not know how to make a complaint and staff were not aware of departmental complaints. Services were arranged to meet some people's individual needs, with specialist support staff people with complex conditions and wheelchair accessible premises.

There were established local governance arrangements, but the department was not integrated into divisional and organisational governance and risk management. Identified risks to patients and service delivery were not being managed through a risk reporting process. The department's initial response to the national recommendations of an important review of maternity services was incomplete and lacked clarity.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

The safety of this service required improvement.

Patients were not always protected from the risk of avoidable harm. Staff did not check essential lifesaving equipment as often as they should. Staff did not carry out routine patient observations as often as they were required to and when findings indicated a risk to a patient's health, the right actions were not always taken. Midwives were delivering post-operative care without the required formal training and competency assessments.

Medicines were managed safely in the hospital but community midwives did not have effective systems in place. Staff reported incidents which were reviewed and lessons learned. There was a process for the investigation of serious incidents. However, it was not clear that all healthcare professionals involved had been given the opportunity to contribute to investigations. Midwifery and medical staffing vacancies were being addressed.

Incidents

- The number of reported serious incidents from March 2014 to February 2015 was 14. There was a significant increase of six in March 2015. Intrauterine foetal death (IUFD) and closure of the unit were the most common incidents reported. The rate of IUFD incidents for the year was about the same as the national average of 4.7 out of every 1,000 births.
- Internal risk summit meetings were held to discuss the increased number of incidents. We looked at four serious incident reports. Analysis did not always identify all of the underlying problems. It was not clearly documented that a team of healthcare professionals were involved with the investigation process. The reports were not always sensitively written.
- An external review of all the serious incidents was commissioned and a report produced. We reviewed the report which identified poor root cause analysis and lack of multi professional reviews in some of the reports.
- Senior staff knew about the Duty of Candour Regulation which came into force in November 2014. This requires healthcare providers to be open and honest with patients when things go wrong.
- The birthing unit rooms contained folders with emergency documentation sheets to facilitate immediate documentation of an incident.
- Staff were able to explain the incident reporting system. There was evidence that incidents were reviewed and discussed appropriately. Learning from incidents was shared in a number of ways: displayed on ward notice boards, and communicated to staff at handovers, ward meetings and via a newsletter. Staff were able to give an example of learning from an incident where a central digital clock system was installed in the birthing unit ensuring that all of the clocks showed the same time. Following three serious incidents where women were admitted to the intensive care unit for a very high level of one to one care, the service re-designed its modified early warning score (MEWS) chart.

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetrics and Gynaecology (RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm included perineal or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety, Apgar score of less than seven at five minutes, and admissions to neonatal units. (The Apgar score is an assessment of overall new-born well-being). The ante/post-natal ward had achieved 100% harm free care for the last six months.
- The gynaecology service, ward 14, had consistently recorded 100% harm free care within the expectations of the nursing safety thermometer for the last six months.

Cleanliness, infection control and hygiene

- The areas we visited were clean and there were ample hand gel dispensers with instructions on how to cleanse hands. Staff followed good hand hygiene and were bare below the elbow to help prevent the spread of infection.
- Equipment was labelled when cleaned, signed and dated. The birthing rooms had notices which indicated if the room had been cleaned, required cleaning or was in use.

- At the time of our visit we found the birthing pool was full of dirty water from a birth earlier that day. The room had been cleaned and was labelled as ready for use. We reported this to a senior member of staff who arranged for the birthing pool to be cleaned immediately. The system to clean the pool at the same time as the room had not been followed.
- Maternity and gynaecology services achieved 90 to 95% compliance with the cleaning audits from January 2015 to April 2015.
- There were reliable systems in place for the management and disposal of waste.

Environment and equipment

- There was a system for checking equipment, however staff did not consistently complete daily checks on life saving baby resuscitation equipment. It ranged from none to five a month being completed in a three month period.
- The doors to gain entry to the ward areas were locked. Staff identified visitors and who they intended to visit, and then allowed them entry. We were asked to present our identification badges when first gaining entry to the wards.
- The two high dependency rooms on the birthing unit were spacious and well equipped.
- All areas we visited were spacious and uncluttered; storage areas were well stocked and labelled.
- Adequate equipment was available to run the service safely; each birth room had piped oxygen and Entonox, (a gas which provides pain relief). All equipment we looked at had been tested and was in date.
- Ninety per cent of staff trust wide attended equipment training; the maternity staff statistics were included within the trust wide database.
- There was a cardiotocograph (CTG) machine, (this monitors the baby's heartbeat in high risk cases) in every birthing room. Staff had been able to use a CTG which enabled high risk women to move around in labour which promoted normal birth.
- The community midwives' clinic area at Newark Hospital was shabby and the furnishings were worn in some areas.

Medicines

- Medicines were usually stored, managed, administered and disposed of safely. However, there were gaps in the checks of medicines used by community midwives, which meant they were not assured that drugs were in stock or in date. We found a bag of intravenous fluid that was out of date. We alerted staff and it was removed from the clinical area.
- Controlled drugs were appropriately checked twice a day in most areas. The staff on one ward checked controlled drugs once a day. This was not in line with trust policy which required twice daily checking.

Records

- Patient records were kept securely in all areas.
- Hospital records were paper format. Midwives gave mothers their records to keep with them and bring to every appointment. Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development.
- We looked at 14 maternity records. The majority were legible, dated and signed. Individualised care plans were evident in the records. The woman's name and hospital or NHS number were not documented on each page in the majority of hand held records. This posed a risk of detached pages not being returned to the correct records.
- The gynaecology ward audited records monthly to continually evaluate practice. The maternity service did not perform a regular audit of records to monitor compliance of accurate record keeping. Staff told us they reviewed one set of records on the midwives training day.

Safeguarding

- There was a designated safeguarding midwife for maternity services who provided support and supervision. Midwives told us that they were able to raise concerns and knew how to report a safeguarding incident.
- Staff were aware of the female genital mutilation (FGM) guideline. A midwife gave an example of a woman who was identified as having FGM. The woman was referred to the safeguarding midwife and the Department of Health (DOH) were notified. This was in line with national guidance.
- Attendance for level 3 safeguarding training by all disciplines was 95% for the year 2014 -2015. This was in line with the trust's target compliance rate of 95%.

Mandatory training

- Staff were supported to attend training days. The midwives told us that they had very good facilities to accommodate training. They told us the quality of the training days had improved since the appointment of the practice development midwife in October 2014.
- Staff told us that they attended a trust mandatory training day, a multidisciplinary emergency skills and drills training day, a midwives issues training day, information governance and conflict resolution. Attendance for 2014-2015 was between 95% and 100% Conflict resolution and information governance training attendance were included in the trust wide statistics. Information governance e-learning completion was poor at 58%. Time to complete this was included on the midwives issues training day.
- Gynaecology training was managed by the trust wide practice development team and recorded on the trust wide statistics. The ward leader told us that the staff were up to date with their training. 90% to 94% of staff had completed training.
- Medical staff reported good trust induction training with the medical director being present on day one. Locum doctors attended half a day induction and were supervised during their placement.

Assessing and responding to patient risk

- Early warning scores were used to monitor patients and identify when their condition may be deteriorating. Early warning scores enable early recognition of a patient's worsening condition by grading the severity of their condition and prompting nursing staff to get a medical review at specific trigger points.
- The modified early warning scores (MEWS) chart had an option at the score of three for staff to notify a doctor if they were concerned about the patient's condition. This gave the staff making the observations the choice not to notify a doctor. Staff did not always take basic observations at the times that they were due.
- The service used neonatal early warning scores (NEWS) to record baby observations. We saw evidence that doctors had not been notified of a baby with a high score. We observed the care of a second infant with a high NEWS score; the response from medical staff following the escalation process for this baby was not effective. It required further escalation to a senior member of the medical team and insistence from the midwife which ensured the baby was reviewed.
- The completion of observations and escalation process of the MEWS and NEWS charts were not always used. This meant the women/patient's condition could have deteriorated and staff would not have been monitoring them effectively.
- The modified early warning scores (MEWS) tool was introduced in April 2015, and its use was audited in May 2015. This showed that although higher scores were acted on appropriately, the section which provided guidance for staff on how frequently to carry out observations was only completed in 40% of records.
- The gynaecology ward used an electronic system for recording patient observations which recorded and monitored the frequency of MEWS observations. It alerted staff if observations were overdue.
- Midwives did not receive training to care for women who became acutely ill and required one to one care. This did not prepare them to identify deterioration of women with high risk conditions.
- Midwives cared for women on the ward immediately after a general or local anaesthetic. Women remained in theatre until they could breathe on their own, and returned to their room on the birthing unit. If a local anaesthesia was used, they returned immediately to their room. Staff had not received recovery training and competency assessment to comply with recommendations from the British Anaesthetic and Recovery Nurses Association.
- We observed good communication and teamwork in theatre on the birthing unit. The theatre staff followed the WHO surgical safety checklist pathway (designed to reduce the number of surgical errors) appropriately to ensure patient safety.
- We looked at six maternity records risk assessments. None were fully completed. Items missing included times, MEWS frequency of observation scores and postnatal venous thromboembolism (a blood clot in the deep veins of the leg) assessments.
- We looked at nine patient nursing records in the gynaecology department. All risk assessments were fully completed.

Midwifery staffing

- The ratio recommended by 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Midwives 2007), based on the expected national birth rate, is one whole time equivalent (WTE) midwife to 28 births. The maternity

service had a ratio of one WTE midwife to 29 births. The service vacancy level was two WTE midwives. The service planned to recruit students who were due to complete their training. Staff worked extra shifts to provide cover as needed. Expected levels and actual levels of staffing were displayed on notice boards in all ward areas.

- The birthing unit did not use an acuity tool to determine staffing levels in response to the amount of care the women needed. The staffing tool calculated the required staff on each shift based on one to one care for women. Senior staff had stopped using an acuity tool last year because they felt the results were not analysed at a higher level.
- The trust employed coordinators to ensure the smooth running of the department and allocated midwives to women. A number of coordinators told us that one to one care for women in labour was available all of the time. When we spoke to the midwives they said they were unable to provide one to one care every shift, but did not complete an incident form for every occasion this happened. The midwives told us that this was not ideal however they would escalate to the senior midwife if they felt practice was unsafe.
- Midwives told us that they were moved regularly from the maternity ward to help on the birthing unit. This had an adverse effect on the care given to mothers and babies on the maternity ward. Staff reported this as an incident but felt that there were no plans for long term resolution. Staff said without unqualified staff they could not manage on a shift.
- Coordinators were supposed to be supernumerary, so as to be able to carry out their coordinator role. However this did not always happen, and although midwives were allocated to care for women safely, sometimes the coordinator was responsible for the care of a woman.
- Sickness absence for 2015 was just under 5%, worse than a target of up to 3.5%. This was an improvement on 2014 when sickness absence had been as high as 9%. This was covered by staff taking extra shifts. The service did not use agency staff. A text messaging system was used to ask off-duty staff if they could work an extra shift. Staff we spoke with said they did not mind because it was optional.
- There were four community midwifery teams with a manageable caseload of around 75 women each. Community midwifery staff (CMW) were requested to cover the birthing unit when it was short staffed or if there were lots of women attending the unit. Staff told us that they used to have four community midwives on call which was reduced to two. The community midwives were very proud of their home birth rate. We were told that the home birth rate had dropped by two per cent in the last year. The community midwives felt this was because there were less community midwives on call and they supported the hospital service when it was busy.

Nursing Staffing

- The gynaecology ward and the surgical assessment unit were staffed as one unit. There was one specialist gynaecology nurse allocated for each shift. Planned staffing was two registered nurses and three health care assistants for the day shift and two registered nurses with two health care assistants for the night shift. It was rare for the ward to use agency staff. This was sufficient staff to meet patients' needs. The ward team leader was not given any women to look after which meant she could supervise and support staff.

Medical staffing

- The quality dashboard showed there were 60 hours a week of dedicated consultant cover on the birthing unit and on call within a 30 minute commute outside of those times. This was in line with national recommendations for the number of babies born on the unit each year. Medical staffing rotas were printed and very accessible to the midwives and nursing staff.
- There were seven consultants with plans to increase to nine. One had already been recruited and was due to start in July 2015 and the other recruitment was in progress. There was a plan to increase medical presence on the birthing unit. It was rare to have to use locums at short notice. One locum doctor had been appointed full time to cover maternity leave.
- There was no designated consultant to take the lead for foetal medicine and the pregnancy day care unit.
- There were 29 medical staff in total. There was a higher proportion of junior staff at the trust compared to the national staffing skill mix proportions. This was offset by the lower proportion of staff at higher grades. Junior staff told us that higher grades of staff were available whenever they needed them.

- Anaesthetic cover was available on the Birthing Unit from 8am to 7.45pm with experienced staff and registrar cover overnight through an on call system.

Handovers

- There were two midwifery handovers a day at 7am and 7pm. Multidisciplinary team handovers on the birthing unit followed the midwives' handover. We observed three effective handovers. The staff used a good handover sheet prepared electronically by the lead of the shift handing over. The handover sheet included the names of women, all staff on duty, home births and babies. There were messages that were passed on to staff shift by shift. The support workers were involved in the handover.
- We were able to observe a patient who returned to the ward following a gynaecological procedure. The theatre nurse gave a good handover and proceeded to check all the equipment with the ward nurse before leaving. We observed a thorough handover in the evening. Nurses signed a handover sheet which indicated they had received the information needed to accept the patient. The support workers were involved in the handover.

Major incident awareness and training

- Staff knew there was a major incident policy and instruction book accessible to use if necessary.

Are maternity and gynaecology services effective?

Requires improvement

The effectiveness of the service required improvement.

Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Women at risk of early labour were not always treated in line with current standards. The monitoring of the baby's heartbeat before birth did not follow current guidance and best practice.

The number of women who had their labour induced (started artificially) was very high at 30%. Staff could not explain why the induction rate was so high.

Outcomes for women using the service were not always monitored regularly or robustly. Nursing and midwifery staff were not involved in routine audits of their service to check quality, measure themselves against other providers and identify areas for improvement.

Caesarean section rates and natural birth rates were better than the national averages. Patients' pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding.

Evidence-based care and treatment

- Guidelines and policies were based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth guidelines.
- We reviewed six guidelines/policies which were all based on NICE or RCOG guidelines. They were in date, but not all of them showed a record of changes so that staff knew they were using the most recent version.
- The service did not meet the required standard for mothers receiving steroid medication in the antenatal period. Steroids should be given to mothers when they are at risk of an early labour but this was not always happening. Staff told us that this was due to a miscalculation on the computerised system. There was no action plan to address this. The service presumed women had received the steroids but there had been no audit of records to check against the computerised system.
- The pregnancy day care unit (PDCU) did not have specific pathways for the service. General maternity guidelines were followed.
- Community midwives were expected to visit women on their first day home, between five to eight days after the birth and then again between 10 to 14 days after the birth. Records we reviewed showed some women had not received a visit for up to 15 days after the second visit. Best practice guidance recommends a visit between day nine and 14.
- In line with local and national guidance, when using a cardiotocograph (CTG), the baby's heartbeat should be reviewed and classified every hour using a CTG sticker or written in full. There should be reviews by another midwife not involved with the woman's care – a 'fresh eyes' review. However, staff on the unit did not do this.

- The service was involved with the national pregnancy in diabetes audit. Other audits were limited and staff we asked could not explain the audit process. The common response was that the doctors led on audit and chose topics when there was a problem.
- There was evidence that the service had reviewed their intrapartum (during birth) practice when the NICE guidance 2014 was published. The birthing unit changed the drug used in the active management of delivering the placenta to meet the new guidance.

Pain relief

- The pool provided pain relief for women who wanted to have a water birth. Staff told us that some women used the pool for pain relief in labour but would get out for the actual birth.
- Staff trained in the use of aromatherapy offered women another form of pain relief. Entonox, (a medical pain relieving gas), was piped in all rooms. If women required further pain relief midwives could offer a choice of stronger painkillers by injection.
- Women were able to access pain relief as required in a timely manner, including a local injection to numb the area if requested and clinically appropriate. The women we spoke with all told us they were given adequate pain relief during their labour and in the postnatal period.

Nutrition and hydration

- Women we spoke with told us there was a good choice of menu and the meals were good. We saw menu cards had clear colour coding for specialist diets. Alternative menu cards were in large print and they were also available in a range of languages. The kitchen was situated on the maternity ward and women had the choice of two hot meals a day. Snacks were available if women wanted them.
- Mothers were encouraged to make an informed choice to feed their babies and were very well supported by midwives and support workers.
- The service was awarded UNICEF stage three Baby Friendly Initiative accreditation in July 2014. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding.
- The infant feeding coordinator managed a team of six infant feeding support workers, known as the 'lime greens'. Their additional support helped women to overcome any breastfeeding problems and enabled them to feed for longer.
- The support team were highly regarded by the women, hospital staff and community midwives. They offered additional support to women with their chosen method of feeding. Women who chose to bottle feed were provided with support and information on how to make up milk and feed their baby safely.
- The infant feeding coordinator was trained to treat tongue tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve feeding problems.

Patient outcomes

- The maternity department maintained a quality dashboard which reported on clinical outcomes before, during and after delivery.
- The number of women who had their labour induced (started artificially) was very high at 30%. We asked several members of staff why that was and they could not explain any contributory factors. An audit was planned to review the reasons women were referred to have their labour induced.
- Unexpected admissions of babies to the neonatal unit were not captured within the maternity quality dashboard. Staff on the birthing unit told us they recorded details if babies were transferred out to a neonatal intensive care unit and that the neonatal unit managed the data for unexpected admissions.
- The number of women who had a normal birth was 67%. This was better than the 2012-13 national average of 61%. Staff told us that home birth rate was two per cent lower than the year before and had not met the target of 6%.
- The caesarean section rate of 21.5% was low compared with the national average of 25.5%, but was above the trust target of 20%.
- Community midwives referred women who smoked to a smoking cessation clinic for a one to one consultation. They discussed the risks associated with smoking in pregnancy and demonstrated visually how their smoking habit affected their baby. This was good practice. However, statistics showed there was an

annual overall increase from the number of women who were smokers at the time of their booking appointment to the number who were smokers at the time of the baby's birth.
- The number of women who had third and fourth degree perineal tear rates was 2.42%, which was better than the trust target of 4%.
- Women who had obstetric haemorrhage (bleeding following birth) greater than 1.5 litres was 1.12%, which was better than the trust target of 1.86%

Competent staff

- Staff had not received recovery training and competency assessment to comply with recommendations from the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia.
- Support workers carried out observations for high risk babies. Although this would usually be the role of qualified staff, the support workers' training and competency package was comprehensive.
- All staff we spoke with had attended an annual appraisal. Staff told us they found appraisals very useful to discuss any issues they had and to plan their objectives for the following year. Completed appraisals from July 2014 to April 2015 for the service was between 89% and 100%.
- Supervisors of midwives (SoMs) help midwives provide safe care and are accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation was for a supervisor to have 15 midwives; in this case the SoMs were just above this ratio with 16 midwives to supervise. The Local Supervisory Authority (LSA) annual audit in February 2015 recommended that the trust worked towards 13 midwives to one SOM to allow for succession planning. At the time of the visit there was a student SoM undertaking preparation of SoM educational course, due to qualify in July.
- Newly qualified midwives completed a competency pack before progressing to a higher grade. When completed it was presented to the Head of Midwifery HOM who signed them off. Staff told us it took around 18 months to complete but sometimes it was delayed because of the availability of the mentorship course.
- Midwives' competencies were maintained by working for six months at a time in each area of the service. A small number of midwives did not do this which enabled stability and expertise in that area.
- Staff reported live skills and drills training sessions (practising real time emergencies) were held and a weekly CTG meeting was used to discuss high risk cases.
- Midwives were supported to attend external training. This maintained individual competencies to develop training days within the department.
- Medical staff had weekly training opportunities, and they attended all of the deanery, (department responsible for doctors training programme), training sessions.

Multidisciplinary working

- Staff told us multidisciplinary team (MDT) working was good in the hospital and the community. A good example of this was when a partner told a midwife how calm the team were during an emergency which involved his wife.
- Hospital midwives told us communication and working relationships with the community maternity team were efficient and effective.
- Staff reported good working relationships with the neonatal team which included monthly meetings. A neonatal case was presented by the medical staff so that issues were discussed and lessons learnt shared.
- The community midwives were based at General Practitioner (GP) surgeries which enabled good team work with all community services.
- The gynaecology wards and departments had effective team working with all disciplines and allied professionals.

Seven-day services

- Maternity & gynaecology services were available 24 hours a day seven days a week. Women were able to access maternity care by telephoning the birthing centre or though referral from the antenatal clinic or their GP. Gynaecology patients could be referred by their GP or via the emergency department.
- The pregnancy day care unit for women to be seen with pregnancy complications was open 8am to 6pm Monday to Friday and 8am to12pm on a Saturday.
- Physiotherapists were available five days a week. At weekends the midwife referred the women to the

physiotherapy department. If the woman remained in hospital they visited her on the Monday. If the woman was discharged home an out-patient appointment was arranged.
- Portable scanners were available in maternity and gynaecology which meant that medical staff could scan pregnant women, postnatal women or gynaecology patients out of hours.
- The early pregnancy unit was open six days a week Sunday to Friday. Plans were being discussed to increase to seven days a week.

Access to information

- Staff were able to access guidelines they needed to deliver effective care and treatment to patients.
- There was a white board which mapped the rooms on the birthing unit. It did not display any of the woman's clinical details to allow medical staff a quick overview of the issues on the birthing unit. The coordinator updated medical staff which meant there could be a delay if they were busy in a room supporting junior staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave verbal consent for their care and treatment and this was documented in the women's records. Written consent for surgical procedures was observed in the records we reviewed.
- We saw signed consent forms for operations in the gynaecology records we reviewed. Correct procedures were followed for obtaining consent from patients.
- Training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was part of the trust mandatory training. Staff had to complete a workbook before attending the training. Ninety per cent of staff had completed this training.
- Staff had an awareness of the MCA and knew to access help from the safeguarding adults nurse. The majority of staff we spoke with were not familiar with Deprivation of Liberty Safeguards (DoLS) and could not describe what it was. The safeguards aim to ensure that those who lack capacity and are in hospital are not subject to excessive restrictions.

Are maternity and gynaecology services caring?

Good

The care provided to patients using this service was good.

Women and their relatives were positive about the care they had received. Staff were kind and thoughtful. Women and their partners felt involved with their care were happy with explanations that were given to them.

Patients on the gynaecology ward were well informed and felt looked after by kind and compassionate staff. Staff spent time with patients to ensure they understood their condition and care. Patients' dignity and privacy were sometimes compromised when male patients from the adjacent surgical assessment unit used the same areas as women on the gynaecology ward.

Compassionate care

- Women and their partners were very positive about the care they received. All of the women we spoke with told us that they had been treated with kindness, dignity and respect. We saw good interactions between staff, women and their relatives.
- Family and Friends Test (FFT) results were generally better than average for birth, postnatal ward and postnatal community care between December 2013 and March 2015. Results for antenatal care were, on average, roughly two percent worse than the England average for the same period.
- We observed staff respecting the women's dignity by knocking and waiting to be invited in to rooms or behind curtains. All birthing rooms had signs indicating they were being used to protect patient's privacy and we saw staff using the signs.
- The gynaecology ward and the surgical assessment unit were located together in what had once been one ward. This meant male patients from the surgical assessment unit could be in the same area as women on the gynaecology ward. Staff told us they tried to ensure this did not happen to protect the dignity and privacy of patients. However we observed a male patient waiting for a scan in the early pregnancy day unit because the main scanning department was busy. Another male patient in a theatre gown was walking around in the gynaecology ward.

Maternity and gynaecology

Understanding and involvement of patients and those close to them

- Women told us they were well informed by midwives and medical staff. They participated in planning their care. All women were encouraged to complete their birth plan at around 36 weeks of their pregnancy. Women felt comfortable to ask questions and were happy that they were answered fully.
- Prior to our inspection we heard from one women who felt she was not involved in her care and felt frightened they were not caring for her or her unborn child, placing her at risk of harm. She told us she had tried to raise her concerns but did not feel anyone was listening to her. We raised this with the trust and they responded straight away to resolve this woman's concerns.
- Partners we spoke to were very happy with the care and their involvement.
- Women discharged home were provided with information about the signs and symptoms they should look for and told if they experienced any of them to seek advice.

Emotional support

- Birthing partners were encouraged to stay which provided extra support to women and enabled early bonding for the family unit.
- Staff dealt with maternal or baby deaths compassionately. They provided support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide support.
- For women who required further emotional support or wanted to discuss their care at a later date there was not a service to provide this.
- The service did not have a designated bereavement midwife. There were midwives with an interest in developing the service, but they told us being released from clinical duties was sometimes difficult.
- We spoke with 12 patients using the gynaecology service. All were very happy with the surgical and nursing care they had received. Patients felt they had been involved in the decisions made and staff were extremely kind and helpful.

Are maternity and gynaecology services responsive?

Requires improvement

The responsiveness of this service required improvement.

The service was not always planned or delivered to meet people's needs. Women stayed on the ward after giving birth for up to five days and there were no plans to work differently to reduce the time women stayed in hospital. Women did not have a choice to give birth in a midwifery led, home from home environment.

Women who needed a planned caesarean section were given a date, but had to telephone on the day to check the operation would go ahead. If the birthing unit was too busy, operations were cancelled and rearranged.

Women and their families did not know how to make a complaint; there were no displays in the unit informing women how to complain, and staff were not aware of departmental complaints.

Services were arranged to meet some people's individual needs, with specialist support staff people with complex conditions and wheelchair accessible premises.

Service planning and delivery to meet the needs of local people

- Women were seen by a midwife promptly in the birthing unit triage centre usually within 30 minutes. This offered reassurance to women to return home if they were not in established labour. High risk women were seen by medical staff usually within 60 minutes. This could be longer if medical staff were dealing with an emergency or in theatre. Staff said if this happened and the women needed an urgent referral they would call the consultant to attend.
- Newark Hospital provided antenatal clinics, scanning sessions and gynaecology clinics to reduce the travelling for local people. Breast screening clinics were provided monthly. Staff working at Newark Hospital felt it provided a good local service to the community.
- The community midwives offered an on-call service to support mothers who planned to have a home birth. Women were given an informed choice about where to give birth depending on clinical need. The community midwives staffed an advice line from Kings Mill Hospital Monday to Friday from 9.30am to 4.30pm.

- There was no differentiation between high and low risk women as they were cared for in the same area. The model of home from home environment for low risk women was not in place. There were no plans to provide a midwifery led unit. Although 53% of women were booked to have midwife-led care, during 2014/15 at delivery this had reduced to 22%.
- The birthing rooms appeared very clinical, containing all of the equipment needed for a high risk birth. The pool room contained a delivery bed in addition to the birthing pool. When we asked staff about this they said there was nowhere else to store the bed. Staff had been asked by the HOM to arrange rooms to look less clinical but this was not monitored and therefore not maintained.
- Women attending termination of pregnancy clinics did not have the opportunity to be seen by a qualified counsellor to ensure that they had been counselled effectively. There were two termination of pregnancy clinics each week, one attended by a consultant and supported by a nurse and the second was run by a consultant only.

Access and flow

- From April 2014 to March 2015 the maternity department met the locally set target of 85% of women referred and booked within the first 13 weeks of pregnancy.
- The maternity service had temporarily suspended services on six occasions in the last 12 months and women were diverted to other maternity units. Three occasions were due to insufficient midwifery staff, the other occasions were because the birthing unit had no empty rooms.
- The maternity ward bed occupancy was consistently over 80%, which was worse than the national average of 55%-60%. There had been no audit to review the length of stay.
- Staff told us that women stayed as long as they wanted to. Women stayed on the ward regularly for three to five days rather than going home early. Senior staff said they had plans for preparing women for short stays but this was not supported in practice. Staff were not concerned about the flow of women through the service.
- There were no dedicated theatre sessions for planned caesarean section operations. The date of the operation was booked by the antenatal clinic and the woman called the birthing unit on that day to see if the operation could go ahead. The operations were sometimes cancelled due to emergencies that would have to take priority. We spoke with a woman who had been admitted that morning and was waiting to go to theatre. She was told later the same day her operation had been cancelled due the number of emergencies requiring surgery. The woman was asked to return the following day.
- Gynaecology patients were able to have treatment in a timely way. Nurses told us that they very rarely had patients from other wards, which enabled them to take their planned admissions and emergency cases. They rarely had delays in discharging patients from the ward or the day surgery unit.

Meeting people's individual needs

- Women received care from the same midwife in the community for the majority of their pregnancy and following the birth.
- Staff told us that if the service was short of staff or suspended, women were not able to be supported to have their home birth.
- A telephone interpreting service was available for staff to use. Staff told us that they found this difficult and they preferred to use family members or an on-line search engine. Staff were aware of the trust policy which said that family members should only be used in an extreme emergency and the on-line search engine was not a recognised translation service.
- The midwife assessed women for mental health issues at their booking appointment and each contact. A junior doctor explained if there were severe concerns with a woman's mental health they were referred directly to other local NHS mental health services. Otherwise, women were referred to the trust on-site psychiatry unit. Midwives and doctors told us that the community psychiatric nurse team and specialist midwife were very supportive.
- Midwives notified the specialist learning disabilities nurse of all admissions of women with a learning disability. The nurse provided support for the woman, relatives and staff in meeting the individual needs of patients with a learning disability. Staff knew how to access the learning disability nurse and told us about using communication passports for women with a learning disability.

- Staff we spoke with described how same sex couples were welcomed and how they had cared for surrogate mothers.
- Wheelchair access was possible into the birthing rooms and wet rooms on the birthing unit and maternity ward.
- Women who needed specialist antenatal care were referred to another maternity unit for investigations. The antenatal screening coordinator saw the women at other appointments during their pregnancy but there was no consultant identified to support the antenatal screening coordinator.
- The women and midwives were supported by specialist midwives including a safeguarding midwife, clinical risk midwife, substance and alcohol misuse and mental health midwife, infant feeding coordinator, screening coordinator, a recently appointed deputy screening coordinator, and a practice development midwife.
- There was no designated diabetic specialist midwife or bereavement midwife. The birthing unit had a well-appointed bereavement suite with a self-contained kitchen and bathroom. Parents were given a memory box which contained keepsakes. Funds were being raised to buy a double bed for partners to be more comfortable.
- The maternity leaflets on the trust internet covered topics that were not in the medical records kept by the women. The leaflets were not available in languages other than English. Staff told us that the leaflets could be translated into other languages using an on-line service. However, when we tried this, only the title of the leaflet was translated, not the content.
- The pregnancy day care unit offered specialist care and support to women who had complex pregnancies. There was a quiet room which enabled privacy for difficult conversations.
- The antenatal clinic and pregnancy day care unit had information displays which covered topics such as infant feeding, stopping smoking, and movements of the baby during pregnancy.
- Staff did not seek women's opinions on where they wanted their postnatal visits. Staff assumed women were happy with the current service.

Learning from complaints and concerns

- There was no information displayed for women and their relatives about how to make a complaint.
- The system for dealing with complaints was not effective. The head of midwifery told us the complaints department dealt with all of the complaints and that they did not inform her of complaints for maternity and gynaecology.
- Complaints were not included within the quality monitoring dashboard or discussed at clinical governance meetings to enable learning.

Are maternity and gynaecology services well-led?

Requires improvement

The leadership of this service required improvement.

The leadership and governance of the service did not always support the delivery of high quality person-centred care. There were established local governance arrangements, but the department was not integrated into divisional and organisational governance and risk management. Identified risks to patients and service delivery were not being managed through a risk reporting process. The department's initial response to the national recommendations of an important review of maternity services was incomplete and lacked clarity.

Although staff demonstrated a strong desire to develop the service, patients and the public were not involved in service development. Women did not have the opportunity to express choices about postnatal care.

Vision and strategy for this service

- The strategic vision for the maternity service was based on the 'Six C's' developed by the Chief Nursing Officer for England in 2012, care, compassion, competence, communication, courage, and commitment. It was displayed in all of the areas we visited.
- All the staff we asked were not aware of the trust's strategy or vision for the future.
- The head of midwifery was not invited to meet with the commissioners to agree key performance indicators for maternity services. This limited the strategic leadership in maternity services.

Governance, risk management and quality measurement

Maternity and gynaecology

- The maternity and gynaecology clinical governance meeting was a sub-committee of the divisional clinical governance meeting. We looked at the divisional clinical governance monthly reports for January and February 2015. Issues relating to maternity and gynaecology were included but there were no service specific discussions of risks and no evidence of receiving the department's clinical governance report. The meetings covered topics including serious incidents, safety thermometer, the risk register, staffing levels and patient experience. Each topic included a section for trends, themes or lessons learnt, but these were rarely completed.
- Senior staff told us they thought that issues taken to the divisional governance meeting were lost and maternity issues were skated over because of the bigger problems in the trust.
- The risk management strategy described the governance and risk structure for maternity services. Meetings had not occurred between the head of midwifery and the executive director of nursing and quality for 16 months which was not in line with the strategy. The head of midwifery did not have direct access to the executive director of nursing and quality, but had to escalate any concerns through the planned care and surgery divisional lead matron. The executive director of nursing and quality told us regular meetings with the head of midwifery were planned.
- The maternity risk register contained only three risks, and did not include some that staff discussed with us during the inspection. Senior staff said the risks were modified and risk ratings were sometimes downgraded at divisional level without their full involvement.
- Governance arrangements worked well locally. The monthly maternity quality dashboard was compiled by ward leaders and discussed at clinical governance meetings every three months.
- Local governance issues were discussed at various forums which included the clinical governance meeting, weekly trigger meeting, CTG meetings, labour ward forum and perinatal mortality meetings. All of these meetings were attended by the multidisciplinary team, and all staff were encouraged to attend. The clinical risk midwife distributed a newsletter containing key service messages including incidents within maternity. There were patient story boards in each area and updates on new guidelines and current research.
- The government commissioned an independent investigation into maternity and neonatal services at Morecambe Bay to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015,and included recommendations directed at the wider NHS, to minimise the chance that these events would be repeated elsewhere. The trust's improvement director requested maternity services benchmark their practice against all of the recommendations. The head of midwifery reported findings to the executive team in May 2015. The draft review did not reflect a multidisciplinary approach, lacked clarity as to what actions were required and who was responsible for making sure they happened, and 'red, amber or green, rating did not always match the progress documented.

Leadership of service

- Nursing, midwifery and support staff told us senior managers were not visible in the departments and were not well known to the teams.
- There was a newly appointed interim clinical director for the service who reported to the medical director. They were in the process of getting used to their new role. They had started a breakfast meeting for consultants to share concerns and areas of practice that could be developed or improved.
- All midwives we spoke with told us they were supported and they had good working relationships. Some midwives commented that they would like to see the senior and specialist midwives on the maternity ward and birthing unit more often, not only when they were really busy.
- Staff we spoke with demonstrated a strong desire to develop the service to offer low risk women an evidenced based home from home birth experience. They were keen to share ideas with the senior team but were not sure what forum to take this to.

Culture within the service

- All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about midwifery care. Staff told us that they were happy to work in the department and were proud of how they worked as a team. Staff felt the maternity service did not have a profile within the trust.

Maternity and gynaecology

- There were strong team working relationships with medical staff and midwives working cooperatively and with respect for each other's roles.
- Some support workers were required to carry out the same tasks as colleagues paid at a higher rate. They told us they were unhappy and had asked the unions to review the situation.
- Medical staff had support from the senior doctors and consultants. One doctor said it was the best placement they had been on for support, education and experience. Another doctor said it was the best hospital they had worked in. If the on-call consultant was busy staff were confident to call another who made themselves available.
- Gynaecology staff said that they enjoyed their job and were very proud of their department.

Public engagement and staff engagement

- The maternity service did not have a local maternity services liaison committee (MSLC). This is a forum for maternity service users, providers and commissioners of maternity services to come together to design services that meet the needs of local women, parents and their families.
- There were no service user representatives at the maternity services meetings. The Local Supervisory Authority audit February 2015 recommended that the Supervisors of Midwives should be proactive in recruiting service users to attend service meetings.
- Staff told us that they did not seek women's opinions on where they wanted their postnatal visits, staff assumed women were happy with the current service.

Innovation, improvement and sustainability

- The midwifery team attended various regional forums to share good practice.
- The service had the highest home birth rate, normal birth rate and the lowest caesarean section rate in the region for a number of years.

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 Kings Mill Hospital included a 34 bed children's inpatient ward called ward 25 which was reduced to 24 beds overnight. The majority of children's outpatient services were located in clinic 11, a dedicated children's outpatient area. Additional facilities on the ward included a four bed ambulatory unit which was open for three half days and a four bedded assessment area used for GP referrals and open access patients.

The hospital provided level two care (special care) for babies in a 12 cot neonatal unit. Two cots were designated high dependency cots. Due to staffing shortfalls the neonatal unit was operating a maximum of ten cots and one designated high dependency cot.

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 Kings Mill Hospital we visited the neonatal unit, the children's outpatient department and ward 25. We also visited the main theatres, radiology and three adult outpatient areas. The adult clinics visited included; clinic eight which is ear, nose and throat, ophthalmology and the orthoptic clinic. We visited these clinics to check if they met the needs of children and young people. We spoke with 18 medical staff, 38 nursing staff including managers, seven members of the multi-disciplinary team, 15 parents and one grandparent.

Summary of findings

This service was good overall.

Although risks to patients were assessed and managed, staff had not consistently monitored the emergency resuscitation equipment. Medication monitoring practices were not effective as we found some out of date medications.

Patients received evidenced based care and there was good multi-disciplinary working between the children's services and the child and adolescent mental health team. However, there was no written guidance on how to manage risks for children and young people who presented with mental health concerns. In adult outpatient clinics staff tried to accommodate children's needs, but the clinic environments were not child friendly, and some patients had excessive waiting times. Staff in adult outpatient areas where children and young people were seen had not received adequate child safeguarding training.

Staff were caring, compassionate and respectful. Staff were positive about working in the service and 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.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The safety of this service required improvement.

There was an increased risk of harm for patients using the service. The service did not have the recommended 10 consultants required to provide the acute on-call support for the service and there were trained nurse shortfalls throughout the acute paediatric service. However, we are aware that the trust had successfully recruited to some of these positions and that recruitment was on-going.

The systems to check resuscitation equipment and stored medication were not effective. There was no written guidance on how to manage risks for children and young people who presented with mental health concerns.

The trusts training target was for 90% of staff to have completed mandatory training. However, training figures identified that this had not been achieved in some areas, for example, level three children's safeguarding, conflict resolution, information governance and health and safety.

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, departmental and clinical governance meetings. Discussions with staff confirmed that they were aware of how to report incidents and had received feedback and learning. Staff told us how incidents had resulted in changes in practice. For example, in clinic 11 (the children's outpatient clinic), rubber protectors now covered the pointed edge of the consultant desks in the consultation rooms. We checked five of the eight consultation rooms desks and noted that four had these protectors in place, whilst one did not. The other three rooms were in use so could not be checked.
- Although incident feedback locally and within the division had been good, staff told us that there had been occasions when feedback had not been received from the senior management at clinical director level and above.
- During the last 12 months 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, learnt from, and actions identified to minimise future risk. For example, locum doctors who worked in the minor injuries unit (MIU) must have completed level three children's safeguarding training in the last year. The lead paediatric nurse confirmed that this had been actioned through the agencies these medical staff had come from.
- National safety alerts were received at ward level and had been actioned as appropriate.
- Performance monitoring was in place. Data and outcomes were identified from April 2014 until April 2015 and were displayed in clinical areas in the form of a ward assurance tool on a ward communication board. The tool used a traffic light system of red and green to highlight identified risks. Some examples of the areas which had been monitored included, complaints, staff vacancies, compliments and medication incidents. The lead paediatric nurse said that the identified risks had been discussed at children's governance board, team meetings, at nursing handovers and at ward board rounds.
- A child death review specialist nurse was available for four days; on day five they worked in a safeguarding role. Mortality meetings had taken place to discuss child mortality. Meeting minutes identified that problems and learning points had been identified and actions agreed following each discussion. We saw documentation which confirmed that monitoring of these actions had taken place and that the child death overview panel would be involved in any discussions.
- The trust had a 'Being Open' policy which included information about the Duty of Candour 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. The staff we spoke with had a basic knowledge of this regulation.

Cleanliness, infection control and hygiene

- The infection prevention and control service was led by the director of infection prevention and control and a nurse consultant. An identified doctor and consultant microbiologist formed part of the wider team and link staff were located within 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.
- Generally good infection control practices were observed. For example, we observed doctors using hand gel on entry to ward 25. Staff were observed using personal protective equipment such as gloves and aprons when undertaking tasks. However, on occasion we observed staff entering clinical areas or another baby's space and touching other baby's notes without gelling or washing their hands. This meant that staff had not followed the trust hand hygiene policy (18 April 2013) as the policy identified that hand hygiene must be performed in these instances.
- The yearly infection control audit matrix identified monthly audits which were due and had taken place in 2015 – 2016. These audits included hand hygiene, isolation precautions, and sharps management.
- In 2014 – 2015 quarterly hand hygiene and isolation management audits were completed. There was 100% compliance throughout the service for hand hygiene. However, for isolation management ward 25 compliance fluctuated between 80% and 90%, whereas the neonatal unit's compliance remained consistent at 100% throughout the year.
- The training target set by the trust is 90% and the training statistics confirmed that 94% and 96% of nursing staff in acute paediatrics had completed infection control and hand hygiene training in 2014.
- Training figures for medical staff had not been provided for infection control training attendance, however, 78% of medical staff had completed hand hygiene training in 2014.

Environment and equipment

- Inpatient wards and outpatient clinics areas were accessible for people with disabilities, in line with the Equality Act 2010.
- We saw equipment suitable for babies, children and young people in all clinical areas. We undertook random checks of essential equipment used by the service and noted that the necessary electrical checks had taken place.
- The systems for carrying out checks of essential equipment were not always effective. In clinic 11 daily equipment checks had not been carried out on six occasions in May 2015 in the procedure room and essential equipment checks for oxygen and suction had also been missed. In clinic 11 reviews of monitoring records for January, February and May 2015 revealed that checks on the 6, 7 and 22 May 2015 had been missed in consultation rooms two and three. A compliance action had been identified by the CQC at their previous inspection that the provider must ensure that emergency resuscitation equipment checks and monitoring were completed regularly.
- The nearest defibrillator (equipment used to treat life-threatening heart conditions) was stored outside of clinic 11 in the main reception area. However, staff were unable to confirm who was responsible for checking the defibrillator.
- Monitoring of paediatric resuscitation checks on ward 25 had taken place between January to May 2015 and the compliance rate was 61.3% to 96.7%. We checked the monitoring records which related to the paediatric resuscitation and emergency management (PREM) resuscitation trolley and saw that daily checks had not taken place. We also found that some sterile equipment did not have expiry dates. This was bought to the attention of the nurse in charge. The shortfalls in monitoring the PREM equipment meant that staff were in breach of the trust cardiopulmonary resuscitation (CPR) procedural policy (Issued 16 August 2014) which identified that 'staff perform daily resuscitation equipment checks and record activity on the emergency equipment daily check log'.
- Staff told us that clinic 11 did not have full paediatric resuscitation equipment on site. A blue sealed, dated resuscitation box containing basic equipment and resuscitation drugs was available. The staff member was unable to name the contents of this box. This lack of

knowledge could pose a risk so was escalated to the services lead paediatric nurse. Monitoring records of this equipment confirmed monitoring had commenced on 1 June 2015.
- Following the inspection we spoke with the trust resuscitation training manager about the management of paediatric resuscitation equipment. On the 29 June 2015 we received an action plan which identified the actions and completion dates for the shortfalls which had been identified through the inspection process.

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 in line with policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys which were separate from the ward keys. We reviewed 12 drug charts and no gaps were seen against the entries.
- We reviewed the drugs in ward 25 medication room and found out of date medicines. The nurses confirmed they had not been aware that these medications were out of date. This was escalated to the nurse in charge who took all out of date drugs out of service and escalated this to the ward sister. The pharmacist was contacted to come up to the ward.
- Daily checks of the temperature of the drug fridges had taken place; we saw records of checks confirming this. However, in the neonatal unit although these checks had been completed and recorded, we observed that when the temperatures fell outside of the expected ranges staff had not documented what actions had been taken.
- Staff received feedback from the medicine champion meeting. The April 2015 meeting minutes identified medicine security, missed and delayed doses of critical medicines, and the red apron campaign. This is when staff wear red aprons to denote they are administering medicines and so are not to be interrupted. We saw that staff had signed to say they had read these meeting minutes.
- Delays in surgical children's discharges had been avoided as medication prescriptions were written while the child was in theatre.

Records

- We observed that babies, children's and young people's records were kept securely.
- We reviewed 21 sets of medical and nursing notes and observed that most had been fully completed including reviews of care by the multi-disciplinary team. Some shortfalls were observed in that the doctor's designation had not been identified.
- Children's care plans were pre-printed, standardised plans, although some had been individualised.
- Risk assessments had been completed for children where required, for example one child had a paediatric pressure ulcer risk assessment completed and the resulting action had been identified. We were told that risk assessments completed for children with mental health needs included the assessment of the child's room and removal of ligature points prior to admission. We asked for a copy of the ligature risk assessment but had not received one.
- An audit of patient records in ward 25, showed problems and actions required. The three sets of notes we reviewed showed the required action had been taken, such as dates for all entries and patient identification on each page.
- Health record keeping audits from April 2013 to March 2014 were measured against 25 individual criteria based on local and best practice policy. Compliance within the children's service ranged from 65% to 99.81% against each criterion. The recommendations for 2014 /15 were that monthly audits would continue and the nursing documentation group would investigate ways to improve the audit tool to include measures of the patient centred care approach.

Safeguarding

- Safeguarding governance reporting arrangements meant safeguarding processes were monitored trust wide. The executive lead was the medical director who met quarterly with the local safeguarding board. The director of nursing was to take on the trust executive lead role for safeguarding from 1 July 2015. There was not an identified non-executive director for children.

- Specialist paediatric advice was available through the safeguarding team or the on-call paediatrician. Two paediatricians shared the named doctor role in safeguarding, whilst another undertook the majority of the serious case review work.
- The lead paediatric nurse is also the Named Nurse for Safeguarding Children. They were supported by one whole time equivalent specialist nurse for safeguarding children and young people. There were also safeguarding children champions in all areas across the t that cared for children and young people. 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. Children's safeguarding team referral and contact information was available for staff.
- The named nurse visited the minor injury unit at Newark and the emergency department every two weeks to discuss safeguarding with staff. Safeguarding supervision was delivered either individually or by group. The two safeguarding champions received quarterly one to one supervision. Monthly supervision had been introduced from April 2015 to staff at Kings Mill and Mansfield Hospitals. Staff at Newark minor injury centre could choose the type of supervision they required.
- An annual trust children's and young people's safeguarding report was presented at trust board. We saw a copy of the 2015 'Safeguarding Children' report and work plan for 2015 – 16 which was due to be presented at the trust board.
- National Institute for Health and Care Excellence (NICE) safeguarding guidance recommends that qualified staff are trained to a level three standard in safeguarding. The 2015 'Safeguarding Children' report confirmed medical safeguarding training compliance for 2014 – 2015 at level two as 66% and level three as 52%. Data from the trust for 2014 – 2015 showed that other staff, which included nursing staff, had achieved 93% compliance against level two training and 58% compliance against level three training. This meant that NICE guidance had not been adhered to in respect of qualified staff being trained to level three in safeguarding children. This was also contrary to the Royal college of Paediatrics and Child Health (RCPCH) Standards for Paediatric Services which recommends there should be access to a paediatrician with child protection experience and skills (of at least level three safeguarding competencies)
- We were told that these shortfalls in training would be picked up through appraisal and monthly level two safeguarding training sessions had been planned for medical staff. The director of nursing had written to all nursing staff who had not completed level three safeguarding children training and asked that they complete the training
- An alert system had recently been developed (June 2015) in conjunction with the emergency department and the information technology department so that staff were alerted to those children who had a child protection plan in place.

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 medical staff and nursing staff had completed this training. However, the training figures provided by the trust identified that the training target of 90% had not been achieved in some areas, for example, conflict resolution, information governance and health and safety.

Assessing and responding to patient risk

- Written guidance was not available on how to manage risks for those children and young people who presented with mental health concerns. However, we were told that the trust's health and safety department undertook ligature audits in response to potential risks when caring for children and young people with mental health needs. We asked for a copy of this risk assessment but had not received one.
- The trust had identified guidelines and protocols to assess and monitor in real time, and react to changes in risk level. The paediatric and neonatal network worked alongside the trust to transfer children and babies to other hospitals for specialist care and treatment. The acute children's service had two designated high dependency beds.
- Trust wide the paediatric early warning score (PEWS) was a system used to monitor children and to ensure early detection of deterioration. For new-born babies this system was referred to as the neonatal early

warning system. The PEWS was implemented in 2014 following joint working with the children's service of a local NHS trust. We were told that monitoring of this system had been through the hospital metrics testing. However, we did not see details of this monitoring or its outcomes within the ward assurance tool.

- Four children's PEWS charts were reviewed to ascertain that appropriate escalation had taken place following each PEWS assessment. The escalation plan had been followed which meant that risks had been managed appropriately.
- Risks to babies on the neonatal unit were identified during their initial assessment and had been reviewed daily.
- Trust training statistics confirmed that 98% of nursing staff and 100% of medical staff had completed paediatric basic life support training. Neonatal nursing staff told us that they attended neonatal life support (NLS) training four yearly. Neonatal doctors said they had all completed the NLS training. Staff told us that they had undertaken baby resuscitation simulation training recently. We did not see the action notes confirming how the session had gone and whether there were any learning points.
- We were told that all junior medical trainees had completed full neonatal life support training accreditation in a one day course, and paediatric intermediate life support training. Senior medical trainees and consultants were advanced paediatric life support trained.

Nursing staffing

- Staffing on the neonatal unit and within paediatrics were identified as risks on the trust risk register. This was because staffing did not meet Royal College of Nursing (2013) and British Association of Perinatal Medicine Guidelines (2011).
- The neonatal network inspected the neonatal unit in October 2014. The visit resulted in immediate remedial action and caused the visit to be halted. This was due to the nurse staffing being significantly below that expected for the level of activity on the unit at the time. Capacity was reduced to eight cots and an additional nurse rostered to work daily giving the unit four registered nurses per shift. The outcome from a follow up meeting in December 2014 was that the unit could safely care for up to 10 babies in total, dependent on their needs. This decision took into account the increased registered nurse number of four (plus one health care support worker) per shift. The network revisited the neonatal unit in February 2015 and confirmed that the unit could increase to 12 cots following successful recruitment and induction. Staff told us that that since this review had taken place they felt the unit had been safely staffed.
- The neonatal unit had recruited six full time nurses not qualified in speciality following the receipt of additional monies. Five of the nurses had started and were on induction.
- The neonatal acuity tool was measured against British Association of Perinatal Medicine Guidelines (2011) which was recorded by the unit's information system. This identified how many staff should be rostered for each shift. Duty rotas were produced by the e-rostering system and we were told that band six staff nurses were rostered to work every shift. We reviewed the duty rotas for week commencing the 19 January 2015 and 15 June 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 and that 80% of the time the shift coordinator did not have to take a care load.
- Robust handover processes were in place on the neonatal unit and staff attended a 10 minute communication meeting following the handover process.
- The paediatric lead nurse confirmed that the trained nurse establishment for paediatrics was 42.13 whole time equivalent (wte) registered nurses of which there were 3.48 wte vacancies. One manager described the challenges to recruitment, following a recent advert they had six potential candidates, none of whom attended interview.
- Monitoring of staffing levels against patient dependencies commenced in 2015. The governance lead created a staffing information spreadsheet which captured information such as, number of patients, trained staff and care assistants. The number of highly dependent patients was also captured. The first six months of data had been submitted to the governance support unit to review.
- Three staff rotas from ward 25 were reviewed. We noted that best practice staffing guidance had been implemented with one exception, a Saturday shift (20 June 2015), within the children's services as senior nurse cover at band six was present on every shift.

- The trust had followed the Royal College of Nursing (RCN) staffing guidance for children and young people's services as children's outpatient staff told us that there was always a trained band five children's nurse available to run the clinic. Senior support was provided by both the band seven sisters who worked on ward 25.

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 did not have the recommended 10 consultants required to provide the acute on-call support for the service. The service had eight full time paediatric consultants, with two part-time consultants who helped with the emergency department and clinics.
- 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, registrars and middle grade doctors as supportive. We reviewed an on call rota for June 2015 and noted that a named consultant was identified for all shifts and registrar cover was available 24 hours.
- Medical staffing – The rota was fully staffed with eight junior grade and seven middle grade doctors. At night there was one middle grade and one junior grade, which could pose a risk should there be multiple urgent patient needs. The ward and neonatal unit were close to each other; the emergency department was about a three minute walk. Consultants were off-site on call but most lived five to 10 minutes away; the consultants who lived further stayed resident overnight in hospital when they were on call.
- Two trainees and one consultant felt that although the department could be busy, their current staffing was adequate and the consultant support meant that they rarely struggled to cover all their clinical and training commitments.
- Handover for paediatric team was consultant led twice daily which met RCPCH standards. We observed well-led and structured handovers and an appropriate level of information conveyed. This ensured that all the important clinical facts were given to ensure that the next team could safely take over care of the patient. Safeguarding concerns were appropriately discussed at handover with consultant input.
- A paediatric anaesthetic consultant confirmed that 16 anaesthetic consultants had completed advanced paediatric life support and European paediatric life support training sessions. Out of hours anaesthetic support was provided for children's services.

Major incident awareness and training

- The trust had a business continuity management – operational plan (undated) which ensured that critical services could be delivered in exceptional circumstances.
- A trust major incident policy (2014) was in place. This policy identified the measures which would be put into place from a paediatric perspective. In the last 12 months staff confirmed that a major incident exercise had taken place and the outcomes had been communicated by email.
- Staff confirmed completion of online major incident training as part of the mandatory update workbook.

Are services for children and young people effective?

Good

The effectiveness of this service was good.

Overall the service provided effective services to the local population. Multi-disciplinary team working had resulted in positive outcomes for children.

Services provided evidenced based care; however, 12 clinical guidelines were due or past their review dates. Discussions with the governance lead identified that these guidelines could still be used past their review date, as long as there hadn't been any significant new evidence arising in this area.

Trust statistics (2014 - 2015) identified annual appraisal shortfalls for trained nursing staff. Staff told us they had been well supported and had generally received development appropriate to their needs.

There were children's focused training shortfalls in some adult clinics and services which saw children. For example, the radiology and the ear, nose and throat clinic.

Services for children and young people

Auditing systems were in place, which had informed practice, introduced changes and lessons learnt to improve outcomes for children and young people. The neonatal service had been accredited with stage three UNICEF Baby Friendly accreditation.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health (RCPCH) and the National Institute for Health and Care Excellence (NICE) were used to inform care. For example, infection prevention and control guidance was evidence based and was due a review in November 2015. The guidance on hand hygiene was in line with the National Patient Safety Agency guidance ' 5 moments for hand hygiene at the point of care'. Neonatal unit guidelines were linked to the network guidelines.
- We found 12 guidelines written from 2005 – 2010 with expired review dates. For example, the asthma guideline had been due for review in 2010 and the upper airway obstruction guideline in 2009. The consultant responsible for governance said that guidelines had been updated on a priority basis and that these guidelines could still be used past their review date, as long as there hadn't been any significant new evidence arising in this area.
- A good range of guidelines were available on the trust's intranet homepage. Shared guidelines from another NHS trust were used, including paediatric intensive care guidelines.
- The guidelines which had been updated were evidenced based and followed best practice.
- The national medicines reference guidance for children was used appropriately. We observed that consultant staff had communicated well and medication choices were explained to the child.
- The guidelines for asthma and cystic fibrosis (CF), followed evidence based latest best practice. The CF guideline was shared with a neighbouring NHS trust where these children received the majority of their care. Evidence based care for asthma had been implemented and British Thoracic Society guidelines followed, for example, inhaler technique had been checked.
- 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.

Pain relief

- The pain team had close links with the regional paediatric service. The paediatric consultant who led on pain management was part of the national paediatric pain group. From the 1 July 2015 paediatric pain team meetings would recommence at the trust.
- The adult pain management team and paediatricians worked closely together to effectively manage children's pain. Should the child be admitted for longer than 24 hours the paediatricians would oversee these children.
- Paediatric pain protocols were in use which included the use of evidence based guidance. For example, scoring and flow charts for the assessment and treatment of pain in children in the emergency department.
- A range of pain relief could be accessed. Recent developments included the development of an intranasal diamorphine policy and a pain management when having surgery video accessed through the trust website.
- We reviewed four of the patient early warning sign charts and saw that appropriate measures had been taken to manage the child's pain episode according to the pain scores.
- The CQC carried out a survey in 2014, collecting the experiences of children and young people who received inpatient or day case care in NHS hospitals in England. The results were published in July 2015. The results for Kings Mill Hospital were about the same as other similar hospitals for parents and carers saying they thought staff did all they could to ease the child's pain.

Nutrition and hydration

- Information advice by the 'Me size meals' Department of Health (March 2010) campaign was displayed in areas accessed by parents, children and young people. A variety of choices was available to babies, children and young people.
- The CQC survey results were better than other similar hospitals for children and their parents or carers saying they liked the food provided.
- The trust had stage three Baby Friendly accreditation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding.

- Designated rooms were available throughout the service for mothers who wished to express milk or breast feed their baby.
- Growth charts and nutrition charts had been fully completed in four of the children's records we reviewed.

Patient outcomes

- A yearly audit plan showed nine proposed audits which included, diabetes, documentation, the paediatric early warning score and children who failed to attend for appointments.
- Childhood asthma had been audited and presented in 2012 with some embedded recommendations. The importance of patient information leaflets and personal treatment plans had been promoted through the ward since then. A repeat audit in 2014 showed evidence of improvement, for example, increasing the use of supportive equipment, reduced antibiotic use, reduced x-rays and an increased evidence of information leaflets and device technique assessment.
- A consent audit was presented in July 2014. This had resulted in the introduction of consent training into the service level induction. Pre-filled consent forms for sweat test and food challenge had been agreed by the trust consent working group and were being produced. The trust planned to demonstrate evidence of improvement through on-going continuous audit.
- The national neonatal audit programme (NNAP) audit data for 2014 had improved because the recording of data on the information system had improved. One NNAP standard included the screening of babies for eye problems before discharge from the neonatal unit. Some children were not screened prior to neonatal unit discharge. Instead they were screened in an outpatient clinic, which led to the risk that they would miss these appointments. To ensure that screening took place prior to discharge one paediatrician and the paediatric ophthalmologist had established an 'ad hoc' review for babies needing this screening on the neonatal unit. The date of the eye screening is also now documented on the coordinators handover sheet so that screening is not missed in those babies who require it.
- An observation of a children's asthma clinic confirmed that they followed best practice guidance. The RCPCH standard is for all children admitted acutely to be seen within 14 hours by a consultant. Most children were seen within this time due to the availability of consultants. However, there was no formal planning or funding to meet this standard.

Competent staff

- There were training shortfalls in adult clinics and services which saw children. For example, the radiology staff had not completed paediatric life support training; however, they had completed level two children's safeguarding awareness training. Adult nursing staff in the ear, nose and throat (ENT) clinic said they had only attended a one hour combined adult / child safeguarding training session.
- We were told that only one nurse had completed training in the care of the critically ill child. We spoke with the lead paediatric nurse and asked for clarification on the numbers of trained nursing staff who had completed this training. Three registered nurses had undertaken modules of the training at Nottingham University. Staff received simulation training twice a month which was confirmed by one nurse we spoke with.
- We were told that 100% of trained nursing staff had completed the European Paediatric Life Support (EPLS) training. We had difficultly obtaining data to support this. Following the inspection the trust told us, 6 of the 7 senior nurses had completed the EPLS course. In addition, 2 band 5 nurses, who regularly took charge of the ward, had valid EPLS training. This ensured there was a minimum of one nurse per shift with EPLS training on duty.
- One staff member told us that mental health training had been provided to them as part of the trust mandatory study day.
- Regular paediatric teaching for doctors took place daily Monday to Thursday. During these sessions the consultant of the week responded to calls to minimise interruptions for junior staff.
- Shortfalls in nursing staff appraisal rates were observed from July 2014 to April 2015. Completion of trained nurse's appraisals across the service ranged from 86% to 88%; unregistered nurse completed appraisals ranged between 91% and 94%. Medical staff appraisal figures confirmed that all except two had received an appraisal.

However, these two consultants' appraisals were due to be completed. Five staff confirmed that formal processes ensured they had received role specific training and an annual appraisal.
- Staff confirmed attendance and satisfaction with corporate and local induction processes.
- Each clinical area had designated nurse clinical supervisors who had completed relevant training to allow them to run clinical supervision sessions. Staff either had group clinical supervision or individual clinical supervision.
- The service met the standards for supervision for doctors, for example, paediatric referrals were discussed with a middle grade doctor or higher. Junior doctors confirmed that had regular supervision with their designated clinical supervisor or education supervisor. Peer review arrangements were also in place for consultant staff.

Multidisciplinary working

- Effective working relationships existed between children and adolescent health services (CAMHS) professionals and the paediatricians.
- Evidence of multi-disciplinary working was documented in children's notes, for example, discussions had taken place between a paediatrician and pharmacist. Reviews by the surgical consultant and interventions by the physiotherapist had taken place. Neonatal network transfer documentation for two babies showed good documentation with clear evidence of handover of relevant aspects of care.
- Shared care took place with a local NHS hospital for the care of patients with cystic fibrosis.
- Close links had been forged with other NHS hospitals for the care of patients requiring endocrinology and cardiology services. A genetic clinic was led by another NHS trust and took place in clinic 11 at Kings Mill Hospital on Friday mornings.
- The service had a wide range of multi-disciplinary specialist clinics available for children to access.
- The trust had started to develop transition arrangements for young people moving to adult services. A transitional service pathway for cerebral palsy patients from paediatric to adult orthopaedic care had been led by one of the hospital's paediatric orthopaedic surgeons.
- Transition for cystic fibrosis (CF) patients happened on an ad hoc basis. The CF lead consultant arranged for an adult respiratory physician to attend this clinic. There were no clear plans for more formalised transition clinics to be held.
- Formal adolescent diabetes transition clinics with the adult diabetes specialists operated every three months.
- A transition service with identified pathways for children with complex neurological needs was being established with an adult consultant.
- The service had five staff within the play team. Play specialists had completed the play specialist course, whilst, play leaders had not. Staff within this team worked a mix of full and part-time hours and also provided play therapy support within the emergency department.

Seven-day services

- Twenty-four hour paediatric and neonatal consultant support was in place. The consultant rota for June 2015 provided details of which paediatricians to contact each week. Medical and nursing staff said they could access consultants out of hours and described the consultant team, registrars and middle grade doctors as supportive.
- Staff said they could access out-of-hours investigations, for example, pharmacy, imaging and urgent laboratory tests.
- Radiology specialists provided digital imaging for non-accidental injury imaging. We were told that radiologists came in early and worked through breaks to ensure that children's magnetic imaging scans were done.
- Paediatric physiotherapy support was provided by another NHS trust, and we were told could be accessed when needed.

Access to information

- The paediatric team were observed discussing parental concerns at handover. The consultant ensured that junior doctors spoke with parents about their babies and every effort was made to enable parents to stay on the neonatal unit to be close to their babies.
- Alert stickers were used in children's notes to signify children's non-attendance at the adult ENT clinic appointments.

Consent

Services for children and young people

- Staff were informed of the consent process and understood the Gillick competency and the Fraser guidelines, (used to decide if a child is mature enough to make decisions about their care and treatment). Discussions with two junior doctors and theatre staff confirmed their understanding of consent processes.
- Staff explained that the consent process had been completed by surgeons for children who required surgery. The notes we saw for one baby included a completed consent form for the investigation they had undergone.
- Informed consent information was displayed in a pictorial and child friendly format throughout the service. The information included: what you can expect from us, what we expect from you and who can you contact. We also saw that the consent process had been explained in detail in some patient leaflets we reviewed, for example, the leaflet about insertion of ear grommets.

Are services for children and young people caring?

Good

The care provided to children and young people using this service was 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, stay and in preparation for their discharge home.

Compassionate care

- Throughout the 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. Four parents of children currently using the service told us they had been happy with the care and support they and their children had received.
- Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- Some parents told us that they had received free parking tickets whilst their baby was in the neonatal unit. This was confirmed by staff who told us that parents received free parking tickets and or bus tokens once their baby had been in hospital for 14 days or more. We were also told that parents who used the flats in the neonatal unit received meal vouchers.
- We observed that parents' and young people's privacy was maintained throughout the service. For example, in clinic 11 shutters were incorporated into consultation room doors and rooms containing baby changing and feeding facilities were available.
- The CQC carried out a survey in 2014, collecting the experiences of children and young people who received inpatient or day case care in NHS hospitals in England. The results were published in July 2015. The results for Kings Mill Hospital showed the experience of young patients there was about the same as other similar hospitals regarding feeling well looked after and respect for privacy.

Understanding and involvement of patients and those close to them

- We spoke with 15 parents and one grandparent about their experiences. They told us that they had been involved in and were happy with the care and treatment their children had received.
- The CQC survey showed results worse than other similar hospitals for parents and carers feeling they were involved in making decisions about their child's care and treatment.
- A wide selection of information was displayed throughout the service 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.
- Staff told us that parents were taught basic resuscitation skills prior to their baby being discharged from the neonatal unit. The parents complete a competency document which was signed off by staff to confirm competence.

Services for children and young people

- Sensory equipment was available for children and young people in both inpatient and outpatient areas. The emphasis of this equipment is to encourage interaction, learning and to offer children control over their surroundings.

Emotional support

- Input from the child and adolescent mental health team to a young person who needed emotional support for her social situation was clearly documented. There was evidence of regular nursing review with attention paid to their emotional needs.
- Clinical nurse specialists including specialists in palliative care, complex needs, diabetes, bereavement and child protection were available to provide additional support to parents and children.
- A band six family care sister worked part-time in the community supporting parents and babies on oxygen or with complex needs. This nurse also supported bereaved parents.
- A bereavement group was available for parents, siblings and carers to access. The hospital had a yearly memorial service for parents and families of children and babies who had died. The next service was due to take place on the 25 June 2015.
- Parents from the neonatal unit could access a 'Mini Miracles' parents support group which met on the third Friday of the month. Meeting dates for 2015 were displayed in the neonatal unit.

Are services for children and young people responsive?

Good

The responsiveness of this service was good.

The acute children's service was responsive and generally met children's needs. Where targets had not been achieved efforts had been made by the consultant staff to meet them. The service had good support from specialist centres in Nottingham and Sheffield.

There was good access to services which met most children's and young people's needs. However, we were told that there were no formalised arrangements in place with the child and adolescent mental health (CAMHS) team. There was evidence of transition pathway development and some newly established transition pathways in place for young people.

The parents and staff we spoke with told us that the care delivered within the neonatal unit, children's ward and paediatric clinics had met their needs.

We visited three adult clinics, the ear, nose and throat, ophthalmology and orthoptic clinics where children and young people were seen to ascertain whether the care provided met their needs. We saw that staff tried to accommodate children's needs, however, the clinic environments were not seen to be child friendly. In relation to clinic waiting times some parents who had attended the adult ophthalmology clinics with their child said they had on occasion had to wait for up to three hours.

Service planning and delivery to meet the needs of local people

- The service was in the early stages of reviewing palliative care provision for children.
- The allergy service was not meeting the 18 week referral to treatment target so clinic capacity was increased so that it will be met by July 2015. Patients should start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions, in line with the NHS constitution.
- An ambulatory clinic operated three days a week on ward 25 where children were seen for minor investigations, for example blood tests. This service had recently been reviewed and extended to operate another ambulatory clinic slot in the emergency department one day a week for four hours.
- The paediatric diabetes service had evolved to meet the needs of the local population. Nurse support meant that a 24/7 advice service could be accessed. Development of this service had been supported by trust management to enable best practice guidelines to be met.
- The waiting areas in the adult outpatient clinics we visited were not sufficiently segregated or child friendly and adult outpatient staff were not aware they could access play therapy support. Play areas were located at the back of the waiting areas.
- Following the paediatric surgery network peer support and service review in October 2014 the trust refurbished

day and main theatre receiving and recovery areas so they were child friendly. Murals had been provided in the radiology areas in main x-ray and the Kings Treatment Centre.

Access and flow

- Following the neonatal network review of the neonatal service in October 2014, operating capacity within the neonatal unit was reduced. This was because staffing was found to be significantly below that expected for the level of activity. Capacity at the time of our visit was ten cots plus one high dependency cot following the recruitment of trained nursing staff. Staff told us that the neonatal escalation policy had been followed to maintain safety within the service.
- There were concerns about outpatients who were booked with the new appointment booking system and may have been lost to follow up. Data was requested from the trust on how many children had been referred but this has not been received. This is a concern especially in terms of potential safeguarding issues which may be missed.
- Two parents said they often had to wait three hours past their outpatient appointment time to be seen in the ophthalmology clinics.
- Clinic 11 kept parents and young people informed of clinic status through the use of an updated white board. The board identified the names of the consultants and nursing staff, how much the clinic was over running by or whether the clinic was running to time.
- There were dedicated paediatric theatre lists and should the child be included on a general adult list the child would be prioritised to the front of the theatre list.

Meeting people's individual needs

- The service did not have a formal service level agreement with the child and adolescent mental health service (CAMHS). This agreement would specify the type of support the children's mental health team would provide to the children's service.
- CAMHS admissions to the paediatric service had increased. We were told that the trust needed to understand what was happening in the external health environment, before developing formal processes. Strong links and involvement existed with the CAMHS team which ensured care was tailored to the needs of the child and that CAMHS reviews took place on the next working day for ward patients. Support and advice from a specialist mental health unit was also provided.
- A meeting took place with the clinical commissioning group (CCG), a CAMHS representative and trust representatives following the recognition of gaps in CAMHS health provision. This resulted in CAMHS providing additional monies for the employment of staff when children's mental health needs increased.
- Children with long term conditions had open access to the paediatric ward. We reviewed the notes of a young person with complex needs who had a specific care plan. One staff member told us that this type of information should also be in the emergency department (ED) for regular attenders. We attended the paediatric area within the ED and could not find this information. The nurse in ED did not know of this information.
- The CCG had invested in a community consultant and specialist nurses for children with autistic spectrum disorders and attention deficit hyperactivity disorders. An adult specialist nurse for learning disabilities could be accessed to provide guidance and support for children with a learning disability.
- Staff had received training sessions in safeguarding and child mental health conditions during induction to inform their clinical practice and decision making.
- To enable understanding and communication access to interpreters or language line was available. Posters by the National Society for the Prevention of Cruelty to Children were displayed in clinical areas. These posters were printed in Polish and Latvian languages, alongside English.

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Patient Advice and Liaison service (PALS) or the trust complaints department. PALS information was displayed in poster form throughout the children and young people's services. Some of the parents we spoke with confirmed they knew how to access this service.
- Complaints feedback within the adult outpatient areas where children were seen had been through monthly divisional and the ENT nurses meeting. There had been no complaints received which related to children and young people.

Services for children and young people

- Seventeen concerns were raised from 1 March to 31 May 2015 of which nine related to communication or staff attitude, six were appointment queries, one related to treatment and one was a waiting time to referral concern. We saw that 13 had been resolved, two identified as a service improvement opportunity and two enquiry currently outstanding. Staff confirmed feedback from managers had been given following complaints investigations.

Are services for children and young people well-led?

Good

The leadership of this service was good.

The leadership, governance and culture of the service promoted the delivery of high quality person-centred care. Clinical strategies and priorities were in place against which were action plans and progress updates.

A clear leadership structure was in place within the service. Individual management of the different areas providing acute children's services were well led. There were mixed views in regard to the support the service had received from the trust executive team.

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

Evidence of on-going innovation and improvement had taken place within the service which meant that service provision had been focused towards the needs of the child's and surrounding community's needs.

Vision and strategy for this service

- The acute paediatrics annual plan identified five strategic priorities, which were supported by service objectives, income generation and cost reduction opportunities and workforce planning for 2015/16. 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.
- We observed that the 'Quality for all' values were displayed in the ward 25 office. These values included, safe, caring, effective, responsive and well-led.
- Two consultants said that their neonatal unit was a designated local neonatal unit (LNU) as they took some ventilated babies for more than 24hours. They felt their nursing staffing was now adequate but their medical staffing was not enough to sustain a full LNU. Their vision was to recruit another neonatal consultant and to boost the medical juniors' rota to improve capacity.

Governance, risk management and quality measurement

- There was an identified divisional quality governance structure in the women's and children's division.
- Discussions of risk and quality had taken place at a number of forums, for example, monthly paediatric governance meetings, mortality and morbidity meetings, paediatric audit and guideline meetings. Escalation of issues to the trust board was through the planned care and surgery divisional board, or the clinical lead could access the trust executive team directly. Issues identified as high risk were discussed at the monthly trust board meeting.
- We reviewed five sets of minutes. Four were from the speciality clinical governance report and one set of minutes was from the clinical quality and governance committee and an agenda from the meeting of the board of directors. The meetings had been held from 14 January 2015 to 26 May 2015. Items discussed included, risk register and new risks, resuscitation equipment, surgical pathway, paediatric bereavement group terms of reference approval, policies / guidelines, audit, incidents, serious incidents, never events and the patient experience. This showed that children's issues had been discussed at a senior level.
- Quality and governance information updates had been communicated in team meetings.
- The service had a performance dashboard and local risk registers which were monitored monthly.
- 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

- The service was part of the planned care and surgery division. The management structure included: head of nursing, a child protection and strategic lead nurse, two

band seven ward sisters and 5.4 wte band six senior staff nurses. The nursing leadership structure in the children's service was described by staff as supportive up to the head of nursing level.

- We received a mix of views from staff regarding support from the executive team at the trust.
- A top down initiative from the paediatric leadership team was clear consultant presence on the paediatric ward throughout the day so that available support can be accessed by junior staff.
- The lead clinician could access the executive board including the chairman if something needed to be done. An example of this was when monies were available for a parent bathroom on the NNU; however this was being delayed by the trust. The chairman was approached to progress this which resulted in the parent bathroom being installed.
- There were weekly meetings for medical managers and a multi-disciplinary service line management meeting for paediatrics. The service line management meeting was also attended by human resources and finance.
- Nurses reported that the consultant of the week could sometimes be different each day. Review of the current rota on the intranet showed there had been some swapping which may result in a different consultant managing the unit each day. The issue is also complicated by the fact that the neonatal lead does a ward round three times a week.
- Staff leadership development opportunities were confirmed by staff. A leadership programme and shadowing executives was available. However, one nurse said there had been little opportunity for career progression within the service.
- Staff told us that members of the trust executive team had visited the service, namely, the chairman and director of nursing. However, some staff were unaware of the names of the executive team and their positions.
- Daily '15 step leadership rounds' took place on ward 25 and the neonatal unit (NNU) to capture information in areas such as patient satisfaction, staff uniform compliance, the completion of patient information boards and storage of patient notes and files at the bedsides. Weekly feedback had been documented for staff to access, the feedback we saw was from the 18 May to 1 June 2015. This feedback identified positive feedback, gaps in processes and asked whether staff required additional training in specific areas, for example, feeding cues.

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 generally morale was good.
- Staff worked well together and positive working relationships existed between the multidisciplinary teams and other agencies involved in the delivery of children's health services.
- Staff told us that should they need to raise a concern they felt confident and supported to do so.

Public engagement

- We saw and staff told us that people could communicate their experiences on the trust website.
- The '2014 National Children's Inpatient and Day case Survey' had been carried out within the acute children's service. The survey findings had been communicated to staff two weeks ago and staff had been asked to comment on the findings. A meeting took place with senior staff in May 2015 when feedback from parents and carers was reviewed. An undated action plan minutes document had resulted which identified that a formal action plan was to be developed.
- An action plan had been developed following the 'Children's and Young People's In-Patient Survey' (Undated). Clear actions were identified, however, it was not identified they had been achieved.

Staff engagement

- Staff had been kept updated through the trust awareness bulletin 'Keeping your finger on the pulse'. The bulletin's purpose was to keep nurses up to date with regards to certain areas, for example, a study into a new approach to wound care (Nursing Times news).
- We saw that staff had received weekly and monthly updates. The team brief was communicated monthly. The April 2015 team brief contents included the quality improvement plan, staff engagement, performance in brief and a focus on flow. Weekly updates included information in areas such as staff benefits, Ebola and hospital performance.
- Staff told us that the last staff survey had taken place approximately a month ago. Staff had received feedback from the survey through the monthly team brief and at team meetings.

- Staff meetings took place within the neonatal unit every two to three months. The minutes of the June 2015 staff meeting were displayed in the staff room. The meeting prior to this had taken place in March 2015. Discussions during the June 2015 meeting included documentation feedback, audit feedback, hand washing audit feedback.

Innovation, improvement and sustainability

- Paediatric orthopaedic services had been reorganised and services improved. The service expansion benefited patients from the Mansfield and Ashfield district. The service improvements had improved the child's experience. These improvements included the arrangement of one stop baby clinics, reduction of waiting times when attending clinics and the creation of stronger links with children's services in another NHS hospital. A transitional service pathway for cerebral palsy patients from paediatric to adult orthopaedic care was being provided by one of the hospital's paediatric orthopaedic surgeons.
- Evidence of improvement initiatives funded from the top down, a new pilot to have a paediatric consultant in the emergency department during peak hours (3pm-11pm) to try and reduce unnecessary tests and admissions. This has only been piloted over the last few months.
- Ward 25 had developed a 'Proud folder'. This folder contains evidence of positive changes and policy development for the service. For example, a paediatric nursing care plan called 'Preparation for procedural pain' had been developed for use within the service. The supporting care plan could be individualised to the needs of the child.

End of life care

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

Information about the service

Kings Mill Hospital provided end of life care within many of the wards throughout the hospital. Patients requiring palliative or end of life care were therefore nursed throughout the hospital. There were around 1500 deaths per year at Kings Mill Hospital.

End of life and palliative care services were provided as part of the medicine and emergency care division, although the mortuary and chaplaincy services were delivered through the division of diagnostics and rehabilitation.

Specialist palliative care was commissioned by the clinical commissioning group (CCG) and the specialist palliative care team were employed by another NHS Trust. The Specialist palliative care team were based at the local Hospice (which was not part of Sherwood Forest Hospitals NHS Foundation Trust).

End of life care was not seen as the sole responsibility of the specialist palliative care team but was also delivered by general nurses and other staff who worked on the wards throughout the hospital.

Before our inspection we reviewed performance information from, and about the trust. During our inspection we visited all of the wards where end of life care was provided, the mortuary, the bereavement centre and the multi-faith centre. We spoke with 55 members of staff, which included the specialist palliative care team, the clinical champion for end of life care, the lead nurse for end of life care, doctors, nurses, health care assistants, allied health professionals, senior managers, trust board members, porters, administration staff, chaplaincy and bereavement staff and mortuary staff.

We reviewed documents relating to the provision of end of life care provided by the trust and the medical and nursing care records of 14 patients receiving end of life care. We observed care and treatment being provided by medical and nursing staff on the wards. We spoke with six patients who were receiving end of life care and four of their family members.

End of life care

Summary of findings

This service required improvement overall.

Staff knew how to report incidents but there was little evidence that learning from incidents and near misses were shared throughout the organisation. We were not assured that all incidents were reported as they should be. There were few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust and to benchmark against end of life care services nationally.

An executive lead had been identified at board level, but there was a lack of engagement and commitment on behalf of the trust to invest in adequate resources so that a quality end of life care service could be sustained. There was no service level agreement for the specialist palliative care team from a local hospice who were commissioned to provide specialist support within the trust. This meant the trust had no protection from this service being withdrawn.

The end of life care team acknowledged there was a lot of work that needed to be done and improvements were underway. The operational lead nurse had worked hard to improve the quality of end of life care.

Are end of life care services safe?

Requires improvement

The safety of this service required improvement.

There was an increased risk of harm to patients. Although there had been very few reported incidents relating to end of life care, we were not assured that all incidents were reported and investigated as they should be. Staff knew how to report incidents but there was little evidence that learning from incidents and near misses was shared throughout the organisation. Mortuary staff told us they did not always report incidents when they should have done.

There were insufficient numbers of specialist palliative care nurses and doctors to provide the level of specialist care required for a trust that experienced somewhere in the region of 1500 deaths per annum.

There was effective infection prevention and control. Systems were in place for the safe management of medicines and equipment needed for dying patients was available and well maintained.

Incidents

- Incidents were reported through the trust's electronic reporting system. All staff we spoke with said they knew how to report incidents, accidents and near misses. However information provided by the trust indicated there were very few reported incidents relating to end of life care. Staff in the mortuary told us they did not always report incidents when they should have done.
- Information supplied by the trust indicated that between January 2015 and May 2015 there had been three incidents relating to end of life care. However, we were made aware of two further incidents the trust had not shared with the Care Quality Commission (CQC). One of these was later classified as a serious incident. Both of these incidents related to the mortuary.
- We looked at the actions identified following the three incidents relating to end of life care, however we were not assured that the actions identified were always undertaken. For example, one incident related to the wrong relatives being informed that their loved one had died. The specialist lead action attached to this incident

stated the incident had been discussed at the General Palliative and End of Life Care Strategy Group. We looked at the minutes of the meetings but could find no evidence to indicate this incident had been discussed.
- The Duty of Candour regulation came into force in November 2014. It intends to ensure providers are open and transparent with patients and sets out specific requirements that providers must follow when things go wrong with care and treatment. Staff were able to tell us that duty of candour referred to being open and honest but they had not received any training in relation to duty of candour.

Cleanliness, infection control and hygiene

- Patients receiving end of life care were cared for on many of the wards throughout the trust. The wards we inspected were visibly clean. We saw that hand washing facilities were available and that soap and hand towel dispensers were adequately stocked. We observed staff following hand hygiene practice and 'bare below elbows' guidance.
- Staff who worked in the mortuary were aware of procedures for the prevention and control of infection, such as the management of clinical waste and environmental cleanliness. However, the trust did not have a specific policy relating to the prevention and control of infection for mortuary staff to follow.
- Mortuary staff had sufficient access to personal protective equipment (PPE) and there was adequate access to hand washing facilities.
- The mortuary had facilities to store the bodies of deceased patients who were deemed to be at a high risk in relation to infection control and therefore required isolation.
- The mortuary was visibly clean, however the trust did not undertake audits relating to cleanliness, infection control and hygiene.

Environment and equipment (only include if there is a palliative care ward)

- There was sufficient equipment available to meet the needs of people receiving end of life care on all of the wards we visited.
- The trust used syringe pumps for patients who required a continuous infusion to control their symptoms and these met the current NHS Patient Safety guidance. This meant that 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

- The National Care of the Dying Audit 2014 showed the trust was in line with the England average for their clinical protocols relating to the prescribing of medication for the five key symptoms [pain, excessive respiratory secretions, breathlessness, nausea and vomiting and agitation] at the end of life.
- The trust had comprehensive anticipatory prescribing guidelines, and we were told by nursing and medical staff that patients receiving end of life care were written up for anticipatory medicines. (Anticipatory medicines are medicines that are prescribed in case they are required).
- The chief pharmacist told us that medication could be accessed in a timely manner for patients who had expressed a preference to die at home.
- We noted on ward 22 that a medicine prescription lacked important details. There was a risk that the patient could have been given a different medicine than intended. This had not been picked up by the hospital's pharmacy team. We escalated this to the pharmacy team at the time of our inspection.

Records

- Information Governance training was included in the trust's mandatory training programme.
- Records were paper based and records such as fluid balance charts, care plans and risk assessments were kept by each patient's bed space and so were easily accessible to staff.
- Staff within the emergency department could access the community record system and this made it easier for them to identify patients who had a 'do not attempt cardiopulmonary resuscitation' (DNA CPR) order in place.
- We reviewed the medical and nursing records for 14 patients who were receiving end of life care and had been identified as being in the last days of their life. These records were mostly complete, accurate, legible and up-to-date.

Safeguarding

End of life care

- The trust had a safeguarding lead and staff told us they could approach them for support if they needed to.
- Nursing staff we spoke with had a good understanding of their responsibilities regarding the safeguarding and protection of vulnerable adults. Staff knew how to respond to safeguarding concerns and allegations of abuse.

Mandatory training

- The end of life care operational lead was working hard to ensure ward staff received training in relation to end of life care. They told us they had developed a mandatory training module for all staff to undertake. However when we looked at information provided by the trust, end of life care was not included as a mandatory module. We could therefore not be assured that the end of life care module had been embedded into the mandatory training programme for staff to undertake.

Assessing and responding to patient risk

- The trust used a recognised early warning score to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores were used to monitor patients and ensure timely assessment and treatment by medical staff.
- We looked at the nursing and medical records of 14 patients who were receiving end of life care. Risks to patients were assessed using nationally recognised risk assessment tools. For example the trust used Waterlow to assess each patient's risk of developing pressure ulcers and a malnutrition universal screening tool (MUST) was used to assess patients' risk of malnutrition. We also saw risk assessments were completed for moving and handling, falls and the use of bed rails.
- Risk assessments for patients were completed appropriately and were re-evaluated within the required time frame to ensure risks were minimised.

Nursing staffing

- There were no dedicated end-of-life care beds at the trust. Patients receiving end of life care were cared for by nursing staff throughout the trust.
- The specialist palliative care team (SPCT) included two whole time equivalent (WTE) specialist palliative care nurses from the local hospice, who provided a service between 9am and 5pm Monday to Friday.
- End of life care champions had been established on all wards throughout the trust. End of life care champions had received additional training to help them to promote a high standard of care for patients in receipt of end of life care.

Medical staffing

- The care of each patient was managed by the consultant who was most relevant to that patient's condition.
- A locum consultant geriatrician with an interest in end of life care was employed as an End of Life Care Champion on a locum contract for one year. Forty per cent of the consultant's allocation was to work clinically throughout the elderly care wards and the remainder of the time was allocated to providing end of life care guidance for staff throughout the trust. They also provided support with developing a one year strategy, with the aim of improving governance and service delivery.
- Two specialist palliative care consultants from the local hospice provided three face to face clinical sessions per week. This was equivalent to 0.3 whole time equivalent staff.
- Out of hours, advice and guidance about symptom control was provided by doctors at the local hospice.

Major incident awareness and training

- The trust had an emergency planning policy which set out how the trust would meet its statutory and mandatory duties should a major incident occur. This was supported by a major incident plan, action cards and contingency plans.
- We looked at the mortuary contingency plan and noted there were plans in place to ensure the contingency plan was initiated. Information provided by the trust indicated the contingency plan had been initiated four times between January 2015 and April 2015. In this time period, the bodies of 12 patients had been moved from Kings Mill hospital to Newark Hospital.
- The mortuary had a total capacity to store 79 deceased patients. Staff within the mortuary told us they would transfer patients to Newark hospital if the contingency plan was initiated.

Are end of life care services effective?

End of life care

Requires improvement

The effectiveness of this service required improvement.

Outcomes of patients' care and treatment were not monitored regularly or robustly. The service did not measure the quality of care delivered and did not use assessment tools to measure performance against the National Institute for Health and Care Excellence (NICE) quality standards. The trust had committed to improving the skills of nursing and medical staff throughout the trust to enable them to deliver quality care to patients at the end of their life. However, the trust had not invested the required resources to deliver training and education programmes on new approaches to end of life care.

Staff did not always adhere to or understand the principles of the Mental Capacity Act. We did not see any evidence that patients or their representative had been included in decisions made to support patients in their best interests.

Care and treatment were delivered in line with recognised guidance and evidence based practice. The last days of life care plan had recently been rolled out throughout the trust.

Evidence-based care and treatment

- The trust had responded to the national recommendations of the Liverpool Care Pathway (LCP) review in 2013 by discontinuing the use of the LCP.
- Following the withdrawal of the LCP, the trust had put in place an individualised last days of life care plan. This had been rolled out throughout the trust but was not used on the Integrated Critical Care Unit (ICCU). However, the ICCU used a document called 'withdrawal of active treatment on ICCU'. This document was dated January 2011 with no date for review and also gave the option to commence the LCP, which has been discontinued. We brought this to the attention of the nurse in charge of the unit.
- The trust rolled out the AMBER care bundle on two wards to support the identification of patients with an uncertain recovery. This approach encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the worst happen. At the time of our inspection the operational lead nurse for end of life care told us this was not in place on other wards due to the limited resources within the team. The trust had also rolled out the Gold Standards Framework (GSF) on four wards. This is a systematic, evidence based approach to optimising care for all patients approaching the end of life.
- The trust had participated in the National Care of the Dying Audit 2014 and had performed better than the England average for nine of the ten clinical standards and three of the seven organisational standards. The trust had an action plan to enable them to track the actions required to meet all of the key performance indicators of the audit. However, some of the deadline dates had passed and the action plan had been reviewed but no new target date had been identified for completion.
- The trust had local guidelines and policies that were up to date and based on current guidance relating to end of life care.

Pain relief

- The trust did not carry out local audits to assess the effectiveness of treating and managing pain. Results from the National Care of the Dying Audit 2014 showed the trust had achieved the organisational key performance indicator relating to clinical protocols for the prescription of medications for the five key symptoms at the end of life.
- Pain was assessed as part of the last days of life on-going assessments. However we did not see any specific pain scales in use to assess levels of pain.

Nutrition and hydration

- Nutrition and hydration was assessed as part of the last days of life nursing documentation**.** We reviewed the records of 14 patients and found that patients' nutritional status and risk of malnutrition had been assessed on admission using a malnutrition universal screening tool (MUST).
- The results of the National Care of the Dying Audit 2014 indicated the trust performed better than the England average for reviewing patient's nutritional and hydration requirements.

Patient outcomes

- The End of Life Care Quality Assessment Tool (ELCQuA) was not used to support staff in self-assessment against the National Institute for Health and Care Excellence

(NICE) quality standards. In addition, the end of life care team had not introduced any quality criteria to monitor the quality of care delivered to patients or support the training and education programme.

- The improving care at end of life commissioning for Quality and Innovation (CQUIN) had been agreed locally between Sherwood Forest NHS Foundation Trust and the Clinical Commissioning Group. This CQUIN was based on ensuring end of life care champions were in place; ensuring patients died in their preferred place; ensuring patients were discharged safely and effectively and improving the rates of staff training in end of life care. There were end of life care champions on every ward. They were actively supporting the role out of education and training of staff around end of life care, the AMBER care bundle and the Gold Standards Framework.
- The lead nurse for end of life care had initiated a small retrospective audit which looked at the records of 87 deceased patients in July and August 2014, October and November 2014, and March to May 2015. The audit was small but looked at the documentation of aspects of end of life care such as whether preferred place of death had been documented. In March to May 2015 only 50% of the records had documented preferred place of death. This was an improvement on the records from July and August 2014 where only 25% detailed the person's preferred place of death.
- Information provided by the trust indicated that between April 2013 and March 2014 293 patients had been referred to the specialist palliative care team (SPCT); whilst between April 2014 and April 2015 375 patients had been referred. The trust could not tell us the number of patients who were referred who did not have a diagnosis of cancer. The SPCT however provided information relating to the percentage of patients who had been referred to them who had a non-cancer diagnosis. Each quarter between January 2014 and March 2015, the number of these referrals to the SPCT was low at between 4% and 13%. This meant that patients who had a diagnosis other than cancer were less likely to be referred to the SPCT if they required support.

Competent staff

- The operational lead nurse and the clinical champion for end of life care recognised that not all patients required the input of the specialist palliative care support team (SPCT). They told us they had invested in improving the skills of the general nurses and doctors throughout the trust to enable them to deliver quality care to patients at the end of their life. However the trust had not invested in the resources required to deliver systematic end of life care training to all staff throughout the trust. This meant patients may be supported by staff who had not received any training in end of life care.
- Most nursing staff told us they had received training to administer medication via a syringe driver. Information provided by the trust indicated that between April 2014 and March 2015, 136 nurses across the trust had received intravenous drugs and infusions training, which had included the use of syringe drivers.
- Porters received training around end of life care and transporting deceased patients to the mortuary. Porters who attended a focus group meeting confirmed they had received this training.
- All of the end of life care champions told us they had received training to prepare them for this role. However, information supplied by the trust indicated that 32% of these staff had attended the first day and 60% of staff had attended the second day of the end of life care champion's course.
- Information provided by the trust indicated that between April 2014 and March 2015 end of life care training had been undertaken by 100% of nursing and medical staff who had undertaken an induction at the trust.
- AMBER care bundle training had been rolled out on wards 43 and 44. Training had been received by 61% of nursing staff on these wards. Further AMBER awareness days had been delivered to ward 24 and Sconce ward at Newark hospital.
- The Gold Standards Framework had been rolled out on wards 42 and 51 and training had been received by 67% of staff on these wards.
- End of life care was included as part of learning events and the clinical champion for end of life care had presented at one.
- Staff were encouraged to register on the National End of Life Care for All (e-ELCA) e- learning programme, however the trust had no record to demonstrate the numbers of staff who had undertaken this programme.

End of life care

- The operational lead nurse for end of life care told us there were plans to enable senior health care professionals to undertake advanced communication training and all health care professionals to undertake a dying to communicate course in 2016.
- Nursing staff on some wards such as ward 22 told us they had received limited training in relation to end of life care. Some staff reported they had received just ten minutes of training whilst other staff reported their training lasted an hour.

Multidisciplinary working

- Each ward had their own multidisciplinary team (MDT) meetings for their own specialities. End of life care was discussed at these meetings. Board rounds took place on a daily basis and patients who required a fast track discharge were also discussed.
- The SPCT held an MDT meeting on a weekly basis. This was attended by the SPCT consultant, SPCT nurses, operational lead nurse for end of life care, chaplain and a consultant with a palliative care background from the emergency assessment unit. The purpose of the meeting was to discuss new patients who had been referred to them, and in particular patients with complex needs. Outcomes were recorded in patients' notes to enable communication with the medical teams on each ward.
- There was no regular attendance of SCPT at routine ward MDT meetings. However, the SPCT were core members and had regular attendance at speciality MDTs.
- Although there was some evidence of multidisciplinary team working between the SPCT and the trust, for example throughout the palliative and end of life care strategy group meetings, joined up care between the trust and the SPCT did not always happen. Staff on the ward told us they would contact the end of life care lead rather than the specialist palliative care nurses for guidance about patients receiving end of life care.
- The SPCT reported good working relationships, but the appointment of the locum consultant for end of life care services had never been discussed with them. SPCT staff were not aware of who the end of life care champions were on all of the wards.

Seven-day services

- General end of life care was provided by general nurses and medical staff on the wards throughout the hospital seven days a week and 24 hours a day.
- The specialist palliative care team were employed by a local hospice. There were two whole time equivalent (WTE) specialist palliative care nurses who provided face to face support Monday to Friday 9 to 5. Two 0.3 WTE specialist palliative care consultants provided three face to face support sessions per week. Out of hours, specialist advice could be obtained by telephone from staff at the hospice.

Access to information

- The trust did not have an integrated information system that could be accessed by all. Staff in the emergency department could access the same system as staff in the community. This meant that staff in the emergency department were alerted to patients who had an allow a natural death (AND) order in place. There was also another electronic system that could be used to identify patients receiving end of life care was therefore not always immediately accessible to all staff throughout the trust. This meant that information about a person's wishes at the end of their life may not always be recognised or respected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not always adhere to or understand the principles of the Mental Capacity Act 2005 (MCA). For example we looked at the care records of a patient who had an 'allow a natural death' (AND) form in place who was living with dementia and who also had a learning disability. A nurse told us that care was delivered in the patient's 'best interest'. We saw that decision specific best interest decisions were in place because the patient was deemed to lack capacity to make decisions. There was no evidence of what attempts had been made to promote decision making with the patient or to show that decisions had been made in consultation with the patient, their relatives or representatives.
- Trust data indicated that nearly all nursing staff and some medical staff had attended training in the MCA.
- We did not see any patents being deprived of their liberty during the inspection. Referrals were reviewed by

the executive director of nursing before being sent to the local authority. Staff reported some delays in the local responding to referrals so some extensions to urgent authorisations were requested.

- The trust had an 'allow a natural death' (AND) policy which related to decisions around cardiopulmonary resuscitation. All AND forms should be documented accurately, clearly and with all key sections completed and stored in the correct position in the case notes. We looked at 14 AND forms across the wards and found the forms had mostly been fully completed and included an assessment of the patient's capacity to consent to the AND had been taken into consideration. Where discussions with patients or relatives had taken place these were recorded in the patient's records. We saw one AND form that had been completed two years ago. This had been documented on an old form that did not take into account the patient's capacity to make decisions.
- A trust audit reviewed a sample of 97 AND forms from 2014. They showed worsening compliance with completing them properly from previous years, including that 86% did not contain full patient identification and around a half did not have senior endorsement when they were completed by a junior doctor. Although an improvement from previous years, two thirds did not document that the decision was communicated with the patient and their family. A more recent trust audit of all AND forms for the year to April 2015 showed improvements. Between January 2015 and April 2015 806 AND forms were audited and it was found that 80% of the AND forms were endorsed by a consultant. This just met the trust's compliance standard target of 80%. For the same time period, the audit showed that discussions had taken place with the patient or their family in about 79% of the AND forms audited.

Are end of life care services caring?

Good

The care provided to patients and relatives using this service was good.

Patients and their relatives were usually treated with compassion, dignity and respect. There were involved in discussions about their care and kept informed by staff. There were facilities for relatives to stay in the hospital and visiting hours were flexible.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Privacy was maintained by keeping curtains drawn round if requested by the patient or their representatives.
- The bereavement centre undertook a bereavement survey, the results of which were published in May 2015. The survey process used a care of the dying evaluation tool from the Marie Curie Palliative Care Institute. One hundred and sixty seven questionnaires were returned. The data was presented in a simple report format, identifying what the trust was doing well with examples of positive comments, and where the trust was not doing so well. However, there was no analysis to show the percentage of people who received a positive or negative end of life care experience.
- Visiting hours were relaxed for visitors of patients who were identified as being at the end of their life. This ensured family and friends could spend unlimited time with the patient.
- The general palliative and end of life care strategy group were working to introduce comfort packs to support visitors who wished to stay overnight. These packs were to contain essential items such as a toothbrush and toothpaste, water and hygiene products.

Understanding and involvement of patients and those close to them

- The trust had participated in the National Care of the Dying Audit 2014. The results showed the trust was identified as being better than the England 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 better than the England average for communication regarding the patient's plan of care during the dying phase.
- One of the patients we talked to told us they had initiated a discussion about going home. They were fully involved in decisions about their care and had made a decision that they wanted to die at home. Staff were

working to ensure the patient could be discharged home as soon as possible. The patient's relative told us they had also been involved in decisions about the patient's care.

- Not all of the people we spoke with had received a positive end of life care experience at Kings Mill hospital. We received concerning information from the family of a patient who had died at the hospital. The family told us they had been asked to come into the hospital at night because their relative had deteriorated. The family asked to speak with the doctor but was told the doctor was too busy to speak with them. They reported that communication was poor and they were not aware of whether an allow a natural death (AND) form had been completed and if it had they had not been a part of the discussion.

Emotional support

- On ward 44 there was no quiet room for relatives or carers to go if they needed some time alone or they needed to talk to a member of staff. The quiet room had been changed into a doctor's room for the medical team
- Ward nurses and medical staff provided emotional support in addition to the specialist palliative care team. The trust also had a chaplaincy service that provided support for staff, patients and their representatives. The chaplain could access leaders from other faiths if required.
- We spoke with six patients and four of their carers or relatives on the wards we visited. All of the people we spoke with told us they felt supported emotionally by staff.

Are end of life care services responsive?

Requires improvement

The responsiveness of this service required improvement.

End of life care services did not always meet the needs of patients. Although patients referred to the specialist palliative care team (SPCT) were seen according to their needs, the numbers of non-cancer patients referred to the SPCT were very low. We were not assured that appropriate support was being provided for people who had dementia and were receiving end of life care.

The needs of patients were considered in relation to delivering end of life care including flexibility around visiting times for carers and relatives. However, we saw very little evidence that advance care planning was taking place.

Service planning and delivery to meet the needs of local people

- There were no specific consultation groups in place for patients and the public to contribute to the development of end of life care services in the trust.
- In addition to bays, each ward had numerous single rooms, and patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. However, if the patients wish was to be nursed in a bay this would also be accommodated.
- A butterfly symbol placed outside a person's room was used to identify patients receiving end of life care. However, this was not consistently used throughout the hospital. A nurse on ward 43 told us they didn't use the butterfly because people such as ancillary staff were more reluctant to go into the room if they saw one. A nurse on the emergency assessment unit incorrectly told us they used a daffodil to identify patients receiving end of life care.

Meeting people's individual needs

- Patients were discussed at the weekly specialist palliative care multidisciplinary team meetings. There was no dedicated specialist palliative care ward. People reaching the end of their life were nursed on the main wards throughout the hospital. Patients were cared for in single rooms to offer a more peaceful and private surroundings for the patient and their visitors. We saw this happened when we visited the wards.
- We were not assured that appropriate support was being provided for people who had dementia and were receiving end of life care. We saw one patient with a learning disability who was unable to communicate verbally. The patient looked unkempt, was unshaven and had not received mouth care. Although this patient was not imminently at the end of their life, they did have an AND form in place and was acutely unwell. The patient did not have a care plan in place to support their underlying condition of dementia or their learning disability. There were no clear guidelines to enable staff to communicate with this patient.
- The trust had a telephone service they could use to access interpreting services if they were required.

- The trust had fold out beds that could be used to enable relatives to stay overnight if they wanted to remain with their loved one.

Access and flow

- Patients were not always referred to the SPCT if they had been identified as requiring end of life care and we were not assured that the SPCT always knew where patients receiving end of life care were within the trust.
- Patients who were identified as requiring end of life care in the emergency department were transferred to a suitable ward wherever possible. This meant that patients were not unnecessarily transferred to the emergency assessment unit.
- The trust had an integrated discharge advisory team (IDAT) who were based at Kings Mill hospital. The team consisted of 12 whole time equivalent staff who worked from 8am until 6pm seven days a week. The team were able to support fast track continuing care and rapid discharge of patients to enable them to be cared for and die in the place of their choice.
- Between January and May 2015 there had been a total number of 713 hospital deaths at the trust. 148 patients had been discharged to their preferred place of care. Of the patients who were discharged 25 patients were rapidly discharged. There had been no audit to identify the time it took to discharge these patients.

Learning from complaints and concerns

- The trust data did not indicate any complaints specifically relating to end of life care. There were posters in ward areas which told patients and their representative how to make a complaint.
- Complaints featured on the agenda for the General Palliative and End of Life Care Strategy Group Meetings but at all meetings there were none reported to discuss.

Are end of life care services well-led?

Inadequate

The leadership of this service was inadequate.

The delivery of high quality care was not assured by the leadership, governance or culture in place. There was no effective leadership of end of life care services. An executive lead had been identified at board level, but there was a lack of engagement and commitment on behalf of the trust to invest in adequate resources to ensure a quality end of life care service could be sustained. The executive lead for end of life care rarely attended the strategy group meetings and when interviewed had a limited understanding of the risks and issues relating to end of life care throughout the trust. The trust had not appointed a non-executive lead at board level. There were few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust and to benchmark against end of life care services nationally.

There was no service level agreement for the specialist palliative care team from a local hospice who were commissioned to provide specialist support within the trust. This meant the trust had no protection from this service being withdrawn.

The end of life care team acknowledged there was a lot of work that needed to be done to improve end of life care throughout the trust and the allocated operational lead nurse had worked hard to improve the provision of end of life care throughout the trust. There was a one year strategy which set out the direction and framework the trust wished to take to ensure end of life care and care of the dying was part of its core business.

Vision and strategy for this service

- The operational end of life care lead had developed a strategy for 2015. The strategy set out the direction and framework the trust wished to take in order to reach its vision of becoming an exemplar acute hospital trust that recognised person-centred end of life care and care of the dying as part of its core business.
- There was some confusion about which directorate end of life care came under. The executive director of nursing and quality told us that end of life care services did not sit within a directorate, but sat at corporate level. The lead nurse for end of life care told us that end of life care came under the division of emergency care and medicine. Bereavement and mortuary services sat under the division of diagnostics and rehabilitation.

Governance, risk management and quality measurement

- There was no risk register specific to end of life care, although there were clearly identified risks in respect of resources to provide training and to deliver face to face

specialist palliative care seven days a week. We were therefore not assured that adequate steps had been taken to monitor risks and performance issues within end of life care services.

- There was an action plan to monitor the actions required to meet the key performance indicators of the National Care of the Dying Audit 2014. However, some of the deadline dates had passed and the action plan had been reviewed but no new target date had been identified for completion.
- The specialist palliative care team (SPCT) were employed by a different NHS Trust and had been commissioned to provide specialist palliative care support within Sherwood Forest Hospitals NHS Foundation Trust. There was no service level agreement for this service. This meant the trust had no protection from this service being withdrawn. The trust did not monitor the quality of the service provided by the SPCT and never requested data or written reports from them regarding the service.
- The trust had developed a general palliative and end of life care strategy group. The aim of this group was to provide the trust with assurance that effective coordination and consistent practices were being maintained. The terms of reference for the group stated the group would produce quarterly and annual reports to the trust management board in order to communicate the group's priorities, progress and service evaluation.
- The executive lead for end of life care rarely attended the general palliative and end of life care strategy group meetings and when interviewed had a limited understanding of the risks and issues relating to end of life care throughout the trust.

Leadership of service

- The leadership for end of life care services was not clear. There was confusion amongst staff about who led end of life care services within the trust. The director of nursing and quality told us the service was led by a locum consultant and a lead nurse, whilst the lead nurse and the consultant told us that end of life services were led by the director of nursing and quality.
- The director of nursing and quality represented end of life care at board level. However the director of nursing told us they would be handing over this role to the medical director at the end of the month. The trust had not appointed a non-executive lead for end of life care services at board level.
- The end of life care team included a lead nurse who was supported by a locum consultant geriatrician and an integrated discharge nurse who had been seconded to the end of life care team for a period of six months. At the time of our inspection, there was uncertainty about the future input from the consultant and the integrated discharge nurse. The integrated discharge nurse's role within the end of life care team was due to finish at the end of June 2015. The director of nursing and quality could not tell us whether this role was going to be extended.
- The lead nurse for end of life care told us their role was operational and they did not work in a clinical capacity; however, at the time of our inspection, the lead was working clinically because the integrated discharge nurse was on holiday. In addition, ward staff told us they would contact the lead for end of life care if they required any advice or guidance about patients' symptoms.

Culture within the service

- Nursing and medical staff spoke positively about the end of life care service they provided for patients. Staff reported positive working relationships and we observed that staff were respectful towards each other, not only within their specialities but across all disciplines.
- Staff within the specialist palliative care team spoke positively about the service they provided for patients but expressed concern in relation to the lack of service level agreement within the trust.
- The mortuary and bereavement staff culture was positive and enthusiastic about the provision of care at the end of a person's life. This was demonstrated and evidenced through their approach to patient care.

Public and staff engagement

- The bereavement centre sent a bereavement questionnaire to relatives six weeks after their loved one had died. This enabled the end of life care team to evaluate what they did well and identify areas for improvement. 436 questionnaires were sent out between October 2014 and April 2015 and 38% of the questionnaires were returned. Although the report

identified comments made by respondents, there was no attempt to analyse the findings to establish the extent of the experience of people who had been bereaved.

- Each ward had an end of life care champion. End of life care champions were responsible for auditing end of life care on their ward areas. We asked the trust to provide us with information relating to these audits. The trust submitted a draft report relating to a small case note audit that had been submitted by the clinical champion for end of life care and made no reference to audits undertaken by the end of life care champions at ward level. We were therefore not assured that auditing was being undertaken by end of life are champions at ward level.

Innovation, improvement and sustainability

- The end of life care team acknowledged there was a lot of work that needed to be done to improve end of life care throughout the trust and the allocated operational lead nurse had worked hard to improve the provision of end of life care throughout the trust. However, although an executive lead had been identified at board level there was a lack of engagement and commitment on behalf of the trust to invest in adequate resources to ensure a quality end of life care service could be sustained.
- The trust had made nominal progress since our last inspection; however, there were very few audits and quality measures in place to monitor the effectiveness of end of life care throughout the trust and to benchmark against end of life care services nationally.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient and diagnostic services were managed by the Diagnostics and Rehabilitation Division. Outpatient and diagnostic services at Kings Mill Hospital were provided in the Kings Treatment Centre.

Kings Mill Hospital provided clinics for a wide range of specialties, including orthopaedics, ophthalmology, respiratory, gastroenterology, cardiology, ear nose and throat (ENT), sexual health services, and podiatry. Between July 2013 and June 2014 more than 250,000 people attended outpatient appointments. Outpatient appointments were provided to assess, treat, monitor and follow up patients referred to the services.

Diagnostic imaging services included carrying out plain film imaging, computerised tomography (CT scans), magnetic resonance imaging (MRI), nuclear medicine, ultrasound, breast screening, fluoroscopy, cardiac angiography and interventional radiology.

During our inspection we spoke with patients and staff members. Staff we spoke with included medical, nursing, allied health professionals, administrative and clerical, reception and patient appointment booking staff. In diagnostic imaging we spoke with radiologists, nurses, imaging assistants, senior radiology service managers, lead radiographers, sonographers, clerical assistants and porters

We observed care and treatment and looked at patient records. We reviewed information provided by the trust.

Summary of findings

This service was inadequate overall.

People using the service were at high risk of avoidable harm. A significant number of reported incidents had not been systematically and routinely reviewed or assessed for severity of harm caused to patients. Learning from incidents was not always shared with staff. Not all staff had received training about reporting incidents.

A significant number of patients were overdue a follow up appointment or had no record of their previous attendance and therefore it was not clear if they had received essential treatment. The trust's response to this issue was not sufficiently timely or effective.

There were some notable gaps in the completion of staff mandatory training, putting patients at an increased risk of harm. Staff were aware of the need to ensure patients gave appropriate consent for their care, though not all staff had received relevant training.

The time waited by patients from referral to treatment was worse than the England average and below the expected standard. When attending clinics, some patients experienced long delays for their appointments. Despite historical problems with the administration of outpatient services, there remained many practical problems. Some teams were staffed by agency staff only, with limited training, induction and support.

Outpatients and diagnostic imaging

The leadership, governance and culture did not always support the delivery of high quality care. Attendance at divisional governance meetings was inconsistent. The divisional risk register did not show who held responsibility for each risk and timescales for action were not always included. Although staff felt supported at a local level, they felt there was a disconnect between the trust and divisional senior management teams and themselves. Staff morale had deteriorated in individual teams.

Outpatient clinics and diagnostic imaging areas were clean and equipment was properly maintained. Medicines were safely managed. There were sufficient nursing, medical and other staff to meet patients' needs but there was no method for assessing if the numbers and skill mix of staff was appropriate. There was effective multidisciplinary working for patient care. Most patients spoke positively about how they had been treated. We observed patients were treated with kindness, dignity, and compassion when receiving care and treatment.

Are outpatient and diagnostic imaging services safe?

Inadequate

The safety of this service was inadequate.

People using the service were at high risk of avoidable harm. A significant number of reported incidents had not been systematically and routinely reviewed or assessed for severity of harm caused to patients. Learning from incidents was not always shared with staff. Not all staff had received training about reporting incidents.

In January 2015 the trust identified a significant number of patients, around 19,500 in total, where the outcome of their outpatient appointment was not recorded in the electronic system correctly, or they were overdue for review appointments. The trust's initial response to the backlog of patients did not identify which patients needed review most urgently. There were delays in responding to the issue and in completing the work as planned.

The safety issues identified were related to the outpatients service and not to the diagnostic imaging service.

Outpatient clinics and diagnostic imaging areas were clean and equipment was properly maintained. Medicines were safely managed. There were sufficient nursing, medical and other staff to meet patients' needs.

Incidents

- The outpatients and diagnostic imaging service reported 160 patient related incidents between January and May 2015. Of these, 66% were classed as causing no or little harm to patients. Incidents included lack of patient notes, double booking of clinic appointments and clinic appointment cancellations of which patients and/or staff had been unaware.
- In the same time period one incident was reported as having caused severe harm to the patient. The patient had a four month delay for an appointment to be booked in the eye clinic. By the time the patient was seen and the incident reported in February 2015, the patient's condition had severely deteriorated and they required urgent surgery.
- This incident was still awaiting review in the trust's incident reporting system and there was no evidence of

lessons learnt from the incident. There was no record on the incident reporting system of any investigations undertaken as a result of this incident. The trust incident reporting system had not been fully completed and updated following the incident.

- A significant number of reported incidents had not been systematically and routinely reviewed or assessed for severity of harm caused to patients. Fifty two of the160 incidents reported (nearly one third) were awaiting review or being reviewed. The severity of harm caused to patients had not been assessed in any of the 52 incidents. The earliest reported incident date was 7 January 2015.
- Learning from incidents was not consistently shared with all staff. Of the 160 incidents reported, there was no record of lessons learnt and investigations undertaken for 65 of them, (41%). An exception was the therapies team, who had shared learning following reported incidents. Therapies included physiotherapy and occupational therapy.
- The majority of staff we spoke with were aware of the trust incident reporting system. However, not all staff had received training to report incidents and in particular, healthcare assistants told us they did not report incidents because this was done by qualified nurses.
- The diagnostic imaging team at Kings Mill Hospital had recorded all incidents internally. Any notifiable radiation incidents were reported to the Care Quality Commission and the Health and Safety Executive as appropriate in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). All diagnostic imaging staff were aware of how to report incidents and what the reportable radiation threshold was.
- Staff did not always fully understand the requirements of the Duty of Candour regulation. Providers of healthcare services must be open and transparent with people using services when things go wrong with care and treatment.
- However, staff in diagnostic imaging knew about the Duty of Candour requirements and were encouraged to be open with patients regarding incidents involving them.

Cleanliness, infection control and hygiene

- Clinics and waiting areas, including diagnostic imaging, were clean. Staff effectively managed, prevented and reduced the risk of infection.
- Staff followed trust policies on infection control and hygiene in the clinics. We observed staff using appropriate hand washing techniques and personal protective equipment, including aprons and gloves. Hand alcohol gel dispensers were readily available in clinics and patient waiting areas.
- We saw items of equipment which had been cleaned were labelled with 'I am clean' stickers. Staff completed cleanliness audits for clinic environments and equipment.
- Legionella is a type of bacteria spread through water systems that can cause illness, including pneumonia. Regular Legionella testing was carried out by staff in the therapies clinic. However, the member of staff responsible for Legionella testing had not received formal training in how to do this.
- In many clinics, all of the nursing and allied health professional (AHP) staff had completed infection control and hand hygiene training as required.
- There were some exceptions, for example, in the child and adolescent sexual health (CASH) clinic only 67% of medical staff had completed the training and none of the consultants in clinical chemistry had completed it. The required trust mandatory training rate was for 90% of staff to have completed infection control and hand hygiene training.

Environment and equipment

- Audits to check equipment availability and expiry dates had been completed regularly.
- In diagnostic imaging there were no trained risk assessors but risk assessments for new equipment and procedures were undertaken in conjunction with the medical physics service.
- There were protocols for specific pieces of equipment throughout the department. Staff had access to these on the trust's internal computer systems. A full quality assurance programme was in place and at the time of inspection no piece of equipment was outside of acceptable tolerance levels for testing or performance.
- Radioactive waste was appropriately managed and audits showed compliance with relevant regulations.
- The medical engineering department was accredited by the international organisation for standardisation (ISO).
- The orthopaedic clinic in Kings Mill Hospital was cluttered. Staff told us there was a lack of storage facilities in the clinic.

Outpatients and diagnostic imaging

Medicines

- Patient Group Directions (PGDs) were used to administer a number of medicines in outpatients. These mean that a nurse can give patients commonly used prescription-only medicines in certain situations. These had been produced in line with legal requirements and national guidelines.
- We saw PGDs that had been updated in April 2015 and which had been signed by the nurses. However, nurses working to these PGDs were still undergoing training and had not yet had their competency checked.
- Medicine prescription pads were stored securely and systems were in place to track them to detect any losses.
- Medicines in the main clinical room were stored appropriately. There were two drug fridges and temperature readings were taken daily. Staff had recorded temperature readings outside the maximum range for one of the fridges and had reported this to the hospital pharmacy for guidance on required action.

Records

- A centralised patient records area had been created with increased storage facilities. Staff told us they had begun to see improvements in the availability of patient records for outpatient clinics.
- However, staff in some clinics told us patients' medical records were not always available when they attended outpatient appointments. This included clinics for orthopaedics and genitourinary medicine.
- In diagnostic imaging patients' records were held securely on the radiology information system. The trust had a picture archiving and communication system with secure access.

Safeguarding

- Staff had access to the trust safeguarding policy. Staff we spoke with were aware of the procedures to follow should they need to report a safeguarding concern.
- Most staff in outpatients had completed training in safeguarding adults and children. This included nursing and allied health professionals.

Mandatory training

- Mandatory training included moving and handling, health and safety and equality and diversity training. The trust target was for 90% of staff to have completed their required training.
- Although most hospital staff and teams had completed mandatory training in line with trust targets, there were some exceptions. None of the nursing staff in the child and adolescent sexual Health (CASH) clinic had completed health and safety training.
- Consultant clinical chemistry staff had not completed information governance training and only 17% of consultant radiologists had completed it.

Assessing and responding to patient risk

- In January 2015 the trust identified a significant number of patients, around 19,500 in total, where the outcome of their outpatient appointment was not recorded in the electronic system correctly or they were overdue for a review appointment. This included patients attending at Kings Mill Hospital.
- Where the outcome of appointments was not recorded, patients were at risk of appropriate action not being taken regarding the care and treatment they needed. Patients who were overdue for a review appointment were at risk of essential treatment being delayed and the adverse effect this could have on their health.
- The trust's response to the backlog of patients was not progressed in a timely way to ensure patients were reviewed and their follow up appointments booked.
- The clinical commissioning group (CCG) told us that when the problem was first identified, the trust did not believe there were any patient safety issues associated with the backlog. The trust had started a review of the backlog, but this did not follow a risk-based approach. This meant there was no recognition of which patients should be seen most urgently. The CCG requested the trust to undertake an urgent systematic review based on a risk-assessed methodology.
- In response, the trust started an outpatient improvement programme in April 2015. The programme board met weekly and the work was led by the deputy director of operations. Review of the patients whose appointment outcome was not recorded was completed in June 2015, though this took longer than originally projected by the trust.
- The trust reported that by 19 June 2015 nearly 83% of patients who were overdue for review had

appointments booked. We had verbal assurance from a senior manager that these appointments were all before the end of August 2015, though the written information from the trust did not say this.
- The trust has reported that no patients have suffered harm because of the delay in their review.
- The diagnostic imaging team was well supported by medical physics at Nottingham. The trust had an appointed radiation protection advisor, radiation waste advisor and the support of medical physics experts.
- We saw local rules and Employers Procedures under Schedule 1 of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R), all of which were regularly reviewed and revised.
- National Diagnostic Reference Levels (DRL's) were displayed throughout the department and regular dose audit was carried out. There was consistent radiation protection awareness throughout the department and adherence to radiation regulations.

Nursing staffing

- Specialist nursing staff were provided for clinics by the relevant divisions in the trust.
- Senior divisional management staff could not confirm how they assessed the numbers and the skill mix of staff needed to work within the outpatient service and meet patients needs. The nurse staffing levels and skill mix required were based on individual clinic lists. Staff told us there was minimal use of bank and agency nurse cover to fill shifts.

Medical staffing

- Medical staff were provided for clinics by the relevant divisions in the trust.
- Locum medical staff were employed to cover clinics at Kings Mill Hospital as required for staff holidays or other leave.

Other staffing

- In diagnostic imaging staffing levels were good with minimal vacancies in the radiographer workforce. Bank staff were occasionally used to cover shift shortages.
- There were four vacant radiologist posts and this was attributed to a national shortage. Four locum radiologists were in post at the time of inspection.
- An on-going recruitment programme was in place for radiologists.

Major incident awareness and training

- The trust had a major incident plan in place. Staff in diagnostic imaging confirmed major incident exercises had taken place.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging services.

Staff continuous professional development was encouraged. Staff told us they had received appraisals but the trust did not supply us with the data to analyse completion rates. There was effective multidisciplinary working for patient care. Implementation of the new patient administration system had caused difficulties; this was being addressed. Staff were aware of the need to ensure patients gave appropriate consent for their care, though not all staff had received relevant training.

Evidence-based care and treatment

- Staff had access to trust policies and procedures. They used them to deliver care and treatment to patients in outpatients and diagnostic imaging.
- This included the access, booking and choice policy and the cancer access policy.

Patient outcomes

- For radiology departments to become accredited with the Imaging Services Accreditation Scheme (ISAS) they must undertake an analysis of their service. Diagnostic imaging staff had carried this out, looking at their performance compared with desired performance levels. The department was not accredited, but was working towards applying for accreditation.
- The WHO surgical safety checklist for interventional radiology procedures was in use. The checklist is used internationally to safeguard patients undergoing invasive procedures. The most recent audit of the use of the safety checklist showed 100% compliance for a sample of 18 patients.
- Audits carried out showed there could be a variable quality of images in some cases. This was addressed

through additional training and staff communication and feedback. The lead radiographer had worked with the equipment manufacturer to achieve high quality images in children's imaging. This technical change had been adopted by the manufacturer and was being installed in all similar equipment.

Competent staff

- Diagnostic imaging staff told us continuous professional development (CPD) was encouraged throughout the department. There was no specific training coordinator but CPD was built into the rota for all staff.
- Outpatient staff were clear about their roles and the work they completed.
- However, in fracture clinic we found a nurse was delivering treatment and completing plaster work to patients without a proper assessment of their competency to undertake the work.
- Staff told us they had undergone appraisals with their line managers. Information provided by the trust showed that although most staff had received an annual appraisal in 2014 / 2015, the trust's target of 95% had not been met for all staff groups.

Multidisciplinary working

- Diagnostic imaging staff were fully supported by radiologists locally.
- The interventional radiology team was multidisciplinary with a good skill mix and cohesive approach to work.
- Therapies staff worked in a multidisciplinary approach.
- We saw referrals were made for patients which involved multidisciplinary team working and the input of allied health professionals, such as physiotherapists and occupational therapists.

Seven-day services

- Kings Mill Hospital did not provide seven day outpatient department services. Senior divisional management team members told us work was on-going to review the provision of the outpatient service.
- At the time of our inspection some eye clinic appointments were being offered to patients at weekends to reduce the backlog of follow-up appointments.
- Diagnostic imaging staff told us seven day working was seen as a challenge to meet and adopt. In magnetic resonance imaging (MRI) the service had been extended to seven days a week, plus a mobile MRI facility on three days a week to meet the current demand.

Access to information

- Staff did not report any concerns about access to and availability of patients' test results.
- Staff in outpatients had access to patients' records using the trust information systems.
- A new patient administration system (PAS) had been implemented. Staff had received and continued to receive training in its use. Staff told us the implementation of the new PAS had created delays.
- Senior divisional management staff confirmed the implementation of the new PAS had created difficulties for staff using the system. They told us work was on-going to improve use of the PAS.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging were aware of the need to ensure patients gave appropriate consent for their care.
- Most staff in outpatients had completed Mental Capacity Act (MCA) training.

Are outpatient and diagnostic imaging services caring?

Good

The care provided to patients using this service was good.

Most patients spoke positively about how they had been treated. We observed patients were treated with kindness, dignity, and compassion when receiving care and treatment.

Patients using the diagnostic imaging service were well informed about the examinations they were undergoing, onward care and availability of their results. Nursing staff provided emotional support to patients and those close to them when it was required.

Compassionate care

Outpatients and diagnostic imaging

- Most patients told us staff treated them with compassion.
- We observed staff spoke with patients respectfully and reassured patients whose appointments were delayed.
- However, some patients told us they had experienced staff who were rude and not approachable.
- In diagnostic imaging we observed the radiographers had a caring and respectful approach, maintaining patients' dignity. Staff offered support to patients in relation to leaving the department and finding out the results of imaging.
- In the interventional radiology and cardiac catheter suites we observed nursing care was excellent and patients appeared comfortable and well attended to.
- Patients said outpatient clinics were busy and often delayed but staff tried to assist them individually.

Understanding and involvement of patients and those close to them

- Patients were encouraged to provide feedback about their care and their experience in outpatients.
- Patients told us they had been informed about their appointments and felt able to discuss their care.
- Patients in diagnostic imaging were well informed about the examinations they were undergoing, about onward care and when their results would be available.

Emotional support

- Nursing staff in outpatients provided emotional support to patients and those close to them if needed. They reassured and supported patients who were waiting for their appointments or who had been seen.
- Clinical nurse specialists, such as ophthalmology specialist nurses, provided specific support to their patients.
- The trust had a chaplaincy service which was available for patients to use. There was a chapel within the hospital.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The responsiveness of this service required improvement.

The service did not always meet patients' needs. The time waited by patients from referral to treatment was worse than the England average and below the expected standard. When attending clinics, some patients experienced long delays for their appointments.

There were problems with the administration of outpatient services. Some administration teams were staffed by agency staff only, with limited training, induction and support.

There was a range of outpatient clinics and diagnostic imaging services to meet the needs of local people. Interpretation services were available for patients who required this. Chaperones were available, though it was not always clear if patients had been offered this.

Service planning and delivery to meet the needs of local people

- The trust worked with local commissioners to provide outpatient and diagnostic imaging services for local people.
- The facilities and clinic premises were appropriate to deliver outpatient clinics and diagnostic imaging procedures. There was ample car parking for patients attending appointments.
- Treatment and clinic rooms were clearly signed and volunteers were available if patients needed directions to specific clinics.
- During our inspection visit the eye clinic was very busy. The waiting room for this clinic was full and the environment was not calm for patients waiting for their appointments.
- Genitourinary medicine (GUM) clinics for family planning and sexual health appointments provided late night clinics. Patients could book appointments in advance and walk in appointments were also available.
- There was a dermatology (skin) clinic every week day. Additional clinics were scheduled to increase the number of patient appointments available.
- Staff in the cardiac catheter laboratory carried out planned and unplanned procedures and were flexible in meeting demand for the service. The working day and week were extended according to need. Staff told us they were satisfied with this arrangement and felt it provided the quality of care required for these procedures. A business case was being put forward for a more specialised team and extended working day.

Outpatients and diagnostic imaging

- Due to a shortage of radiologists and the loss of specialist staff two years ago, more complex interventional procedures were no longer offered at the trust. This is when radiological image guidance is used to target therapy precisely. There was no out of hours interventional radiology, but the working day was extended to meet the needs of the service with the provision of six visiting radiologists.

Access and flow

- Data provided by the trust relating to patient waiting times from referral to treatment was for all patients across the trust and not broken down for each hospital. Operational standards are that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. For nine months between November 2013 and November 2014 the trust fell below this standard and was worse than the England average. The percentage of patients seen within 18 weeks deteriorated sharply between December 2014 and January 2015, and continued down to a two-year low in April 2015 (89.9%). There was an improvement in May 2015 to just over 93%.
- Operational standards are 92% of patients on waiting lists should start consultant-led treatment within 18 weeks of referral. Between April 2013 and November 2014 the trust met this standard except for one month. In the first quarter of 2015, the percentage of patients starting treatment within 18 weeks fell below standard and was worse than the England average . The statistics improved in April and May 2015 (to 91.4%).
- The standard for a patient appointment within two weeks of urgent GP referrals for all cancers was mostly met by the trust between April 2013 and March 2015. The standard for patients who waited at most one month from a decision to treat to a first treatment for cancer, for all cancers, was 96%. Between April 2013 and March 2015 the trust consistently met this target.
- The 62 day operational standard from urgent GP referral to a first treatment for cancer is 85%. The trust had met this standard between April 2013 and March 2015, other than in February 2015 when the trust achieved 75%.
- Between July 2013 and June 2014 the number of patients who did not attend their appointments was in line with the England average of 7%.
- Between October 2014 and April 2015, 58,099 clinic sessions were booked. Of this total, a high number of clinic sessions had been cancelled: 5688 which was around 10% of all scheduled sessions.
- Of the cancelled clinic sessions, 52% were cancelled within six weeks of the appointment date. The most common reason for cancelled clinics was staff annual leave.
- The administration of the outpatient appointment bookings and patient booking teams was managed by another trust division, Planned Care and Surgery. Senior management staff in the Diagnostics and Rehabilitation division confirmed patient booking teams were to be transferred to their division but no date had been set.
- Partial booking gives patients a target date and places them on a waiting list, so that an exact date and time can be arranged nearer the time. Patient partial booking teams were not operating in a responsive way to meet patients' needs. They were staffed by large numbers of agency staff only. These staff members had received limited training and induction in trust appointment booking procedures. The partial booking team had no facility to transfer calls to other patient booking teams when they were all busy answering calls. We found patients' experience of contacting patient booking teams, particularly the partial booking team, was often poor.
- The trust had completed audits on 18, 26, 27 and 28 May 2015 of clinic waiting times. This showed average waiting times for patients in some clinics varied. For example clinical haematology 41 minutes and ophthalmology 55 minutes. Vascular surgery showed no waiting at all. During our inspection, orthopaedic fracture clinics and ophthalmology clinics had excessively long wait times for patients.
- In the eye clinics, the wait times and delayed appointments resulted in the patient waiting area becoming overcrowded. We saw it was difficult for staff to clearly identify patients for their appointments.
- However, diagnostic imaging teams had good procedures in place to manage patient access and flow in the departments. For diagnostic imaging, there was complete clerical oversight of all hospitals in the trust. There was a centralised booking service which allowed appointments to be divided between departments according to capacity and, as far as reasonably practicable, accommodated patients' requirements and requests.

Outpatients and diagnostic imaging

Meeting people's individual needs

- In diagnostic imaging the radiology services manager acted as the local dementia champion to ensure the department was up to date on training and new research.
- Interpreter services were available as required for individual patient appointments. If interpreters could not be booked, a telephone interpretation line was available for staff to use during appointments.
- Chaperone services were available for patients if they wished to use this during their consultations and appointments. However, it was not clear in patients' records if they had accepted or declined offers to use the chaperone service.
- In the genitourinary medicine (GUM) clinic, a patient had commented on the use of appropriate language in patient information leaflets, specifically regarding sexual orientation. We saw that this feedback had not been put into action.

Learning from complaints and concerns

- Complaints had been received from patients about the attitude of staff in the diagnostic imaging service. Appropriate action was taken, including staff completing customer care and excellence courses, and new telephone etiquette protocols.
- Information on contacting the trust's Patient Advice and Liaison Service and making formal complaints was available in all clinics and departments.
- Outpatient staff told us complaints were recorded in their own department and efforts were made to resolve issues or concerns locally with the patient.

Are outpatient and diagnostic imaging services well-led?

Inadequate

The leadership of this service was inadequate.

The leadership, governance and culture did not always support the delivery of high quality care. Attendance at divisional governance meetings was inconsistent. The divisional risk register did not show who held responsibility for each risk and timescales for action were not always included.

Outpatient service issues, including the considerable backlog of patients overdue for review, were not promptly recognised or addressed.

Staff said they did not feel the Diagnostics and Rehabilitation division had a high profile within the trust. Although staff felt supported at a local level, they felt there was a disconnect between the trust and divisional senior management teams and themselves. Staff morale had deteriorated in individual teams. Some staff had been able to contribute to discussions about improvements, but others had not been asked for their input. Staff had varying levels of knowledge about the vision and strategy for the outpatient service. Patients were asked for their feedback and their experience was discussed at divisional governance meetings.

Vision and strategy for this service

- The Diagnostic and Rehabilitation division aimed to provide care which met the needs of patients. However, we found work was still required in outpatients.
- The responsibility for outpatients was shared between two of the trust's divisions, but this did not work well in practice.
- The trust had created an outpatient improvement programme board in April 2015. The board had not made substantial progress in addressing concerns in outpatients which included patient appointments backlog, administrative processes, waiting times and access to services.
- Outpatient staff had varying levels of knowledge about their service's vision and strategy.
- At a local level, diagnostic imaging teams had a good understanding of their service's vision and strategy to provide patient focused care.

Governance, risk management and quality measurement

- Concerns about the backlog of patients awaiting review were identified in January 2015 but the trust outpatient improvement programme board was not in place until April 2015. The board had not made substantial progress in addressing concerns in outpatients at Kings Mill Hospital.

Outpatients and diagnostic imaging

- Diagnostic and Rehabilitation divisional governance meetings were held monthly. These included discussion about reported incidents, reports received from outpatients teams and divisional specialty teams and patient experiences.
- However, attendance at the divisional governance meetings was not consistent. Out of 15 staff who should attend each meeting (or send a representative) only two had attended all three meetings held January to March 2015. A meeting on 30 March 2015 did not have the required minimum number of staff attending for effective discussion and decision making.
- A divisional risk register was in place but did not show who held responsibility for each risk identified. Not all risks had timescales for action to address identified risks.
- There was a robust governance structure in the diagnostic imaging service. There were regular radiation protection, clinical governance and radiology staff meetings. The risk register was regularly reviewed and incidents were well managed by medical physics staff and the radiology service managers.

Leadership of service

- Staff in outpatients and diagnostic imaging reported good levels of local operational management support. They told us their local managers were approachable and available to discuss concerns.
- However, staff throughout the services told us they felt there was lack of communication between the trust, divisional senior management teams and staff looking after patients.
- Outpatients staff told us senior managers from the trust executive team had not visited their departments and were not well known by staff.
- Diagnostic imaging staff told us changes in the trust board and Chief Executive role had been disruptive.
- Staff throughout the division said they did not feel the Diagnostics and Rehabilitation division had a high profile within the trust.

Culture within the service

- Diagnostic imaging staff told us that there was a culture of openness and honesty. Department staff were encouraged to report incidents and also to present new ideas or suggestions of change to the radiology service manager. Staff also told us departmental managers were sensitive to their concerns and held their well-being in high regard.
- Outpatient staff told us they enjoyed working with their colleagues and in their local teams. Staff were committed to deliver care which met patients' needs but were not always able to achieve this due to factors outside their control.

Public engagement

- Patients and those close to them were asked for feedback.
- Patients' experiences were discussed at divisional governance meetings.
- Some clinics in outpatients were extremely busy, such as the eye clinic and the fracture clinic. Staff dealt with patients within the busy clinic environment but the clinics were not conducive to positive patient experiences.

Staff engagement

- Staff completed trust surveys regularly. Staff told us morale had deteriorated in individual teams. They felt this was because of the trust's current position and the lack of engagement by the trust senior executive management team.
- Staff in outpatients and diagnostic imaging told us they were able to discuss suggestions for their team and services with their managers.
- However, medical records staff felt less able to discuss ideas and suggestions for improvement. They told us they had not been asked for their input.

Innovation, improvement and sustainability

- There was no service director in post for the diagnostic imaging service. This was due in part to staff shortages and also a lack of managerial experience within the majority of the radiologist workforce. The department was confident a replacement would be found.
- The outpatient improvement programme board was set up in April 2015 to address issues in outpatients. We found the board had not made substantial progress to tackle and resolve these issues.

Outpatients and diagnostic imaging

- Staff working in pathology teams had completed work to improve quality assurance, governance and team working. They had benefitted from having dedicated quality leads in individual teams, which had produced effective results for work related performance.

Outstanding practice and areas for improvement

Outstanding practice

- There was some innovative work taking place at King's Mill Hospital where the trust had developed a new changing facility for patients with complex disabilities. The facility offered a large changing area that would meet the needs of patients with profound disabilities.
- Staff went out of their way to meet the needs of their patients on the critical care unit. Some patients could be moved on their beds out of the critical care unit to an outdoor area. Staff told us they tried to do this when possible as patients appreciated being outside and away from the unit. Staff had been able to allow visiting by patients' pet dogs in this way.

Areas for improvement

Action the hospital MUST take to improve

1. Ensure all staff receive training in safeguarding children and vulnerable adults. The training must be at an appropriate level for the role and responsibilities of individual staff.
2. Ensure staff are appropriately trained to provide the care and support needed by patients at risk of self-harm.
3. Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.
4. Ensure all patients in the emergency department are able to summon help if they need it.
5. Ensure all patients over the age of 75 have a cognitive assessment when arriving in the emergency department.
6. Ensure learning from complaints is shared with staff in the emergency department which leads to improvement in care.
7. Ensure the governance framework in the emergency department clearly identifies risks, responsibilities and actions required to manage those risks within a stated timeframe.
8. Ensure systems and processes are effective in identifying where quality and safety are being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to outpatient appointment issues.
9. Ensure any remedial actions taken to address outpatient appointment issues are regularly audited to give assurances improvement has taken place.
10. Ensure patients in the critical care unit are routinely and properly assessed for delirium.
11. Ensure the provision of level two critical care on Ward 43 includes nursing staffing levels in line with the 'Core Standards for Intensive Care Units' published by the Intensive Care Society and the commissioners expectations.
12. Ensure patients requiring critical care at level two on Ward 43 are cared for by appropriately trained staff in line with the 'Core Standards for Intensive Care Units' published by the Intensive Care Society.
13. Ensure staff delivering end of life care receive suitable training and development.
14. Ensure all patients at the end of life receive care and treatment in line with current local and national guidance and evidence based best practice.
15. Ensure the quality of the service provided by the specialist palliative care team is monitored to ensure the service is meeting the needs of patients throughout the trust.
16. Ensure risks for end of life care services are specifically identified, and effectively monitored and reviewed with appropriate action taken.
17. 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
18. Ensure that the resuscitation trolleys and their equipment are checked, properly maintained and fit for purpose in all clinical areas in the children's and young people's service.

Outstanding practice and areas for improvement

19. Ensure that medication is monitored, in date and fit for purpose in all clinical areas of the children's and young people's service.
20. Ensure emergency lifesaving equipment in the maternity service is checked regularly and consistently to ensure it is safe to use and properly maintained.
21. Ensure staff have the appropriate competence and skills to provide the required care and treatment to women using the maternity and gynaecology service. Specifically, women who are acutely ill or who are recovering from a general or local anaesthetic.
22. Ensure patients in the medical care wards receive person-centred care and treatment to meet their needs and reflect their personal preferences, including patients living with dementia and those with a learning disability.
23. Ensure all staff working in the medical care service receive appropriate supervision, appraisal and training to enable them to fulfil the requirements of their role.
24. Ensure adequate provision of defibrillators and cardiac monitoring equipment within the emergency department.
25. Ensure patients in the medical wards are treated with dignity and respect at all times.
26. Ensure sufficient provision of hand gel dispensers within the emergency department.

Action the hospital SHOULD take to improve

1. Ensure there are effective and consistent systems for learning from incidents to be shared across the trust at all locations.
2. Ensure there are sufficient computers available for staff use in the ambulatory care area of the emergency department.
3. Ensure there is appropriate signage and information in the emergency department and that this is available and accessible to all people using the service.
4. Ensure the process for diagnosis of fractures and how learning is analysed and shared within the emergency department reduces the impact of missed diagnosis on patients.
5. Improve the time taken for the transfer of patient care from ambulance staff to emergency department staff.
6. Ensure clinical leadership in the emergency department is delivered at a consistently high standard 24 hours a day, seven days a week.
7. Ensure patient records are available when patients attend outpatient and diagnostic imaging clinic appointments.
8. Ensure patient records are available when patients attend outpatient and diagnostic imaging clinic appointments..
9. Ensure systems and processes are operated effectively to minimise delays for patients in outpatient clinics.
10. Ensure there is a review the hours of service provided by the specialist palliative care team to consider a face to face service available seven days a week.
11. Ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients.
12. Ensure that medical consultant staffing for the children's and young people's service is in line with Royal College of Paediatrics and Child Health (RCPCH) standards.
13. Ensure acute paediatric clinical guidelines are reviewed and follow best practice guidance.
14. Ensure that the paediatric allergy clinic meets the 18 week referral to treatment target.
15. Ensure that all nursing and medical staff in the children's and young people's service receive a minimum of yearly appraisals.
16. Ensure controlled drugs are checked twice a day on the maternity ward, in line with the trust's policy.
17. Ensure that staff in the maternity service follow the trust hand hygiene policy.
18. Ensure that workforce requirements are analysed in terms of what women using the service need, rather than what midwives do.
19. Ensure accurate data is collected regarding the use of steroid medication for pregnant women at risk of early labour.
20. Ensure information and guidance about how to complain is available and accessible to patients and visitors in the maternity service.
21. Ensure appropriate care and treatment pathways are developed for women using the pregnancy day care unit.
22. Ensure that midwife visits to mothers with new-born babies are in line with current National Institute for Health and Care Excellence (NICE) guidance.
23. Actively seek and record women's views and preferences regarding one to one care and postnatal visits by midwives

Outstanding practice and areas for improvement

24. Ensure cardiotocograph documentation follows current local and national guidance.
25. Consider appointing a designated bereavement midwife and a diabetic specialist midwife.
26. Ensure all staff in the maternity and gynaecology service understand their role and responsibilities regarding the Deprivation of Liberty Safeguards.
27. Provide a home from home environment for giving birth for women at low risk of complications.
28. Ensure women attending the termination of pregnancy clinic are seen by a diploma level qualified counsellor.
29. Ensure there is a designated consultant to take the lead for fetal medicine and the pregnancy day care unit.
30. Ensure there are sufficient operating theatre facilities and time dedicated for planned caesarean section operations.
31. Review the protocols for how long women remain in hospital after giving birth and consider changes to improve access to the maternity service.
32. Ensure staff in the maternity and gynaecology service understand and comply with the trust's policy regarding interpreter and translation services.
33. Ensure that all identified risks in the maternity service are regularly reviewed and added to the trust risk register where appropriate.
34. Ensure maternity information leaflets are easily available in languages other than English.
35. Consider the development of a maternity services liaison committee.
36. Ensure systems are operated effectively to reduce delays in transfer from theatre recovery to the surgical wards.
37. Review the use of theatres to improve flow and reduce delays between surgical cases.
38. Ensure the delays in orthopaedic surgery caused by limited access to a skilled periprosthetic consultant are monitored and reviewed and appropriate measures put in place to mitigate risk.
39. Ensure that staff practices on the medical care wards are in line with trust policy and current legislation regarding the prevention and control of infection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(2)(a)** • Staff must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. • Not all staff had received appropriate training in: safeguarding children and vulnerable adults; the assessment and treatment of sepsis; the care and support needed by patients at risk of self-harm • Not all staff understood the requirements of the Mental Capacity Act 2005 • Patients requiring critical care at level two on Ward 43 were not cared for by staff with a relevant qualification in critical care nursing. • Staff in the maternity service did not always have the appropriate competence and skills to provide the required care and treatment of patients who were acutely ill or who were recovering from a general or local anaesthetic. • Not all staff providing end of life care had received suitable training. • Not all staff in the medical care service had received appropriate supervision and appraisal. **Regulation 18(1)** **Sufficient numbers of suitably qualified, competent and skilled persons must be deployed** • The nursing staffing levels for the provision of critical care on Ward 43 did not meet the Intensive Care Society standards or the expectations of the commissioners.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(d)** • Care and treatment must be provided in a safe way for service users by ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. • There was no call system in the cubicles in the 'majors' area of the emergency department. Patients could not always summon staff assistance quickly when needed. **Regulation 12(2)(e)** • Care and treatment must be provided in a safe way for service users by ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way. • Resuscitation trolleys in the children's and young people's service were not always properly checked, maintained or fit for purpose. • Emergency lifesaving equipment in the maternity service was not always regularly or consistently checked to ensure it was safe to use and properly maintained.
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1)** **The care and treatment of service users must (a) be appropriate, (b) meet their needs, and (c) reflect their preferences** • Some patients over the age of 75 using the emergency department did not have an assessment carried out of their cognitive abilities. • Patients in the critical care unit were not routinely or properly assessed for delirium. • Patients at the end of life did not always receive care and treatment in line with current local and national guidance and evidence based best practice.

This section is primarily information for the provider

Requirement notices

- Patients in the medical care wards did not always receive person-centred care and treatment to meet their needs and reflect their personal preferences, including patient living with dementia and those with a learning disability.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)** • Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided. • Systems were not effective in assessing, monitoring and improving the quality and safety of the services provided by the specialist palliative care team. • Learning from complaints which led to improvements in care was not always shared with staff in the emergency department. **Regulation 17(2)(b)** • Systems or processes must be established and operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users • Systems and processes were not effective in assessing, monitoring or mitigating the risks regarding issues with outpatient appointments and patients' records not always being available. • Systems and processes were not effective in assessing monitoring or mitigating risks in the emergency department and end of life care service.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10(1)**

This section is primarily information for the provider

Requirement notices

Service users must be treated with dignity and respect.

- The privacy and dignity of patients in the medical care wards was not always respected.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

Why there is a need for significant improvements	Where these improvements need to happen
The Registered Provider does not ensure the effective operations of systems to assess, monitor, and mitigate risks to people receiving care as inpatients and outpatients. The Registered Provider does not ensure the effective operations of systems to improve the quality and safety of the services it provides to people using its services as inpatients and outpatients. The Registered Provider does not have proper processes in place to enable it to make the robust assessments required by the Fit and Proper Persons Requirement. We have issued a s29A Warning Notice to the Registered Provider, as the quality of health care provided for the regulated activities listed requires significant improvement.	Kings Mill Hospital