The University Hospitals of North Midlands NHS Trust

The Royal Stoke University Hospital

Quality Report

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

Ratings

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

Summary of findings

Outpatients and diagnostic imaging	**Requires improvement** 

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Stoke Hospital is part of University Hospitals of North Midlands NHS Trust. The trust was created on 1 November 2014, following integration with Stafford Hospital from the Mid Staffordshire NHS Foundation Trust. The hospital is based in Stoke on Trent and provides general acute hospital services as well as some specialised services.

We recognise that the leadership of the new trust has had the significant task of bringing together two organisations at a challenging time. We have seen that progress has been made but there is still more to be achieved.

We inspected this service in April 2015 as part of the comprehensive inspection programme. We inspected all core services provided by the trust at both hospital sites.

We visited the hospital on 22, 23 and 24 April 2015 as part of our announced inspection. We also visited unannounced to the trust until Tuesday 5 May 2015. Our unannounced visit included A&E, Medical Care Services and Critical Care.

Overall we have rated this hospital as requiring improvement. We saw that services were caring and compassionate. We saw a number of areas that required improvement for them to be assessed as safe and effective. We saw that leadership of services also required improvement at both a local and an executive level. The responsiveness of services was assessed as inadequate.

Our key findings were as follows:

- Staff were caring and compassionate towards patients and their relatives, we saw a number of outstanding examples of good care right across the hospital.
- There was a strong culture of incident reporting and staff were encouraged and supported by their managers to engage in this. This made staff feel empowered.
- Achieving safe staffing levels was a constant challenge for the organisation and there was a heavy reliance on agency and locum staff to support this.
- Systems and processes did not support patients flow through the organisation.

We saw several areas of outstanding practice including:

- A range of initiatives in services for children and young people to enhance their patient experience
- Diagnostic imaging services had received accreditation from the Royal College of Radiologists through the imaging services accreditation scheme (ISAS).
- The hospital Alcohol Liaison team had reduced hospital stay for patients with alcohol related issues by an average of 1 day per patient. This equated to 2762 hospital days saved during the last two years.
- A specialist one stop clinic had been developed for women with substance misuse issues where they could obtain the script for their medicines and then see the consultant and specialised midwife for their antenatal care.

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

Importantly, the hospital must:

- Review systems and processes to ensure patients flow through the organisation in a timely manner
- Address high waiting times in the emergency department
- Review the capacity and adequacy of the critical care services.
- Review the sustained use of recovery to accommodate critically ill patients
- The hospital should review staffing arrangements in medicine and the emergency department to ensure there are sufficient numbers of nurses and that the planned and actual staffing levels for each shift are displayed.
- The hospital should ensure that resuscitation trolleys throughout the hospital are appropriately stocked and are checked as regular intervals

Summary of findings

- There must be sufficient and appropriately experienced staff to provide safe and effective patient care.
- There must be appropriate systems in place and available to respond to deteriorating patients and the outreach team must be able to provide a service to all parts of the hospital.
- Implement the individualised care plan as soon as possible so that patients who are actively dying are supported holistically.
- Improve must be made to the discharge process for patients who wish to go home to die so that fast track discharges can be completed within 48hrs.
- Patients preferred place of death should be recorded and monitored so that the hospital can meet patients' choices.
- The hospital must review the sustained use of recovery to accommodate critically ill patients
- The hospital must review arrangements for gynaecology patients to ensure they are provided with a safe service and are cared for by staff with the relevant skills and expertise.
- Out of hours medical cover and arrangements for emergencies in critical care must be reviewed.
- Multi-disciplinary working in critical care must be reviewed to ensure that effective working arrangements are in place.
- Patients who appear to lack capacity should be assessed appropriately when decisions about their care are being discussed.

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	Requires improvement 	The trust has failed to meet the national standard of 95% of patients being seen within 4-hours of arrival for over two years and, over the winter period, has had unprecedented numbers of patients waiting more than 12-hours to be admitted to hospital. Capacity issues across the hospital impacted on the department's ability to transfer patients who required admission from being transferred to more appropriate locations within the hospital. We did not see evidence that the department exerted sufficient pressure on other departments or senior managers to address the issues for patients who were in the department for unacceptable lengths of time. Despite the pressures on capacity and flow, services were safe and we saw that staff were caring and compassionate in their dealings with patients. Patients felt well informed and engaged in their care.
Medical care	Requires improvement 	Medical care services ensured that actual and potential patient harm incidents were reported and investigated promptly. Staff were told about the results of investigations so that patient safety could be improved. All of the wards had noticeboards displaying their performance against quality targets. We had concerns about the management of some patient records and the storage and administration of medicines on some wards. Many wards had staff vacancies and staff were working overtime shifts to cover these shortfalls. Not all shortfalls could be covered in this way and on occasions wards were short staffed as agency staff were not available to cover all shifts. Staff told us that the ward management up to matron and consultant level was supportive, visible and approachable, however the executive team were not visible to ward staff and staff were not generally aware of the trust executives' vision and plans.
Surgery	Requires improvement 	The national referral to treatment time target for 90% of patients to have surgery within 18 weeks

Summary of findings

was not met overall. The hospital had a high volume of elective surgery which was cancelled, including for those patients who were suffering from cancer.
High numbers of patients remained in the theatre recovery areas for post -operative care with inadequate facilities to promote privacy and dignity of these patients.
Essential and emergency equipment such as resuscitation trolleys were not managed safely and in some instance these were not fit for purpose.
Medicines were managed safely most of the times. Although we found issues with safe keeping of some medicines not being maintained at the correct temperature.
Safety thermometer information was displayed on all the wards, the results showed variation in the quality of care provided. Where the compliance level was well below safety margins, this was not addressed.

Critical care **Requires improvement** 

The capacity of the critical care services was insufficient at the time of our inspection and this had a wider impact on the safety of patients in the hospital. The consistent use of the recovery area of theatres for extended periods to accommodate critically ill patients was not good practice. The lack of availability of outreach staff whilst they provided care in recovery meant they were unable to respond to deteriorating patients on other wards.
Nursing staffing levels had improved in recent weeks but the adequacy and skill mix of staff remained inappropriate.
A failure of cardiac critical care to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) meant that the effectiveness of the service could not be compared to other critical care units.
Multi-disciplinary working and collaborative care across critical care relied on individuals rather than suitable working arrangements in place and did not meet best practice guidelines.
The critical care managers were a newly appointed management team. They had identified that improvements were required and had a plan in place to address this; however this was work in progress.

Summary of findings

There were systems in place to review critical care service delivery although timely actions were not consistently taken to address areas of concern and ensure that risks to patients were minimised. Staff did not all feel that senior management were listening to or addressing their concerns.

Maternity and gynaecology

Good

Policies were based on national guidance, treatment was planned in line with current evidence-based guidance, standards and best practice.
Patients told us that they felt well informed and were able to ask staff if they were not sure about something. We saw a wealth of inpatient, day patient and outpatient's information leaflets available.
There was an active maternity services liaison committee (MSLC), which met quarterly.
There were many good examples of the maternity unit being safe but the gynaecological service was not able to offer the same level of reassurance. Women waited for long periods in the emergency department or the surgical assessment unit for review and on-going treatment. Once on the wards, they were not cared for by nurses trained in gynaecological nursing.

Services for children and young people

Good

There were effective procedures to support children and young people to have safe care. There was an open culture of reporting incidents. There was enough trained staff on duty to ensure that safe care was delivered. Although, not enough staff were trained in providing advanced paediatric life support and the trust had identified this on their risk register.
Parents commented that the facilities were very good and that there was plenty to occupy children. Although we found more space was required in the oncology day-case unit to provide care to children who were receiving care lying down and dedicated patient toilets.
Children and their families were treated with compassion, kindness, dignity and respect. Staff went that extra mile and involved children and their families in decisions about their care and

treatment. We found extensive evidence that staff emotionally supported children and their parents. Many aspects of the service were very responsive to the needs of children and young people.

End of life care	**Requires improvement**		The hospital did not have safe arrangements in place regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The completion of the documentation was not always done as per trust policy. Since the removal of the Liverpool Care Pathway, the hospital had failed to implement an individualised plan of care for the dying patient, with the trust still in the evaluation process of the new pathway. The specialist palliative care team (SPCT) was adequately staffed, however it was not their responsibility to deliver care for all the palliative and end of life patients at the hospital; we saw that staffing challenges on the wards resulted in some people and families receiving care that was not optimum. Caring within the service was good; staff were committed, compassionate and emotionally supportive. The SPCT team were expert communicators and demonstrated this during the inspection.
Outpatients and diagnostic imaging	**Requires improvement**		Systems and processes were not always reliable or appropriate to keep people safe**.** Cancer waiting times were constantly fluctuating and referral to treatment time targets were not being achieved. The diagnostic waiting times had been higher than the England average but were seen to be improving. A significant number of patients were waiting for follow up appointments. The organisation of the outpatient services was not always responsive to patients' needs. There were numerous delays and clinics consistently over-ran. Diagnostic imaging had nationally recognised accreditation in place. Staff were suitably qualified and skilled to carry out their roles effectively, they were approachable, open and friendly. Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Summary of findings

There was a clear vision for the trust and the service. Staff in the outpatients department were engaged in developing services and staff in diagnostic imaging had a good understanding of the department's vision and approach.

The Royal Stoke University 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 The Royal Stoke University Hospital

On 1 November 2014, the University Hospital of North Staffordshire was integrated with Stafford Hospital (part of the Mid Staffordshire NHS Foundation Trust) to form the University Hospitals of North Midlands. The newly formed organisation is working towards becoming a foundation trust in 2017 – 2019. The hospital serves the people of Staffordshire and the city of Stoke-on-Trent, which was ranked as the 16th most deprived local authority. Royal Stoke is a teaching hospital, in partnership with Keele University and the site includes a patient centre clinical research facility.

The Royal Stoke hospital has been inspected five times since registration with CQC, and was last visited in December 2013, when it was judged as compliant.

Our inspection team

Our inspection team was led by:

Chair: Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

Chief Operating Officer, director of clinical quality, safeguarding children specialist, medical consultants, consultant radiologist, radiology manager, clinical oncologist, speciality registrars, consultant obstetrician and gynaecologist, consultant anaesthetist, consultant paediatrician, specialist nurses, speciality matrons, head of A&E nursing, senior nursing sisters.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

How we carried out this inspection

We inspected this service in April 2015 as part of the comprehensive inspection programme.

Detailed findings

We visited the hospital on 22, 23 and 24 April 2015 as part of our announced inspection. We also visited unannounced to the trust on Friday 1 May and Tuesday 5 May 2015. Our unannounced visit included A&E, Medical Care Services and Critical Care.

We held two public listening events before the inspection; one in Stafford on 13 April 2015 and one in Stoke on 15 April. These events provided the opportunity for people using services, relatives and members of the public to come and talk to us about their views and share their experiences. Approximately 80 people attended across the two events.

During our visits to the hospital we held 14 planned focus groups to allow staff to share their views with the inspection team. These included all of the professional clinical and non-clinical staff. We also held a "drop-in" focus group for any staff unable to attend the other planned sessions. Through these groups we spoke to 232 members of staff.

We met with the trust executive team both collectively and on an individual basis, we also met with ward managers, service leaders and clinical staff of all grades. We also spoke to patients and their relatives and carers we met during our inspection.

We visited many clinical areas and observed direct patient care and treatment.

Facts and data about The Royal Stoke University Hospital

Royal Stoke Hospital has 1219 beds and employs 8,844 whole time equivalent staff. During 2013/2014 there were 133,186 inpatient admissions, 612,497 outpatient attendances and 148,193 accident and emergency department attendances. The hospital provides general acute hospital services for approximately 700,000 people living in and around Staffordshire and specialised services for three million people in the wider area.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department at Royal Stoke provided consultant-led emergency care and treatment 24 hours a day, seven days a week.

There was a separate paediatric emergency department. A helicopter pad adjacent to the ambulance entrance enabled patients to be transported by air ambulance to quickly access medical attention. There was a dedicated assessment unit for patients transported by Air Ambulance adjacent to the resuscitation and majors units which allowed seriously ill or injured patients direct access to the most suitable location. The department also included a clinical decisions unit (CDU).

Emergency services are provided at both sites although County hospital emergency department closes to new admissions each day between 10pm and 8am. During these closed period patients who might have used County hospital use Royal Stoke or have to identify alternative services.

Royal Stoke emergency department is one of the busiest in the country. During the 2013/14 period the department saw 148,193 patients.

The emergency department was originally built in anticipation of receiving 100,000 attendances but is currently seeing in excess of 140,000 attenders. The trust anticipates that this figure will rise by 3% per annum. The hospital have recently introduced a single point of access reception which triages patients into the urgent care centre operated by a neighbouring Trust, which has reduced the pressure on A&E.

In order to make our judgements we spoke with patients or their families or carers. We spoke with clinical and nursing staff and with support service staff such as porters, cleaners, and administrative staff. We visited all the areas within the department and observed how staff interacted with patients. We attended meetings and staff handovers. We spoke to approximately 35 patients and reviewed information from comment cards that were completed in the waiting area.

Urgent and emergency services

Summary of findings

The hospital has failed to meet the national target of 95% of patients being seen within 4-hours for over two years and has had unprecedented numbers of patients waiting more than 12-hours to be admitted to hospital. Despite these long delays, patients were managed well and were kept safe whilst in the department.

Capacity issues across the hospital impacted on the department's ability to transfer patients who required admission from being transferred to more appropriate locations within the hospital.

We did not see evidence that the department exerted sufficient influence on other departments or escalated issues to senior managers to address the issues for patients who were in the department for unacceptable lengths of time.

Despite the pressures on capacity and flow, services were safe and we saw that staff were caring and compassionate in their dealings with patients. Patients felt well informed and engaged in their care.

Are urgent and emergency services safe?

Good

Despite the long delays experienced by patients, we found that policies and procedures in the emergency department were designed to keep people safe.

Staff were knowledgeable and skilled; they understood their role and followed recognised best practice. Although there were vacancies for nursing and medical staff, there were arrangements in place to ensure that patients were not put at risk as a result.

Where capacity issues caused queuing for services we saw that additional staff were drafted into the department in line with locally established agreements with other departments in the hospital.

A new electronic drug storage and dispensing unit had recently been installed improved medicines management in the department and better management of risk to patients.

Some minor issues were identified in relation to checking equipment, but not to the extent of exposing patients to harm.

There were robust arrangements around major incident planning and training which extended beyond the emergency department.

Incidents

- Staff reported all incidents and 'near misses' through a centralised web-based reporting system (DATIX). This system automatically escalates incidents according to their type and the department affected.
- Serious incidents and 'never events' were reported nationally at trust level. Never events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken. During 2014/15 the hospital had not reported any 'never events' and no serious incidents attributable to emergency services at the Royal Stoke Hospital.
- A total of 2825 low or no harm incidents were recorded between 2 November 2014 and the end of January 2015. The majority of these related to recording of pressure sores which were evident when patients were admitted.

Urgent and emergency services

- Over the winter period, the department had a high number of patients waiting more than 12 hours to be admitted to a ward. Up to February 2015, there had been 731 12 hours breaches. The trust had completed a root cause analysis review of each of these incidents and provided assurance that patients safety had not been compromised as a result of these delays.
- Incidents were discussed by staff during team meetings and handovers. Nursing staff told us that the electronic system was an effective method of recording and sharing information about incidents once they had been entered on the system, however many staff told us that entering incidents was slow and laborious and it was difficult to find time to enter incidents when the department was busy. They said that they were supported by senior nursing staff who would either complete entries or facilitate time for them to complete them.
- Meetings to review mortality and morbidity took place monthly. All deaths in the department were reviewed by the clinical lead so that learning or issues could be identified.

Safety Thermometer

- The target time for handover from ambulance to the ED is 15 minutes. National recording of breaches over 30 minutes and over 60 minutes are used as an indicator of performance. In March 2015, 94.9% of patients were handed over in less than 30 minutes, 205 patients (5%) experienced delays over 30 minutes and 5 (0.1%) were delayed by over 60 minutes. Over the period November 2014 to February 2015, on average 8.2% of patients experienced a delay of over 30 minutes.
- Initial assessment and treatment times for 2013 were consistently above the national target of 60 minutes. No recent performance data was provided by the trust.
- Hospital acquired pressure ulcers, falls or catheter associated urinary tract infections (UTI's) were below target levels. Between August 2014 and December 2014 no hospital acquired pressure ulcers or falls were recorded. Two incidents of hospital acquired catheter associated (UTI's) were recorded.
- During March 2015 a total of 10,174 patients attended the department, of those 3,775 or 37% had a total stay in the department of over 4 hours for discharge, transfer or decision to admit.
- Trolley waits where patients could not be allocated beds increased between August 2014 and December 2014. In August, two patients waited in excess of 12 hours and in December 92 patients were affected by long waits.

Cleanliness, infection control and hygiene

- We found all areas of the emergency department to be clean, tidy and free from clutter.
- We saw examples of treatment bays being cleaned in between use, including wiping of equipment and fittings.
- Staff observed the 'bare below the elbow principles of infection prevention and control.
- Cleaning schedules were maintained and followed.
- All staff we spoke with understood the principles and importance of infection prevention and control. All the staff we spoke with said they had completed received training during their induction into the hospital and during mandatory training sessions. We saw that 78% of emergency department staff had completed specific infection prevention and control training and all but two staff had completed a combined statutory mandatory training session.
- We were assured that hand hygiene audits were completed, although we did not review the findings during this inspection.

Environment and equipment

- We found that all medical equipment was well marked showing required service dates and indicating that all equipment in use was within its current service schedule.
- We saw that resuscitation equipment was maintained ready for use. Checks were completed regularly and marked in the log books kept with each trolley. We did find an open 'chest kit', on one trolley in the resuscitation bays; however, this was because the equipment had been recently used, when we checked later the trolley had been replenished ready for use.
- Medical equipment was all seen to be within service dates
- Treatment rooms and cubicles were spacious, well equipped and well lit.
- The department was well planned and had a separate paediatric emergency department. Entrance in and out of the unit was controlled by video link to nurse stations which enables staff to monitor who were entering or leaving the department.

- Ambulance and Air ambulance entrance had a dedicated assessment unit adjacent to the resuscitation and majors units which allowed seriously ill or injured patients direct access to the most suitable location.
- Emergency services were complemented by having diagnostic services adjacent to them making easy transfer for x-ray and other scanning services.
- Access to some areas of the department was controlled by electronic card entry systems. Staff ID badges also acted as their access control. This enabled the hospital to restrict access to sensitive areas to particular members or groups of staff.
- The card access system could be audited if required to show which staff had used their card to enter a specific area. In addition if security controlled doors did not close within set limits alarms activated in the control room where CCTV could monitor activity or dispatch a security officer.
- The hospital had facilities to deal with patients who may have been exposed to hazardous chemicals, with shower and changing facilities to prevent contaminants being spread to the department.

Medicines

- We saw good medicines management in resuscitation bays;
  - IV Fluids and drugs kept in locked cabinets
  - Drugs in date
  - Cupboards clean and clearly marked
- During our inspection we identified a potential issue where patients arriving by ambulance or via triage may have been given or taken Paracetamol and then been given a further dose by emergency department staff. As the original dose may not have been recorded, staff would not be aware of this and the potential for over-dosing. We brought this to the attention of staff in the department. We saw that during the inspection a protocol was written and distributed to eliminate the likelihood of this risk.
- A new electronic drug storage and dispensing unit had recently been installed in main bay area. The system automatically audited the drugs dispensed against the patient's prescription, which ensured that only appropriate quantities and strengths of drug were dispensed. The system recorded details of the staff who dispensed the drugs and linked with the main pharmacy department to show stock levels and enabled automatic ordering. Expiry dates of stock were also monitored automatically which meant less waste and less risk to patients.
- Access for staff was via fingerprint scanning which prevented unauthorised access. Senior nursing staff held emergency bypass keys to enable access to life saving drugs in emergency situations. Staff who used the system were very complimentary of it and the time savings. A second unit had been acquired and was waiting to be installed in the resuscitation bay.

Records

- We reviewed records relating to the management of the emergency department, auditing of processes and patient notes. We only review patient notes in order to ensure that specific issues or assessments had been completed in line with policies and information we had been told by staff.
- We found that all written records were concise and accurate and mostly easy to read. Electronic records were complete and staff who used the systems demonstrated how information was extracted to monitor performance and feedback to managers or staff. An example of this being the validation process for 4 hour and 12 hour breaches in the department which we observed being completed.
- Risk assessments were completed in respect of general running of the department which were designed to ensure that patients, staff and visitors remained safe whilst in the department. Risk assessments formed part of operational policies such as the helicopter landing and take-off procedures.
- Individual risk assessments were completed for patients with specific needs; these included falls risk assessments, Waterlow assessments which were used to determine patient's risk of developing pressure sores and nutrition assessments for patients whose food or fluid intake required monitoring.
- We saw that monitoring and updating of risk assessments took place throughout patients stay in the department.

Safeguarding

- Staff in the department had received safeguarding training in line with their role. Healthcare assistants we spoke to showed an awareness of what might constitute abuse, and told us they would raise concerns with nursing staff.
- We saw records which showed that as of 31 March 2015, 94% of staff had completed child protection awareness training (equivalent to level 1) and 95% had completed vulnerable adult awareness training (equivalent to level 0) and. This training is on a 3-year cycle. The trust target is that 95% of all staff have completed this training.
- Seventeen percent of all staff in the emergency medicine directorate had completed level 2 or above training in child protection. This data could not be broken down to site level. The trust told us that directorate managers had not yet determined which staff should undertake this training.
- The trust's safeguarding team were available for advice either by phone or through visiting the department.
- Staff in the children's emergency department had close links with the Staffordshire and Stoke on Trent local authority safeguarding team, and members of the safeguarding team were active members of local safeguarding children boards.
- An on call system ensured that paediatricians were available 24-hours per day, 7-days a week for child safeguarding issues.

Mandatory training

- All staff had been subject to an induction process when they joined the trust. Mandatory training was provided to ensure staff remained up to date with techniques and procedures. Attendance levels had fallen over the past months due to training being cancelled to cover winter pressures.
- Mandatory training was available to staff via computer based training and face to face, classroom based training. Mandatory training topics had to be repeated periodically to ensure that staff remained up to date with the latest techniques and guidance. Some training was repeated annually whilst other topics are covered every three years. We saw how computerised records were used to monitor staff attendance.
- Staff were responsible for booking their own training and had access to electronic training booking system.

Assessing and responding to patient risk

- Triage services for patients who made their own way to the emergency department at Royal Stoke were provided by a private company. General practitioners and nurses saw patients after they had booked in at the reception.
- Patients were assessed to identify if they needed to use the emergency services or could be referred back to their own GP service. Where patients required emergency treatment they were routed to the most appropriate department which was usually the minor injuries or majors units. The service was staffed by a combination of general practitioners (GP's) and streaming nurses. Outside the commissioned hours, the departments own triage nurses cover the service.
- Triage for patients arriving by ambulance or air ambulance took place in a dedicated six bedded bay. There is dedicated receptionist cover 24/7 who books patients into the system which helps reduce ambulance waiting times. Once booked onto the computerised system colour coding on the screen enables clinicians to identify who has been seen and what stage of their treatment they were at.
- The triage was staffed by three doctors at all times with at least one being a senior registrar or consultant. These were supported by two nurses and a health care assistant.
- An Electrocardiograph (ECG) technician also worked in the department during the day and evening. Electrocardiographs record the electrical impulses in the heart.
- The hospital had an outreach team consisting of specialist trained nurses whose role included providing advice or assisting nursing staff to cope with deteriorating patients who required more intensive nursing. Staff in the department told us that it was difficult to get a response from the team as they were constantly being taken away from their role to provide additional nursing staff in other areas of the hospital.
- Recognised pathways of care ensured that patient's acuity was assessed and appropriate treatment provided. The design of the emergency department with majors sitting between ambulatory care and minors, enables staff to in each area easy access to advice and support from colleagues.
- We saw evidence of how the department had responded to issues. New documentation had been introduced following a review of falls. The new documents ensured that consideration was given to

assessments for pressure ulcers, falls and other risks, so that staff were prompted to consider the issues in all cases which meant there was less chance of patients who required these assessments not receiving them.
- Recognised acuity tools were used to assess and monitor patients.

Nursing staffing

- Planned nursing staff levels were based on NICE guidance. The number of nursing staff employed was less than guidance suggested and bank and agency staff were used to make up the difference. A business case was being submitted to increase nursing levels in line with guidance and reduce the need for bank and agency cover.
- We saw that the different departments and areas of the emergency department displayed details about the numbers of nursing and healthcare staff on duty and also the numbers who had been planned. In some instances we saw that planned numbers exceeded the numbers on duty we were told this was caused by sickness and unavailability of agency staff to fill posts at short notice.
- The department had a 10% vacancy rate which was filled with bank and agency staff.
- The department had run recruitment campaigns which included overseas recruitment. Overseas nurses had been provided with extended periods of training during which they were supernumerary to staff numbers. The trust also had a preceptorship programme to support the nurses. Preceptorship is a period of transition for new nurses and allied healthcare professionals during which they receive additional support to enable them to develop their skills.
- We observed nursing handovers, we saw that general issues such as capacity and flow were discussed and details about individual patients were highlighted where additional monitoring or issues existed.
- The emergency department had recently established a role for a second matron. The two matrons had split the workload into administrative and hand-on tasks, whilst both were capable of and did perform both functions, it enabled the administrative matron to dedicate more time to planning and auditing which included ensuring appropriately skilled staff were rostered and available.

Medical staffing

- Royal Stoke medical staffing consisted of 24% Consultants, 10% middle grade doctors, 18% registrar and 48% junior doctors. Medical staffing of the Royal Stoke emergency department had a high proportion of junior doctors compared to other grades. This reflected the trusts status as a teaching hospital. Consultant and middle grade doctor ratios mirrored national averages and together with registrars provided adequate supervision and support to the junior doctors.
- Royal Stoke had two Consultant vacancies at the time of the inspection. Registrar level doctors were running at a 25% vacancy rate although two new staff had recently been recruited but not started at the hospital.
- We observed comprehensive, supportive handover between medical staff, individual patient cases were discussed in open forum. Diagnosis of patients was challenged by the consultants and all the other doctors present thus prompting discussion and consideration of other options for the patient.
- Locum doctors were used to cover vacancies. We saw that effective induction was given including access to computer based systems. One locum consultant we spoke with showed us a written guide which he had been given which provided basic information on practices and systems at Royal Stoke.

Major incident awareness and training

- The hospital had robust major incident awareness training. Training events were a regular feature in the department and major incident training events were held monthly and were open to all staff from all areas of the hospital. This included porters, security staff and car park staff who all had identified roles in emergency plans.
- Major incident plans were available on the trust intranet and action cards were kept by senior nurses for distribution in emergency situations.
- The hospital had declared its own major incident earlier in the year in January, when capacity issues had meant that further admissions might prejudice the safety of patients already in the hospital. The trust worked with community based health services and ambulance services to divert patients who did not need emergency treatment. Local media were used to asked people to use other services wherever possible.

Urgent and emergency services

- Security in the department was provided by the trusts facilities management provider. A uniformed security officer patrolled the emergency department. We saw that the security officers were properly licensed by the security industry authority (SIA).
- Security officers understood their role and saw themselves as a preventative presence. Security officers had their own radio/phones and could contact a central control room if further officers were required. The control room also monitored CCTV on the site including in some public areas of the emergency department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Results of national audits showed that outcomes for patients were not as good as they should be when compared to standards or other hospitals, particularly in relation to renal colic, severe sepsis and septic shock.

The mortality figures were comparable in relation to the volume of patients seen in the department. Although slightly higher than the target figure the hospital is well within the parameters of expected mortality rates.

Recognised clinical pathways were followed and care and treatment was provided in line with national guidance.

Evidence-based care and treatment

- Treatment and care pathways were based on recognised national guidance and best practice.
- Management of sepsis, stroke and fractured neck of femur followed recognised pathways, and learning from previous national audits had been used to inform staff. An example of this being the pain assessments completed for all patients.
- The emergency department consisted of a number of areas where patients were streamed dependent upon their needs. The department had been designed such that the bays were adjacent to a central imaging department which meant patients in any area were all within a short distance of imaging services where these were needed.
- Information collated by NHS England showed that Royal Stoke University Hospital had reduced the number of patients admitted to the hospital following treatment in the emergency department. During 2013/14 the hospital admitted 28% of patients to the hospital. During 2014/15 this had reduced to less than 23%. Reducing admissions is indicative of effective treatment and improved discharge support.

Pain relief

- Patients all reported being asked about pain and being offered pain relief as appropriate. We saw how one patient waiting to go into ambulance triage was assessed and given pain relief. This demonstrated that patient's safety and comfort were considered by the staff.
- Records we checked indicated that pain relief had been assessed and where appropriate analgesia provided.
- We were told of one instance where a patient said they had been given paracetamol at triage when they had arrived six hours earlier; however they had received no further input or consultation or checks since that time and had been left sitting in the main reception area. They told us that the pain relief had worn off. This meant that some patients may not be receiving adequate pain relief throughout their attendance.

Nutrition and hydration

- Patients were offered food and drink whilst in the department. Where appropriate recognised assessment tools such as the malnutrition universal screening tool (MUST) were used to assess the needs of vulnerable patients.
- We saw healthcare and nursing staff providing drinks to patients and their carers of relatives.
- There were full cafeteria and shop services available in the hospital for those able to use them although these were a considerable distance from the emergency department. There were drink and snack vending machines in the main waiting room of the department.

Patient outcomes

- The trust participated in the College of Emergency Medicine (CEM) audits which enabled staff to compare performance against similar hospitals, the data

collected in respect of Royal Stoke site relate to the site prior to the amalgamation with County Hospital, and are recorded under the sites former identity as University Hospital North Staffs.

- In the overall patient experience survey for 2014, the hospital scored about the same as other trusts in all areas other than 'did patients believe staff had done everything they could to help control their pain'. The hospital scored worse than other trusts for this area. As a result, pain control was included in the guidance to staff for initial assessment. We observed how patients were asked about their pain control.
- The renal colic (CEM) audit for 2012/13 showed the hospital was in the lowest quarter of all trusts in relation to six of the seventeen standards measured. The exception being that the hospital met the 100% target for dipstick analysis of patient notes.
- In the fractured neck of femur (CEM) audit for 2012/13 the hospital performed in line with national averages in most areas but was worse than average in regard to pain relief and time before x-rays were completed. As a result, pain management screening was a required field in patient review charts which meant it would not be overlooked. Senior staff told us they were confident that pain management in ED was understood and prioritised by staff. Staff anticipated that new figures would show the hospital had improved in this area when the latest CEM audit data is published in June 2015.
- The severe sepsis and septic shock (CEM) 2013/14 audit showed that in the thirteen criteria measured the hospital underperformed in all areas against the targets. However when compared to England averages the hospital performed better than most others in two areas and equalled them in five others. In the remaining six areas the hospital performed less well. The trust did not provide us with an action plan in respect of this but we were shown an audit newsletter which demonstrated that audit findings had been shared with staff and actions planned.
- NHS England collates information regarding unplanned re-attendance rates. Unplanned re-attendance rates refer to the number of patients who have been seen in emergency departments within the last seven days and have needed to re-attend for the same reason. Statistics showed that between January 2013 and September 2014 the England average fluctuated between 7% and 7.5% against a target of 5%. Trust figures fluctuated between 5.5% and 6.5% during the same period. This showed that whilst the hospital did not meet the target, they did perform significantly better than the England average.
- The hospital had an alcohol liaison team consisting of three specially trained staff. The team had reduced time to discharge for patients referred to their service by 26% since 2012. This meant that each patient with alcohol related issues spent on average one day less in the hospital than they had previously. When considered in relation to the number of referrals to the team which were 1342 during 2013/2014 and 1420 during the present term 2014/15. This equates to considerable impact on patient outcomes.

Competent staff

- We found that clinical and nursing staff were knowledgeable and understood their role within the organisation.
- All nursing staff in the department had been appraised during the last twelve months. Most staff felt that the appraisal system enabled them to highlight their aspirations and issues; however they felt that capacity issues in the department prevented opportunities to advance as there was little or no time for study or to attend external courses.
- Practice was continually assessed by peers and senior nurses who offered advice and guidance and support by leading by example. This included the second matron who we witnessed supporting nursing staff during comfort rounds.
- Clinical staff and nursing staff are required to revalidate their registration. Revalidation involves gathering evidence of experience and remaining up to date with current techniques and information. Both nurses and doctors told us they had been supported to revalidate. One consultant we spoke with expressed concern regarding the process which enabled them to mentor junior doctors whilst at the same time they had been told they required more evidence in order to confirm their own revalidation. They felt that if they had not revalidated the trust should not consider them suitable as mentors. They saw this as double standards.
- Nursing staff and some health care assistants had received additional training and performed tasks to assist clinicians. These tasks included cannulation,

venepuncture, and ECG's. Cannulation refers to the insertion of a needle into a vein to allow blood samples to be taken or drugs to be given. Venepuncture refers to taking of blood samples.

Multidisciplinary working

- We saw that multidisciplinary working occurred within the emergency department, both within the main treatment areas and the CDU. Specialist nurses and other healthcare professionals were fully involved in and engaged with patient care.
- We spoke with staff from the mental health rapid assessment interface and discharge (RAID) team, and with one of the alcohol liaison nurses. Raid services were provided by a neighbouring trust under a service level agreement, however the raid staff told us that they were fully integrated with the hospital teams and were called extensively to assess and monitor patients in the emergency department. Raid services only operated during day and evenings. The alcohol liaison nurse described how the team worked with the department to reduce length of stay by arranging community based support for patients.
- The hospital had provided additional consultant led training to advanced nurse practitioners in the emergency department. In addition to the national training these specialist nurses received they were provided with skills which enabled them to take their own patients from the majors area and some cases from the resuscitation lists.
- The advanced nurse practitioners (ANP's) felt valued and empowered to take on more responsibility. Doctors of all grades were complementary of their work and the support they provided to the department. The training and expertise enabled them to work as second doctor in major trauma cases. ANP's were also able to work automatously in the CDU and were able to discharge patients. We felt this was an example of outstanding practise.
- We saw other evidence of multidisciplinary working with therapist visiting the unit although it was unclear if they were there primarily to cover patients who should have been moved to wards but had remained in the department due to the capacity issues.
- Effective communication and working with ambulance trusts and with local communities had ensured that patients were transported to the appropriate locations dependant on the time of day.

Seven-day services

- Emergency services and associated imaging services were all provided on a 24/7 basis. Consultants worked between 8am and midnight after which a call out system operated.
- Triage services in the main emergency department reception were provided under contract during the day and evening by a private company. During the night trust staff filled the role.
- Support services such as therapies, RAID, alcohol liaison team worked during the day and evenings.
- The alcohol liaison service has recently undertaken a pilot project covering 7 day working rather than their previous five day working. An additional member of staff was drafted in during February and March 2015 enabling the team to cover weekend working. As a result a total of 66 patients were seen during the weekend periods. 24 patients were discharged direct from A&E. Seven patients were discharged from A&E as a direct result of the alcohol liaison teams interventions; preventing unnecessary admission. The remainder of the patients were referred onto community based alcohol services or given appropriate advice or community support in order to prevent readmission. A progress report had been submitted and the team were hopeful that they would receive support to continue the seven day service.

Access to information

- Staff had ready access to information to enable them to provide a comprehensive service to patients. Risk assessments, care plans and comfort rounds were all well documented.
- Due to the capacity issues the hospital were experiencing it was not always possible for patients transferred out of the emergency department to go onto the specialist ward most appropriate to their condition. These patients are referred to as outliers. However; where the patient's condition required a higher level of specialist care the patient notes were stamped to identify that patient needed to be cared for in the specialist department or ward. This had been highlighted as good practice during a recent Trust Develop Authority (TDA) review.

- When we spoke with junior doctors we were told that during busy periods it could be frustrating trying to find a free computer terminal to access information. We were told that there could be up to five doctors and nurses all trying to access two computer systems.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were followed to ensure decisions were made in the best interests of patients.
- Resource packs were available for DoLS and MCA to guide staff.
- Where patients were unconscious treatment was given in emergency circumstances based on the information available such that decisions were made in the patient's best interest. Such decisions were documented and fully discussed with patients or next of kin when the opportunity arose.
- Patients who were conscious and able to engage with staff were told what was happening and asked for their consent prior to care or treatment being given.
- Patients told us that they had been fully informed by staff both clinical and nursing; about proposed actions and they understood what they were consenting to.
- Clear guidance was available and understood by staff in the children's emergency centre in relation to consent to care and treatment and the involvement of parents or those with parental responsibility. Nursing staff and medical staff were able to describe how children over 16 years had the same rights as adults and in the same way adults are presumed to have capacity to consent, children over 16 were also entitled to the presumption.
- Children under 16 were considered not to have capacity and parental consent was sought before treatment was given. Staff also understood the need for the parental consent to be given by a person who themselves had capacity to make the decisions.

Are urgent and emergency services caring?

Good

We rated the quality of caring in the department as good.

Staff were passionate about the care they provided to patients.

Patients described staff as friendly and helpful. Even patients who had experienced extended periods in the department said that staff could not do enough for them, which had made the waiting tolerable. Friends and family test results showed a lower satisfaction level than other emergency departments.

Patients were involved in their care, and felt informed and engaged.

We saw how patients were supported emotionally in addition to having their physical needs addressed.

Compassionate care

- All patients described nursing staff in the department as helpful, attentive and caring. We witnessed many incidents of healthcare assistants and nurses attending to people, we saw that the interactions between staff and patients were friendly and relaxed.
- We observed nurses and health care assistants completing the comfort rounds, which had been introduced in response to the long waits experienced by some patients. We saw how patients were comfortable in the presence of staff and seemed happy to join in conversations.
- During afternoon and evenings we saw that the department extremely busy. Patients arriving by ambulance or air ambulance were queuing in corridors waiting to be assessed; we saw that initial assessments were completed whilst they were queuing. This meant that others in the queue could see and hear what was being said. Patient privacy and at times their dignity was potentially compromised by this system.
- The ambulance triage area was a six bedded bay and in comparison to the other areas of the emergency department was quite cramped. The close working conditions and busy environment meant that confidentiality and privacy of patients could be compromised, as personal information and medical issues could be easily overheard by other patients and their relatives.
- During busy periods patients queued in corridors on hospital trolleys waiting to be triaged or following triage waiting for appropriate bed space. This meant that patients were transferred from ambulance trolleys to hospital trolleys in open corridor areas in full view of

other patients and their relatives. Whilst hospital staff and ambulance staff did what they could to protect the patient's dignity, the public transfers often impacted on patient's dignity.

- Responses to the NHS England friends and family test showed that satisfaction with Royal Stoke emergency department was below nation averages. For the four months November 2014 through February 2015, results showed that only 78.7% of people were likely or extremely likely to recommend services. The all England average for the same period was 88.7%. Response rates to the survey were also much lower at Royal Stoke. For example, the response rate in February 2015 was 11.7%, compared to the England average of 21.2%

Understanding and involvement of patients and those close to them

- Patients reported that doctors were very informative and explained everything very well. One patient said, "I couldn't fault the doctors".
- We observed interactions between doctors and patients and their families, we saw how issues were explained and patients had opportunity to discuss what they were being told. Consent was always obtained prior to any interventions taking place.
- Nursing staff were attentive and listened to patient concerns. Patients told us that their main concern was waiting. They had asked staff about waiting times and had been told they were waiting for beds to become free.

Emotional support

- Patients and families told us how they had been supported by the nursing staff and doctors. They described how staff had remained calm and professional when treating them and speaking with them. They told this had enabled them to relax and worry less about their condition.
- We witness staff dealing with scared and worried patients and relatives as they arrived in the department, we saw that they showed compassion and understanding in the way they approached, supported and spoke with people.
- The hospital had a chaplaincy service available seven days per week between 8.30am and 4.30pm. An on-call service operated outside those hours.

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

(for example, to feedback?)

Inadequate

We rated the service as inadequate in relation to the responsiveness of the service. The trust has failed to meet the national target of 95% of patients being seen within 4-hours for over two years and had had unprecedented numbers of patients waiting more than 12-hours to be admitted to hospital.

Although we observed that staff were doing their upmost to respond to patient's needs, excessive waiting times from decision to admit to actual transfer to wards caused additional anxiety for both patients and their relatives. We observed systemic issues with protocols for referral and bed occupancy which impacted on the department's ability to facilitate patient flow.

Triage services were provided by a private company, within a standard operating procedure. These working arrangements had been in place since October 2014 but had not been formally evaluated.

Patients transferred from the County Hospital, who should have gone to specialist wards, were being accommodated in the emergency department, due to lack of bed space elsewhere in the hospital. This was putting additional pressure on the department to respond to emergency department patients.

The hospitals alcohol liaison team provided an outstanding service reducing overall length of stay for patients with alcohol related issues.

Service planning and delivery to meet the needs of local people

- Triage services were provided by a private company. General practitioners and nurses saw patients after they had booked in at the reception. This service was under contract to the CCG and had been implemented following liaison between the CCG and the trust chief executive.

Urgent and emergency services

- The service was commissioned by the Clinical Commissioning Group (CCG) with a view to relieving pressure on the emergency department and educating the public in respect of alternative more appropriate services. It had been in place since October 2014.
- The service was staffed by a combination of general practitioners (GP's) and nurses. GP services operated between 9am and 11pm on weekdays and 10am and 11pm at weekends. The nurses worked staggered shifts of 8am to 10pm and 9am to 10pm weekdays and 9am to 10pm weekends. Outside the commissioned hours, the departments own triage nurses covered the service.
- We spoke with department managers and with the manager of the private service. Processes were in place to enable the effective management of the staff and the service. Regular face to face meetings were held between the management teams which enabled issues and ideas to be passed between the services. Standard operating procedures were in place which ensured that staff from both organisations were aware of each other's role.
- A formal review of the service had not been undertaken.
- Patients who were transferred from County Hospital for specialist treatment were accommodated in the Royal Stoke emergency department because specialist wards had no bed space. This was putting additional pressure on the department to respond to emergency department patients.

Meeting people's individual needs

- Translation services were available in form of telephone interpreter services. We did not see evidence of information being available in alternative languages even though the demographics of the area included a number of large ethnically diverse communities.
- Patients with mental health needs were provided with a service under a service level agreement with the North Staffordshire Combined Healthcare Trust. The rapid assessment interface and discharge (RAID) team provided specialist psychiatric support to patients 16 years and over with mental health issues. The team were on site between 7am and 11pm. Outside these hours patients were dealt with by the emergency department staff and referrals made to the service.
- We saw that Royal Stoke hospital had excellent paediatric emergency services. After booking in at the main reception children and their carers were sent through to the children's emergency department, which was specifically designed to meet their needs. The paediatric emergency department also had a dedicated ambulance entrance which meant that all but the most serious cases were brought directly into the unit.
- The paediatric emergency department was decorated with child friendly collages and play equipment was available in waiting areas with a variety of equipment to cater for children and young people of different ages.
- The hospital had an alcohol liaison team consisting of three specially trained staff. The team had reduced time to discharge for patients referred to their service by 26% since 2012. This meant that each patient with alcohol related issues spent on average one day less in the hospital than they had previously.
- The hospital had a dementia care team who provided training and support to staff. The department did not use overt indicators to identify dementia patients or those with other memory issues. Patient notes were marked to indicate to staff which patients were affected. 'This is me' packs were provided to relatives or patients so that they could provide additional information to help staff provide appropriate support and guidance.
- Where patients exceeded the 12 hour waiting target for treatment we saw that a full root cause analysis review was completed. As a result of this, the trust had made changes to nursing documentation and introduced 'comfort rounds' to ensure that patients who were subjected to long waits were kept as comfortable as possible. Healthcare assistants had received additional training and led on comfort checks supported by nurses.

Access and flow

- National standards require that 95% of patients should be seen within four hours of arrival at the emergency department. Since December 2013, the department has failed to meet this standard and its performance has been amongst the worst in England. Between April and December 2014, the average percentage of patients waiting 4-hours or less was 84.5%. In December 2014, only 75% of patients were seen within four hours.
- On the day before our inspection there had been 332 patients attending the unit, of these 242 had been seen within 4-hours (73%). Two days prior there had been 324 patients of which 198 had been seen within 4-hours (61%).
- NHS England has placed contractual obligations on trusts in relation to patient waiting times following a decision to admit them to hospital. This requires that

patients should not have to wait longer than 12-hours from the decision to admit, to be transferred to a ward. The hospital had had a total of 731 patients waiting in excess of 12-hours (up to February 2015); this figure accounted for two-thirds of all the breaches of this target in England during 2014/15, despite seeing only 1% of total A&E attendances.

- As a result of this, the NHS Trust Development Authority (TDA) conducted a review of these patients to assess if they had come to harm during the delay or as a result of it. The outcome of the review identified that no patients had suffered harm.
- The review included analysis of deaths during the same time period. 52 deaths had occurred eight of which involved patients who had remained in the emergency department in excess of 12 hours. However it concluded that the delays had not contributed to the patient deaths.
- Approximately 4% of patients leave the hospital without waiting to be seen. The national average for patients leaving without being seen is roughly 3%. Between July 2013 and June 2014 this amounted to 2,684 patients who left without being treated. This measure is a useful indicator of patient satisfaction with waiting times.
- The trust were persistently unable to move patients out of the emergency department. We observed systemic issues with protocols for referral and bed occupancy which impacted on the department's ability to facilitate patient flow.
- We noted that two patients remained on ED for excessive periods of time during our inspection. One patient had been there for over 27 hours and another for over 30 hours. We escalated our concerns to the chief operating officer.
- During our visit to the department, there were eight patients queuing to go into triage at 3:00pm, and the estimated waiting time for the eighth patient to reach triage was two hours. By 3.30pm the number of patients waiting in the corridor had risen to 11 and at 4pm there were 14 patients queuing.
- We saw how a patient was referred to surgery by the emergency department. Surgery refused to accept the patient as the patient also had other medical needs and refer back to the emergency department to get a medical assessment. The emergency department then make a referral to medicine, the assessment is eventually done and the emergency department then had to re-refer to surgery.
- A clinician described to us a situation which had occurred the previous week. At 8:00am on one particular day, the department was full with over 100 patients. Of those five were actually emergency department patients, the remainder all had referrals to specialist departments but there were no beds for them.
- Clinical staff told us that they could refer patients to the medical team and if they were very ill the medical registrar would attend and examine patients in the resuscitation area. Surgical teams would only see patient once they reached the wards unless they were acutely unwell in which case they would visit the department. Nurses were unable to refer patients direct to speciality teams other than the stroke team. This meant that patient pathways could be delayed until clinicians became free.
- The department staff did what they could to ensure patient's needs were met. We saw that additional nursing staff were brought into the area to see to patient's needs. The ratio of nurses to patients was 1:6. Routine drinks rounds were extended to include those patients who were in corridors.
- Patients transferred to the Royal Stoke from The County for specialist assessment or treatment were admitted through the Royal Stoke emergency department rather than directly to a ward area.
- We asked staff how this affected patients who had transferred, and in particular how the length of time patients had been waiting were calculated. We were told that because the patient is entered onto the electronic system when they arrive at Royal Stoke their clock re-starts. The time of first assessments at County Hospital is recorded in the patient notes and breaches of waiting times are collated and reported. However, the patients who may already have waited a number of hours at County Hospital re-join the acuity cue at Royal Stoke and can face further hours of waiting.
- As the ambulance triage became busier throughout the day we saw how patients were lined up in the corridors on trolleys waiting to be seen. When patients had been triaged they were placed in the corridor waiting to be allocated space in majors or on wards. Patients were transferred from ambulance trolleys to hospital trolleys in the corridors often at the expense of their dignity.
- We spoke with the hospital ambulance liaison officer (HALO) about ambulance waiting times. Part of the

Urgent and emergency services

HALO's work is to monitor the times taken for ambulances to handover patients to hospital staff. They told us that staff were very efficient but some lapses occurred during very busy periods.

- The hospital had good relations with community based charities and services. Red Cross ambulances were used to provide a flexible transfer service when discharging patients. St Johns ambulance staff assisted in the emergency department, providing meals to patients and recording vital signs. We spoke with a representative of Age UK who was commissioned by the hospital. They explained how they staff referred elderly patients who might need assistance with issues at home, setting up or referring on to services to enable people to retain their independence and return home quicker.

Learning from complaints and concerns

- We saw that complaints and patient experiences were discussed at team meetings and nursing handovers in the emergency department.
- Members of the senior management team spoke with all patients or families of patients who had experienced waits in excess of the 12-hour decision to treat targets. This was done either by visiting the patient if they were still in the hospital or by telephone if they had been discharged. The purpose of the calls was to apologise and allow the patient an opportunity to explain how this had affected them. Where patients expressed a desire to complain during these encounters we saw that the complaints were recorded and the trust complaints procedure followed.
- We saw examples of complaints which had been recorded, investigated and responded to. We saw that where possible explanations had been provided to explain how or why issues had arisen. An example being in relation to excessive waiting times in the reception, where reference had been made to the high volume of ambulance patients most of which had needed to take precedence to the seriousness of the patients.
- We saw information about the trust Patient Advice and Liaison Service (PALS) system and how to make a complaint were displayed in waiting areas. We did not see these in any other language than English.

Are urgent and emergency services well-led?

Requires improvement

Staff respected managers and felt supported.

Local leadership was good but there were many systemic problems that needed to be addressed by looking beyond the departments and engaging with leaders across the rest of the organisation.

Managers remained focused despite extended periods of excessive capacity impacting on patient flow through the department. However we did not see evidence of influence being exerted towards other departments or escalated issues to senior management to find beds for patients who were in the department for unacceptable lengths of time.

Vision and strategy for this service

- The trust vision and strategy did not appear to be foremost in the minds of staff in the department. Local managers understood the trust vision and clearly wanted to develop an excellent service to patients, but the high volume of patients and challenges with transferring patients to other parts of the hospital; meant that staff felt they were trapped in a reactive cycle.
- It was a testament to the management that they had not allowed the long standing capacity issues to normalise their approach to breaches of the 4 and 12 hour targets. All breaches were taken very seriously and reviewed and patients were contacted by a member of the team.

Governance, risk management and quality measurement

- Regular management meetings took place on weekly basis. These enabled senior staff to meet and discuss governance and quality issues. Key performance indicators were discussed including items such as compliance with safety thermometer targets, complaints staffing issues. Minutes of the meetings were recorded.
- We were able to see how managers responded to risk during the inspection. It was identified that some patients were being given paracetamol by ambulance staff prior to arriving at the hospital. When they arrived at the hospital and they were assessed for pain relief.

The drugs given by ambulance staff did not appear in patient notes and staff were not routinely considering the medication already provided. This meant that there was a possibility of patients being given doses of paracetamol above safe limits. This was escalated to the management team and a standard operating procedure was developed and circulated to all staff in the department which was designed to ensure all medication taken prior to arrival at the department was identified and recorded in patient notes.

- The trust declared a major incident in January 2015 during which senior department managers were engaged in daily conference calls with trust executives and the CCG's. Additional ward space was created by re-opening areas which had been closed. Liaison between the trust, ambulance services and community based services such as walk in centres and GP services all took place.
- Capacity issues in A&E had been identified and were on the department and trust risk registers. An escalation plan had been introduced which was implemented when patients were queuing on trolley's or other issues reduced patient flow. An emergency department SOS system had been developed which meant that as patient flow slowed down, matrons in other departments were contacted and provided the additional nursing staff to the emergency department on a rota basis.

Leadership of service

- Local leaders understood their role in the organisation. They provided the resources and environment for staff to fulfil their role.
- Healthcare workers and nursing staff were positive about their line managers and department managers. They told us that they felt understood and that they were supported to do their job.
- Clinical leadership was good. Consultants took responsibility for their junior staff and provided a learning environment. During the medical handover we saw how doctors were challenged about diagnosis and care pathways, what if scenarios were considered so that junior doctors could recognise how different symptoms might suggest alternative issues.

Culture within the service

- There was a genuine desire from all staff we spoke with to provide effective care and treatment to patients. Some sections of staff were frustrated by not being able to progress patients through the system.
- The emergency department did not seem to receive the support it required from the command team in relation to the capacity issues. For example, two patients had been accommodated in the department for excessive periods of time. We queried this and were advised that the chief operating officer had been made aware through the regular bed management meetings, but there had been no physical visit or direct intervention to move the patients on. This was escalated and the patients were transferred to ward.

Public and staff engagement

- The trust work closely with the local Healthwatch. Over the two week period 2 to 15 February 2015, the Staffordshire Healthwatch and Stoke on Trent Healthwatch conducted a survey of the Royal Stoke emergency department.
- A total of 460 patients were surveyed and the responses were analysed alongside statistical information from NHS England. A comprehensive report was produced and shared with the trust. The report findings were shared with the trust.

Innovation, improvement and sustainability

- The hospital had provided additional consultant led training to advanced nurse practitioners in the emergency department. This provided staff with the skills and abilities to deal with more complex issues and support the doctors in their role. Staff were empowered to increase their skills and provide an excellent service to patients. We felt this was an example of outstanding practice.
- The hospital Alcohol Liaison team had reduced hospital stay for patients with alcohol related issues by an average of 1 day per patient. This equated to 2762 hospital days saved during the last two years. In monetary terms this meant the hospital saved over £4.25million during the same period. This was also seen as outstanding practice.
- The trust is working in partnership with Teesside University to roll out the Excellence in Practice

Urgent and emergency services

Accreditation Scheme. The Emergency department achieved platinum level (the highest) in May 2014**.** The department was the first nationally to receive this award.

Medical care (including older people's care)

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

Information about the service

The Royal Stoke University Hospital is a regional centre for cardiology and cardiothoracic care. It is a specialised centre for liver disease and a regional centre for many types of cancer.

Between July 2013 and June 2014, the former University Hospitals of North Staffordshire received 60,347 medical admissions.

We visited 16 medical wards, including: coronary care, acute medicine, respiratory medicine, stroke care, elderly care, oncology and haematology. We also visited the 'shared care ward' on the neighbouring Harplands Hospital site, which run by another NHS trust.

We talked to 44 patients, 14 relatives and 128 members of staff to include consultants, doctors, nurses, therapists, managers, pharmacy technicians and healthcare assistants. We observed care and treatment, and looked at the records of 90 patients on the wards. Before the inspection, we reviewed performance information about the hospital. We attended nursing and medical handovers and multidisciplinary team meetings.

Summary of findings

Medical care services ensured that actual and potential patient harm incidents were reported and investigated promptly. Staff were told about the results of investigations during handovers and via emails so that patient safety could be improved. All of the wards had noticeboards displaying their performance against quality targets.

We had concerns about the management of some patient records and the storage and administration of medicines on some wards.

Many wards had staff vacancies and staff were working overtime shifts to cover these shortfalls. Not all shortfalls could be covered in this way and on occasions wards were short staffed as agency staff were not available to cover all shifts.

Staff told us that the ward management up to matron and consultant level was supportive, visible and approachable, however the executive team were not visible to ward staff and staff were not generally aware of the trust executives' vision and plans.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We had concerns about, safe storage of patient records, storage and administration of medication on several of the wards we visited.

On a number of wards including wards 76a, 79, 124, and the Frail Elderly Assessment Unit (FEAU) we found patient notes or prescription charts left unattended and not all the wards had lockable trolleys to keep patient records secure. On one ward a wall-mounted computer screen was left unlocked with patient details displayed. Ward 202 stood out with regard to security of patient records: we saw no notes whatsoever left unattended or unsecured and every computer terminal was locked when not in use.

Not all medicines were kept in secure areas. A type of injectable medicine, 0.9% saline solution, was not always prescribed by a doctor before it was administered to patients.

Many of the ward supervisors, staff and patients we spoke to told us they were concerned about staffing levels. We looked at staff rosters on several wards including the acute medical unit (AMU) and wards 79 and 124 and saw that they were sometimes short staffed and many staff worked overtime to cover vacant shifts.

Infection prevention and control processes were found to be effective and all the wards we visited were clean and they had noticeboards clearly displaying their performance against safety targets.

Reporting of actual and possible patient harm incidents was encouraged by ward sisters and ward managers and staff we talked to told us they knew how to report them. Learning from incidents was fed back to staff to improve safety for patients.

Incidents

- "Never Events"; are serious, largely preventable patient safety incidents that should not occur if the appropriate preventative measures have been implemented. We saw there was a process for reporting on never events and these were appropriately investigated and discussed at governance meetings.
- There was one medical "Never Event" at the hospital in 2014 which was where a nasogastric tube used to provide feed to patients was misplaced. The trust were able to provide us with a full investigation report which demonstrated the process and a clear plan of actions taken to ensure lessons are learnt.
- Between 1 November 2014 and 31 March 2015, there were 39 serious incidents reported which required investigation, including 12 grade three pressure ulcers and 19 slips and falls. In gastroenterology 13% of patients reported to the safety thermometer had had a fall with harm, including two severe falls. In addition there were two healthcare-acquired infections, three patients discharged with cannulas still inserted into a vein and three instances of ward or unit closures due to outbreaks of diarrhoea and vomiting. There were no grade four pressure ulcers reported during this period.
- Staff across all medical wards were encouraged to report incidents and were able to access the trust's electronic incident-reporting system. Staff were confident to report incidents and told us there was a 'no blame' culture within the hospital. The senior management team told us that root cause analyses were carried out for any incidents where serious harm has been caused to a patient. These were completed within six weeks of the incident and an action plan produced from the evidence. The action plan was then presented to the trust's board.
- Staff told us that they had feedback from complaints and incident investigations by a variety of means such as face-to-face, information folders, and email.
- A robust process was in place to review mortality and morbidity information in line with Hospital Standardised Mortality Ratios (HSMR) and Standard Hospital Mortality Index (SHMI).

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care. We were provided with a summary of the results of the monthly safety thermometer audit up to the end of December 2014, and results for January to March 2015 appear on the safety thermometer website. Although we did not see the safety thermometer data displayed on wards we

did see that each ward we visited had a noticeboard displayed in a public area showing performance against the trust's own safety and patient satisfaction targets, which included some safety thermometer data.

- The information on the safety thermometer includes prevalence of pressure ulcers, falls, venous thromboembolism (VTE or blood clots) and catheter-acquired urinary tract infections (CAUTI). The safety and patient satisfaction information on the noticeboards we saw included pressure ulcers, falls, MRSA and Clostridium difficile (types of infection), medication incidents, complaints and 'Friends and Family Test' returns.
- The total number of avoidable grade three or above pressure ulcers across medical services in October 2014 was six. This decreased to one incident in November and December 2014 and in February 2015. There were no recorded incidents in January and March 2015. From November 2014 to March 2015 there were 529 falls reported across all medical services. This showed a significant increase from 98 reported falls in November 2014 to 125 in December 2015, which steadily decreased month by month reporting 94 falls in March 2015.

Cleanliness, infection control and hygiene

- Between 1 November 2014 and 31 March 2015 there were a total of 25 reported instances of MRSA or Clostridium difficile infections across medical services. The lowest number of incidents occurred in November 2014, when there was one; and the highest in January and March 2015 when seven instances were reported in each month.
- All the staff we spoke with were aware of current infection prevention and control guidelines.
- There were sufficient hand-washing facilities at the entrance to and all of the medical wards we visited and all the equipment we inspected were clean. All other clinical and communal areas were visibly clean and in a good state of repair.
- We spoke to cleaning staff on several of the wards we visited. On wards 80, 81, 124 and the AMU they told us they had regular training on infection prevention and control and on patient safety.
- We observed staff consistently following hand hygiene practice and 'bare below the elbow' guidance. Aprons, gloves and hand cleansing gel or foam were readily available in all areas. The trust completed a weekly hand hygiene audit across all medical wards and the results ranged between 95 to 100% compliance. The weekly hand hygiene washing audit showed that staff used every opportunity to wash their hands in between providing care to patients
- Side rooms were used as isolation rooms for patients identified as an increased infection control risk (for example, patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms were also used to protect patients with low immunity. For example on ward 124, the kidney unit, staff told us that their policy is to nurse patients in side rooms from admission until the hospital laboratories confirm they are free from infection. Only when they are known to be free from infections are patients moved from side rooms into bays on the ward. We spoke with two patients who told us that this had happened when they were admitted to the ward.
- Staff on ward 117 told us that they experienced delays of up to an hour in arranging for side rooms to be deep cleaned because of the process for requesting the service from the trust's cleaning contractors. This meant a delay in admitting new patients.

Environment and equipment

- Resuscitation equipment on most of the wards we visited had been recorded as checked regularly; equipment was in date, appropriately packaged and ready for use. On ward 124, however, the record sheets from February and March 2015 for the trolley on bay B could not be found, and of the three weeks in April leading up to our visit it had not been checked on two days. We inspected the record sheets for the trolley on bay A and found that over the eight weeks from 23 February to 21 April 2015 it had only been part checked on four days and had not been checked on six days.
- On AMU staff told us there was sometimes a shortage of equipment for monitoring patients' observations (blood pressure, pulse, oxygen levels), especially when any of their machines are sent for repair.
- On ward 76a a relative told us that a doctor had had to obtain a special nasogastric tube (a tube used for feeding patients who are unable to swallow) with an introducer (a device to assist with inserting it) from another ward as they were not held there. The relative told us that doctors on the FEAU and on ward 76a had

tried to insert a standard nasogastric tube but had been unable to do so; if the specialised tube had not been obtained and used staff would not have been able to feed the patient, putting him at risk of malnutrition.
- Pressure-relieving mattresses and cushions for people at risk of pressure damage were in place. The trust had a central equipment bank for pressure-relieving equipment and an effective process for issuing, returning and cleaning the equipment.
- All medical wards had a good supply of manual handling equipment such as hoists, slings, sliding sheets and condition-specific equipment such as nebulisers, syringe drivers and monitors, which were well maintained.

Medicines

- On the acute stroke ward (ASU) the medicine refrigerator was faulty and out of use. Another refrigerator had been delivered but was too small and a second had been reordered which had not yet arrived. We were told all medication which required refrigeration was held on ward 231. During the medication round on ASU nurses had to arrange collection of the medication from ward 231 and deliver it back there, this disrupted the medication round and delayed patients receiving prescribed medication.
- Apart from the ASU all medical wards had appropriate storage facilities for medicines and most medicines were stored and handled safely. On ward 124 we found an unlocked store cupboard containing a number of five-litre containers of acid concentrate for haemodialysis. We raised this with the matron who told us that the cupboard was usually locked after the dialysis team had finished on the ward. We also found 10ml vials of 0.9% saline, a type of injectable medicine on unattended and unsecured trolleys containing equipment for intravenous access on several wards.
- On ward 124 we found a container of 5% glucose solution, a medicine that is given through a cannula into a vein, which was out of date at the end of the preceding month. A senior staff nurse was made aware of this while we were on the ward and the out of date medicine was immediately removed from stock. This shows that systems to ensure the safe management of medicines are not effective.
- Most ward-based staff reported a good to excellent service from the pharmacy team. However on ward 80 staff told us that that porters took prescription charts to the pharmacy for medicines to be dispensed and sometimes they were not returned in time for the patients' next medication round. Staff on ward 81 told us that patient discharges were sometimes delayed while they waited for medicines to take home with them to be dispensed.
- There were suitable arrangements in place to store and administer controlled drugs. Stock balances of controlled drugs were correct and two nurses checked the dosages and identification of the patient before medicines were given to the patient. Regular checks of controlled drugs balances were recorded.
- Refrigerator temperatures were regularly recorded and checked, recorded and adjusted as appropriate.
- Patients across most medical wards were prescribed and administered medication as per their prescription charts. One doctor on ward 117 told us that the patients' medicine charts were unduly complicated and slowed treatment rounds down.

Records

- On wards 76a, 79, 124, and the FEAU we found patients' records left unattended in unsecure areas. Many of the wards used open filing trolleys for patients' notes that had no way of being locked. Staff on ward 79 were aware of the issue of security for patients' notes and told us that new, lockable, trolleys had been ordered.
- Nursing records were updated regularly and included care plans.
- Four patients on ward 232 (acute stroke care) had been assessed as requiring hand control padded mittens to reduce the risk of them pulling out their NG (nasogastric tube) and self-harming. Appropriate records should support their use as this is a form of restraint. We were told by nursing staff and the ward doctor that verbal decisions were made during the doctors' rounds about the continued use of hand mittens for each of the four patients but there was no record to support these decisions.
- We saw comprehensive timely assessments of pressure ulcer risks using the Waterlow score (a tool to measure patients' risk of a pressure ulcers), skin and nutritional assessments. When patients were assessed as being at risk of or had a pressure ulcer appropriate repositioning, care plans and use of equipment to minimise damage and promote healing was documented. All of the wards we visited had at least one nurse who specialised in assessing tissue viability.

- Patient wounds were documented on body maps and regularly evaluated wound care plans were in place.
- Falls, use of bed rails and manual handing assessments were completed appropriately as were plans of care.

Safeguarding

- Staff demonstrated through interviews a good knowledge of the trust's safeguarding policy and the processes involved for raising an alert.
- Staff received safeguarding training at induction and at regular intervals on a 3-yearly cycle, this was well-attended. Figures provided by the trust showed that 90% of staff had completed child protection awareness training (equivalent to level 1) and 91% had completed vulnerable adult awareness training (equivalent to level 0). The trust target is that 95% of all staff have completed this training.
- Staff knew the name of the trust safeguarding lead. They told us they were well-supported and would seek advice if they had safeguarding concerns.

Mandatory training

- Mandatory training attendance such as such as fire, infection control, resuscitation and major incident training was variable across medical wards. Performance was static against a target of 95% with December performance at 84%.
- Performance against the Information Governance training standard sat at 81% against a target if 95%.
- Nurses and healthcare assistants across medical services told us that ward managers ensured they completed all their mandatory training.
- On AMU we spoke with a member of domestic staff who told us that the cleaners have monthly training sessions on infection prevention and control and patient safety.

Assessing and responding to patient risk

- Patients' individual risk assessments were completed weekly or sooner if their condition deteriorated.
- Staff used a standardised early warning system as a tool to alert if a patient's health deteriorated.
- Nursing staff told us that, should a medical assessment be required for a deteriorating patient, attendance to the ward was swift and assessments were thorough.
- Patient handovers took place at the beginning of every shift change. Patient information sheets were given to each member of staff.
- Nurses routinely attended ward rounds, making communication of nursing and medical information efficient and enabling nursing and medical staff to respond to patients' needs in a timely manner.
- Non-invasive ventilation (NIV) trained nurse from ward 222 would frequently attend to deteriorating patients on other wards. They were able to set up NIV for those patients while they were waiting for a high dependency bed so that they did not have to wait for treatment. This service formed part of the Clinical Quality Indicator (CQUIN) target for patients with long-term breathing problems

Nursing staffing

- Planned and actual levels of nurse staffing were displayed on every ward we visited.
- Nurse staffing levels were planned in line with guidance from the National Institute for Health and Care Excellence (NICE)
- Senior staff on four wards told us they were concerned about low staff numbers, and low staffing numbers on ward 202 had been added to the risk register.
- Where ward vacancies for qualified nurses and healthcare assistants were identified, senior staff told us that shortfalls were covered by the ward's own staff working overtime. We saw that where this was not possible agency staff had been used. A recruitment drive was on going but the hospital was finding nurse vacancies were difficult to fill.
- Agency nurses who were used in the hospital completed a competency book before being allowed to work there, and they were always paired with a permanent qualified nurse until senior staff were happy that they could care for patients safely.
- Ward managers were supernumerary and not counted in the daily staffing rota , although they sometimes had to form part of the core staffing to cover short notice vacancies due to staff sickness.

Medical staffing

- The proportions of consultants across medical services were slightly higher than the national average.
- Apart from on the elderly care wards there was adequate staffing levels of doctors and consultants across all medical services, ensuring that patient assessments, care and treatment were conducted in a

timely manner. On elderly care we were told that two consultants had recently left and had not yet been replaced. We saw an action plan which included proposals for recruitment of replacement consultants.
- Nursing staff reported excellent medical cover across all wards, with minimal delays when requested to assess patients whose condition had deteriorated.
- Junior doctors covered weekends and had access to medical registrars as required.
- There was minimal requirement for medical locum use.

Major incident awareness and training

- Major incident training levels were recorded as 100% attendance.
- The major incident response plan was in place and written with reference to the NHS Emergency Planning Guidance 2005.
- The plan provided detailed information for how the trust would respond to a major incident, including primary and secondary command centres and local action cards specific to each division and department.

Are medical care services effective?

Good

Care was provided in line with national best practice guidelines and the trust participated in many clinical audits where they were eligible. Results of national audits were varied.

Patients were well-supported with nutrition, hydration and pain relief by well-trained, competent staff.

Multidisciplinary working was well-embedded in the trust and patients had access to nursing, and medics seven days per week. Therapists were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.

Evidence-based care and treatment

- All medical services delivered evidence-based practice and followed recognised and approved national guidance across the medical directorate.
- We talked to 128 staff of various clinical and non-clinical grades and found that they understood their roles and clinicians worked within their scope of practice in accordance with their professional governing bodies.
- We were told that medical teams made timely internal and external referrals to other healthcare professionals to ensure that patients were seen by the right person at the right time, and that this process worked efficiently.
- On ward 76a we were told about an outstanding plan to improve and streamline quality of care for frail and elderly patients by the creation of an electronic 'Frailty Passport', the potential benefits of which had been established through research carried out by members of the elderly care team at RSUH. This record will be created in conjunction with patients, families and doctors. It will hold details of care plans and crisis management plans and other important documents. The electronic record will be held on hospital computer systems and an alert that the frailty passport exists will appear as soon as the patient is admitted to the hospital.

Pain relief

- Patients were administered pain relief according to their individual prescriptions and nursing staff were vigilant when monitoring patients' pain levels.
- We saw staff were quick to identify patients in pain, for example on AMU, coronary care and oncology doctors were readily available to assess and prescribe pain relief to patients as and when required.

Nutrition and hydration

- A Malnutrition Universal Screening Tool (MUST) was completed on admission and at regular intervals to monitor patients' nutritional status.
- Referrals to the dietician were carried out promptly when required and patients' weight was recorded weekly.
- All but one of the patients we spoke with told us that the food was tasty and enjoyable and portion sizes were adequate. There was only one negative comment about the food when one patient on ward 232 told us that the food wasn't always good.
- Hot and cold drinks were offered to patients at regular intervals and fluid balance charts were recorded appropriately.
- On ward 233 we spoke with a relative of a patient who had difficulty chewing and swallowing and who needed soft food which is described as 'fork mashable'. We were told that the fork mashable menu was always the same and that the patient hadn't been offered alternative meals during the six weeks they had been an inpatient.

Medical care (including older people's care)

Patient outcomes

- All wards had a quality board on display, showing performance against trust targets for pressure ulcers, MRSA infections, falls, and also included 'Friends and Family Test' responses, compliments and complaints.
- All medical wards had a 'quality nurse' who was given two days per week to carry out regular local audits relating to patient safety issues such as infection control, pressure ulcers, falls and record keeping and displayed the results on ward notice boards for patients and visitors to read. The results showed low incidents of infection, low numbers of falls and low numbers of pressure ulcers.
- The results of these audits were fed back to the ward staff in several ways such as email, team meetings and information folders. We saw several examples of audits, and other staff we spoke with confirmed they were told about audit results, however on ward 222 we were told that the monthly ward meeting for April 2015, during which staff are given feedback from audits, had been cancelled because the ward was too busy.
- **The Myocardial Ischaemia National Audit Project** (MINAP) audit for 2013/14 showed that the trust performed better than the national average in the three applicable areas. The audit 2013/2014 demonstrated that the trust performed better than the national average for people with ST segment elevation myocardial infarction (nSTEMI – a form of heart attack) being seen by a cardiologist, with a record of 97% against the national average of 94%. Patients admitted to cardiac unit or ward scored significantly better at 87% against a national target of 55% and patients that were referred for or had angiography (heart procedure involving widening of the arteries) scored 80% against the national average of 78%.
- The trust saw a mixed performance in the National Diabetes Inpatient Audit (NaDIA) recording 14 out of 22 areas as better than the national average and worse across 7 areas which included medication errors, management errors and insulin errors.
- We talked to two quality nurses on the FEAU and coronary care who told us that when patients had arrived on the wards with pressure ulcers they were reassessed and the ulcers graded according to how severe they were. If the new grade was different to the one they were given before being transferred to the ward this was fed back to the staff who did the original assessment so that learning outcomes could be recorded.
- A consultant cardiologist, a senior doctor specialising in heart conditions, told us the hospital's congestive cardiac failure service had halved the mortality rate from that condition and had won a Care Integration Award for their work. They told us this will be reflected in mortality data reported nationally by the trust however it had occurred too recently for this data to be available. The hospital was unable to provide us with any local data to confirm this.
- We were given an example of one incident where a patient had died from sepsis over the winter period (a serious type of infection) after a wait on a trolley in the Emergency Department. Following investigation and the root cause analysis a plan was put in place to diagnose patients at risk of sepsis much earlier and to start treatment sooner. We were told it was too soon to evaluate the outcome from this yet but that initial figures were indicating a 50% drop in numbers of patients dying from sepsis. We were not shown any data to support this.
- We talked to staff and saw that ward staff carried out audits of impact for areas of care for patients living with dementia, including the use of a blue butterfly symbol to identify patients who need more staff support and the use of "'This Is Me'" documents to help staff understand more about patients' backgrounds, individual needs and personal preferences.

Competent staff

- We observed clinical practice, attended staff handovers and MDT meetings and saw that staff across all medical services were competent and knowledgeable within their chosen wards.
- We observed nursing and medical staff handovers where staff demonstrated a high level of specialist knowledge, particularly on the AMU, oncology and renal services. We also saw high levels of clinical competence, through observing practice between staff and patients.
- On coronary care (ward 201) two junior doctors told us that the nursing staff were the best they had ever seen, because they were competent and skilled and delivered excellent care.
- Competency assessments were in place to show that staff had been assessed and were proficient within their

respective specialist wards. For instance coronary care had a band five competency booklet in place which showed a range of specialist training to include: ultrafiltration which is alternative approach for effective fluid removal, and balloon pump training which is a mechanical device that increases myocardial oxygen perfusion while at the same time increasing cardiac output.

- We observed good practice around dementia awareness training and the integration of Registered Mental Nurses (RMNs) onto medical wards. We were shown details of university accredited degree level modules about physical health that have been written for RMNs to allow them to work effectively on medical wards. This practice was the subject of a research evaluation with Keele University and its development was endorsed by Health Education England.
- We asked the senior management team from the medical directorate about specialist training for nurses on the high dependency unit for patients with long term breathing problems. They told us that qualified nurses were given a six-month competency training package to up-skill them to work on this unit, and that there was a business case in progress to increase the number of nurses and non-invasive ventilation beds; specialised training was included in this plan.
- Respiratory, cardiac, stroke and renal specialist nurses were situated on their designated wards and provided specialist support and advice to staff and patients.
- We were told that in the elderly care wards weekly teaching sessions were held for staff to help them look after people living with dementia and that staff have been given access to four level six higher education modules about dementia. Some staff in elderly care were undertaking master's degrees in older people's care.
- New staff received dementia awareness training as part of their induction process and dementia training was being provided for healthcare assistants and therapy assistants.
- On ward 80 we spoke with a nurse from overseas who had recently moved to the UK to work at the hospital. The nurse told us that she felt well supported in settling in and that she was getting all the training that was needed. We also spoke with a student nurse who told us that she had good learning outcomes from her time on the ward and that she was well supported by senior nurses to make sure that these outcomes were achieved.

Multidisciplinary working

- Staff demonstrated good internal multidisciplinary working across medical services, particularly at stroke, elderly care and respiratory services.
- Staff demonstrated a wider team knowledge, which enabled them to refer patients in a timely manner to other specialist areas.
- On coronary care and AMU we observed ward rounds being carried out with doctors, nurses and therapists involvement.
- There was an obvious professional respect between doctors, nurses and therapists which made communication of patient information at handovers, ward rounds and multidisciplinary team meetings effective and efficient.
- Clinical nurse specialists such as tissue viability nurses, non-invasive ventilation nurses, dementia leads, falls lead and dieticians provided an in-reach service to wards on request. ('In-reach' staff helped to move patients to wards and assisted with patient discharge).
- On ward 230 staff had good support from with the Alcohol Dependency and the mental health Rapid Access, Intervention and Discharge (RAID) teams.

Seven-day services

- We saw that consultant cover was a seven-day service for renal, stroke and cardiology specialties. This service provided continuous patient review and staff told us they felt supported to manage patients' care effectively.
- The oncology service provided seven-day, 24-hour consultant cover.
- Therapy services, such as respiratory and musculoskeletal physiotherapists, occupational therapists and the mobility team were available from 8.30am to 4.30pm seven days a week and on an on-call basis overnight.

Access to information

- All medical wards used a WIS (ward information system) large screen monitor detailing number of beds available and occupied, patient details, admission and estimated discharge date and listed healthcare professionals

involved in the patients care. This information was accessible to all medical wards and provided staff with instant information as to the location and condition of each patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated through interviews they had good knowledge of the Mental Capacity Act 2005 (MCA). Patient advice leaflets about the MCA were displayed at each ward.
- Four patients on ward 232 (acute stroke care) had been assessed as requiring hand control padded mittens to reduce the risk of them pulling out their NG (nasogastric tube) and self-harming. Appropriate records should support their use as this is a form of restraint. There was no record to support these decisions.
- None of the patients had an assessment tool in place or a mitten care plan to guide staff how often the mittens were to be removed. Nursing staff we spoke to were unclear in regard to the management of the mittens, despite the trust's standard operating procedure stating the mittens should be removed twice daily. We saw this was not the case for any of the four patients.
- On ward 230 we were told about two patients who had Deprivation of Liberty authorisations in place. We were shown the forms for both patients and we found them to be correctly and fully completed, with good explanations of the reasons that they were necessary. We were also told that if patients had to be suddenly physically restrained due to a lack of mental capacity an assessment under the MCA was completed and recorded as soon as possible afterwards.
- On ward 76a we saw a clear and detailed display on a noticeboard, giving staff information about the MCA. We also looked at several patients' records and saw that MCA assessments had been carried out and documented.
- On ward 230 we saw a "Focus of the Month" noticeboard prominently displayed, with a clear and comprehensive explanation of Deprivation of Liberty Safeguards (DoLS) including what they were, why they were needed, what staff should know, a process flowchart, when it was appropriate to use DoLS, when a hospital or care home was allowed to use the process and example stories about four patients who had been subject of DoLS.
- We spoke with the senior quality dementia nurse who told us that the hospital's safeguarding team had delivered MCA and DoLS training for staff throughout medical services.

Are medical care services caring?

Good

Staff were caring, kind and respected patients' wishes. We saw compassionate nursing care on all the wards we visited and in the discharge lounge and AMU where staff interacted with patients regularly, explaining options, treatments and side effects.

All patients had only positive comments about medical services and told us staff were kind and caring and when providing care and treatment.

We saw staff treating people with dignity and respect across all medical services and 'going the extra mile' to ensure patients' individual needs were met and patients were looked after.

Compassionate care

- All of the wards we visited monitored responses from the NHS Friends and Family Test and the number of compliments received. In February 2015, 96% of patients said they were likely or extremely likely to recommend the service. This was better than the England average.
- Patients we spoke to across all medical wards were satisfied with the quality of service they received and all 44 patients and relatives we talked to told us they had no complaints.
- Patients we spoke with on the wards we told us that they were treated with dignity, compassion and respect by the staff who were caring from them, including domestic and catering staff. Several patients also told us that they were treated in a personalised manner such as staff addressed them by their preferred names and catering staff remembering how patients liked to have their hot drinks.
- Several patients told us that curtains were always drawn around their beds while personal care or treatment was being carried out.
- On ward 124 we observed nurses assisting patients with mobility, walking at the patients' pace and taking rests

along the ward corridor when mobilising as part of their programme of therapy. They acted in a caring manner and maintained the patients' dignity throughout. It was obvious from the interaction and the way the patients responded that this level of care was normal.
- Patients told us they felt that the nurses and doctors "really do care". Another commented "nothing is too much trouble".
- In the discharge lounge we saw a nurse and healthcare assistant greeting and helping elderly patients who were waiting to go home. All the patients we saw were treated in a caring and respectful manner, and they were all offered drinks while they waited.

Understanding and involvement of patients and those close to them

- All the patients we spoke with told us they felt generally involved in aspects of their care and treatment.
- We observed a conversation between a nurse and a patient's family, explaining the patient's treatment and the reasons behind it and the reasons that the patient had been transferred to the ward.
- We spoke with a long stay patient and their relatives on ward 80, and they told us they are very happy with the care that has been provided, that they always feel supported and included in decisions about their mother's care.

Are medical care services responsive?

Requires improvement

Many medical services proposals for service development had been realised. The hospital had accepted that problems with flow (the movement of patients into the hospital, through wards and departments according to their medical needs and discharge to other care) was not solely the responsibility of external care services and that they could make changes to their own systems and practices to improve flow.

Patients' individual needs were generally met. Patients living with dementia were well-supported, and plans were in place to improve services for patients with learning disabilities.

The trust's complaints system was robust and staff took complaints seriously and followed the complaints policy. Complaints were viewed as an opportunity to learn and to improve services.

Service planning and delivery to meet the needs of local people

- All medical wards were proactively planning patient discharges, however delays experienced with external social services packages of care slowed down the process. Senior management told us that the trust had started to look at their own practices and performance rather than putting the blame on external providers and were working on treating patients quicker so that their length of stay in hospital was shorter, which should result in improved flow.
- Between November 2014 and April 2015 the trust reported average length of stay to be longer than the national average in areas of cardiology, haematology, nephrology, general and geriatric medicine, and significantly longer in respiratory medicine. Senior management told us that this was because of the extensive industrial heritage in the county, which resulted in a large number of patients with long-term breathing difficulties. To address this situation a business case had been written to increase the number of nurses on respiratory wards and to increase the number of beds equipped to provide non-invasive ventilation, which was a treatment for patients with severe breathing problems. The business case also included plans for staff training.

Access and flow

- National standards state that 90% of referred patients should start consultant-led treatment within 18 weeks of referral. Between November 2014 and January 2015, general medicine, geriatric medicine and neurology services achieved 100% for patients who were admitted. All other services such as cardiology, gastroenterology and thoracic medicine achieved the target with figures between 95% and 99%.
- For patients who were referred but not admitted the target was 95% of patients to be treated within 18 weeks of referral. Between November 2014 and January 2015,

general medicine 100% and all other medical services apart from thoracic medicine achieved the 95% target. Thoracic medicine achieved 97% in November 2014, 95% in December 2014 and 94% in January 2015.

- The hospital had had a total of 731 patients waiting in excess of 12-hours (up to February 2015) in the emergency department. This was due to the hospital being unable to move patients out of the emergency department. We observed systemic issues with protocols for referral which had an impact on this.
- We asked the trust about the number of medical outliers, this where a medical patient is place on a ward not specified for medical care, usually a surgical ward. The trust told us that for March 2015, there were on average 12.5 medical outliers across all the surgical wards. No other data was provided.
- Between November 2014 and March 2015, there were on average 4906 ward to ward transfers. Of these transfers, 2.4% occurred between the hours of 8:00pm and 8:00am, excluding emergency related transfers. The data provided did not indicate how many patients had be subjected to multiple moves.
- No mixed sex breaches were reported by the hospital between November 2014 and March 2015.

- Ward 230 (gastroenterology) operated an in-reach service. This meant that staff from the ward visit the AMU and the emergency department to identify patients who they could care for and arranged for them to be moved to the ward earlier. This was intended to improve both the experience for the patient and patient flow within the hospital.
- On ward 202 (oncology and haematology day cases) we found a well-managed appointment system with appropriate time slots allocated for treatment, which meant that patients were not kept waiting after they arrived to be seen.
- Senior staff on the FEAU told us that they accepted patients who were referred from the emergency department, AMU, family doctors, community nurses and paramedics. This meant that elderly patients who were seen in their own homes and required hospital treatment could often go direct to the specialised ward rather than having to go to the emergency department first.
- Staff on the FEAU had access to up-to-the-minute details of patients who had come into the emergency department and the acute medical unit, which meant that they were able to predict which patients are likely to need to be transferred to the FEAU and so could plan bed spaces to improve flow.
- On the AMU we spoke with a pharmacy assistant who told us that medicines for the ward were ordered electronically and took less time to be delivered, usually half an hour whether during normal working hours or at night and weekends. However, on ward 201 a pharmacist told us that most commonly prescribed medicines were stored on the ward and it took about an hour and a half for other medicines to arrive from the pharmacy.
- Arrangements for elderly patients being cared for in the west building to have diagnostic tests were time consuming and inefficient. Diagnostic tests were carried out in other buildings on the site, and patients from the west building had to be taken to and from other locations by ambulance, with a nurse escort. When we visited ward 76a there were six patients due to be taken for tests during the same morning. They had to be taken one at a time because of the capacity in the ambulance and because the ward could not afford for more than one nurse to be released for escort duties at a time.

Meeting people's individual needs

- Patients living with dementia or learning disabilities had a booklet called 'All about me'. This provided information to staff about the patient's life history, likes and dislikes and how the patient preferred to be cared for. Across most medical services we saw the booklet was completed well.
- The lead nurse for dementia told us that the medicine directorate trained staff about dementia in a number of ways, such as the Dementia Friends scheme (an initiative from the Alzheimer's Society to improve understanding about people living with dementia), weekly staff training sessions about caring for older people and access to higher education modules about older people's care.
- In the west building, where the elderly care wards were located, we saw that the 'memory room' had been lost to create a discharge lounge due to flow pressures. We were told about plans to convert rooms elsewhere in the building, creating a better memory room and two relatives' rooms.
- On ward 222 (acute lung medicine) staff told us about a service whereby nurses from that ward went to other

wards and units in the hospital when patients were identified to require a specialist breathing treatment called non-invasive ventilation, which was normally only available on acute lung wards. The acute lung nurses started this treatment wherever the patient was while they waited for a bed to be available on ward 222. This prioritised care for patients who needed it most.

- On ward 230, where some of their adult patients were known to be at risk of suddenly becoming confused and violent, the ward manager told us that a number of the staff were trained in safe methods of control and restraint so that they could intervene while the trust's security staff were on their way. This level of training was not normally found outside of mental health hospitals and its provision reduced the risk of harm to patients, staff and visitors. The ward manager also told us that because of the increased risk, the ward was a high priority for security staff and they responded quickly when called.
- A senior nurse from stroke care told us that a specialist team of nurses from the unit provided an 'in-reach' service to the emergency department to identify patients with early signs of stroke and move them to the ward quickly. This allowed staff to provide specialised assessment and treatment as soon as possible.
- Registered mental nurses were being recruited and given extra training to allow them to work on the hospital's medical wards to improve services for people with dementia.
- The lead nurse for dementia told us that a project was being worked on to improve services for patients with learning disabilities similar to the work that has been done for patients living with dementia.
- In the discharge lounge we saw guidance for patients and relatives about selecting care homes, details of a medicines helpline and leaflets with information for older people and a guide about caring for yourself during winter.
- The trust provided a translation service. Staff told us this was used frequently.
- Call bells were answered quickly by staff, and several patients told us that this was normal and they had not been kept waiting when they needed help during the day or night.

Learning from complaints and concerns

- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally such as complaints about ward moves, treatment plans or lost property or and how to escalate more serious concerns when required.
- The Patient Advice and Liaison Service (PALS) team told us that lost property, especially property such as glasses, false teeth, hearing aids and wallets belonging to elderly patients, was an area in which the hospital needed to improve.
- PALS leaflets explaining how patients and relatives could tell the hospital about "compliments, concerns and complaints" were displayed on each ward, either at the nursing station or at the ward entrance. All of the wards also had a secure post box for comments forms, which was checked and emptied regularly by the PALS team.
- Not all of the patients we spoke to said they knew how to make a complaint, but all of them were confident that they would be able to find out if they needed to.
- Senior managers told us that their biggest area for complaints was about communication, and the Associate Chief Nurse told us that she monitors all reports of incidents resulting in harm to patients and reads all complaint response letters. She meets with relatives and patients if needed.
- The management team told us that feedback from complaints was passed to staff, and that the number and type of complaints is analysed weekly and reviewed in executive board meetings.
- 122 complaint were registered by the trust relating to medical services between November 2014 and April 2015, of which 45% were upheld or partially upheld.

Are medical care services well-led?

Good

Clinical governance and risks, together with quality measurements, were priorities across all medical services, however staff were unclear about the vision and strategy for the future development of medical services.

The majority of staff across medical services were well supported with caring leaders who provided good support for individual staff and teams at both local and senior levels.

Medical care (including older people's care)

Vision and strategy for this service

- Some senior staff were clear on the direction of travel of the trust and told us they felt the alignment of the new County Hospital and reconfiguration of new trust was a positive move but would take 12-18 months to in-bed with front line staff.
- We talked to 128 staff from various disciplines and grades across 16 wards and the majority of staff could not tell us what the trust's or their respective service's vision or future strategy was.
- Individual staff spoke with pride and compassion about what they thought good care looked like and how they demonstrated this on a daily basis.

Governance, risk management and quality measurement

- The quality of care was measured using clinical performance dashboards, and ward performance was ranked within their division and against the rest of the trust.
- Under-performing wards were monitored closely by ward managers and matrons and plans were put in place for remedial action.
- Medicine's risk register identified 52 risks trust wide. Ten risks related to recruitment of nurses, doctors and locums. 18 risks related to the need to purchase new equipment or improve ward environments. Other risks related to operational issues such as: acknowledgement of high volume of medical outliers trust-wide. Each risk had a timescales for completion of actions. Once the actions were completed, the item was removed from the register. We saw they were actively looking at ways to solve some of the problems and actions were being undertaken, for example, recruitment of nurse from overseas.

Leadership of service

- All nursing staff spoke highly of senior sisters and ward managers as local leaders and told us they received good support. This was particularly evident at the AMU, in Stroke Care, coronary care and the FEAU where staff described their local leadership as nurturing, understanding and inspirational.
- The dementia lead nurse told us he worked closely with the trust directors and was well supported with regular one to one meetings with the Chief Nurse and the Chief Operating Officer.

Culture within the service

- In general, we found the culture of care delivered by staff across all medical services was dedicated, compassionate and strongly supported at divisional and ward level.
- Consultants told us there was a positive cultural change over last 12 months and management genuinely listened to consultants and medical staff about issues such as: recruitment, training and improvements for medical patients.
- Staff were hard-working and committed to providing the best care possible to their patients on a daily basis.
- Staff from all disciplines spoke with passion about their work and conveyed how happy they were to be working at the trust.

Public and staff engagement

- The percentage of patients who completed the NHS Friends and Family test across all medical services in February 2015 was 44.9% this was above the England average for that month of 39.8%. This test measured patients who were likely or extremely likely to recommend the trust. The results showed between November 2014 and February 2015 the average score was 96%.

Innovation, improvement and sustainability

- We were invited to visit the shared care ward in the neighbouring Harplands Hospital, where general nursing staff from Royal Stoke worked with mental health staff to care for patients with medical and mental health needs.
- We were told that the environment at Harplands was better for patients living with dementia and that their experience was much improved from being cared for there. We were told patients who had previously remained in bed on general medical wards were dressed and walking around the shared care ward, sometimes within hours of arrival.
- The shared care ward started out as a temporary 10-bed facility to ease winter pressures in Royal Stoke but has now been recognised as a benefit to patients and has been expanded to 15 beds. The service we saw provided there was outstanding.

Medical care (including older people's care)

- The trust is working in partnership with Teesside University to roll out the Excellence in Practice Accreditation Scheme. The elderly care wards achieved a gold level award in September 2012.

Surgery

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

Information about the service

The hospital provides emergency and elective surgery for a range of specialties including general surgery, trauma and orthopaedic surgery, ear nose and throat, plastic, urology, gynaecology and oral surgery. Between July 2013 and June 214 there were 44,000 surgery spells at the hospital, 46% of which were day cases.

We inspected the trust over three days between 22 and 24 April 2015. A further unannounced inspection took place on 1 May 2015 as part of the inspection process. This report reflects our findings at the Royal Stoke site.

As part of our inspection of the surgical directorate we visited eight wards, the operating theatres and post anaesthetic care unit at the hospital. We spoke with approximately 21 patients, 16 relatives/visitors and 42 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, dieticians, pharmacist and senior management.

We observed care and treatment and viewed 32 care plans and associated records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. Before the inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

The national referral to treatment time target for 90% of patients to have surgery within 18 weeks was not met overall. The trust had a high volume of elective surgery which was cancelled, including for those patients who were suffering from cancer.

High numbers of patients remained in the theatre recovery areas for post -operative care with inadequate facilities to promote privacy and dignity of these patients.

Essential and emergency equipment such as resuscitation trolleys were not managed safely and in some instance these were not fit for purpose. Medicines were managed safely most of the times. Although we found issues with safe keeping of some medicines and not being maintained at the correct temperature.

Safety thermometer was used in all the wards, the results showed variation in the quality of care provided. Where the compliance level was well below the safety margins, this was not addressed.

Surgery

Are surgery services safe?

Requires improvement

Patients were not always protected from the risk of avoidable harm and unsafe care and there is limited assurance about safety.

Surgery staff told us they were encouraged to report incidents, and these were discussed at ward meetings and monthly quality meetings. Root cause analysis was completed following incidents and robust action plans were developed. However, we were not reassured that all staff were using the system and reporting of themes at ward level was not consistent, sharing learning from incidents was not effectively managed.

Safety thermometer was used in all the wards, the results showed variation in the quality of care provided. Where the compliance level was well below the safety margins, action plans were not developed to address shortfalls and safeguards not put in place.

Essential and emergency equipment were not managed safely and in some instance these were not fit for purpose. Resuscitation equipment was checked; however we found there were items which were out of date and would not be available to patients in an emergency.

Medicines were not always managed safely. There were issues with safe storage of medicines that required refrigeration and we observed some poor practice in the theatres.

Records showed that risks were assessed; however these were not consistently reviewed to ensure they were relevant and up to date. Records were regularly audited but when audits highlighted gaps this was not followed up.

Patients were cared for in the recovery area of theatres for extended periods, this environment is not suitable to be used in this manner and could put patients at risk. These included lack of appropriately trained staff and delays in patients receiving essential care and treatment.

Incidents

- There were no never events registered for surgical services from 1 November to 31 December 2014. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between January 2014 and December 2014, there were 31 incidents in surgery which were reported to the National Reporting and Learning System (NRLS). The majority were classed as moderate harm. Two incidents were classed as severe harm, these related to surgical errors. Other reports were for avoidable harms such as pressure ulcers grade 3 and above, healthcare acquired infection (HCAI) such as clostridium difficile, ward closures and falls.
- Incident reporting was encouraged, however not all staff were aware of the procedure to follow for reporting on the electronic reporting system (Datix).
- Root cause analysis (RCA) investigations were carried out where serious incidents occurred such as pressure ulcers and these were discussed with staff at team meetings. We saw the report for an RCA following an incident of MRSA bacteraemia; an action plan had been developed.
- Nursing staff on the wards told us they did not feel they were involved and information was not shared with them, such as analysis of trends from incidents. Opportunities for learning were missed such as necessary actions to take to reduce the risks of re-occurrence.
- The trust's theatre risk register had identified presence of level 2/3 patients in recovery for longer than a defined time period (e.g. 6 hours) and these should be considered an exceptional event (akin to a local 'never event') and a full RCA should be completed on each occasion. This was not happening. Managers told us they are now planning to complete RCA investigations on these events and review in May 2015.
- The trust surgical mortality and morbidity meetings were held monthly. The information was reported through the governance structure to ensure early intervention.

Safety thermometer

- The surgical wards undertook a monthly audit as their "safety thermometer". This was an audit of the occurrence of avoidable harms, including pressure ulcers, venous thromboembolism (VTE), and falls.

- Safety Thermometer information provides a means of checking performance and is used alongside other measures to direct improvement in patients' care.
- Safety thermometers were displayed on all the surgical wards we visited. The results varied between wards which suggested inconsistencies in the quality of care provided to patients. In some areas where staff audited their performance on safe care, they had achieved 58% in their audits compared to a target of 90%or more.
- For example, on ward 111, the safety thermometer outcome for April 2015 showed that pressure risk assessments had only been completed in 44% of cases against a target of 99%. Other measures fell well below trust targets; MRSA was 38.9%, the Malnutrition universal screening tool (MUST) score 44.4% and VTE 33%.
- There were 45 incidents of hospital acquired pressure ulcers for surgery between January and December 2014. Of these 36 were grade 2 and 9 were grade 3. Patients developing pressure ulcer was better than the England average at 2.6% in 2014.
- The wards were working on the trust's targets to reduce and prevent falls. Although falls assessments were completed on admission, in 8 records viewed these were not completed post operatively in surgical patients who would be at risk with reduced mobility as a result of the procedure they had undergone.
- Safety thermometers results indicated some of the surgical wards were achieving 100% on hand hygiene audits.

Cleanliness, infection control and hygiene

- The surgical wards visited were visibly clean and staff followed trust policy on infection control. We observed staff regularly washed their hands and used hand sanitizer gels between patients. The bare below the elbow policy was adhered to by all staff. Some wards used "I am clean" stickers on equipment after it had been cleaned to indicate that it was ready to be used; however we found use of the stickers was not consistent, we did not always see stickers on equipment.
- Hand sanitizing gels were prominently located and at the entrance of the ward, bays and side rooms, as well as hand wash basins. Personal protective equipment (PPE) for the prevention and control of infection such as gloves and aprons, were available and used by staff and complied with trust policy.
- Visitors were aware of the hand hygiene procedures and were complimentary about the cleanliness of the wards.
- Staff followed procedures for screening patients for MRSA pre-operatively or on admission if they were unplanned admission.
- A complete clean of patients bed areas were observed to be carried out following discharge and prior to new admissions.
- Action plans were in place; to be implemented following an incident of bacteraemia. This included reduction of the number of patients in the bays to meet with infection control guidelines. Monthly audits for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile for the surgical wards were displayed.
- Surgical wards benefitted from infection control audits which were carried out by infection control link nurses. Audits also provided advice and guidance to help staff maintain or improve performance.
- Cleaning rotas were available on the wards; although they were not all fully collated.
- There were dedicated staff teams who were responsible for cleaning in the operating theatres, and regular checks and audits were completed.
- Procedures were followed in theatre 28, where all staff wore green gowns when transferring patients inside theatre to reduce the risk of cross infection.
- Procedures for the control and prevention of infection were not followed consistently. There was no "sterile corridor" from the day care unit, which meant staff entered the anaesthetic room without putting on gowns.
- Theatre staff were issued with "scrubs" for use within the theatre area. We saw that infection control was compromised by at least one member of staff who was seen wearing scrubs outside the theatre environment in one of the hospital lifts.

Environment and equipment

- There was a procedure for the checking of resuscitation equipment, for use in emergency to ensure these were fit for purpose.
- Although staff were documenting checks had been completed as per their policy at least daily. There were serious shortfalls found during the inspection. In one ward the oxygen cylinder for use on the resuscitation

trolley had expired in 2013. A number of essential items of equipment such as cannulas were out of date. This included an out of date item on a resuscitation trolley in theatre.
- The resuscitation trolleys were not maintained securely in line with trust policy. A number of these trolleys were either open or did not contain a seal to prevent unauthorised access to equipment and potentially drugs.
- Where patients remained in the recovery areas for long periods and in some instances a number of nights, there were no amenities such as toilets, commodes or facilities for washing, to meet the needs of patients in a safe and dignified way.
- The process for managing consumables in theatres was effective. It was under the control of theatre staff who explained the procedure and how they did not need to rely on "top ups" from stores.
- Bariatric equipment such as theatre table and trolleys were available.
- Shelving used for storage of surgical instrument sets in theatre was unsafe as it was clearly not strong enough for the weight of the instruments. This had not been identified as part of their risk assessment in order for remedial actions to be taken.
- The "bone freezer" in theatre had a check list for temperature which should have been recorded on a graph. This was not being completed, we were told the staff member responsible for this had left and did not hand over the information.

Medicines

- Medicines were not always stored securely and safely on the wards and in theatres.
- In anaesthetic rooms, pre-filled syringes were left on the side which were not secure and not "capped". This included potent anaesthetic drugs.
- Staff in theatres told us for three weeks prior to our inspection, they had reported issues with the department's medicines refrigerator. The temperatures were not consistently within the required range to ensure temperature sensitive medicines were stored safely. When we asked to check the records they could not be found and the refrigerator was still being used. This was brought to the attention of senior staff during the inspection.
- The temperature of medication fridges on the wards was monitored; however this was not consistent in all the wards including the lack of minimum and maximum temperature recordings. This meant staff were not aware when the fridge temperature was either above or below the normal range. Medicines stored at the wrong temperature and not according to the manufacturer's recommendations could reduce the efficacy of medicines given to patients. Some medicines need to be kept within certain temperatures to ensure they are fit for use.
- Concerns were raised with us about staff failing to follow safe procedures in the administration of medicines. Observations indicated medicines were overall administered safely. We observed staff had left medicines on the table for patients to take later; however the medicines records were signed to show patients had received their medicines which may not be accurate. There were also potential risks of these medicines being accessed by other patients or being stored by patients who might later take an excessive amount of the drug.
- Drugs such as those used for intubation were left on top of the resuscitation trolley unsecure on the ward. We raised this with the manager during the inspection for immediate action to be taken. On 1 May 2015 we returned to complete an unannounced visit as part of the inspection process. We found that the situation had not improved.
- In one of the surgical wards, the medicines missed dose audit identified that 38% of patients had not been provided with their medication in a timely way. There was no action plan developed to mitigate the risk of patients not receiving their medicines as prescribed.
- Medicines incidents were monitored monthly and on one particular ward, 11 medicines incidents had been recorded at the time of the inspection. Actions had been taken to reduce the number of incidents, these included staff training in medicines management.
- Medicines charts on some wards contained gaps and staff were not able to ascertain if patients had received their prescribed medicines. The process for auditing these was not robust.
- Medicines were available to patients on discharge from the "pods" attached to the wards and this worked efficiently. However patients experienced long delays when they waited four medicines from the main pharmacy which could take up to 4-6 hours.
- Dedicated pharmacy staff were allocated to the wards; they undertook checks of medicines charts and

provided staff with advice such as drug dosages and contraindications, however these staff had not identified the and addressed with staff the gaps in the medication charts.
- We viewed the controlled drug (CD) registers in theatres and found these to be appropriately completed, with CDs checked at the beginning and end of each operating sessions.
- CDs were kept securely and the registers were appropriately maintained on the wards. Staff were aware and followed the procedures as required.

Records

- Food and fluids charts were poorly completed for patients in seven out of ten records for those who were at risk of malnutrition due to poor eating or drinking. Staff could not be assured patients were receiving adequate amounts of food and fluids in order to meet their needs.
- There were regular audits of patients' records to ensure they met professional standards. These audits had highlighted some gaps in patient record keeping; however, this was not followed up by a robust action plan to address the shortfalls and prevent further errors.
- Risk assessments such as pressure risks, falls and VTE were completed by nursing staff. Some VTE assessments were not always completed by the surgical team; although preventative treatment was prescribed. This was discussed with a doctor who told us the assessments should be completed as this provided guidance on the dosage of preventative medicines which were prescribed.
- The World Health Organization (WHO) has produced guidance to increase safety for patients undergoing surgical procedures. The guidance sets out five steps that should be undertaken during every procedure to help prevent errors. The guidance forms a basis from which organisations are able to adopt and adapt practice to reflect the needs of their service.
- The trust developed its surgical safety checklist from the WHO guidance.
- We reviewed 22 patients' records in surgical wards and followed some of these patients through to theatres. Pre-assessments were detailed and theatre teams were using the WHO checklist which was an established process within the teams. We saw that information including the patient's identity, and known allergies and reactions were documented.
- Monthly WHO Checklist Audits were undertaken and this was fed back at monthly team meetings. Whilst there has been an improvement against the WHO data completeness standards, for the first time this year, the surgical division have failed the standard to ensure a WHO checklist is completed for all patients, with performance at 91%.

Safeguarding

- Staff on the wards including non-clinical staff were aware of what constituted abuse and the actions they would take and how to report issues to protect the safety of vulnerable patients.
- Staff would report to the ward sister or matron; however none of the staff said they would follow this up to see what action if any had been taken.
- Staff were aware of the trust whistle-blowing and we were told they could find information on the trust's website.
- We saw records which showed that as of 31 March 2015, 88% of staff had completed child protection awareness training (equivalent to level 1) and 88% had completed vulnerable adult awareness training (equivalent to level 0) and. This training is on a 3-year cycle. The trust target is that 95% of all staff have completed this training.
- Surgical wards had safeguarding link nurse and specialist nurse to provide advice and support to patients and staff.

Mandatory training

- There was an induction programme for all new staff. These covered all the key statutory and mandatory training. Over the last 3 months there is an emerging improving trend against the statutory and mandatory training target, although December performance remains below the target.
- All staff in surgery areas were aware of the need to attend mandatory training in issues such as moving and handling, infection control and safeguarding adults. They told us their training was up to date and were sent reminders via e-mail of any outstanding training.
- Ward managers kept good records of the training needs of staff, and were prompted by the personnel department reports regarding completion and performance. Data provided by the trust indicated as at December 2014, 83% of all staff were up to date with statutory and mandatory training.

- Training sessions has been cancelled for the last few months due to staffing shortages and "winter pressure". Although ward managers told us these would be "started soon"; there was no action plan developed.
- All staff with access to NHS patient information should undertake appropriate information governance (IG) training. The trust's performance against the IG training standard of 95%, has marginally improved at 69%, which is still significantly below the target.

Management of deteriorating patients

- The surgical wards used the modified early warning score (MEWS) to identify if a patient was deteriorating. Staff were aware of actions to take when patients' scores fell outside expected boundaries. However there was some inconsistency as the Mews records were not fully completed on two of the surgical wards. We raised this with the ward sisters during the inspection.
- Outreach nurses who have additional training in relation to deteriorating patients were not always available to patients on the wards as they were used to supplement staff in other areas of the trust.
- We were told that over the weekend, the outreach team had received calls for assistance from the wards and the emergency department which they had to decline, because they were unable to leave the patient in post anaesthetic care unit (PACU).
- Two trauma patients admitted at the weekend were still waiting in the emergency department to be seen by the outreach team on Tuesday when we visited.
- Staff in anaesthetic and recovery areas were competent in recognising deteriorating patients. In addition to the early warning score, observation chart and procedures, pathways for operations were used.
- Patients identified as high risk of falls were monitored in areas close to the nursing station. On the vascular wards they had allocated a six bedded bay where high risks patients were nursed and two staff members were allocated to that bay.
- There was a system of screening all surgical patients pre–operatively for risks of potential blood clots and appropriate therapy was prescribed according to risks. We saw that assessments had been completed and were prescribed appropriate therapy to prevent blood clots in all the patients' records we checked.

Nursing staffing

- The trust used the national safer nursing tool to assess the nursing numbers in providing safe care and identified minimum staffing levels.
- In all the surgical wards we visited, the required and actual staffing numbers were displayed as required. Staffing rotas demonstrated that safe staffing levels (registered nurse to patient ratio) of 1:8 during the day and 1:10 at night, was being achieved.
- Serious concerns about staffing levels were raised in recovery area which is also known as post anaesthetic care unit (PACU). Senior staff reported they were understaffed and raised patient's safety issues as there were at times one nurse for two to three high dependency patients. This is also supported by the paper presented to the board about lack of appropriate skilled staff to care for patients.
- Theatre staffing has been identified as an outlier on the hospital risk register. This was because, whilst the workforce plan was in place, the budgeted establishment was set incorrectly Papers had been submitted to the chief nurse and surgery division and a recruitment plan was in place.
- Vacancies were filled with bank and agency staff. As at December 2014, the turnover rate for surgery was 8.5%, well below the trust target of 11%. The ward managers told us some staff picked up additional shifts to support the wards and they used bank staff. We were told that recruitment was on-going.

Surgical staffing

- Surgical consultants told us they were well staffed and appropriate skill mix. There were 41% consultants, 9% middle career doctors, 39% registrars, and 11% junior doctors.
- Junior doctors felt supported and told us that they could contact senior clinicians including surgical consultants if they required advice or guidance. In general surgery they said they sometimes struggle in receiving support when the registrars were busy in theatre.
- Consultant's presence in theatre for complex trauma cases was available at all times.
- Junior doctors said training was good and included fortnightly protected training; although they were not always able to attend and had missed the last two sessions. They described teaching in surgery as 'poor.'

Surgery

- Junior doctors said they had opportunity to raise concerns and had forum evenings. We heard that the oncology service was responsive to feedback from the junior doctors but not so much in general surgery services.
- In general surgery there was a lack of board engagement with junior doctors; they described a lack of simulation training and opportunity.
- Handovers were consistently formal and structured. During our announced visit we attended a clinical handover. The handover covered care of patients based on the severity of their condition and any anticipated problems
- Surgical consultants from all specialties were on call for a 24-hour period. Consultant's ward rounds took place twice a day. New patients were seen by a consultant following their admission during the day.

Major incident awareness and training

- The trust had developed a major incident contingency plan and the chief operating officer had responsibility for this.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were not in place.
- Theatre staff had not undertaken any simulated major incident training.

Are surgery services effective?

Requires improvement

Effective outcomes for patients requiring surgery were not consistently met.

Patients were not operated on within the timeframe expected after sustaining a fractured neck of femur.

Patients experienced delays in receiving appropriate and timely care in the post-operative care unit due to insufficient surgical and nursing staff.

The surgical directorate contributed to all national audits, for example, the Trauma Audit. Surgical mortality reviews were completed in a timely manner. Patients were provided with appropriate pain relief immediately following surgery. However this was not consistently managed at other times.

Surgical and nursing staff undertook daily ward rounds five days a week but these were not attended by therapy staff to support multidisciplinary care.

Supervision and support for clinical staff was not effectively managed particularly in the recovery areas.

Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient death.
- We found the Royal College of Surgeons' standards for emergency surgery/surgery out of hours were consultant led and delivered.
- Trauma and orthopaedic hip and knee pathways were used; although three out of the five pathway records we looked at were not fully completed.
- The American Spinal Injury Association (ASIA) score charts were completed which formed part of neurological assessment for all patients with a spinal injury and was clearly understood by staff.
- Policies for the prevention and management of pressure injury were in line with national guidelines. All patients had the Waterlow score which is a standardised assessment for risk of pressure injury completed on admission; however there were gaps in reviewing these post operatively in some records.
- Staff did not follow good practice guidance on the management of intravenous cannulas. Records contained venous infusion phlebitis (VIP) scorecards which is a process of checking the cannula site. Five of seven score cards were not fully completed. For example there was no score for a patient who had a cannula left in situ for seven days and methicillin resistant staphylococcus aureus (MSSA) was found in the line.
- The enhanced recovery pathways were used to improve outcomes for patients in general surgery, urology, and orthopaedics. This focused on pre-assessment, pain relief and the management of fluids and diet, as part of post-operative recovery.
- We reviewed the total hip replacement care pathway and this was appropriately completed in most cases.
- According to NICE clinical guideline 65, patient's temperature should be measured and documented on admission to the recovery room and then at 15-minute for incidence of hypothermia, where the patients core temperature may drop. There was no anaesthetic audit for hypothermia when we asked to see them during the inspection. The trust has confirmed they do not carry

out such audit. The British Journal of Anesthesia (BJA) recommends that a combination of audit along with the NICE guideline should make it possible to significantly reduce the incidence of inadvertent perioperative hypothermia.

Pain relief

- Patients were assessed and received pain relief as required. Patients told us their pain was mostly managed although at times they had to wait for pain control at certain periods such as mornings and evenings, as the nurses were busy.
- Concerns were raised with CQC by a family member, as medicines including pain control was left with patients as, "No one checked that he had taken his meds and a couple of times we found he was in pain because he had taken one tablet but not the other one and this was in his pocket".
- We observed medicines round and found medicines were left with patients while they were having their meals. Senior staff told us medicines were often left with patients to take later, the patients we spoke with were happy with this.
- Advice was sought from pain specialist nurse for a patient we case tracked. Pain specialist input was readily accessible and regularly called to assess patients and provided guidance on pain control.
- Pain assessment charts were used and were present in post-operative records we viewed.
- Pain control was discussed with patients at pre-assessments clinics.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. We observed that fluid balance charts were used to monitor patients' hydration status. However MUST scores were not always reviewed post operatively which may impact on care and support people received.
- Patients had access to fluids including beverages. Patients who were at risk of malnutrition were prescribed supplements due to poor appetite. These were not always recorded on five of the fluid balance records seen and staff could not be assured they had received these as prescribed.
- The patients said they were given choices for food and snacks. However, they provided mixed views regarding the quality of the food available; in particular patients told us that breakfasts were "below standard with cold chewy toast".
- Patients told us they had missed their meals on occasions as they had to go for scans during the lunchtime. Staff told us patients should be provided with a snack box if they missed their main meal. We were not assured that this happened in all cases.
- Staff monitored patient's nutritional status and referral to dietician and speech and language therapist were made if required.
- We spoke to a dietician who told us they followed up some patients and provided advice and support to staff and patients.
- The wards had protected meal times to allow patients times to eat without distraction and visitors were not encouraged to visit unless this was to assist their relative to eat.

Patient outcomes

- Data from the national hip fracture database (NHFD) and clinical programme audit published in September 2014 showed the predecessor trust was one of just 11 out of 180 hospitals which recorded 30-day mortality below the lower (95%) limit. This meant they had a good record at reviewing this process.
- The national institute for clinical excellence (NICE) states patients with hip fracture should have surgery on the day of or on the day after admission (NICE QS16).
- The result from the national hip fracture database (NHFD) in September 2014 showed only 65% of hip fracture patients at the hospital had surgery on the day of or day after admission compared to a national average of 72%.
- The surgical division took part in national audits, for example, the elective surgery, Patient Reported Outcome Measure (PROM) programme, national hip fracture database and national joint registry. The PROM scores for both hip and knee replacements were similar to other trusts. The varicose vein audit data was also similar to other trusts.
- Among the traumas and orthopaedics hip fracture audit 2014 patients admitted to orthopaedic care within four hours was 56.6% and higher than the England average of 48.3%.

Surgery

- The proportion of patients assessed by an ortho-geriatrician was 42.5% prior to surgery compared to a national average of 50.5%overall.
- The hospital performed better and achieved 9.7days compared to the national rate of 19.8 overall days for length of stay following hip fracture.
- The predecessor hospital had mixed results from the 2014 Bowel Cancer Audit and the 2014 Lung Cancer Audit. The bowel cancer audit for 2014 showed that the case ascertainment rate (verifying the patient has the condition) was better than the England average, as was the percentage of cases discussed at MDT and CT scans reports. For other items audited, the results were in line with England averages. For the 2014 lung cancer audit, the percentage of patient discussed at MDT was worse than the England average as was the percentage of patients receiving a CT scan before bronchoscopy.
- Overall, day case surgery rates performed below national expectations. The British Association of Day Surgery recommends that 90% of certain surgeries are completed as day cases. The trust was not meeting this due to the high volume of cancelled operations.
- For trauma and orthopaedics patients, between March and October 2014, 132 non elective and 62 elective patients were readmitted as an emergency within 30 days.
- For patients who had undergone general surgery there were 542 readmissions following non elective surgery during that same period.
- For patients nursed in post anaesthetic care unit (PACU) senior clinical staff have raised concerns about delays in patients care. These included sedations holds, delays in intubation/ extubation due to insufficient nursing and surgical cover to carry these out in a timely fashion. This had been presented in a paper to the trust board.

Competent staff

- Senior staff told us they conducted one to one personal development supervision meetings with staff every three months. Staff said they received regular clinical supervision and annual appraisal. The trust wide figures indicated were below the trust's target of 96%.
- New members of staff said they had been supported on joining the hospital. They had completed a trust wide induction programme.
- There were courses for staff's progression; however senior staff told us three staff had applied for courses and only one may get it as lack of funding meant they had to "dip into charity fund for this". Preceptorship allows nursing staff a period of time supernumerary to staff numbers in which to familiarise themselves with and train for their role.
- The education lead on the ear nose and throat (ENT) and maxillofacial (max fax) ward showed us their structured teaching programme which included the management of tracheotomy, and percutaneous endoscopic gastrostomy (PEG) tube management.
- The surgical wards included many medical patients from for example, cardiology. Nursing staff were not always appropriately trained to care for patients from these different specialities.
- Staff in recovery were allocated patients who were being ventilated and told us they had not received any training to care for that type of patient.
- A report by the clinical lead for trauma, resuscitation and anaesthesia presented to the trust in March 2015 identified 29 staff requiring some level of supervision and not suitable to support critical care patients within the PACU area. The number of patients being nursed in PACU had shown a continuous increase from November 2014 to March 2015.
- In the General Medical Council (GMC) National Training Scheme Survey 2014, the trainee doctors within surgical specialities rated their overall satisfaction with training as similar to other trusts.

Multidisciplinary working

- Daily ward rounds were undertaken seven days a week on all surgical wards. Surgical and nursing staff were involved in these together with physiotherapists or occupational therapists as required. When we observed ward rounds during the inspection. We did not see evidence of therapies staff on the rounds.
- A trauma patient we tracked in the intensive care unit (ITU) indicated they had received appropriate and frequent neurosurgical and plastics input and multi-disciplinary notes were completed.
- We observed a good working relationship between theatre and ward staff during our visit.
- Patients' records showed they were referred, assessed and reviewed by multi-disciplinary team (MDT) such as dieticians, speech and language therapist and the pain management team when required.

- Pain specialist undertook daily review on the surgical wards. Referrals were dealt with on the same day if possible. At other time the surgical nurse practitioner who was not a pain nurse provided support and prescribed pain control.
- Medical support was accessed when required to support patients' medical needs.
- Doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards and other units.
- Pharmacy support was available served by "pods" on wards and facilitated patients' discharges with take home medicines.
- The records viewed identified family involvement as necessary for effective discharge planning. This included referral to the community team for support of a patient requiring equipment and training for enteral feeding.

Seven-day services

- The surgical services was consultant led and available over the weekend.
- Consultants worked throughout the week within the surgical services and were supported by specialist registrars during the weekends.
- Access to clinical advice at night came from the hospital at-night team which was made up of nurse practitioners and junior medical staff. Staff said they were very responsive. Although the outreach team was not able to provide support as they were committed supporting patients in the recovery area which was not their principle role.
- There were no physiotherapy and occupational therapy support staff at the weekends.
- The pharmacy was open on Saturday and Sunday mornings. Outside of these hours, there was an on-call pharmacist to dispense urgent medications.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to care and treatment. Where patients lacked capacity to consent, the principles of the Mental Capacity Act 2005 were followed to ensure decisions were made in the best interests of patients.
- We observed consultants visiting patients prior to surgery and giving explanations to patients prior to them signing consent forms.
- Patients said clear explanations about the surgery and procedures had been given and staff had checked that they understood what they were consenting to. A patient commented "Everything was fully explained and you had a chance to ask questions".
- Wards had resource packs for DoLS and MCA to inform staff's practices.
- An application for DoLS had been made for a patient who lacked capacity, although they were awaiting approval from the local authority at the time of the inspection. Interim measures for management of this patient had not been developed in the absence of DoLS.
- Staff across surgery had completed their training on Mental Capacity Act and Deprivation of Liberty and Safeguarding. There were no figures on the wards relating to the number of staff who had not completed this training. Senior staff told us training had been cancelled in the last few months due to staffing shortages.

Are surgery services caring?

Good

Staff were caring and compassionate and treated patients with dignity and respect.

Patients told us they were treated in a caring way, and staff were available to offer support and care when they needed.

Patients were kept informed and they received good information about their surgery. Patients felt involved in their treatment.

Compassionate care

- Patients were positive and complimentary about the care and treatment they received on the surgical wards. They told us the care was, "very good and, "can't fault care".
- They commented the staff were, "very kind" and treated them with, "utmost care and respect". Another patient told us, "The care is second to none".
- Surgeons introduced themselves and sought patients 'consent prior to examination.

Surgery

- The surgical wards had a 19% response across the hospital to the friend and family test (FFT). Between December 2013 and November 2014, FFT responses relating to recommending the hospital's surgical wards varied between 66% and 100%.
- Throughout our inspection we witnessed patients being treated with care and compassion. Staff spent time talking to patients and answering their queries or supporting them with food and fluids.
- We observed interactions between staff of all disciplines and the patients they cared for; patients appeared comfortable in the presence of staff.
- Patients were encouraged to provide feedback and this was analysed to improve the care provided.

Patient understanding and involvement

- Patients said they were able to speak with the consultant and other doctors caring for them and involved their family which they felt was important to them.
- They said 'the staff' nursing and surgical staff provided them with clear information about the procedures and post-operative care. Where options had been available these had been discussed and patients had been able to question decisions and influence their care.
- Pain control was also discussed.

Emotional support

- Patients and relatives told us they received the support they needed to manage their treatment and hospital stay.
- Patient's comments included "I was very feeling emotional as I had tests in another hospital and could not find what was wrong" They said the doctors were marvellous and staff supported them. Another comment was "Emotionally I feel reassured" and they said they were prepared for their operation.
- A relative who had been very anxious about their family member told us they had been made to feel welcome on the ward and had been supported and kept informed.
- There was a chaplaincy service available for people of all religious denominations; although staff were aware of the Church of England chaplain who visited but not from other religions. Facilities at the hospital included a Chapel, Mosque and Contemplation room with washing facilities. The Chaplaincy has contacts with various local faith groups throughout the community and nationally.
- Counselling was available, for example on the vascular ward, patients undergoing limbs amputation were referred to counselling service.

Are surgery services responsive?

Requires improvement

The hospital was not meeting the national 18 week referral to treatment time in some surgical specialities. The hospital was working on reducing the numbers of cancelled operations and the improving the numbers of patients with cancelled operations being treated within 28 days, but was still not meeting these targets. The hospital was not meeting the referral to treatment times for cancer patients. Some progress had been made in clearing the back log of delayed operations.

Bed occupancy levels in the hospital were high and the lack of available beds was resulting in patients spending longer times in the post anaesthetic care unit (PACU). This included a large number of ventilated patients being nursed in that area following surgery.

The hospital were sighted on further improvement although plans did not include specific targets or an assessment of impact in other areas, for example, critical care services and PACU.

Service planning and delivery to meet the needs of local people

- The Trust Special Administrators (TSA) recommended that all non-elective and emergency general surgery would no longer be undertaken at the County Hospital. To support this, the trust has been developing services at Royal Stoke so that patients requiring surgery can be accommodated there.
- Day surgery unit surgery offered treatment for minor procedures without patients having to stay overnight in hospital.
- The Commissioners have been involved in the integration and planning of services. This includes the transfer of acute surgery, gynaecology, trauma in February 2015. The need for supporting anaesthetic cover for consultant-led obstetrics and emergency surgery meant that the transfer of these services during January and February were managed together.

Surgery

- As part of the changes to services, the trust had involved the Commissioning Care Group (CCG) and quality and impact assessment were undertaken looking at any inequality created by the changes, transport issues the changes may bring to specific high-risk and vulnerable patients.

Access and flow

- Ninety-six percent of patients who are referred urgently by their GP with a suspected breast cancer were seen in less than seven days. However for other cancers the hospital achieved 45%in November and 44.8 %in December 2014 below their target of 70%.
- In December 2014, for both the 31 day (diagnosis to treatment) and 62 days (urgent GP referral to treatment) cancer waiting time standards the hospital fell just below the target at 75% for colorectal and 76%for urology.
- Patients had a pre-operative assessment which included testing for MRSA. The hospital had a maximum limit of 12 weeks for surgery after the pre-operative assessment. The trust was not meeting this target as operations were conducted outside the twelve week limit with had an impact as additional screening needed to be carried out.
- The Department of Health (DOH) guidelines state that if patients require surgery and their operation is cancelled for non-clinical reasons, their operation should be re-arranged within 28 days.
- The volume of cancelled operations has been higher than anticipated by the hospital, in the last 2 months there had been a significant increase in cancelled operations due to the hospital's capacity issues caused by winter pressures.
- There were 33 cancelled operations in October, November 49 and 74 in December 2014. This includes cancer patients who had their surgery cancelled due to lack of availability bed. Senior staff also told us between 3 and 5 neuro surgical patients a week had their surgery cancelled due to the acuity of emergency patients, but did not have any data to confirm this.
- In December 2014, the surgical division failed to reschedule all cancelled operations within 28 days. Staff told us that operations were often cancelled due to lack of theatre capacity, acuity of patients, staffing or inefficient planning.
- The hospital had had a total of 731 patients waiting in excess of 12-hours (up to February 2015) in the emergency department. This was due to the hospital being unable to move patients out of the emergency department. We observed systemic issues with protocols for referral which had an impact on this. For example, we saw how a patient was referred to surgery by the emergency department. Surgery refused to accept the patient as the patient also had other medical needs and refer back to the emergency department to get a medical assessment. The emergency department then make a referral to medicine, the assessment is eventually done and the emergency department then had to re-refer to surgery.
- Patients were cared for in the post anaesthesia care unit (PACU) area following surgery. Senior staff told us they felt this had reached a crisis point. Post-operative patients were nursed in the PACU for days due to no beds being available within the speciality wards and with no appropriate discharge planning provided.
- Data showed there were 70 ventilated patients nursed in the PACU area every month. Ventilated patients require more intensive nursing and consequently impact on staffing numbers and patients flow.
- Senior staff in PACU raised concerns with us about patients requiring level 2 care (high dependency care) being operated on despite having no appropriate facilities for their post-operative care which then impacted on the number of patients in PACU. This was raised with senior managers at the time of the inspection.
- PACU staff were taken away from their duties and anaesthetic staff had to undertake the recovery process with patients which had a knock on effect and ongoing surgery could not be undertaken in a timely fashion as planned and delaying other surgical procedures on the list. Anaesthetists told us it was not unusual for them to stay and look after patients in PACU.
- The clinical lead for trauma, resuscitation and anaesthesia presented a report to the trust in March 2015 highlighting major shortfalls in the care provision of patients whose post-operative care took place in PACU which was not appropriately equipped or staffed.
- The bed occupancy within the hospital had been significantly higher than the national average of 88%

over the past year at 92%, and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the overall management of the hospital.
- Length of stay was longer than the national average for elective general surgery, neuro surgery orthopaedics surgery and non-elective trauma. Staff believed the acuity of patients had impacted on how patients had needed to stay. The trust had not assessed or monitored this.

Meeting people's individual needs

- Patients told us the staff were responsive to their needs. Most people who had used their call bells when they needed help said, staff always responded fairly quickly. However, patients on the neurosurgery ward told us that staff were slow to respond to calls for help and felt that staffing levels were inadequate. A comment included, "They go away and forget all about you". The ward manger told us it was a busy ward. The safer staffing information displayed showed they were achieving their staffing requirement including a patient receiving 1:1 care.
- Patient's individual needs were not always considered in order to provide care in a person centred way. In the urology ward a patient was admitted as a day care case, they told us they had to sit in a chair as the bed was needed for another patient. We raised this with the ward manager who said they had an average of 7 day care patients per week. Ambulatory patients were not allocated a bed due to bed flow pressure. Patients were placed in a bay in a chair for a number of hours while they received treatment and may be more comfortable if appropriate chair such as in a recliner chair which was not available.
- Patients in PACU did not receive care in a way which protected their privacy and dignity. Staff told us this was due to bed flow issues as these patients were remaining in PACU when they should be transferred to the wards. For example, Patients who were receiving end of life care were placed opposite the paediatric bay.
- Patients had access to written information regarding the type of operations or treatment they had planned for them. Information was sent to patients with booking information and some were available at the pre-assessment clinics.
- Leaflets were available on some of the wards; however this was not consistent in all the wards we visited. A member of staff said due the number of ward moves, they had not been able to have an established area on the wards for information leaflets to be displayed.
- Patients described the level of information as variable. A patient told us "I have received more information today from the nurses than I did when I had my operation a couple of months ago."
- On the wards there was a discharge coordinator responsible for discharge planning. The ward manager said this started as soon as a patient was admitted onto a ward.
- Staff had access to translation services and those we spoke with knew how to access this and told us that it was available when required. We did not see information about this.
- Staff had access to the dementia and learning disability care teams as needed and felt they were accessible and provided appropriate support.

Learning from complaints and concerns

- Staff followed the trust's complaint policy and would report complaints from patients to the manager or matron.
- Patients said they were confident to raise their concerns and said they would speak to the ward sister.
- Information on how to complain was available in some of the wards we visited. Senior staff told us due to recent moves from other areas their display board was not in place; however they would provide information and support to patient if needed.
- Staff said they also advised patients to contact patient support services for help and support. In addition there was information on the trust website if people wished to pursue issues after they had left the hospital.
- The ward manager undertook complaints investigations and escalated them if needed. A sample of recent complaints' investigation was seen; we saw that staff followed the procedure and provided feedback to complainants as needed.
- An audit of complaints was completed and these were discussed at team meetings as part of learning. Action plans were put in place and details recorded in team meetings minutes we viewed.

Surgery

Are surgery services well-led?

Requires improvement

Surgery was well led at ward level where staff felt supported by the multi-disciplinary team, joint working and strong clinical leadership. Local management understood their staff and supported them in their roles. We saw that managers were approachable and knowledgeable. In return managers were respected by their staff.

The trust vision was not recognised by staff and staff felt at trust board level, management was neither visible nor accessible. There was a disconnect between senior management and junior staff who regarded the management style as autocratic and unwillingness to fully engaged with the ground staff. There were good leadership at ward level and staff felt supported by their immediate managers and real sense of working together.

Vision and strategy for this service

- The trust has a development plan looking at the long term provision of care for the local community.
- Trust's vision and strategy included the development of strategic alliance with other local partners. Development of a high quality trauma centre. Delivery of 92% bed occupancy or less. Delivery of the £100m capital programme to time and cost over three years. Reduction of avoidable patients harm by further 20% by 2018.
- Staff did not know what the trust's vision and values were as they felt disengaged from the wider trust's management. However there were total commitments from all staff grades about providing quality, safe care for patients.
- Staff were passionate and proud to make the hospital a place where patients would want to be treated.

Governance, risk management and quality measurement

- The division had a quality dashboard for each of its services and ward areas. Dashboard data included performance information against quality and performance targets. Members of staff told us these were discussed at team meetings.
- Risks management at local level was not consistent in the management of risks as action plans were not developed to mitigate the risks. We identified a number of safety issues which the service was not aware of. We were also concerned that problems with patients flow across the hospital had not been recognised or addressed by leaders in surgical services.
- Regular audits were completed such as infection control, hand washing, falls, medicines. However there were inconsistencies as actions plans were not developed to minimise the risks of re occurrence
- There were divisional risk registers that identified key risks to the service. Risks were reviewed and monitored at both division and board levels.
- The service held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed.
- Senior clinicians were all aware of the duty of candour and the process to follow and information was available on some of the wards.
- The ward managers provided monthly assurance reports which were shared at trust's governance meetings. Although the hospital was measuring their outcomes against the six fundamental values - care, compassion, competence, communication, courage and commitment (the "6Cs") standards. None of the staff on the wards were able to tell us about this and how this impacted on the care they provided.

Leadership of service

- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. Nursing staff told us their immediate manager operated an open door policy and worked on the ward as part of the team and very approachable.
- Staff in vascular, trauma orthopaedic, ENT and urology told us they worked as a team and a staff member commented " we all pull together and get the job done".
- There were mixed views about the provision of training, support and supervision for staff.
- Staff shortages meant that senior staff provided clinical care and could not fulfil their managerial roles.
- The transition of service and staff had not been well managed with a negative impact on staff's morale. Managers were unable to provide the level of support to the staff during through the process.

Culture within the service

- Staff felt at trust board level, management was neither visible nor accessible. Senior clinicians (doctors and nurses) had serious concerns about the culture of the organisation.
- Staff were passionate and committed to providing good care to patients but felt that this could not always be achieved due to the pressure of work.
- Staff we spoke with worked well together as a team and said they were proud to work for the hospital. They spoke positively about the lessons learnt from reporting incidents and RCA which were discussed at team meetings and action plans developed.

Public and staff engagement

- Information was displayed in all the surgical wards we visited. These included incidents such as falls and infection control audits and actions plan to address any shortfalls. We spoke to some visitors about the safe staffing numbers and some of them were aware of this. Comments included “this is good and we look to see if they have enough staff”.
- Patients’ views and experiences were taken into account and they were encouraged to complete satisfaction surveys. There was information displayed in wards showing and what the friends and family test results were telling them.

Innovation, improvement and sustainability

- There were initiatives developed to improve the quality of service provision as part of the corporate plan.
- Clinical staff were committed to improving the outcome for patients, however there were no projects and staff said this was due to acuity of patients and lack of staffing and resources. Improvements were managed at local/ ward levels for example an anonymous survey by staff highlighted lack of training. This has been implemented and staff said they felt valued.
- The trust was taking part in a Royal College of Physician pilot for fracture neck of femur which was running for 10 weeks.

Critical care

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

Information about the service

The Royal Stoke University Hospital had three critical care units: a general critical care unit (which consisted of four pods); eight beds in pods 3, 4 and 5 and twelve beds in the recently commissioned pod 6; a separate surgical critical care unit (SSCU) which had 14 beds but was currently commissioned to provide 12 level two beds. The SSCU was managed by the general critical care management team. The general critical care unit provided up to 36 beds which could be used or 'flexed' between level three and level two depending on patient need (high dependency beds are assessed as 0.5 due to nurse staffing requirements). Level three beds are beds for critically ill patients, who are ventilated and have other complex care requirements and level two beds are for patients who have high dependency needs but are not ventilated.

The cardiac critical care unit (CCU) also known as pods one and two, consisted of two eight bed pods and was under a different division management team. CCU was primarily used as a surgical postoperative unit and provided 16 cardiac surgery beds for both level two and three patients. These beds were flexed in response to patient need and dependency.

Between 1 September 2014 and 28 February 2015 the general critical care pods had admitted 1678 patients and the cardiac critical care pods had admitted 595 patients.

The trust are members of the regional critical care and trauma networks.

We visited all the critical care units during our announced inspection. We spoke with 12 patients, 10 relatives and 53 staff: nurses, doctors, therapists, domestic staff and managers. We observed care and treatment, and looked at the records of 12 patients on the critical care units. Before the inspection, we reviewed performance information about the hospital.

Critical care

Summary of findings

The capacity of the critical care services was insufficient and this had a wider impact on the safety of patients in the hospital. The consistent use of the recovery area of theatres for extended periods to accommodate critically ill patients was not good practice and left other parts of the hospital exposed to potential risk whilst the outreach team were fully occupied in recovery, they were unable to respond to deteriorating patients.

Nursing staffing levels had improved in recent weeks but the adequacy and skill mix of staff remained inappropriate.

A failure of cardiac critical care to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) meant that the effectiveness of the service could not be compared to other critical care units.

Multi-disciplinary working and collaborative care across critical care relied on individuals rather than suitable working arrangements in place and did not meet best practice guidelines.

The general critical care managers were a newly appointed management team. They had identified that improvement were required and had a plan in place to address this; however this was work in progress.

There were systems in place to review critical care service delivery although timely actions were not consistently taken to address areas of concern and ensure that risks to patients were minimised.

Staff did not all feel that senior management were listening to or addressing their concerns.

Are critical care services safe?

Requires improvement

The capacity of the critical care service was insufficient and this had a wider impact on the safety of patients in the hospital.

Critically ill patients in the recovery area of theatres were supported by the outreach team. This meant that the outreach nurses were unable to respond to deteriorating patients on the wards. Whilst nursing levels within general critical care services wards had improved there were occasions when nurses needed to provide care for more than one level three patient which was unsafe.

The lack of experienced nurses who were supernumerary to oversee junior and agency staff also put patients at risk. Medical staffing was generally satisfactory. However there was a need to ensure that sufficient doctors were available to cover the cardiac critical care out of hours and ensure that doctors were available to care for critically ill patients. There was an increased risk that patients may be harmed due to concerns about patients accommodated in recovery and insufficient nursing staff.

Staff had not received all required mandatory training but actions were in place to address this. The critical care units were clean and there were mostly appropriate systems in place to minimise the risk of cross infection. Cleaning chemicals were not securely stored. The availability of equipment was found to be appropriate although not all staff had received timely training in its use. The majority of medicines were stored and administered appropriately. However there was a need to review the safe administration of medicines in syringe drivers and the safe and appropriate administration of oxygen.

Incidents

- No never were linked to the critical care units. A never event is a largely preventable serious patient safety incident that should not occur if the preventative measures have been implemented.
- There were five serious incidents which were reported to the Strategic Executive Information System (STEIS) from January 2014 to March 2015 for the critical care unit.

These related to an MRSA infection and three grade three pressure ulcers. We looked at a the root cause analysis (RCA) investigations, and saw that when required actions had been, or were being, addressed.

- The trust had an established system for reporting incidents and near misses through an electronic reporting system. The general critical care unit had reported 302 and cardiac critical care had reported 75 incidents between 1 November 2014 and 28 April 2015. Each incident submitted was reviewed and graded by a senior nurse or consultant and the investigation was proportionate to the grading and any harm to the patient involved.
- When the staff member completed an incident report they received acknowledgement that the report had been submitted. Staff confirmed they always received feedback from incidents they had reported. All staff, including bank staff were able to report incidents. Agency staff required a permanent staff member to complete the form for them online. Staff (both medical and nursing) we spoke with said that they had reported incidents, such as pressure ulcers or general concerns about care.
- We spoke with a band seven nurse who told us about their concerns in relation to appropriate staffing and patient safety within critical care. The nurse told us that they had written to the matron to raise their concerns but had not completed an incident report. The nurse told us that they had not completed an incident report because they would constantly be doing so and felt that this would not be worthwhile. This meant that the concerns may not be appropriately investigated and senior managers may not be fully sighted on the degree of concern and risk.
- Incidents including clinical adverse events (CAEs) were reviewed by medical and senior nursing staff depending upon the nature of the incident. Incidents and CAEs were discussed at the monthly critical care clinical governance meeting.
- Mortality rates were discussed both within the critical care governance meeting and the quality and safety framework. There have been no mortality outlier alerts for critical care services.

Safety thermometer

- The safety thermometer was displayed on the unit for patients and relatives to view. The information showed the number of complaints, falls, pressures ulcers and infections within the last month and also the accumulated annual total.
- There had been six patient falls within cardiac critical care and 12 within general critical care (which includes five in surgical critical care) between 1 November 2014 and 31 March 2015
- There had been one pressure ulcer in cardiac critical care and one in general critical care (the surgical critical care unit).
- The hospital used a management tool which contained information about each ward or unit's performance against agreed targets. It included: staffing information (such as sickness, vacancy rates and bank and agency staff usage), incidence of infections, and incidence of pressure ulcers, slips, trips and falls and patient feedback and compliance with mandatory training.
- We saw that performance within the critical care unit was mixed from November 2012. SSCU had scored 100% for harm free care, cardiac critical care had scored 100% for harm free care between 1 November 2014 and February 2015 but in March 2015 scored 93.3%. Performance for general critical care was mixed but failed to meet the trust target of 95% of for three months between November 2014 and March 2015. This management tool was shared with all ward managers and senior managers every month to identify where improvement was required.
- Generally all critical care units performed poorly for venous thromboembolism (VTE) risk assessments. In March 2015 performance was 86.7% for SSCU, 66.7 % for cardiac critical care and 41.4% for patients in general critical care. Although performance for VTE risk assessments was poor, performance for treatment to reduce the risk of venous thrombosis generally met the trust target of 99% in March 2015 with the exception of cardiac critical care which achieved 93.3%
- Information provided by the trust showed that completion of risk assessments including pressure ulcer risk, nutrition risk and continence risk did not meet consistently met the trust targets.

Cleanliness, infection control and hygiene

- The critical care units we visited were clean and well maintained. There were cleaning plans in place, which included the frequency that cleaning should take place.

We saw records to show that domestic staff had signed to confirm that they had cleaned identified areas. We saw that weekly cleaning audits were undertaken to check the cleanliness of the critical care unit. The audits identified when areas required additional cleaning and confirmed that required actions had been undertaken.

- The general critical care and cardiac critical care submitted data to monthly ventilator-associated pneumonia (VAP) and central venous cannula (CVC) audits. We saw that that critical care was not meeting the 100% compliance standard for VAP. Corrective actions were in place which included increased oral care and the use of posters to remind staff of recommended practice such as raising the head of the bed.
- Staff compliance with hand hygiene was checked monthly by a senior nurse on both the general critical care and cardiac critical care units. Information we saw on the critical care units identified satisfactory compliance with hand hygiene audits although on the management information tool this information was not completed and TBC (to be completed) was recorded.
- We observed that the majority of staff washed their hands appropriately and wore appropriate personal protective equipment (PPE). However, we saw that cardiothoracic doctors did not always wash their hands before or after each patient contact. Effective hand washing alongside the use of gloves and aprons reduce the risk of cross-infection.
- The trust had a target that 90% of staff should have received infection control training. Within the specialised services division 74% of clinical staff had received infection control. The practice development nurse lead said that further training had been organised and compliance with this training would be met.
- Hand sanitising gel was available at the entrance to the each critical care unit, at each bed space and throughout each unit. Signs to remind both staff and visitors about hand hygiene were visible throughout the units.
- The critical care units had better MRSA infection rates compared to other comparable hospitals since 1 November 2014. There had been one incident of MRSA in cardiac critical care unit from 1 November 2014. There had been one case of C. difficile within cardiac critical care and two cases within the surgical critical care unit (SCCU) from 1 November 2014. Information provided by the trust showed that incidents were investigated, with root cause analyses (RCA) undertaken. When needed, required actions such as an independent investigation of the infection were identified.
- Side rooms were used, where possible, as isolation rooms for patients identified as having an increased infection control risk (for example patients with MRSA). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. These rooms could also be used to protect patients with low immunity.
- Staff told us and this was confirmed by records we looked at that patients admitted for planned surgery were screened for MRSA infection, and patients admitted as emergencies were isolated until it was confirmed that the patient did not have an MRSA infection. However information provided by the trust showed that the critical care units had not met the target for 95% of patients screened for MRSA from 1 November 2014. Average compliance for each unit from 1 November 2014 was: SSCU 91.3%, cardiac critical care 90% and general critical care 64%.

Environment and equipment

- On the general critical care unit we observed that the domestic store room where cleaning chemicals were stored was unlocked. We spoke with a member of domestic staff who confirmed that this room was unlocked to enable staff to gain entry when needed. We also observed that no information was available in this room in case of an incident such as a splash into an eye. There is a need to ensure chemicals are safely stored with appropriate information readily available in the case of an emergency.
- Critical care was reviewing the availability and use of its equipment to ensure the same equipment was available throughout the unit. This provided greater assurance that staff would be knowledgeable in the use of all equipment. Staff told us that the use of different equipment within critical care had been problematic especially for staff who had previously worked at the County Hospital site, as they were unfamiliar with some of the equipment used. Professional development nurses and the critical care technician were providing equipment training for nurses (including nurses from County Hospital) as well as junior staff and agency nurses. However staff told us that not all staff were had been trained to use the equipment and this may be

problematic if their patient required this equipment. Staff told us with current staffing arrangements, the number of inexperienced nurses and lack of supernumerary nurses this represented a risk to patients.
- We saw that the resuscitation equipment was regularly checked and, when needed, restocked. There was a record of when someone had undertaken this check, as well as who it was.
- A buzzer system was used to enter the critical care unit, to identify visitors and staff, and ensure that patients were kept safe.

Medicines

- We found that medicines including intravenous fluids were securely stored. We observed that medicines rooms and cupboards at patients' bed spaces were locked.
- We observed that epidural medicines were administered by a syringe driver (equipment used to administer a specific amount of the medicine within an identified timescale). We noted that National Patient Safety Agency best practice guidance was followed with yellow labels that clearly identified "For epidural only". However these syringes were not locked and could be accessed inappropriately. Staff and the pain specialist nurse told us that patients could be discharged to the wards with this medicine which was a potential patient safety risk. If the syringe driver contained controlled medicines they would remain on the unit which increased the patient's length of stay in critical care.
- The critical care units used a paper-based medical prescribing and medication administration record system for patient. Patients' medicines were prescribed by a doctor and this was recorded on their medication administration record (MAR). Nurses confirmed when they had administered the medicine or the reason it was not given. We observed five patients who were receiving oxygen. There was no record on their MAR sheet that oxygen was prescribed or how much should be administered. We spoke to managers who confirmed that oxygen was not prescribed but this would be considered. This may mean that patients do not receive the amount of oxygen they need which could put them at risk of harm.
- The medicines refrigerator temperatures, including the minimum and maximum temperatures, were recorded daily. A regular check on temperature provided assurance that medicines were stored safely, and their effectiveness was not adversely affected.
- All controlled and high risk medicines with the exception of epidural medicines in syringe drivers and associated paperwork were appropriately and safely stored.
- Emergency medicines were available for use and there was evidence that these were regularly checked.
- There was a senior pharmacist available for each unit to advise doctors about medicines. There was a top up service for unit stock and other medicines were ordered on an individual basis. Staff reported that there was an effective on-call service, out of hours. This meant that patients had access to the medicines they needed.
- Critical care areas were audited at least annually and were all last audited in January 2015. Units were audited more frequently dependent on the overall score and risk. For example SSCU bay one had scored 85% and critical care pod five had scored 86%. We saw that that there was action plan to address the findings had been identified a three month follow up audit had been identified.

Records

- The critical care unit used mainly paper records. Records were completed and filed in a consistent manner to enable staff to easily locate required information about the patient, their treatment and care needs.
- Within the critical care units paper-based nursing documentation was present at each bed space. Each record covered 24 hours and included the frequency and type of observations and risk assessments required. These included pressure ulcer risk, nutrition risk, coma scale, and delirium assessments. We saw that observations were checked and recorded at the required frequency and any deviation from expected results were escalated to medical staff.
- In the general critical care units we observed that patient records contained required information such as their treatment plan and requirement for further review. Critical care management had identified that patients' records did not consistently show that they had been reviewed during ward rounds or the outcome of those reviews. It was positive that the patient records we

looked at contained required information and evidenced that the patient had been reviewed at least every 12 hours as required by intensive care core standards.

- We also looked at five sets of patients records on cardiac critical care. Although staff told us that patients were reviewed every 12 hours we found this was not recorded in their records. A requirement to review patients every 12 hours is identified in intensive care core standards. During our unannounced visit we looked at one patient's notes. The records showed that this patient had been reviewed daily at midday but not otherwise. The nurse in charge told us that this patient had been seen and reviewed during the night but this was not recorded. The nurse in charge also said that although patients were reviewed every 12 hours, frequently this was not recorded.
- The trust had an electronic clinical results reporting system that was available in the unit.

Safeguarding

- The trust policies and procedures were in place for safeguarding children and vulnerable adults.
- Staff that we spoke with knew how to access safeguarding policies and procedures on the trust's intranet.
- Records we saw identified that 95% of staff in the anaesthetics, theatres and critical care sector within specialised services had received safeguarding vulnerable adults training. Staff confirmed that they had received safeguarding vulnerable adults training, and confirmed actions that would be undertaken to keep people safe.

Mandatory training

- The trust had a target of 90% of staff having received all required mandatory training. Training information provided by the trust identified that within specialised services (anaesthetics, theatres and critical care) this target was not met. Records we saw identified that in anaesthetics, theatres and critical care sector within specialised services :
- 78% of staff had received health and safety training;
- 93% of staff had received fire training;
- 24% had conflict resolution training
- 80% of staff had equalities and diversity training
- 59% of staff had received in hospital resuscitation training
- 66% of staff had blood transfusion training
- Mandatory training attendance for nursing staff was monitored by matrons, unit managers and the practice development nurses for both critical care and cardiac critical care units.
- The practice development nurse told us that due to staffing difficulties before the current matron was in post mandatory training was not prioritised. The practice development nurse told us that since the new matron had been in post staffing shortfalls were being addressed and mandatory training uptake was improving.
- Nursing staff in cardiac critical care also told us that they had received mandatory training. Staff training records were not available for us to check the unit's mandatory training.

Assessing and responding to patient risk

- The hospital used the modified early warning score (MEWS) to identify acutely ill or deteriorating adult patients.
- The critical care outreach team consisted of a total of 6.2 whole time equivalent (wte) nurses, which meant that most of the time there was one nurse on duty. There was at least one member of the outreach team available 24 hours a day, seven days a week for the management of critically-ill patients in the hospital.
- The outreach team told us that due to a requirement to provide support to ventilated patients in recovery they were frequently unable to review deteriorating patients on the wards, this represented a significant patient risk.
- The outreach team also provided telephone advice to ward staff should they have any concerns about deteriorating patients. Outreach activity data showed that from 1 November 2014 until 30 April 2015, the team had missed 111 calls whilst they were with other patients in recovery and had been unable to provide advice.
- It was hospital policy that the critical care outreach team reviewed all discharges from critical care to the wards and all patients with a MEWs score of more than eight throughout the hospital. However the outreach team told us that they were rarely available on a full shift to see patients on the wards who may be deteriorating.

- Figures provided by the trust showed that less than half (148 out of 313) patients transferred from critical care to the wards had been seen by a member of the outreach team. This meant that patients were not reviewed and ward staff had not received on going support by the outreach team.

Nursing staffing

- The safer nursing care staffing tool was completed daily by the senior nursing staff on both critical care units. The rotas were managed by the trust's electronic rostering system.
- The required and actual number of nursing staff on duty for each shift for both critical care units was identified and displayed within each critical care area.
- The matrons for both general critical care and cardiac critical care told us that sufficient and appropriate nurse staffing was an on going challenge. The matron for cardiac critical care told us that they currently had eight band five vacancies. The matron for general critical care said that there were 12 band five nurse vacancies in general critical care. Both matrons told us that they had an on going advertisement for experienced band five nurses to work in critical care.
- Nurses told us that nurse staffing levels had improved although they remained challenged. During our inspection we found that nurses on both the general critical care and cardiac critical care were allocated one-to-one care for level three patients and one nurse to up to two level two patients. Healthcare assistants were also on duty to provide assistance with personal care.
- Nurses working in critical care told us that although nurse staffing had improved there were occasions when they had to leave ventilated patients. We directly observed this during the inspection. Leaving level three patients who were critically ill is a significant risk to those patients. Nurses told that they had several spinal patients who required specialist lifting by up to five nurses, which meant other patients were left unsupervised.
- All shifts within both critical care units had a supernumerary senior nurse (band six or seven) who was clinical coordinator/shift leader. Senior nurses told us that there was a need for more supernumerary nurses to ensure that patients received safe and appropriate care. We were told that particularly on night duty the critical care nurse in charge had to oversee and visit recovery and SCCU which meant they were not present in the general critical care unit.
- Nursing staff told us that they were concerned about the number of junior, inexperienced and agency nurses who were not adequately supported. They told us that they felt this put patients at risk of harm.
- Intensive care core standards identify the need for additional supernumerary nurses for critical care units with over 10 beds and their role would be to support the clinical coordinator (shift leader). This would include assistance with admissions, transfers, supporting and supervising nursing staff and arranging staff sickness cover and relief in single rooms.
- According to the intensive care core standards, there should have been at least four additional supernumerary nurses on duty for general critical care and SCCU and one additional supernumerary nurse on duty for the cardiac critical care unit.
- The requirement of one nurse for each level three patient and one nurse for up to two level two patients was met was met on the critical care units. However, this was not the situation for level three patients who were in recovery. We were aware of an occasion during our inspection when there were three level three patients in recovery with only two outreach nurses. Nurses told us that they had difficulty fitting in breaks as this would put patients at further risk. We found this was not safe system of working.
- The general critical care matron told us that there was a plan for a supernumerary senior nurse (band six or seven) on every shift in addition to the shift leader. However due to current staffing challenges they were unsure when this would be achieved.
- When shifts could not be fully staffed from the unit's own staff working their contracted hours, critical care staff worked additional hours on the hospital bank.
- The critical care units used agency nurses and were able to block book agency nurses whenever possible to ensure consistency of nursing expertise. Senior nurses said unless at least one was a nurse whose experience and competence had been assured no more than one agency nurse worked in each pod. There was a basic induction checklist for agency nurses, but not all of the agency nurses we spoke with had received any induction before they worked within critical care.

- Intensive care standards identify a need for one physiotherapist for every four critical care beds. This was not being met. Staff told us and we observed that there was a business case to increase the number of physiotherapists to meet best practice guidance.

Medical staffing

- Medical care within the general critical care unit was led by a team of eight consultants, who were qualified to provide intensive care. There were usually two or three consultants on duty Monday to Friday during the day. The consultant to patient ratio varied between 1:14 and 1:21. This meant that intensive core standards that required one consultant to not more than 14 patients were not consistently met.
- The cardiac critical care had a consultant intensivist on duty between 8am and 6pm, with support from the patient's cardiac surgeon and anaesthetist. These arrangements meet intensive care core standards.
- In the general critical care unit three consultants worked in seven day blocks to aid continuity of patient care.
- At night a registrar was on duty within general critical care with a junior doctor. A consultant was on call to provide telephone advice and, when needed, came in from home. This was also confirmed by the junior doctors we spoke with who stated that consultants were accessible and supportive.
- Evening and overnight medical cover on the cardiac critical care unit was provided by a cardiac surgical registrar and with additional support from the consultant anaesthetist on call. Doctors told us that they could also request advice from the general critical care doctors. Doctors we spoke with said they had concerns about emergency cover and, when required, escalating a deteriorating patient about whom they may require intensive care advice.
- If medical staffing was not adequate (for example, due to sickness), locum support was generally provided by doctors who were currently working or who had previously worked on the units. Only if services could not be covered from within these groups were locum doctor agencies used. If medical cover could not be delivered by junior staff identified as above, the on-call consultant would remain on the unit until cover was resumed.
- The consultants on the general critical care unit had handovers and ward rounds twice daily. This meant that patients' health and recovery was regularly assessed to ensure they received appropriate and timely treatment.
- There were daily consultant handovers and ward rounds undertaken on the CCCU. In addition, there was an evening handover between the day and night registrars. However doctors did not always record this review in patients' records.
- All potential admissions to the general critical care unit were discussed with a consultant. Patient records confirmed that new admissions to critical care were reviewed by a consultant within 12 hours as required.
- Patients who were admitted to cardiac critical care were mostly planned admissions and had been seen prior to their admission. Staff told us that emergency admissions were seen within 12 hours by their cardiac surgeon or a cardiac anaesthetist.

Major incident awareness and training

- As a major trauma centre, the hospital had to be prepared for the likelihood of a major incident**.** The major incident policy for the trust contained relevant sections relating to the roles of critical care staff, preparedness and immediate actions.
- Staff told us that there were key staff who coordinated critical care activity in the event of a major incident or events which might cause a major disruption to the hospital such as severe weather conditions. Staff told us that if they were on duty they were clear who they would report to and if they were off duty they would ring the hospital to check if they were needed. Staff confirmed that there was no system such as text messaging to alert staff of a major incident and a need to contact the hospital urgently.
- The trust was reviewing the daily escalation plans to ensure that any fluctuations in demand and capacity were managed safely and effectively, along with managing the associated clinical risk, within acceptable limits.

Critical care

Are critical care services effective?

Requires improvement

The effectiveness of critical care services required improvement to ensure that patients consistently receive good outcomes that met their needs.

There were appropriate care pathways and clinical audit programmes in place to monitor adherence with guidance. When audits identified a need for improvement actions to address this were implemented. A failure of cardiac critical care to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) meant that the effectiveness of that part of the service could not be compared to other critical care units.

The majority of staff worked seven days a week but there was a need to ensure that there were sufficient staff such as physiotherapists to ensure this was effective.
Multi-disciplinary working and collaborative care across critical care relied on individuals rather than suitable working arrangements in place. We saw good examples of critical care multidisciplinary working but there was a need for further improvement such as daily multi-disciplinary handovers. Multidisciplinary working did not meet best practice guidelines.

Critical care did not meet the required standard for nurses with a post registration qualification in critical care, although this was being addressed. However the sufficiency of arrangements to support nurse's development and competency should be reviewed. Staff had mixed understanding of their responsibilities around the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Critical care used a combination of National Institute for Health and Care Excellence (NICE), Intensive Care Society, Faculty of Intensive Care Medicine (FICM) and Nursing and Midwifery Council (NMC) guidelines to determine the treatment it provided. Local policies were written in line with this.
- There were quarterly audits of patient records. We saw that critical care had identified that reviews of patients during ward rounds were not always recorded and this was to be checked during the quarterly audits.
- Information we received from the trust identified that critical care guidelines were last updated in June 2013, which meant they were out of date.
- Critical care had achieved 100% compliance with antimicrobial prescribing in the quarterly trust wide audit published in January 2015.

Pain relief

- A standardised pain scoring tool was used in both critical care units and could be used for patients who were unable to express pain. The pain assessment included a check on non-verbal responses, or changes to the patient's observations. Patient records we looked at confirmed that staff were using this tool to assess patients' pain.
- The critical care units were both supported by the acute pain nursing team who helped manage patients' pain relief.
- The records we looked at confirmed that patients had regular pain relief. Patients we spoke with told us staff ensured they had the pain relief they needed and they were kept comfortable.

Nutrition and hydration

- Appropriate arrangements were in place to highlight the risk of dehydration within the critical care units.
- The hospital used national guidance for parenteral and enteral nutrition. In the general critical care specialist feeding was managed by intensive care consultants not dieticians. There was a need to ensure that patients consistently received effective dietetic care.
- The cardiac critical care unit had policies in place to enable patients who were unable to take oral nutrition or fluids to be given specialist feeds until they could be seen by a dietician. Patient records we looked at confirmed that these policies were in use. This meant that patients were protected against the risk of malnourishment. Dieticians provided individualised dietetic advice using their expertise in food, nutrients, drug interactions, and enteral feeding. This meant that patients received appropriate dietetic and nutrition advice to meet their needs.
- An audit into the nutritional support received in critical care identified that 25% patients received the recommended energy intake (20-25kcal/kg/day) and no

patients received sufficient protein. This had increased staff awareness of nutritional requirements and changes to prescribed feeding regimes with increased calorific values and protein had been implemented.

Patient outcomes

- The mortality rate for cardiothoracic surgery was comparable to other similar hospitals. However as the cardiac critical care unit did not contribute data to the ICNARC database or undertake comparable local audit benchmarking, comparisons for the critical care component of coronary/cardiac care could not be made.
- The general critical care unit contributed to the ICNARC database. The data demonstrated that the general critical care was comparable with other similar critical care units
- An audit on tidal volumes delivered to mechanically ventilated patients in critical care was undertaken in 2014. The audit identified a need to ensure that nursing staff received additional training. This training was within the plan, along with plans to undertake a re-audit to assess if improvement had been made.
- The critical care units did not collect data for a local audit of central venous catheters (CVC). However when we highlighted this to the trust we were told that this audit would be commenced to ensure a review of the effective management of CVCs.
- The cardiac critical care unit had reviewed their use of antibiotics as a preventative measure. Antibiotics were given on the first day after surgery but then unless there were signs of infection no further antibiotics were administered. This had not led to an increase in infections following cardiac surgery whilst it had protected patients from overuse of antibiotics and concurred with antimicrobial good practice.
- A cardiac critical care nurse consultant provided support and weekly ward rounds throughout the hospital to review patients with a tracheostomy. The nurse consultant also facilitated the patients' discharge from hospital. Information provided by the trust demonstrated that the role of the consultant nurse and the review of tracheostomy patients had improved outcomes for patients by reducing the average length of stay from 114 days to 44 days.

Competent staff

- Twenty-one per cent of nurses working in the units had a post registration qualification in critical care. This meant they did not meet the required standard of at least 50% of nursing staff with a post registration award in critical care nursing.
- Staff told us that new band six nurses did not all have a post registration qualification in critical care. The matron told us that the posts were conditional on the band six nurses completing the critical care post registration qualification within two years. To complete this qualification, staff need support and development opportunities to progress in their role. Concerns were expressed to us that because there were limited numbers of experienced staff in the unit to support the newly appointed nurses achieve these requirements many be challenging.
- The matron told us that they had identified the shortfall in experienced nursing staff with a post registration qualification in critical care, recent increases to funding had been made available to improve the number of critical care courses funded from 10 each year to 20. This meant that staff had the opportunity to develop their knowledge and skills.
- All medical staff received a hospital and critical care induction with critical care-specific teaching which was tailored to the doctors' previous experience.
- All medical staff were involved in teaching other staff. Staff also told us that they were fortunate to have the lead Consultant for the Midlands Critical Care Network working in the unit.
- Junior doctors we spoke with said they felt supported by their mentor and other staff.
- All new nursing staff had a hospital and local induction in critical care. They had a four week supernumerary period, with six weeks for newly qualified nurses. New staff were assigned mentors.
- Nurse competencies were checked against standards identified by the critical care network. Nursing staff had competency booklets that were completed and assessed to check their competency. When we visited the nurse in charge told us that there were two nurses on shift who had not completed their competencies. These nurses required support but there were no nurses available to supervise them. This meant that assurances were not in place to check appropriate staff practice and competency.
- Nursing staff working within the cardiac critical care unit had access to a variety of specialist courses, including

cardiothoracic care, critical care, pain and end of life care. Nursing staff working in general critical care were also able to apply for the critical care course, but could also apply to undertake the neurosurgical course.

- Critical care had a team of five practice development nurses who covered both general and cardiac critical care at the Royal Stoke University Hospital and County Hospital. The practice development nurses said that as a result of staffing challenges staff training had not been a priority until the appointment of the current matron seven months ago. This had resulted in a shortfall in mandatory training and challenges to training support and checks on nurse competency.
- The practice development lead nurse told us that there were 42 newly qualified nurses who required preceptorship support; this was a challenge with current nurse staffing and skill mix. This was in addition to nurses from County Hospital who required training in procedures and equipment used at Royal Stoke University Hospital.
- At the end of March 2015, 95.4% of CCCU staff and 93% of GCCU staff had had an appraisal. All staff we spoke with confirmed that they received an annual appraisal.

Multidisciplinary working

- Daily multi-disciplinary ward rounds did not take place. Core standards for intensive care identify that the consultant intensivist as a key decision maker needs to receive an appropriate amount of information to make decisions. This requires the presence or input of other professionals to facilitate this process.
- There were informal meetings between different professionals who had specialist leads. An example of this was physiotherapists who managed the weaning of spinal patients from ventilators.
- There were weekly rehabilitation ward rounds which facilitated a multi-disciplinary approach to rehabilitation.
- The critical care units had a dedicated team of physiotherapists. Physiotherapists used the Chelsea Physical assessment tool which provided a holistic patient assessment patient goals built around this assessment.
- The physiotherapist lead told us they attended the critical care service delivery meeting and bi-monthly critical care governance meetings. In addition to this they met with the matrons to discuss equipment and best practice guidelines.
- There were daily pharmacist visits to the critical care units during which patients' medicine and treatment needs were discussed. Staff told us that they had a pharmacy toolkit on the critical care intranet to ensure medicine prescribing was safe and appropriate. This meant that advice was provided which reflected changing recommendations and immediate changes could be made in response to national guidelines.
- There was no speech and language therapist employed by the hospital. Staff told us that the speech and language therapist from the community trust visited the unit and would review patients with swallowing and speech difficulties and communication difficulties.

Seven-day services

- There was at least one intensive care consultant present in the general critical care unit between 8am and 8pm and seven days a week.
- Physiotherapy provided a seven-day service for the critical care units.
- Radiology and radiography services were led by a consultant who was available for urgent x-rays and scans seven days a week and during the evening and overnight.
- The hospital pharmacy was open seven days a week, although for reduced hours at the weekend. Urgent medicines could also be accessed by senior on-call staff.
- Speech and language therapists and dieticians were available five days a week.

Access to information

- On the critical care units nursing notes were kept at the patient's bedside and were accessible by staff at all times
- Staff could access electronic care and treatment policies and procedures at all times.
- The ward managers attended senior sister meeting with the critical care matron and shared the outcome of these meetings with staff. Information was shared face to face or by email.

Consent and Mental Capacity Act

- The trust had consent to treatment policy, and an information sharing policy. These policies included: the process for consent, consent refusal, lasting powers of attorney guidance and children giving consent to treatment.

Critical care

- The majority of patients treated in the critical care units lacked mental capacity to allow informed decision-making. We saw that an assessment of mental capacity was in place and was appropriately used by medical staff when required.
- Nursing staff told us they had received some training about the Mental Capacity Act 2005, as part of their safeguarding vulnerable adults but had mixed understanding of their responsibilities around it and the assessment of record of best interests decisions which included sedative medicines or equipment used to stop patients pulling out intravenous lines.

Are critical care services caring?

Good

Patients and their relatives said that staff were caring and compassionate and they were happy with the care they or their loved one had received within critical care.

95% of critical care patients who had completed the NHS Friends and Family Test said that they would recommend the service. Staff built up trusting relationships with patients and their relatives by working in an open and supportive way.

Patients and relatives were given good emotional support, and throughout our inspection we saw patients treated with compassion, dignity and respect.

Whenever possible patients and relatives were consulted and informed about the treatment they or their relative would receive. There was a critical care follow up clinic which provided an opportunity to discuss ongoing problems. Bereaved relatives also received support from the trust and critical care when required.

Staff provided good care by understanding what was significant to patients, and making arrangements to ensure they retained what was special in their lives.

Compassionate care

- Patients were positive about staff and the care they received. One person told us: "The nurses are very good although I am grumpy". One family told us: "They have been so good we can't fault the care".
- Throughout our inspection, we saw patients being treated with compassion, dignity and respect. Privacy curtains were closed and staff were seen to ensure they remained closed to maintain patients' dignity. We observed staff tuck blankets and bedding around patients to protect their modesty and keep them warm and comfortable. During the nurse handover the nurse in charge said that they had asked an unsettled patient's family to bring in underwear and pyjama bottoms to maintain their dignity. We asked the nurse in charge about this and they told us that patients mostly wore hospital gowns but it's so much nicer if they have their own.
- We observed staff talking to patients and relatives in a respectful and friendly manner.
- The matron of the critical care unit said that they were looking into how they could accurately identify patients' views on their experiences within critical care. 95% of critical care patients who had completed the NHS Friends and Family Test said that they would recommend the service.

Understanding and involvement of patients and those close to them

- The nature of the care provided in the critical care units meant that patients could not always be involved in decisions about their treatment. However, whenever possible, relatives were consulted on the patient's preferences and their views were taken into account.
- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.
- Patient diaries were used within general critical care. Staff told us that sometimes patients experienced distressing memories of critical care. The diaries assisted them to retrospectively reflect on their experience of critical illness.

Emotional support

- Staff built up trusting relationships with patients and their relatives by working in an open and supportive way. Patients and relatives were given good emotional support.
- After admission, a meeting would be arranged between the consultant covering the unit and the patient's relatives to update them on the patient's progress. When necessary, further face-to-face meetings were organised.

Critical care

- The relatives we spoke with said they had been updated and had opportunities to have their questions answered.
- The hospital had a follow-up clinic for general critical care patients and relatives. Patients were able to talk about their critical care experiences and discuss unpleasant ongoing symptoms, such as hallucinations. This service had been invaluable to patients and their relatives. Staff all told us about how positive this service had been for patients and relatives.
- A chaplaincy service was available, which provided valuable support to patients and relatives.

Are critical care services responsive?

Inadequate

The responsiveness of critical care services was inadequate. The capacity of critical care was severely challenged with higher bed occupancy than the national average. This had resulted in services that were not responsive to patients' needs. Critically ill patients were frequently moved from critical care during the night. Patients accommodated within recovery had limited patient and visitor facilities until a critical care bed was available.

Support for patients living with physical and learning disabilities, dementia, or those who had communication difficulties, was available if needed.

Service planning and delivery to meet the needs of local people

- There had been recent changes to the trust's critical care service with the downgrading of critical care services at County Hospital. An additional 12-bedded pod was commissioned at the Royal Stoke site, four level 3 beds were transferred from the County, a further four beds have been utilised by the unit and the remaining four beds are yet to be commissioned.
- The hospital was funded to provide up to 28 level three general critical care beds and 13 level three cardiac critical care beds or an equivalent combination of level two and three beds.
- Cardiothoracic beds had been reduced from 18 to 16 to accommodate two neurosurgical beds and in response to a shortfall in general critical care beds. The reduction in cardiothoracic beds had meant that the unit was not meeting the cardiac surgery goal of 1,000 life-saving heart operations "To save 1,000 hearts".

Meeting people's individual needs

- Support for patients living with physical disability, learning disability or dementia was available if needed. Staff told us that they usually received assistance from patients' families.
- Overnight visitor rooms were provided but their availability was limited. Staff had provided information about local hotels for relatives if they were not local.
- There were meeting rooms available for families to speak privately with staff and, when needed, break bad news.
- One family told us that staff had supported them to worship according their faith.
- Regular meetings were held with the patients and family members to ensure they were included in treatment decisions and, where necessary, interpreters/translation services was arranged.
- General critical care had a follow-up service for former patients who had been ventilated. The aim of the clinic was to support the recovery and review the progress of patients who had been critically ill. It also gave them the opportunity to discuss any ongoing problems that they had.
- Critical care had responded to the patient feedback forum. Improvements made had included the availability of toys in the critical care waiting area and the provision of day/night clocks to orientate patients.

Access and flow

- Between May 2013 and November 2014, figures showed that the bed occupancy for critical care was mainly above 92%. The national average critical care bed occupancy was 86%. Persistent bed occupancy of more than 85% suggests a unit is too small.
- Information provided by the trust identified mixed critical care performance from 1 November 2014.
- Night time discharges from critical care have been historically associated with increased mortality and increased patient distress. Since 1 November 2014 19.6 % of patients were discharged from critical care between 10pm and 7am.
- Patients should be moved to a more suitable environment within four hours of the decision that they

no longer require critical care. Since 1 November 2014 there were 201 delayed discharges although it was positive that there had been an overall reduction in the number of discharges delayed identified.

- Unplanned readmission within 48 hours of discharge should be minimal and could imply hasty discharge, since 1 November 2014 it was positive that just 0.5% of patients were readmitted into critical care.
- The critical care outreach service had a remit to facilitate timely admission and discharge from critical care units, prevent readmission to critical care and promote continuity of care for patients who had been critically ill. The outreach team at the time of our inspection were unable to fulfil this due to a need to provide care to level three patients in recovery.
- The hospital had an escalation plan for adult critical care services. If no critical care bed was available the plan identified guidelines to reduce potential risks to patients and included the suspension of outreach to nurse patients in dedicated recovery areas and cancellation of operations.
- All senior critical care staff we spoke with raised concerns about the number and frequency of level three patients who were outside the critical care unit. Staff told us that the majority of the patients were in recovery and were admitted from accident and emergency to the recovery unit. Whilst patients were in recovery there were limited facilities available for patients and their visitors. This was not responsive to patients' needs.
- Between 1 November 2014 and 31 March 2015, 52 operations were cancelled due to the lack of availability of critical care beds.
- Information provided by the critical care outreach team identified that from 1 November 2014 there were 244 patients accommodated in recovery overnight. The frequency and length of time that critically ill patients were accommodated in recovery was not acceptable.
- The hospital had recently introduced a new role of 'flow coordinator' in critical care, who was on duty Monday to Friday between 7.30am and 4.30pm. The flow coordinator checked the numbers and dependencies of critical care patients, and staffing levels alongside potential discharges and step-downs of general critical care patients, including patients accommodated in recovery. The matron and shift leader spoke positively about the impact of this new role.

Learning from complaints and concerns

- There had been two complaints about critical care. One complaint raised concerns about a patient cared for in recovery. We found that there was an appropriate response to the complaints received although the same concerns about patients being cared for in recovery is an ongoing concern.
- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Complaints information was included within the clinical governance meetings. On a monthly basis, senior leadership received a report detailing any complaints received.
- Information on how to raise concerns and make a complaint was on posters displayed within critical care.

Are critical care services well-led?

Requires improvement

The leadership, governance and culture in critical care services did not always support the delivery of high quality person-centred care. There appeared to be a "disconnect" between general critical care and cardiac critical care and their management.

The general critical care management team were newly appointed with the longest serving manager in post for nine months. It was evident that the team had identified that improvement was required and had a plan in place to address this; however this was work in progress.

There were systems in place to review critical care service delivery although timely actions were not consistently taken to address areas of concern and ensure that risks to patients were minimised.

There was insufficient evidence of shared management of the risks between general critical care and cardiac critical care associated with the inadequate capacity of general critical care and the ongoing need to use recovery to care for critically ill patients.

Staff had mixed feelings about working in critical care. Cardiac critical care staff were positive although general

critical care teams recognised the shortfalls and risks of the service. Whilst all staff and particularly general critical care staff raised concerns about the sufficiency of staffing staff did not all feel that senior management were listening to or addressing their concerns.

Vision and strategy for this service

- Staff were mostly aware of and understood the vision and values of the trust and the impact of those values within critical care.
- The matron was positive about the vision and strategy for critical care and how it met the trust's vision. The matron told us that all standards including sufficient and appropriate staff would be met within two years and critical care services would be a centre of excellence within three years. The matron told us and we saw that a business case to increase nurse staffing was already in place.
- Strategies for the service were developed with the involvement of clinical directors, nurse managers and group managers. The specialties' strategy for critical care was to review capacity against demand and the accommodation of patients in recovery.
- The vision of cardiac critical care was, "to mend 1,000 broken hearts".
- Both general and critical care were implementing the role of advanced critical care practitioner to support nursing and medical teams working within critical care.

Governance, risk management and quality measurement

- There were bi-monthly critical care clinical governance meetings which were attended by both general and cardiac critical care representatives. We saw that the meetings reviewed audit findings, incidents and complaints received and identified improvements required.
- The critical care governance meetings had discussed arrangements to prepare for the potential admission of a patient with Ebola virus disease. Actions identified included staff training in the appropriate use of personal protective equipment (PPE).
- The critical care governance meetings also raised concerns about the care and management of critical care patients in recovery by the outreach service and the risks associated with this. The minutes identified that these concerns had been taken to higher levels of management.
- Risks inherent in the delivery of safe care were identified on the trust's risk register: the critical care risk register had six identified risks of which three were identified as high risk and included insufficient staffing levels and difficulties in recruitment. Patients accommodated within recovery were not identified as a risk. Critical care risks were reviewed at the monthly management team meeting to ensure that risks were being managed.
- The management team identified challenges around critical care capacity and nurse staffing. This had required patients who required level three care being admitted to the recovery unit as no critical care bed was available. There was an escalation plan which identified actions that should be undertaken if no critical care beds were available. The plan also identified that if two or more level three patients were outside critical care additional actions should be undertaken such as stopping elective surgery and/or non-clinical transfers to level three critical care units in other hospitals. Information we saw suggested that this plan was not consistently followed and operations were not being routinely cancelled or patients transferred when there were two or more patients outside critical care.
- There appeared to be a "disconnect" between general critical care and cardiac critical care and their management. We did not find that there to be sufficient evidence of shared management of the risks associated with the inadequate capacity of general critical care and the ongoing need to use recovery to care for critically ill patients.
- A root cause analysis was undertaken following each serious incident. Records of investigations which we saw detailed identified actions to reduce the risk of further, similar incidents in the future.
- Cardio critical care held monthly mortality and morbidity (M&M) meetings to discuss CCCU patients treated over the preceding period.
- The directors of the division attended monthly trust executive committee meetings where quality and governance issues for all specialities within the trust were discussed by the executive team. Discussions had included the hospital mortality reduction plan, which included the introduction of various care bundles which were reducing mortality rates. Meeting minutes which we saw identified "a significant reduction in sepsis since this care bundle had been in place"

Leadership of service

Critical care

- Critical care and cardiac critical care both had a consultant intensivist who was the medical clinical lead for critical care. This meets intensive care core standards.
- General critical care and cardiac critical care both had a modern matron (band eight) who had a specialist qualification in critical care in addition to a management qualification and had overall responsibility for the nursing elements of the services. This met core intensive care standards.
- A deputy matron had recently been appointed to assist the critical care matron to deliver a quality focused critical care service.
- There were supernumerary band six or seven nurses in charge of each shift on both critical care and cardiac critical care.
- The general critical care management team was newly appointed with the longest serving manager in post for nine months.
- The critical care management team had identified a strategy for the services which addressed the shortfalls of the service to ensure it met core intensive care standards. As part of its assessment for the service the management team had requested a critical care peer review and were developing an action plan in response to this. There was a business case in progress for increased staffing to address both temporary leave such as maternity leave and a need to meet intensive care core standards.
- General critical care managers had raised their concerns about the ongoing accommodation of critical care patients in recovery with senior managers within the trust. General critical care managers had identified insufficient capacity to meet the increased demand for safe critical care services. Cardiac critical care teams appeared not to be aware of this and focused more on their concerns that heart operations had been cancelled due to a reduction in their beds.
- The leadership ensured that there was shared learning and support for critical care staff. It was not evident that learning and support was in lace between general critical care and cardiac critical care.
- We saw that leadership in both critical care units were actively involved in quality improvement.
- We found that the leadership were responsive to suggestions for improving care outcomes, maximising resources and obtaining best value for money. For example, by negotiating contracts for supplies of specialist equipment and medicines.

Culture within the service

- Staff in the cardiac critical care unit spoke about being a team and working flexibly within that team.
- Senior nurses within cardiac critical care praised nurses for their flexibility, changing shifts at short notice to ensure that staffing was sufficient for patients' needs.
- Staff in general critical care spoke about consistently leaving the unit late, missing breaks and their concerns about patient safety due to staffing and skill mix. Staff had mixed feeling about how senior management were addressing their concerns.
- Staff told us that they felt part of a team although this was not the situation for staff who had moved from County Hospital to the general critical care unit. General critical care managers had raised their concerns about the ongoing accommodation of critical care patients in recovery with senior managers within the trust. General critical care managers had identified insufficient capacity to meet the increased number of patients to ensure that there was sufficient critical care capacity. Cardiac critical care staff appeared not to be aware of this and were more concerned that heart operations had been cancelled due to a reduction in their beds.
- The leadership ensured that there was shared learning and support for critical care staff. It was not evident that learning and support was in lace between general critical care and cardiac critical care.

Public and staff engagement

- The trust and critical care used a combination of email, intranet messages and newsletters to engage with staff.
- There were mixed views from staff in general critical care that their concerns such as the skill mix and sufficiency of staff were not being addressed. Whilst most senior nurses (band six and seven) spoke about improvements to staffing arrangements since the appointment of the matrons not all staff were aware of this.
- General critical care had a patient/relative support group, which was consulted about initiatives and their experiences of being a patient on the general critical care unit.

Critical care

- Nursing staff working in cardiac critical care spoke positively about being consulted about the service.

Innovation, improvement and sustainability

- There were systems in place to review critical care service delivery. However timely actions were not consistently taken to address areas of concern and to ensure that risks to patients were minimised.
- The new general critical care team had identified that considerable improvement was needed to ensure that provide a quality service. As part of their pathway to improvement they were successful in achieving a silver award in Excellence in Practice Accreditation Scheme in March 2015. As part of this award the team had to assess the service, identify gaps in the services provided and how and when they would be addressed. The critical care unit at the University Hospitals of North Midlands was the first critical care unit to achieve this award.
- The employment of junior and middle grade doctors in critical had been problematic. As a result of this the University Hospitals of North Midlands had developed an accredited programme for nurses and other professionals allied to medicine to undertake the advanced critical care practitioner qualification. The first group of staff should complete their training at the end of 2015. Staff were proud of this initiative.
- Critical care had a quality improvement plan which demonstrated a commitment to quality care while obtaining best value for money. Initiatives included a prescribing review to identify cheaper but effective alternatives, reduced antibiotic use in cardiac critical care, reduction in the amount of wasted medicines and a review of product use and negotiation of more favourable costs. There had also been a target to reduce agency staff usage but this was not achieved due to vacancies within critical care.
- There was a plan to increase the amount of cardiac surgery. However due to general critical care challenges and a need to use two cardiac critical care beds for neurosurgery patients this target was not being met.
- Physiotherapists used the Chelsea physical assessment tool. This tool was a holistic view of the patient with goals built around the assessment.
- In collaboration with the University of Keele critical care were actively participating in several research studies.

Maternity and gynaecology

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

Information about the service

The maternity and gynaecology services included a midwife birth centre (MBC) and a consultant-led labour ward, antenatal clinics, a foetal medicine unit, a maternity assessment unit, antenatal and postnatal inpatient. Women could also choose to have a home birth and these, along with antenatal and postnatal care, were supported by community midwives.

Between July 2013 and June 2014 5,816 babies were delivered at the former Royal Stoke University Hospital.

Specialist services were available for example, diabetic care, drug and alcohol liaison and mental health.

Community midwifery was part of UHNM's maternity services. Working in partnership with GPs, health visitors, family nurses, children's centres and lifestyle services they promoted good health during pregnancy and early days following a baby's birth. Five teams of community midwives provided care in the midwifery led units, GP surgeries, health centres and during home visits including antenatal care, parent education classes, home births and postnatal care.

The gynaecology service offered inpatient services and day care and assessment facilities. There was no dedicated gynaecology emergency department or ward. Women were seen in Accident and Emergency or the Surgical Assessment Unit and admitted to Ward 101, a general surgical ward, if they need inpatient treatment. A team of gynaecologists specialised in specific problems and were supported by four advanced nurse practitioners, specialist gynaecology oncology nurses, general nurses and health care assistants.

We visited all the wards and departments relevant to the service. We spoke with 10 maternity patients, 35 midwives and five support workers. We spoke with four gynaecological patients, seven nurses and five support staff who care for gynaecological patients. We met and spoke with 11 medical staff that work across both the maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

There were many good examples of the maternity unit being safe but the gynaecological service was not able to offer the same level of reassurance. Women waited for long periods in the emergency department or the surgical assessment unit for review and ongoing treatment. Once on the wards, they were not cared for by nurses trained in gynaecological nursing.

Policies were based on national guidance, treatment was planned in line with current evidence-based guidance, standards and best practice.

Patients told us that they felt well informed and were able to ask staff if they were not sure about something. We saw a wealth of inpatient, day patient and outpatient's information leaflets available.

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

Are maternity and gynaecology services safe?

Good

People are protected from avoidable harm and abuse. Staff understood their responsibilities to raise concerns and report incidents. We saw that a robust process had been undertaken including a root cause analysis (RCA), establishment of lessons learned, an action plan and dissemination of learning points.

There were clearly defined systems and processes to keep people safe. All areas were seen to be clean and well maintained and resuscitation equipment was mostly checked as per policy although we did note some omissions in the documentation.

The midwife to birth ration was 1:29. The named midwife was model was in place and women told us they had a named midwife. Women received one to one care in labour and women expressed their satisfaction with this.

We were told that midwives routinely care for critically ill women and are supported by the critical care outreach team. There is only one critical care outreach nurse and we were told that this nurse is not always able to leave the critical care unit due to capacity. This could be a risk to women as midwives may not be supported in caring for critically ill women.

We saw that if women with Gynaecological conditions were admitted through Accident and Emergency A&E), they were seen by the A&E medical staff and then referred to the on call gynaecologists. Women could be seen by the on call gynaecologist in A&E or on the Surgical Assessment Unit (SAU). This was dependent on activity. They could also wait considerable time before being transferred to the SAU. This potential lack of timely review could be a risk to women with potentially life threatening conditions such as ruptured ectopic pregnancy.

Incidents

- One surgical error never event was reported in November 2014. This was a surgical swab retained seven

weeks after delivery. We saw that a robust process had been undertaken including a root cause analysis (RCA), establishment of lessons learned, an action plan and dissemination of learning points.
- 21 serious incidents were reported to the NHS strategic executive information system (STEIS) by maternity services between January and December 2014. These were monitored and the action plan reviewed at weekly risk meetings.

·Staff told us that they were able to raise concerns and were confident that their concerns would be listened to.

- Escalation of risk was identified through a computer based incident reporting system (Datix). Royal College of Obstetrics and Gynaecology (RCOG) trigger list was used to guide the inputting of Datix forms. This meant that incidents were identified, investigated and that necessary learning could take place.
- The trust told us that between 1000 and 1200 incident reports were filed each year by staff in the maternity department. Completed Datix forms were at risk meetings every seven days. We saw evidence that separate obstetric risk management meetings and gynaecology risk management meetings were held weekly and that new incidents were reviewed.
- Following every reported serious incident, a full investigation would be undertaken. This would include a root cause analysis (RCA) review and a report would be developed. Review meetings would be held, minuted and attended by the senior management team. Any learning from the incident investigation would be disseminated to staff in meetings or via the risk newsletter. We saw examples of RCA reports from both obstetrics and gynaecology completed and presented.

Cleanliness, infection control and hygiene

- All areas of the maternity unit were seen to be clean and well maintained. An external cleaning company was responsible for the cleaning schedule and we saw that this was displayed in all areas.
- Staff told us that getting delivery rooms cleaned could be difficult out of hours and at times of high activity. This meant that they cleaned the rooms themselves which could detract from patient care.
- Sluice areas were clean and had appropriate disposal facilities, including disposal of placentae.
- We saw that cleaned equipment was labelled with a green' I am clean' sticker.
- Compliance with the trust infection control policies and procedures was evidenced in the maternity environmental and hand hygiene audit data. Compliance of 97% and above was recorded in November 2014.
- Staff were seen using hand gel and protective clothing. Bare below the elbow policy for all staff was adhered to.
- We looked at the birthing pools on all units and found them to be well maintained. Staff we spoke with knew the pool cleaning procedure.

Environment and equipment

- The most senior qualified member of staff on duty had the responsibility to ensure that all resuscitation equipment was checked as per policy. We saw omissions in the documentation which demonstrated the resuscitation equipment had not been checked as per the policy. For example, we saw three omissions in the checking of a rescusitaire on labour ward in three months and five omissions in the checking of the adult resuscitation equipment on the Midwifery Birthing Centre.
- Midwives had access to the equipment they needed to confirm the health and well-being of mothers and babies. We saw that equipment such as foetal monitoring machines, vital sign observation monitors and rescusciatiares had been maintained and stickers applied to confirm that checks were up to date. We saw one foetal monitoring machine that was out of date.
- Telemetry machines were available for women whose babies needed monitoring in labour but did not want to be restricted to the bed.
- Staff were able to tell us about the procedure to evacuate a mother from the birth pool in the case of an emergency
- We saw that there were three High Dependency Unit (HDU) rooms. One was cluttered with broken furniture, women needing high dependency care were cared for in side rooms.
- We observed an effective outpatients/specialist clinic service with good facilities and pleasant patient waiting areas. Privacy and dignity was maintained with quiet areas available for consultations.
- There was no dedicated gynaecology ward. Women were cared for on a general surgical ward, which was visibly clean but cluttered with equipment in the corridors.

Maternity and gynaecology

Medicines

- We saw that medication was stored in locked cupboards within clinical rooms. Controlled drugs were checked twice a day in all areas.
- We saw that VTE scores were recorded in patient's records and monitored. Prophylactic treatment was prescribed and administered in accordance with trust guidelines.

Records

- We saw that records were kept secure and away from public view. Records were maintained in a neat order.
- On the maternity unit we saw the individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born.
- We saw that K2 Guardian System (an electronic records system) was used for recording care in labour.
- We reviewed six sets of records and noted that risk assessments and VTE status was recoded in all records.

Safeguarding

- All ward staff followed the trust's safeguarding policy and reporting procedure. Staff reported that they get good support from the safeguarding midwife who visits the wards daily.
- Ninety-five percent of staff had completed level 1 child protection training. Across the obstetrics and gynaecology directorate, 18% of staff had completed child protection training at level 2 or above. This data could not be broken down to site level. The trust told us that directorate managers had not yet determined which staff should undertake this training.
- Good evidence of safeguarding vulnerable women was evident. We were told that the hospital has been used as a safe-haven in emergency situations in the past when a woman had not been able to get to safe place if she was discharged.
- The safeguarding midwife meets link safeguarding midwives every 4- 6 weeks to discuss concerns. Community midwives do not have safeguarding supervision. This is a Department of Health requirement (Working Together to Safeguard Children, 2010).
- Policies had been developed for Female Genital Mutilation (FGM) and the trust were in the process of developing a policy for child sexual exploitation.

Mandatory training

- Mandatory training for midwives was provided over three days and covered subject matters including; maternal and neonatal resuscitation, electronic foetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Overall completion of mandatory training was high. Safeguarding was recorded at 95%, infection control 89%, health and safety 99% and patient handling 92%.
- Cardiotocography (CTG) machine was used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. CTG training compliance for 2014/15 was recorded as 96%.
- Community staff told us that on occasions, backfill staff were not available to cover them, which makes it very difficult to attend training. This means that the community team may not be compliant with mandatory training requirements.
- As gynaecology services are provided as on the general surgical wards we did not have mandatory training information for gynaecology services staff.

Assessing and responding to patient risk

- **Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman.**
- We were told that midwives routinely care for critically ill women and should be supported by the critical care outreach team. However, access to the team is not always available due to capacity and having to care for patients in other parts of the hospital (recovery).
- Medical staff also expressed concerns around care of critically ill women and lack of access to the outreach team.
- All staff were required to undertake annual new-born life support training and adult resuscitation training as part of the mandatory midwifery training day.
- Women that had problems in pregnancy were reviewed on the Maternity Assessment Unit (MAU) and could be admitted for short periods of time to be reviewed regularly by the obstetric staff.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organization's 'Five Steps to Safer Surgery' guidelines. The checklists we looked at showed that all the stages were completed correctly.

- The senior midwives on duty provided cardiotocography (CTG) review known as 'fresh eyes'. This is recommended by NICE Intrapartum Guidelines. It involves a second midwife checking a CTG recording of a baby's heart rate to ensure that is it within normal parameters.
- We reviewed 10 patient records and saw that there were detailed risk assessments and plans of care.

Midwifery staffing

- The planned staffing levels were displayed at the entrance to each ward. Staffing requirements for the postnatal wards was five midwives on the early shift, four on the late shift and three on the night shift. We did not see actual staffing displayed but were told that staffing had improved since colleagues from The County Hospital had moved across.
- Staff who had transferred from The County Hospital as part of the integration of services had boosted the numbers. 39 WTE staff had transferred. Staff told us that they weren't sure how the Royal Stoke coped before integration'.
- The vacancy rate was 4.2 WTE at the time of the inspection and recruitment was in process.
- We saw that there were 35 band 5 midwives who needed support and mentoring into their roles. Staff told us that this caused a 'patchy' skill mix at times. The band 5's rotate through the service every six months as part of their preceptorship programme and we were told that this can also be problematic in terms of skill mix. This implication of an imbalanced skill mix is that it may be difficult to ensure that the right people are in the right place with the right skills at the right time. Junior staff need more supervision than more experienced staff and this puts pressure on coordinators when allocating and planning workload.
- Staff told us that the biggest problem around staffing was the lack of sign off mentors (Sign off mentors are midwives who have had additional training to comply with the NMC standards for mentoring student midwives and can sign to confirm that student midwives are obtaining the competencies needed for safe and effective practice) which impacts on student's training.
- The rotation of midwives to all areas on the maternity unit has made the escalation policy more robust because midwives are confident to work in all areas.
- The midwife-to-birth ratio is currently 1:29 (one midwife to 29 births). Midwives told us that they were able to provide one to one care in labour 'most of the time' but this is not formally audited so is difficult to demonstrate.
- We saw that the Band 7 labour ward coordinator was supernumerary and we were told that in times of increased activity, they may have to look after labouring women. This could impact on the safety of labouring women in as the co-ordinator needs to have an overview of activity at all times in order to manage the ward safely. The role of the labour ward coordinator id to coordinate the activity on the ward. She needs constant oversight of the ward so that decisions can be made regarding care and treatment.
- We saw that Maternity Support Workers (MCAs) were on duty in all areas to provide additional support according to their training and designated responsibilities.
- The ratio of supervisors of midwives (SoMs) to midwives was 1:15 which is the ratio required by the LSA. This meant that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.

Nursing staffing

- We saw that whilst the directorate had responsibility for four advanced nurse practitioners and the team of gynae-oncology nurses, it did not have operational responsibility for nurses who cared for women with gynaecological conditions in the Surgical Assessment Unit or the wards.
- We reviewed the minutes of the AD-HOC-Gynaecology Risk Management Review Meeting held on Tuesday, 9 December 2014. An incident was noted that impacted on the care of a patient because prescribed treatment was not carried out. It was minuted that 'this type of incident is becoming increasingly common due to gynaecology patients not having a specific ward, resulting in the nursing staff not being used to specific gynaecology oncology management post operatively'. The minutes also cited that shortness of staff meant that nurses did not attend the ward rounds and were therefore not aware of changes to care plans. We asked the trust what improvements had been made to services as a result of learning from this incident, this included developing business case for a Women's Hospital, assurance ward rounds, training planned for nurses and clinicians and establishing a gynaecology forum.

Maternity and gynaecology

Medical staffing

- The medical staffing mix was similar to the England average. As at September 2013, the former Royal Stoke University Hospital employed 36 whole time equivalent medical staff in the maternity services. There were no middle grade doctors compared to the England average of 8% for the same period.
- Consultant obstetric cover on the labour ward on average 100 resident hour' per week at the time of the inspection. The consultant staff stayed on the labour ward every evening (Mon – Fri) until 22.00 hours and attended at weekends for 8 hours both days.
- Handovers were carried out four times during each day. We observed the formal 8.30am handover which started late due to the consultant being delayed. Handover included discussion on inpatients and overnight deliveries. A paediatrician was not present but it was noted that the neonatal team needed to be informed of a possible imminent birth of a premature baby.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- At any time two registrars covered gynaecology patients and the labour ward; we were told that delays were experienced for gynaecology patients due to their workload.

Major incident awareness and training

- Staff were aware of the major incident policy and senior staff knew of the business continuity plans.

Are maternity and gynaecology services effective?

Good

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

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

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

Staff were mostly competent in their roles and received performance reviews and supervision. We found that not all midwives were trained in the care of arterial lines which is unsafe when caring for critically ill women. We found that nurses without specific training in gynaecology were caring for women on the general surgical wards.

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

Women were provided with information which helped them to understand their treatment and care before consenting to this.

Evidence-based care and treatment

Maternity

- Policies were based on NICE/Royal College guidelines so the best clinical outcomes were promoted.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to; the organisation, safe staffing levels, staff roles and education, training and professional development. In addition to the facilities and equipment to support the service.
- Staff had access to guidance, policies and procedures via the trust intranet. The guidelines from University Hospital of North Staffordshire NHS Trust had been archived and the guidelines from University Hospitals of North Midlands NHS Trust were adopted when the new trust was formed.
- A guidance co-ordinator was responsible for managing policies and guidelines. We were told that pathways and guidelines were still being developed to ensure consistency across the new trust. We were told that an initial cross trust meeting had been held and more meetings were planned.
- We saw that there was a good process for screening for foetal abnormality. High risk women were invited into the clinic for counselling and on-going treatment. We saw that 25% of women declined screening for Downs

Syndrome and three women declined termination of pregnancy for spina bifida in the past year. This indicated that the counselling offered was appropriate and robust.

- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included for example; having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw that a 'fresh eyes' approach was used to peer review electronic recordings of the baby's heart rate. This involves a second person assessing the baby's heart rate against certain criteria to conform that the baby is coping with labour.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff were supporting women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.
- We saw that the Royal College of Obstetricians and Gynaecologists (RCOG) evidence based guidelines related to feticide: Section 6.7 was being adhered to. This sets out the premise that Feticide should be performed before medical abortion after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.
- We saw an audit of the Modified Early Obstetric Warning System (MEOWS). The aim of the MEOWS is to improve recognition of the seriously ill obstetric patient. The audit recommended that the chart was reviewed and updated and that the updated chart and guideline should be re-launched as part of 'Campaign of the Month' to help improve compliance. We saw the action plan put in place to achieve these recommendations.
- The trust provided us with further audits on handover and swab counting and we saw the same robust approach to audit and the implementation of findings.
- The trust actively participated in national audits such as the National Screening Committee antenatal and newborn screening audit. A team of research midwives coordinated the trust's activities which included participation in national trials.

Gynaecology

- Minor gynaecological surgery was undertaken on the day unit. The expectation was that the patient went home on the day of the procedure. Patients told us they had received good care and they had been informed about their discharge home.
- The Central Treatment Suite had British Society for Colposcopy and Cervical Pathology (BSCCP) accreditation. This means that women are cared for by appropriately trained staff.
- There was evidence from information reviewed and from discussion with staff that the service adhered with The Abortion Act 1967 and Abortion Regulations 1991. This includes the completion of necessary forms; HSA1 and HSA4. We found that the documentation completion of both forms followed a robust process. A record of all HSA4 forms, used to notify the Department of Health, was kept by the nurse in charge.

Pain relief

- Patients we spoke with felt that their pain and analgesia administration had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including Tens machines and Entonox. Epidurals were available 24 hour a day

- Birth pools were available on the MBC and labour ward so women could use water emersion for pain relief in labour.
- We saw that the time from request to insertion of epidural had been audited in response to complaints of women waiting for epidurals. 80% of women received an epidural with half an hour and 90% within one hour. As a result of this audit a resident anaesthetist in charge was located on labour ward.
- A woman on the Surgical Assessment Unit (SAU) told us that she 'had been well looked after, the nurses came regularly to do my obs and see if I wanted and pain killers'.

Nutrition and hydration

- An infant feeding midwife was responsible for the oversight of infant feeding .The trust promoted breastfeeding and the important health benefits now known to exist for both the mother and her baby. Their policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how they will feed their baby.
- The trust had been awarded and maintained UNICEF Baby Friendly Initiative stage 3 accreditation.
- In November 2014 breastfeeding initiation within 48 hours of birth was 54.4% which is worse than the national average of 73.9%.
- In relation for food and drink, women were able to choose from a varied menu, which also met their cultural needs.

Patient outcomes

Maternity

- Information on the maternity dashboard demonstrates that, since integration in January, there was no evidence of risk for maternal and neonatal readmissions. There have been 10 unexpected admissions to NNU.
- The trusts results for the former Royal Stoke University Hospital in the National Neonatal Audit Programme (NNAP) Annual Report, 2013 showed that they were below the NNAP standard on three questions. These were whether babies born under 32 weeks or below 151g at birth were screened for Retinopathy of Prematurity, the proportion of babies born under 33 weeks who were receiving breast milk on discharge form hospital and whether a senior neonatologist had discussed the baby's care and treatment with the parents within 24 hour of birth.
- The maternity dashboard showed that there were 147 births in February 2015 – 63.43% normal, 10.63% operative vaginal delivery and 25.0% caesarean section. Breakdown for elective and emergency caesarean was not provided.
- We were told that the induction of labour rate was 26.7%, slightly higher than the national average of 25%. The trust was aware of this and had carried out an audited. The results were not available at the time of our visit.
- There was access to interventions such as radiology. We saw that the interventional radiology suite was used to perform a complicated caesarean section supported by a full team.
- The substance and alcohol misuse midwife provided care to woman and acted as resource for colleagues. The midwife told us that the 'did not attend' (DNA) rate for the ante natal clinic was 98%. Since the introduction of a one stop clinic where the women saw the obstetrician, midwife and obtained their medication, the DNA rate has fallen to 2%. There had also been a reduction in the numbers of babies admitted to the neonatal intensive care unit. Babies' Apgar scores had improved and their birth weights had increased. (the Apgar score is the assessment of a baby's heart rate, respiratory effort, reflex response to stimuli, muscle tone and colour)
- We noted an increase in the number of babies born before admission (BBA). This had risen from 1 in January 2015 to 11 in February 2015. The hospital was investigating this at the time of our visit.

Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the surgical assessment unit. A team of professional staff supported patients in investigative procedures, giving advice as necessary.
- There was no dedicated gynaecology ward. Women were cared for on a general surgical ward. A team of Advanced Nurse Practitioners visited the wards daily to see women with gynaecological conditions. We spoke to two women who felt they had been well cared for.

Competent staff

Maternity and gynaecology

- The lead midwife for education and development was responsible for mandatory training and other learning within the directorate.
- Mandatory training was provided over three days and covered subject matters including; maternal and neonatal resuscitation, electronic foetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Day one and two were multidisciplinary and included Practical Obstetric Multi-Professional Training (PROMPT), evidence based training package for obstetric emergencies. PROMPT is associated with direct improvements in perinatal outcome and has been proven to improve staff knowledge, clinical skills and team working. We saw evidence of 78% compliance with this training. Day three covered the trust mandatory elements and included the Home Office Female Genital Mutilation e-learning package.
- We were told that the lead midwife education and development had undertaken the Maternal Acute Illness Management (AIM) at another provider. The course was developed following the most recent Confidential Enquiry in to Maternal Death (CMACE, 2011). The report outlined key priorities related to managing acute illness in this patient group which included identifying and managing deteriorating illness. Learning from the course will be implemented in the near future.
- 12 midwives had undertaken a high dependency module at Keele University and 17 midwives had been trained in Newborn and Infant Physical Examination (NIPE).
- We were told that training days are developed in response to Datix reporting. For example, it was noted that there was a problem with documentation relating to antenatal screening and a session was planned for community midwives in July 2015.
- We were told that training needs analysis was carried out twice a year and that they are working on achieving 75% compliance.
- Staff told us that mandatory training was easily accessible but they had concerns about support for undertaking training other than and the mandatory training. They were particularly concerned about completing mentorship programmes and NIPE.
- All newly qualified midwives undertook a 24 month preceptorship package. This was followed by a 12 month consolidation period prior to obtaining Band 6.
- Appraisal rates for midwifery staff were provided for us and these demonstrated that 90.10% (248 out of 272) had been appraised.
- The function of statutory supervision of midwives to ensure that safe and high quality midwifery care is provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- Supervisee ratios were 1:15, which is the ration recommended in the Midwives Rules and Standards (2012).
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- Gynaecology patients were cared for on a surgical ward along with Ear Nose and Throat, burns and plastics and maxillary-facial patients. Staff told us that they had no particular training in the care of gynaecology women and were concerned about their lack of specific skills in this area. They told us they 'had to learn as we go along'.

Multidisciplinary working

- We saw good examples of multi-disciplinary team (MDT) working in the hospital in both the specialised antenatal clinics and on the labour ward. Community staff told us they had support from health visitors, GP's and social services.
- We observed staff and medical handovers where patient care was discussed and discharges planned.
- Communication with community maternity team was efficient. In the community we were told of effective multidisciplinary team work between Health Visitors, GP's and social care. The gynaecology wards and departments ensured patients discharge arrangements were appropriate.

Seven-day services

- There was a consultant on the labour ward Monday to Friday between 08.30 and 22.00. At the weekend, a consultant was present between 08.30 and 17.00. There were always two consultants on call out of hours to cover obstetrics and gynaecology.
- Access to medical support was available seven days a week.

Maternity and gynaecology

- The lead anaesthetic consultant for obstetrics was available during weekdays from 08.00 until 19.30, with on call cover out of hours.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- We found that the notes, IT systems and hospital numbers used by the two hospitals had not been amalgamated which meant that staff did not always have the information they required to treat patients effectively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed six sets of notes and saw that the process for obtaining consent was thorough and robust.
- Staff told us that training on mental capacity and DOLS will soon be available as an e-learning package.
- The trust informed us that they will be adopting the County Hospital policy on the Mental Capacity Act (MCA).

Are maternity and gynaecology services caring?

Good

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

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

Staff respond compassionately when people need help and support them to meet their personal needs and those of their babies. People's privacy and confidentiality is respected.

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

Compassionate care

- Maternity Services were added to the Friends and Family Test (FFT) in October 2013. The November 2014 FFT, which also includes the County Hospital, achieved the following results:

- How likely are you to recommend the antenatal service to friends and family if they needed similar care or treatment? A score of 100% was achieved compared to the national average of 95.5%.
- How likely are you to recommend our labour ward/ birthing unit to friends and family if they needed similar care or treatment? A score of 96.8% was achieved which is the same as the national average.
- How likely are you to recommend our postnatal ward to friends and family if they needed similar care or treatment? A score of 96.1% was achieved compared to the national average of 93%.
- How likely are you to recommend our postnatal community service to friends and family if they needed similar care or treatment? A score of 100% was achieved compared to the national average of 97%.

- The CQC maternity survey of December 2013 surveyed women who gave birth in February 2013. A total of 169 women returned a completed questionnaire, giving a response rate of 43% compared with the national response rate of 46%. It showed that all measures were similar to national average.
- We observed caring and compassionate interactions between staff and patients. We also observed supportive and caring attitudes between the staff.
- A patient on the postnatal ward had suffered a complication and told us that she felt 'overwhelmed by everything' and that the staff had been 'exceptional' in caring for her and her baby.
- Staff went the extra mile and demonstrated determination and creativity to overcome obstacles to care for a woman with complex social needs. .

Understanding and involvement of patients and those close to them

- Patients told us that they felt well informed and able to ask staff if they were not sure about something. One patient who experienced complications told us that she 'had been really well looked after' and was 'appraised of all the risks associated with the procedure. Staff couldn't do enough for you'.

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- Another patient who also experienced complications after the birth of her baby told us 'the anaesthetist has reviewed me every day, explained everything and gave me choice about my treatment options'.

Emotional support

- Patients reported continuous one to one support during in labour. One woman told us that she had a high risk pregnancy and 'was never left on my own during labour – I wouldn't change a thing'. Another woman who experienced complications told us that she 'started to feel really overwhelmed by everything but staff have been exceptional'.
- Women with low risk labours were equally supported. One told us 'All staff who I have met have been lovely. They have introduced themselves. They never left my side during labour'. Another told us that the midwife and student midwife caring for her were 'both fabulous, they never left me in labour. I felt very well supported'.
- Midwives observed women for anxiety and depression levels. They referred as necessary to the mental health team.
- A specialist mental health midwife and obstetrician offered support to women in the Parents Emotional Antenatal Clinic for Health (PEACH). The team had links to the mental health team for on-going support and continuity. This meant that women with mental health conditions were seen in a 'one stop shop' style clinic where their needs were assessed and treatment plans developed.

Are maternity and gynaecology services responsive?

Requires improvement

There was no dedicated gynaecology assessment unit and women were seen on the Surgical Assessment Unit (SAU). Women accessed the SAU via Accident and Emergency or by GP referral. This led to delays in assessment and treatment. Staff on SAU told us that problems with flow were 'a daily occurrence'. There was no dedicated ward for gynaecology patients.

Restricted visiting hours on the maternity unit caused distress for some women and there were no facilities for partners to stay overnight except on the midwifery birth centre.

The maternity and gynaecology services were recently integrated with County Hospital and processes were on going to reconfigure parts of the gynaecology service and the maternity assessment unit in order to improve access and flow.

The maternity service is flexible and provides choice and continuity of care. People's individual needs and preferences were considered when planning and delivering maternity services. There were arrangements in place to support people with particular needs. Translation services could be arranged as required.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly
- A range of information leaflets were seen to be available across the service a leaflet, 'Developing services for mothers to be in Staffordshire', was available on the trust website. This comprehensive leaflet outlines the services offered and explains the options available for birth.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and where necessary doctors. The Red Book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- The chair of the Maternity Services Liaison Committee (MSLC) spoke with us during our inspection. The MSLC had been involved in some changes to service delivery.
- We were told that women were involved in the planning of the Central Treatment Suite. This unit treats women for colposcopy, hysteroscopy and urodynamic and men for erectile dysfunction and prostate care. 100 patients were asked what they would like to see in the waiting room.
- Plans for a women's hospital were in their infancy and we were told than an external management review had been undertaken which recommended that 11 beds were needed to cover gynaecology inpatient activity.
- We were told that a coordinated approach to the gynaecology service was in the process of development since integration of services with County Hospital.

Maternity and gynaecology

Access and flow

Maternity

- The hospital reported that the maternity unit had no closures between July 2013 and December 2014.
- We were told about and saw written documentation which confirmed women were supported to make a choice as to the place to give birth. This decision was made at 34 weeks and information was provided to assist in making their choice. We saw that there were specific risk factors, which needed to be considered and would lead midwives to advice of a hospital birth, rather than home or a midwifery-led unit.
- We were told that the recent integration with the County Hospital had impacted on access and flow. Staff told us 'The increased workload has impacted more than we anticipated'.
- A Maternity Assessment Unit (MAU) provided care to women with concerns such as such as reduced foetal movements and also triaged women referred by community midwives or those who self-referred. Additionally the unit contained a bay for women who were having their labours induced. This unit had up to 70 attendances per day and this had increased since the integration with County Hospital in November 2015. We were told that there is only four hours dedicated medical cover per day and that this impacts on access and flow.
- The MAU was run by three midwives in the daytime one of whom cared for women having their labours induced and two midwives in the evening. Staff told us that the MAU was very busy, that staffing is an issue and that no extra staff were allocated to MAU following the integration with the County Hospital. This has an impact on waiting times and we were told that women may wait a long time before being seen. Staff told us that if women wait longer than two hours, they report it as an incident and call a consultant for support.
- We met the newly appointed manager for the MAU who described the planned changes which involves developing a triage service. A MAU had also opened at County Hospital that will ease the pressure on the unit.
- We saw that some contingency was in place to help with flow through the service. For example, there was a midwife prescriber on the postnatal wards which meant that women did not need to wait for a doctor to proscribe medication.
- We saw that 6 extra beds had been opened on one of the postnatal wards to accommodate the extra numbers of women using the service. An extra six midwives and two maternity support workers had transferred from the County Hospital.
- Midwives were competent in examination of the newborn which enabled efficient discharge of low risk babies. However women and babies with high risk needs had to be seen by a doctor which could result in them not being discharged in a timely manner.
- Bed occupancy for maternity for at the former Royal Stoke University Hospital during July, August and September in 2014 was 80% compared to the England average of 59.9%. This indicated that women were having longer stays in hospital in comparison to the other trusts.
- We were told that there are times when induction of labour is delayed due to activity. Staff said this was sometimes difficult to prioritise because the reason for induction was not always clear. The indication for induction was written in the hand held notes that were with the patients. This resulted in the coordinator telephoning women to clarify the reason for induction in order to ensure women with higher risk factors had their labours induced in a timely manner. Women waiting for induction of labour were invited into MAU to monitor the baby.
- We were told that car parking is an issue for women. Staff told us of incidents where women had not attended for antenatal appointments even though they arrived at the hospital because of the frustration at the inability to find a parking space. They also reported that women who were advised to attend MAU because of reduced foetal movements declined because of car parking problems.
- The Early Pregnancy Assessment Unit (EPAU) was open from 08.00 until 18.00 weekdays and 08.00 – 13.30 on Saturdays. It was staffed by a nursing assistant and two nurse sonographers who normally saw patients within 24 hours. Referrals were accepted from midwives, GPs, nurse practitioners and A&E.

Gynaecology

- Women were seen on the Surgical Assessment Unit (SAU) and accessed it via the emergency department (ED)or by GP referral.

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- We met one woman who had attended ED at 17.00 and spent until 12 noon the following day on a trolley waiting for a bed on the SAU. Another patient had been referred by her GP and had been waiting on SAU for four and half hours to see a doctor. .
- We saw that there was no dedicated gynaecological ward. Women were cared for on Ward 101, a surgical ward. There was capacity for six to nine gynaecology patients but the management team told us that at least 11 beds were needed. We saw that women could not be cohorted together and were spread across the ward. Patients with urogynaecology were cared for in the Central Treatment Suite.
- Women with suspected gynaecological cancers were cared for by a team of specialist doctors (Gynaecology Oncologists) supported by a specialist team of nurses who followed women through their treatment journey.
- There were four Advanced Nurse Practitioners who saw women with gynaecological problems, including those with urogynaecology conditions.
- The SHO and registrar on call for gynaecology out of hours were also on call for the MAU and labour ward which meant that response times were sometimes delayed.

Meeting people's individual needs

- Women with complex requests or needs were said to be discussed with the supervisor of midwife and a plan was then developed. We saw evidence of detailed recordings where a woman had made specific requests around the birth of their baby, which were outside of normal expectations that midwives would have.
- The hospital ran a number of specialist clinics to support women with complex needs through their pregnancy. These included A perineal clinic, PEACH, foetal medicine and combined obstetric and neurology clinics.
- A number of midwives had chosen to specialise in a specific area of practice. Many of the midwives worked with specialists to provide a link between community maternity services. Having undertaken additional training they gave additional advice and support to midwives and parents in areas such as female genital mutilation (FGM) diabetes, substance and alcohol misuse, antenatal and newborn screening, mental health, bereavement support, infant feeding and child protection.
- We saw evidence of specialised epilepsy, diabetic and mental health clinics in the antenatal clinic at the Royal Stoke site.
- The specialist substance misuse midwife told us that a one stop clinic had been developed with combined health. This meant that women could obtain the script for their medicines and then see the consultant and specialised midwife for their antenatal care. The rate of women who did not attend for antenatal care had reduced from 98% to 20%. We were told that the outcomes for women who attended the clinic had improved year on year. There were reduced numbers of babies admitted to the NNU and birth weights were higher.
- There were no facilities for partners to stay on the postnatal wards. Despite the MSLC enquiring about this, the hospital declined to allow partners to stay overnight because of security reasons. Staff expressed concern that this was inequitable because partners could not stay with high risk women on the postnatal wards who needed more assistance in the first few hours after birth, for example women who had a caesarean section.
- We saw that partners could stay overnight on the Midwife Birth Centre and the maternity unit is equipped with reclining chairs to facilitate this, there were also beds in the side rooms of the maternity unit for partners on request.
- The trust told us that following a consultation with mothers, the visiting hours have been restricted from 9am – 9pm for visitors other than partners and children. However, these restrictions were not flexible enough to take into account individual needs. For example, we saw a complaint from a woman who had been at the hospital for 27 hours to support her daughter in labour. She was asked to wait on the postnatal ward whilst the baby was born by caesarean section. When her daughter arrived on the ward, the woman was told that she could not see the baby as it was not visiting time
- Women had a choice regarding the management of the termination of a pregnancy. For example when there was a miscarriage women could choose medical or surgical termination or await the natural expulsion. For ectopic pregnancies the choice was either medical or surgical. Information leaflet was available to help women in making their choice in addition to discussion with staff.
- We saw that there was a translation service both face to face or via telephone.

- The Midwifery Birth Centre promoted a 'home from home' experience, where partners could stay overnight, for low risk women who wished to have the comforts of a home birth with the added reassurance of being in a hospital. They offered a birthing pool, home furnishings and specialist equipment such as beans bags, mattresses and birthing balls to promote the comfort of women in labour.
- Privacy and dignity was protected by the use of privacy screens. Women with gynaecological conditions were examined in a room with a lockable door in the Surgical Assessment Unit.
- We found that woman who had experienced still birth were cared for in a suite that had its own entrance and sitting room so they and their partners could remain private and avoid areas where women had just given birth.
- There were arrangements in place that recognised women and babies with additional care needs and for referring them to specialist services. For example, there was an on-site Neonatal Unit (NNU). We were told about and were shown the ward that would become the transitional care ward for babies that needed close observation but did not need admission to the NNU.
- Supervisors of midwives (SoMs) were available to help midwives provide safe care the mother, baby and her family. SoMs are experienced midwives, with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met the mother's needs.
- We were told of an example of how SoMs worked with a quadriplegic woman to plan her birth. The woman felt comfortable in water as it helped her mobility. A birth plan was developed in partnership with the woman to enable her to use the birth pool.
- The hospital offered a bereavement service for parents and a dedicated self-contained suite with two individual rooms was available. This provided excellent facilities for parents and meant that they did not have to access the suite through areas where women had babies with them.

Learning from complaints and concerns

- We saw an information leaflet for patients informing them of how to raise concerns of make complaints. The leaflet entitled 'Compliments Concerns Complaints' had a rear of section that could be used to put in the Patient Advice and Liaison Service box in the unit.
- Complaints were managed by a centralised team who investigate the complaint, including asking staff to review the letter of complaint. The team then prepare a response letter that was reviewed by the divisional manager for factual accuracy.
- There were 57 formal complaints made regarding the former trust between November 2013 and October 2014.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecology services were one of the first services to be integrated and were managed by the Obstetrics and Gynaecology Directorate of the Women's and Children's and Clinical Support Services Division. Integration took place on January 19 2015. Following consultation staff were relocated to the Royal Stoke Hospital or to the Royal Wolverhampton University NHS Trust. We recognised that this is very much a service in transition.

The management team told us that 'staff who came to work here have settled really well and have contributed ideas'. Staff told us 'All people are pulling together to make it work'. They told us that they were proud to work here and managers are supportive of them.

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

The governance arrangements facilitated discussion and review of quality and safety matters, with dissemination of learning. There was oversight of quality and safety at the Trust Board.

Vision and strategy for this service

- We were told the Maternity Strategy is in line with the Trust Strategy. The Directorate wanted to develop services to meet people's needs. They told us of a plan to develop a woman's unit that will bring maternity and

gynaecology services together. This would include seeking gynaecological oncology accreditation along with other sub specialities. These plans were still in their infancy

Governance and risk management

- We saw that robust clinical governance and risk management arrangements were in place.
- We saw evidence that separate obstetric risk management meetings and gynaecology risk management meetings were held weekly and that new incidents were reviewed. These meetings were attended by clinical risk managers, obstetric and gynaecology consultant leads for risk and clinical nurse and midwifery managers.
- Perinatal case reviews were held to review intrauterine deaths, stillbirths and neonatal deaths. These meetings were attended by paediatricians as well as obstetric and midwifery staff to provide a full and robust review and make recommendations.
- All incident reporting forms were reviewed by the Head of Midwifery, the Deputy Head of Midwifery, clinical matrons and ward managers. Staff told us they recieved feedback if they had completed an incident reportng form.
- We saw evidence of a robust approach to investigations. Root Cause Analysis was undertaken in line with the NPSA format. Blind copies of each case for review was distributed prior to a round table review and then approved at the Direcotrate Performance & Clinical Governance meetings. A Divisional Clinical Governance review was then undertaken and escalation to the Trust Quality and Safery and Governance Forum was made if approproate. We were trold that parent were involved in all reviews because of the duty of candour.
- Staff told us that they recieved feedback in various ways. Specific issues were taken up with the individual. A Quality and Risk newsletter was available electornically and in hardcopy.
- We asked what was on the Risk Register and were reassured that the integration with County Hospital and the lack of a designated gynaecological ward were actively being reviewed on a monthly basis at risk.
- There was a labour ward forum although there was no lay representation on it

Leadership of service

- We were told that the senior management team felt confident that the integration with County Hospital had been managed effectively. Following consultation, integration champions were established amongst the staff to support colleagues through the changes. Staff spoke positively about how the integration with County Hospital was managed.
- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership at ward level. For example, on ward manager told us that she found it difficult to hold ward meetings so she implemented a daily 'huddle'. This followed morning hand over and lasted ten minutes. The manager was able to communicate issues such as feedback from incidents that had been submitted, updated policies or guidelines and general ward business.
- Staff told us that the Head of Midwifery was very visible and came to the wards. She knew everyone by name. We were told the Head of Midwifery had access to the trust board.
- Staff said they had access to senior managers whose offices were based on the unit. We saw an 'open door' policy in operation.
- Staff told us that members of the trust board are not visible.
- The executive team expressed concern that they had no operational responsibility and for the wards in which women with gynaecological conditions were cared for. This meant they did not have day to day oversight of issues that affect patient care such as staffing. They considered that the lack of a designated gynaecology admissions unit and ward was a risk because patients were cared for by staff that did not have the necessary skills and experience to nurse gynaecological patients.

Culture within the service

- The Trust promoted a positive safety culture and encouraged incident reporting.
- Staff were supported to meet with parents who had suffered pregnancy loss in response to requirements of duty of candour.
- Staff told us that they felt valued and enjoyed working at the hospital. A doctor told us that the relationship with between the medical staff and midwives is 'very good' and that they 'rely on and trusts the shift leaders'. Junior

doctors told us they were 'never afraid to ask senior for advice, they are always around'. A maternity support worker said she 'feels appreciated by midwives and loves her job'.

- We were told that two to three medical students a year expressed a desire to train as obstetricians after their experience at the hospital. One medical student told us 'its brilliant here'. Student midwives also chose to work at the hospital following qualification. This demonstrated a positive culture towards people and towards the hospital's approach to maternity services.
- From our observations and discussion with staff there was a strong commitment to meeting the needs of and experiences of people using the service. In particular midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery.

Public and staff engagement

- Staff that transferred into the service were provided with three days orientation and selected a 'buddy' to support them. Staff told us they 'felt really supported and informed about integration'.
- Staff who transferred from County Hospital told us that they felt welcomed and happy in their work. One ward manager told us 'I am very proud of the new staff that have joined, they are excellent midwives which has made it easier for them to settle, they have come with an open mind'.
- There was an active Maternity Services Liaison Committee that active met quarterly The MSLC reviews patient information leaflets. Chair We met and spoke with the chairperson who felt that the trust asked for the MSLC's for opinion and on the whole did listen to their views and recommendations.
- The MSLC and staff agreed that women were not as well informed about changes as they could have been. However, the changes did not directly affect people locally.

Innovation, improvement and sustainability

- The integration with County Hospital enabled a review of how the trust provided maternity and gynaecology services. There are plans in place to offer enhanced services but at the time of our visit, these were 'plans in progress'.
- A specialist one stop clinic had been developed for women with substance misuse issues where they could obtain the script for their medicines and then see the consultant and specialised midwife for their antenatal care. The rate of women who did not attend for antenatal care had reduced from 98% to 20%. We were told that the outcomes for women who attended the clinic had improved year on year.
- The trust has maintained Baby Friendly Initiative accreditation at level three consistently.

Services for children and young people

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

Information about the service

Services of children and young people are provided at the Cheethams children's center, which is based inside The Royal Stoke University Hospital main building. The centre offers a wide range of diagnosis, treatment and support facilities for children and their parents.

The services offered across the centre included:-ward 216, a 26 bedded ward providing care for mainly medical, complex need and high dependency patients, ward 217, a 25 bedded ward providing care for mainly surgical and oncology patients, an oncology day care unit, a surgical day care unit, an outpatient department, a 23 cot Neonatal Intensive Care Unit (NICU), ward 215, an 8 bedded Children's Intensive Care Unit (CICU), a 9 bedded Children's Assessment Unit (CAU) and a children's emergency department (the children's emergency department was inspected as part of our review of urgent and emergency services).

The neighbouring hospital, The County, will no longer provide any inpatient children's services as a recommendation by the Trust Special Administrators commencing in May 2015. Inpatients from The County Hospital will be cared for by the Cheethams children's centre at The Royal Stoke University Hospital and The Royal Wolverhampton Trust. The Royal Stoke University Hospital Cheethams children's centre plans to add another children's ward in May to accommodate this move. Cheethams children's centre will initially open eight beds in May but will have the capacity to open 30 beds dependant on the impact of the closure of The County Hospital children's ward.

We inspected the service by interviewing staff, reviewing records and undertook observation over three days. We received comments from patients who contacted us to tell us about their experiences and we reviewed performance information about the trust. We reviewed data submitted by the trust which had been collected prior to the hospital joining the University Hospital North Midlands. More up to date data was not available however it still provided invaluable intelligence of the trusts quality measurements.

During our inspection we visited Cheethams children's centre and spoke with 34 nurses, 7 doctors and 13 supporting staff including allied health professionals and managers of the service. We spoke with 44 parents and children currently using the service. We reviewed 20 patient care records across a selection of wards and units.

Services for children and young people

Summary of findings

There were effective procedures to support children and young people to have safe care. There was an open culture of reporting incidents. Ward areas and equipment were clean. Medicines were appropriately managed. There was enough trained staff on duty to ensure that safe care was delivered. Although, not enough staff were trained in providing advanced paediatric life support and the hospital had identified this on their risk register.

The parents commented that the facilities were very good and that there was plenty to occupy children. Although we found staff required more space in the oncology day-case unit to provide care to children who were receiving care lying down and better facilities such as, dedicated patient toilets.

Children and their families were treated with compassion, kindness, dignity and respect. Staff involved children and their families in decisions about their care and treatment. We found extensive evidence that staff emotionally supported children and their parents. Many aspects of the service were responsive to the needs of children and young people.

Are services for children and young people safe?

Good

There was an open culture of reporting incidents and learning was discussed and cascaded. There were effective procedures to support children and young people to receive safe care. Ward areas and equipment were clean.

Medicines were appropriately managed. There was enough trained staff on duty to ensure that safe care was delivered. Safeguarding procedures were understood and followed. A Paediatric Early Warning Score (PEWS) system was used to enable the early detection of any deterioration in a child's condition.

We found good infection control practice although, oncology day care unit staff were concerned that patients with a weakened immune system only had public toilets available to them during treatment. This meant they were at an increased risk of being exposed to harmful bacteria. However this was identified on the directorate risk register and there were plans in place to reconfigure the unit to ensure they had their own patient toilets.

Incidents

- Staff reported incidents via electronic information systems, managers were clear about their responsibilities for reviewing and escalating incidents.
- Reports provided by the hospital showed that a total of 142 patient safety incidents had been reported between October 2014 and January 2015. All had been reviewed by managers and action had been taken in order to reduce harm to the patient and details of lessons learnt.
- Staff told us they received feedback, learning was disseminated through e-mails and ward meetings.
- Practice changed and improved as a result of monitoring trends of incidents. One example we saw was incidents been reported around the lack of completion of the patient surgical safety checklists. The matron completed a weekly audit ensuring all checklists were completed. Staff were now 100% compliant in filling in every aspect of the checklist.
- We noted that root cause analysis was carried out when a serious incident took place.

- There had been no 'Never Events' reported and two serious untoward incidents reported one in relation to a healthcare acquired infection and one medication incident between Jan 2014 – Dec 2014.
- Quality nurses, who supported ward managers in auditing the quality of care on the wards, did not report incidents identified whilst auditing. We found evidence of signature omissions on medication charts which the quality nurse identified. The quality nurses informed the other responsible nurse of the error and would escalate patterns to the ward manager. Although these were not formally reported on electronic information systems the ward manager would discuss these patterns during ward meeting and lessons were learnt.
- The hospital monitored monthly harms on all wards as per national guidance, we saw from the results there had been no pressure ulcers, falls or infections from urinary catheters from February 2014-January 2015.
- Paediatrics Mortality Data submitted by the trust revealed that mortality rates were within expected ranges based on the case mix and activity.
- Staff told us that duty of candour was upheld by their managers and that they had an open transparent way of reporting incidents. Junior staff told us they would feel confident in reporting incidents and that the managers were always supportive. Senior staff were passionate about learning from incidents and were able to explain the importance of duty of candour to us.

Cleanliness, infection control and hygiene

- All the areas we visited were clean, we observed housekeeping staff cleaning on the wards and in the departments throughout our visit. We spoke with 44 parents and children who all thought the area was clean except for two people. One parent told us that their child's room had not been cleaned in four days. The parent had been supported in making a complaint to Patient Advice Liaison services (PALs). All other rooms on the ward had been cleaned.
- Hand washing facilities and hand sanitising gel were readily available and we observed staff adhering to the trust's policy regarding 'bare below the elbows' policy.
- The importance of visitors cleaning their hands was well publicised and we observed parents and other visitors using hand gel and washing their hands.
- Monthly infection control audits and hand hygiene audits were undertaken; in the sample that we reviewed the areas were fully compliant. Staff told us that if they were not compliant that an improvement plan would be put in place.
- The Children's Assessment Unit (CAU) did not have any cubicles for infectious patients, staff told us infectious patients would have to be cared for in a treatment room or if a cubicle elsewhere on a paediatric ward was available. Action was being taken in order to have two cubicles made. It was also identified on the risk register.
- We observed good infection control practice on the Children's Intensive Care Unit (CICU) and Neonatal Intensive Care Unit (NICU) staff adhered to protocols to reduce the risk of cross contamination.
- Oncology day care unit staff were concerned that patients with a weakened immune system only had access to public toilets during their treatment. This meant they were at an increased risk of being exposed to harmful bacteria. This was also identified on the risk register and there were plans in place to reconfigure the unit to ensure they had their own patient toilets.
- We were told the hospital had two episodes of methicillin-resistant staphylococcus aureus (MRSA) apportioned by the hospital and four episodes Clostridium difficile (C.Diff) not apportioned by the hospital between the period of October 2014 to March 2015.
- Cleaning checklists were in place, and we noted that these were well completed. Staff told us toys were cleaned by domestic staff twice daily.
- Personal protective equipment, such as gloves and aprons, were available for use by staff in clinical areas, we observed this equipment being used appropriately.
- Swabs were taken of the babies for MRSA before they entered into NICU with other babies. They would be kept in a separate room until the swabs had been confirmed as negative. This prevented the spread of bacteria and infection.
- We saw escalation plans for hospital acquired infections such as MRSA, C.Diff and norovirus.

Environment and equipment

- Entrances to all children's areas were secure, with access by a swipe card for staff, or entry granted by a member of staff via an intercom system. Although two of

the children's' wards needed to improve their safety access arrangements at one point of access, the staff had already raised this as an area of concern and added this to the risk register for action.
- Surveillance cameras were in operation throughout all the corridors of the Cheethams children's center.
- Age appropriate resuscitation equipment was available and there was evidence it was checked regularly. In some areas staff ticked the checklist as oppose to signing it making it unclear who the accountable individual was.
- Equipment in the children's centre was clean and green stickers were used to indicate what was clean.
- NICU and CICU had the dedicated support of a technician during office hours. Staff told us technicians would check all ventilators between patients.
- Other equipment, such as monitors and electrical equipment had been checked in line with their testing requirements. We noted that labels were in place to confirm the last check date.

Medicines

- Medicines were all stored securely, including the safe storage of controlled drugs. Administration of medicines was observed and found to be of a satisfactory standard. The staff we spoke with were able to demonstrate a good knowledge of systems for reporting of errors, adverse events and how the learning would be shared in relation to medication.
- During our inspection we reviewed medicine charts at random throughout all wards and units and found them to be well completed. Although, we found staff on CICU were not always ensuring two nurses signed to say they had checked intravenous fluids and medication, as per the policy. We found several omissions during our random check where two signatures were required. The quality nurse had also pointed this out for the attention of the staff.
- The parents and patient's we spoke with told us that they were well informed about their medicines, and any changes to medicines were well explained.
- We saw gaps in monitoring of fridge temperature on ward 217 and highlighted this to staff. The pharmacy team were aware of this and told us they sent out regular reminders to staff via 'Prescriber's newsletter'. Staff confirmed that they received and read these newsletters.

Records

- Records were kept confidential on the wards as per trust policy.
- Records across children and young people's services were found to be accurate and legible. We reviewed 20 case notes and care plans from a selection of wards and units, food and fluid balance sheets were often partially completed and discharge plans were not always clear for those who had been in some time. Risk assessments and observational charts were consistently completed.
- Quality nurses supported ward managers in auditing patient records they would ensure medication charts were completed, vital patient details were completed and ensure risk assessments were completed, although, they did not judge the quality of the daily notes made by nurses.
- We found daily nursing notes to be comprehensive and of a good quality.

Safeguarding

- The trust works in partnership with the local children safeguarding boards, they produce an annual report. The hospital has been involved in a number of case file audits conducted and lead by Stoke-on-Trent children safeguarding board. There had been no significant issues raised relevant to the trust over 2013-2014. The trust safeguarding steering group and trust child protection working group each met four times a year to promote and safeguard the welfare and interests of all children of Staffordshire. The board co-hosted a conference on 25th March 2014 focusing on neglect, including neglect of teenagers and sexual exploitation. The conference was attended by members of the child protection department and a representative from the emergency department.
- Safeguarding policies and procedures were in place. Staff understood their safeguarding responsibilities and knew what to do if they had concerns, 93% had completed level 1 child protection awareness training. We found evidence that staff were confident in having sensitive discussions around safeguarding issues with parents and escalating issues.
- We asked the trust to tell us how many staff had undertaken additional child protection safeguarding training. Data provided showed that across the

children's directorate 51% of all staff have completed this training. The trust have not identified which staff required this training so we cannot assess whether this is compliant with trust targets.

- The trust employed children's safeguarding liaison nurses who worked with wards and departments, raising awareness and offering support, advice and resources where necessary. The liaison nurse also managed complex cases and worked between other health and social care organisations. She also attended the doctors' handover in order to review cases coming into hospital to ensure any risks or potential concerns were not overlooked.

Mandatory training

- From data submitted by the trust we saw the percentage of paediatric staff that had completed their mandatory training such as : a local induction, a corporate induction, 26% completed conflict resolution, 71% completed equality and diversity, 46% in hospital resuscitation, 62% blood transfusion, 84% information governance, 75% fire, 74% health and safety (including manual handling theory), 75% infection control (clinical), 83% infection control (non-clinical), 93% child protection awareness and 91% had completed vulnerable adults awareness training.
- Staff confirmed this and told us they had completed their mandatory training. Managers were aware of those staff that were due to be updated.

Assessing and responding to patient risk

- A Paediatric Early Warning Score (PEWS) system was in place on the children's ward, based on the NHS institute for innovation and improvement PEWS system. This tool supported early identification of children at risk of deterioration.
- PEWS assessments had been completed in the 20 care records we reviewed.
- Staff were able to explain the process of reviewing the scores, and what to do when there were changes in the score, which indicated that a child's health was deteriorating.
- We observed care in NICU and saw staff were able to respond rapidly and calmly to deteriorating patients.
- Nurses developed their own comprehensive risk assessment tool for children based on recent research in order to improve the checking of children's skin. We noted this was last reviewed in December 2014. Risk assessments were consistently completed.
- Medical staff told us junior nursing staff were confident in contacting them if they were concerned regarding a patients care. Junior medical staff also told us they were confident in contacting consultants and felt as though they were supportive. NICU and CICU nursing staff told us there was medical staff available anytime of the day and night.
- Parents stated that they felt their children were safe.

Nursing staffing

- Staffing levels were adequate, as was the required skill mix on the day of our inspection. Staffing levels conformed to the Royal College of Nursing (RCN) guidance. We were told staff had recently resigned from oncology and ward 217 and they had struggled to maintain optimum staffing levels. Although ward 217 and the oncology unit had several vacancies, staff told us this had been an issue and had not compromised the safety of the patients. Staff form these two areas told us it they did always get time to sit with the children and talk. They told us play specialists were supportive and that they would assist in spending time with the children. These issues were on the risk register.
- We were told by the management team that they had recently recruited 19 newly qualified nurses and had planned to review the skill mix on all wards to ensure there was a balance of new and experienced staff.
- Planned and actual nursing staffing levels were clearly displayed on status boards on the wards.
- Agency staff was only utilised on ward 217 during their recent episode of vacancies. The agency nurse worked 36 hours a week. The ward utilised bank staff who were familiar with the ward and patients. The ward manager told us that they did not have any issues with the use of agency and bank staff and felt they were knowledgeable.
- Staff on the oncology day care unit told us it was difficult to support the oncology staff on the ward because the areas were not near enough to be able to work efficiently. Staff told us this would improve once the unit was reconfigured and they were nearer to the inpatients.

Services for children and young people

- Nurses told us they felt confident to raise issues around staffing levels to their manager should they need to. We saw managers had completed incident forms for the previous days they were short staffed.
- Where there were shortfalls in staff due to sickness or annual leave, staff across the ward areas would be flexible and cover shifts. The ward manager told us there were no issues with high levels of sickness in any of the areas nor work related sickness.
- During the interview with the management team they told us their areas for concern were ensuring skill mix and staffing levels are adequate, they described how they have addressed these issues and told us they would continue to reassess and monitor.
- Regular handover meetings took place so that up-to-date information about each individual patient could be shared.

Medical staffing

- The medical staffing skill mix figures were that of the England average, 51% were registrars, the same as the England average, junior doctors was 8%, compared with the England average of 7% and 36% consultants in comparison to the England average of 34%. There were 36 paediatric consultants in post. The medical staff that we spoke with confirmed they were fully staffed.
- There were two handover sessions per day for the medical teams. We confirmed that the consultant was present at both handovers.
- We observed an afternoon medical handover that incorporated senior nurses and the safeguarding lead nurse which aimed to ensure a multi-professional overview of the patient's needs. Discussions ranged from: safeguarding concerns; care planning, estimated discharge dates and any outstanding tasks were appointed. We observed that the medical handover was very professional and detailed.
- The General Medical Council (GMC) National Training Scheme Survey 2014 is a way in which the council ensures medical education and training is meeting the standards they set to support high quality medical care and patient safety across the UK. The results showed all were in line with the expected standard except that feedback from senior doctors was worse than expected. Although when speaking with junior medical staff they told us they felt well supported by consultants and had regular feedback.
- Locum use was infrequent as the medical staffing levels had reviewed and as a result had been increased to ensure adequate coverage of shifts.

Major incident awareness and training

- Staff were aware of the major incident and the business continuity policy, and understood their roles and responsibilities within a major incident.

Are services for children and young people effective?

Good

National Institute for Health and Care Excellence (NICE) guidance was being used and practice against these guidelines was being monitored and reviewed. Multidisciplinary working was evident across the care group.

The parents commented that the facilities were very good and that there was plenty to occupy children.

We received mixed feedback about the food available to children, although we saw they did have 'child friendly menus'. Nurses told menus were going to be reviewed at the 'nutritional meeting'. Breastfeeding mothers told us they were always offered food by staff.

Ward managers told us they wanted to improve additional training for their staff. They had recently appointed a nurse educator. Appraisal rates for nurses varied but on the whole these needed to be improved. Nurses did not receive clinical supervision.

Evidence-based care and treatment

- Children were treated according to national guidance, including guidance from the National Institute for Health and Care Excellence (NICE), UNICEF and the Royal College of Paediatrics and Child Health (RCPCH).
- Appropriate care pathways were in use and were in keeping with the relevant NICE clinical or nursing guidance.
- Policies, procedures and guidelines were available to all staff via the trust intranet and hard copies were available on the ward. Staff we spoke with knew how to access them when necessary.

- Where national policies did not exist we saw medical staff had developed their own in order to support staff. Medical staff on Children's Intensive Care Unit (CICU) showed us how they developed checklists and guidelines for nurses in order to reduce incidents and ensure continuity. We noted consultants would review these and sign them on an annual basis to ensure they were correct and up to date.
- There was a planned approach to monitoring compliance with the NICE guidance. Compliance with the NICE guidance was reviewed centrally therefore none of the staff we spoke with were able to tell us if there were any issues with compliance. We requested evidence from the trust of their NICE compliance percentage but did not receive this.

Pain relief

- Pain was assessed and managed appropriately. Nursing staff developed a 'comfort round' tool to ensure the regular assessment of the children's' comfort. We reviewed comfort round assessments and saw they were completed as required.
- Nurses were knowledgeable about recent research and using evidenced based assessments to monitor pain. They explained tools they had used in the past previous to the comfort round tool. They were knowledgeable about monitoring certain behavioural signs and non-verbal signals to identify pain.
- The play specialist team were available in each ward and department, and provided valuable distraction therapy for children undergoing different procedures.

Nutrition and hydration

- We received mixed feedback about the food available to children. We saw they had 'child friendly menus'. When asking staff about the food they had also told us some children like it and some don't. Nurses told us this was going to be raised at the 'nutritional meeting'.
- We saw the results of the food survey conducted on ward 216, it did not review the quality and satisfaction of the food but if families were offered menus, alternatives, enough drinks and snacks throughout the day. We noted actions were to offer more snacks and to replenish water jugs more frequently.
- Children and young people were able to choose what they wanted to eat from a menu. The menu was handed out the day before for children and their families to view.
- There was support from paediatric dieticians, who were available for specialist advice and support, with special diets and feeds. The staff were also aware of how to order specialist menu choices, such as halal food or gluten-free meals.
- Breastfeeding mothers told us they were always offered food by staff. There were fridges available for parents to keep a stock of food.
- The records we reviewed during our inspection showed that any fluid or dietary intake was monitored and recorded where necessary for patients.

Patient outcomes

- Readmission rates were in line with England averages, though slightly worse than the average for children below age one year old following emergency admissions. Rates were slightly worse for 1-17s year olds in paediatric medical oncology and paediatric clinical haematology.
- Readmission rates for children and young people with asthma, epilepsy and diabetes were better than the England average for July 2013 to June 2014. However, for epilepsy the readmission rate was slightly worse than the England average.
- The service took part in all the national clinical audits that they were eligible for. The trust took part in the National Paediatric Diabetes Audit (NPDA), published in 2013. The audit showed that the trust was in line with the England average of children with a glycated haemoglobin (HbA1c), indicating that diabetes was appropriately managed.
- CICU contributed to the Paediatric Intensive Care Audit Network (PICANet). PICANet data has been used to plan services, model demand and to assess interventions and outcomes.
- The children's services also contributed to Epilepsy12 the United Kingdom collaborative clinical audit of health care for children and young people with suspected epileptic seizures.

Competent staff

- Medical staff told us they thought their clinical supervision and educational days were excellent. They felt that the consultants were very supportive in their learning and their induction was very comprehensive.
- Nurses all told us they did not receive clinical supervision; we raised this with the matron who agreed this was an area in which they needed to improve.

- Appraisal rates for CICU were 34%, 89% for ward 216 and 43% for 217. Ward managers recognised they needed to improve these figures.
- We saw that staff had the right qualifications and had access to further development. For example, the hospital employed advanced nurse practitioners who were highly skilled members of staff, making a positive contribution. They worked with and were supported by junior medical staff.
- We were told most band six senior nursing staff had completed specialist courses in the specialities in which they worked.
- Ward managers told us they wanted to improve additional training for their staff. They had recently appointed a nurse educator. When speaking to the nurse her aim was to review all skills and gaps in knowledge and was passionate about a developmental plan for the nurses.
- Staff working in specialist areas such as oncology, CICU and Neonatal Intensive Care Unit (NICU) had an induction into the area and close supervision shadowing before being able to care for patients autonomously. They completed a competency work books with the support of their mentor. Staff told us all areas were very supportive and had good team working.
- When asking nurses about additional training some told us they had recently completed asthma awareness, mentorship and advanced paediatric life support. Physiotherapist had trained nurses in providing chest physiotherapy out of hours. A parent corroborated this and told us the nurses were skilled in providing chest physiotherapy. All parents told us staff were knowledgeable and competent.
- Play specialist had completed therapy courses. The hospital teacher previously held a leadership role and discussed her competency around teaching a range of ages.
- Nurses told us they could rotate between the wards which they felt was great in developing their skills in different clinical areas.
- NICU staff reported that they regularly took part in simulation sessions. The sessions were simulations of potential paediatric emergencies, and allowed staff to utilise their skills and learn from any failings.
- Managers recognised that they did not have enough staff that had completed advanced paediatric life support training and this was on the risk register. We noted on most wards only four staff had completed their training however three more staff from each of the ward had been booked onto the training.

Multidisciplinary working

- We observed multidisciplinary handovers which aimed to ensure that all staff had up-to-date information about the needs of children within the service.
- There was strong evidence of multidisciplinary team working in all departments. We also saw evidence of external engagement with other agencies such as social services.
- CICU worked closely with the 'KIDS' (Kids Intensive Care and Decision Service) initiative and the intensive care unit at Birmingham Children's Hospital to ensure that the best care is available to critically ill children in the area. The children's acute transport service provided regional retrieval service for paediatric patients requiring intensive care.
- NICU made a particular effort to develop strong links with health visitors in the community in order to improve the continuity of care for a neonatal baby in the community. They met with health visitors on a twice weekly basis.
- Oncology staff and the hospital teacher told us they would invite teachers to multidisciplinary team meetings and send them updates of the child's progress or health needs.
- Parents of a child who uses the gastroenterology services thought they had excellent multidisciplinary working and saw all the staff at the same time as oppose to individually.
- We saw there was close partnership working with community nursing services for children with chronic conditions that could receive some treatment at home.

Seven-day services

- There is a 24 hour paediatric service seven days a week with a paediatric consultant available at all times. General surgical staff orthopaedics and spinal surgery worked on call rotas.
- Physiotherapy services were available seven days a week, out-of-hours support was available through an on-call system.
- Outpatient clinics were held Monday to Friday from 07:00- 19:30.

Services for children and young people

- Child and Adolescent Mental Health Services (CAMHS) were provided by another organisation. This service was available 9am to 5pm on week days.
- There was a paediatric pharmacist available on a bleep system but staff were told to prepare any general stock orders on a Friday as routine.

Access to information

- Ward and outpatient areas had trust policies and procedures available, which were accessible to staff on the trust's intranet.
- The directorate produced information guides for families which gave insight into what work the staff were engaging in and explained the different roles of the staff. We saw practical information was displayed throughout the hospital such as parking, visiting times and how to make complaints.
- Information leaflets were available on a number of topics, including bullying, alcohol, low mood, self-harm and a large array of health matters. These were available in both inpatient and outpatient settings.

Consent

- We spoke with staff, who confirmed that parental consent would be sought prior to any procedures or tests being undertaken. We saw consent was recorded in the care records we reviewed.

Are services for children and young people caring?

Outstanding ☆

Patients and parents are respected and valued as individuals and are empowered as partners in their care. Children and their families were treated with compassion, kindness, dignity and respect. Staff involved children and their families in decisions about their care and treatment.

We found extensive evidence that staff emotionally supported children and their parents and relationships were close. Staff took children on ventilators and chemotherapy on days out. Neonatal care staff had developed 'Helping hands' which was an online forum support group for parents with neonatal babies. Oncology staff used a 'Beads of Courage' programme which is designed to support children going through their treatment. Staff had developed diaries for critically ill children to take home, following recent research that showed diaries were important for the psychological wellbeing of the parents and children after discharge. We also found evidence that staff emotionally supported one another.

Compassionate care

- Parents we spoke with told us they had been treated with respect and compassion by the staff and praised their attitude and approach. Several parents noted the staff were "Exceptionally polite".
- In January 2015 the hospital collated the results of 277 questionnaires from the friends and family test we saw evidence that 69% said they were 'Extremely likely' to recommend the service 11% 'Likely' and only 0.7% 'Not At All'.
- In March 2015, a further 505 questionnaires were collated 77% said they were 'Extremely likely' to recommend the service, 20% 'Likely' and 3% were not sure. Staff were proud to tell us the outcomes were generally positive and told us one of the negative outcomes identified was that they needed to review the menu to have more choice available. We noted that there were plans in place for reviewing the menu.
- In the friends and family test people commented that the staff were 'brilliant', 'very helpful', 'kind', 'friendly', 'professional' and 'polite'. We spoke with 44 parents and children who further supported all these comments.
- Parents told us they would recommend the hospital to other parents and staff told us they would be happy to have their children cared for here.
- A mother in the Neonatal Intensive Care Unit (NICU) said that "The nurses are like another mother to my baby."
- We saw staff had taken patients on days out. Children's Intensive Care Unit (CICU) staff took long term ventilated patients on a day trip to an aquarium. The oncology staff had taken patients and their families to a theme park and the zoo.
- We saw the standard of privacy for patients and parents to be of a very good.
- NICU staff had their own survey in which they developed; we saw one of the outcomes was that they needed more toys to entertain siblings.
- We were told reception staff were helpful.
- Staff were very knowledgeable about patients, they knew details from past medical history to siblings to the child's comfort blanket's name.

Services for children and young people

Understanding and involvement of patients and those close to them

- During our inspection, we observed staff communicating with children and families so that they understood their care and treatment. Parents told us they felt well informed and could ask any questions of the staff if they wanted to. Parents stated that staff never used jargon and always explained things clearly. They told us they also involved the child and siblings where appropriate and were able to speak age appropriately.
- Oncology staff had an annual sibling's day where they would do an activity such as team building. The child psychiatric staff always went along to provide support.
- Parents told us that they only had to tell staff things once and thought the communication and continuity of care was very good.
- CICU staff developed diaries for the children and parents to be able to take home with them when they left. Staff recognised recent research that showed they were important for psychological wellbeing after discharge. We saw these were maintained mostly by staff and parents could write in them if they wished. Staff wrote compassionate remarks and added photographs to show the child's journey.

Emotional support

- NICU staff had developed 'Helping hands' which was an online forum support group for parents with neonatal babies. They told us this was purely for emotional support and did not give any medical advice. NICU staff also set up a monthly meeting in which parents could join in activities such as baby massage, messy play and make hand and foot print moulds.
- NICU staff told us they would engage with previous patients and request updates on the children, families would write stories and staff would pin these on the 'Hope wall'. They told us parents liked to hear of other positive journeys in which the baby was living a healthy life. NICU would introduce parents to each other through a buddy system so parents.
- Parents in NICU told us medical staff always made themselves available for questions. Medical staff knew the importance of providing regular reassurance and updates on the baby's health to the parents. They told us nurses encourage the use of the parent's room to help them relax.
- Oncology staff used a 'Beads of Courage' programme which is designed to support children going through their treatment. The beads are used as meaningful symbols of courage that commemorate different milestones such as blood transfusions, bone marrow transplants, hospital stays, and chemotherapy and radiotherapy treatments.
- NICU staff explained that they encouraged parents to contact them if they needed and made themselves available for support over the phone. Staff told us how they empower parents to care for their babies and support them to ensure they are fully confident when caring for the baby by the time they are discharged.

Are services for children and young people responsive?

Good

Many aspects of the service were responsive to the needs of children and young people. Staff were involved in the planning of the service to ensure it continuously met the needs of the children and their families. Services offered direct access meeting the needs of children with long term complex conditions. Children that had long term care were known to the hospital school teacher. She told us how she would work with the children in developing a learning plan to ensure their educational needs were met.

There was little evidence for staff training around mental health care for children and saw this could be a potential gap in meeting the needs of this patient group. There was discussion that they would have an increased amount of admissions of children with mental health needs after County ward closes but had not prepared for this element of the service delivery. We saw plans were in place patients coming over from the County Hospital site.

Staff were knowledgeable about the complaints process and we found evidence that parents were supported in this process. The hospital had received four complaints last year mainly around communication.

Service planning and delivery to meet the needs of local people

- Management meetings ensured that services were planned and delivered to meet the needs of the local population.

Services for children and young people

- Services were flexible and developed with the needs of local children in mind.
- Staff participated in daily bed meetings to highlight any issues. Staff were to maintain the web based escalation management system (EMS) which was checked regularly by the clinical site manager. This monitored particular issues like bed occupancy levels.
- There was a clear comprehensive algorithm for increasing staffing on the ward and who to contact for support. The requirement for continuity of staff was fundamental theme throughout the algorithm and it pressed the importance of using consistent members of staff as oppose to agency.
- The hospital employed a complex care co-ordinator who was heavily involved in the integration of County Hospital staff and patients. Staff told us that the co-ordinator assisted with complex discharges and was a vital member of the team in service planning, access and flow.
- Plans were in place to review all children that had a length of stay longer than 14 days, to ensure an appropriate management plan was in place and discharge planning if appropriate.
- Neonatal Intensive Care Unit (NICU) staff had identified health visitors need more training in supporting parents of neonatal babies in the community, and had designed and delivered some sessions. We found the staff had received positive feedback from the training that they had initiated, 72% believed the training to be of great value to their role and 68% regarding the course as 'Excellent'.
- Asthma nurses were currently reviewing how their clinics ran in order to make them more streamlined and efficient.

Access and flow

- We noted there was good evidence of forward planning in regards to full occupancy levels. Staff told us that 100% occupancy levels were not a reoccurring theme. Wards had commissioned beds which were in use but the design allowed for extra beds for flexibility. When County paediatric ward closes in May, ward 218 (which is now adult surgical inpatients) will be renovated to be a paediatric ward. The management team planned for eight beds to be opened initially with the capacity to open up to 30 beds eventually. We saw clear comprehensive algorithms for staff to follow if they reached full occupancy.
- There was a copy of the escalation process on the ward for staff to follow if they were suffering any pressures for beds. The guide highlighted who was responsible for closing beds, cancelling elective surgery and who would liaise with neighbouring hospitals.
- Nursing staff told us that at times of fuller occupancy, staffing levels became stretched. They told us this happens around winter. Managers told us they would use bank staff, agency and that staff would work overtime working flexible hours to be able to cover as many shifts as possible.
- We discussed access into Children's Assessment Unit (CAU) which demonstrated flow of patients through to other wards was well planned and pathways supported this. CAU planned their staff to cover what they found were the busy times in order to reduce waiting times. We observed and were told people were seen within 30 minutes. The staff were aware that this has been area of complaints for patients, if the unit is full and they have to wait longer. Staff told us that this was not often.
- Patients could be referred to CAU by GPs and the accident and emergency (A&E) department, and known patients could have direct access to the unit which allowed for a quicker assessment.
- Parents told us discharge plans were well organised. We saw management had developed a flow chart of community services for staff and how to refer to external care agencies.
- In outpatients we saw that clinics were busy but provided a flexible service. Parents we spoke with said that there had been no problems with appointments on the whole and that they were seen within 30 minutes in the clinic. One parent told us that they had been able to co-ordinate multiple gastroenterology appointments for their child to minimise appointments.

Meeting people's individual needs

- The wards and units were purpose built, and designed with children in mind. The modern building provided a safe environment for children and families.
- The only area of concern noted by staff was that the oncology day care unit which was not purpose built. It did not have enough space or adequate facilities such as toilets. Nurses told us they did not have enough space when children are on trolley's laying down and the nurses need to be able to provide care. This had been identified and was due to be reconfigured in May.

- Parents had purpose built accommodation in CICU and NICU in which they could stay overnight. On the wards parents had fold away beds in which they could sleep next to their child. The wards had a parents lounge with a kitchenette which was available for use at all times. Some staff on ward 217 felt that the lounge on the ward was clinical and did not have comfy furniture. We agreed with the staffs' comments.
- We noted there was an adolescence room which was colourfully decorated, had Wi-Fi and the latest games consoles. There was an indoor and outdoor play area for children with age appropriate toys and a sensory room.
- Children that had long term care needs were known to the hospital school teacher. She told us how she would work with the children in developing a learning plan to ensure their educational needs were met. They liaised with teachers and if appropriate invited them to multidisciplinary meetings. The teacher currently had 20 patients on her case load and would see approximately eight pupils a day on a one to one basis. She told us how they had recently employed a teaching assistant so they could hold some sessions in small groups.
- Nursing staff developed a 'comfort round' tool to ensure the regular assessment of the children's comfort. It reviewed whether the child needed to be repositioned, their pain score, any action taken, access to a drink, fluid balance, toilet or nappy changing requirements, call bell in reach, safe environment, medication up to date and family aware of current plan of care. Once daily they check to ensure the family know the location of the parents lounge, play room and the name of the nurse looking after the child.
- We noted that comfort round assessments were consistently completed. Although, we noted staff were signing to say they were completing the fluid balance sheets but were not.
- Staff told us that the hospital had access to interpreters if required, but we did not observe them being used during our inspection.
- The wards and department areas were decorated with age-appropriate décor and toys for younger children. Outpatients were trialling Wi-Fi for older children, although this was not working on the day of inspection. We recognised a lack of space for treatment and play in oncology this was being reconfigured.
- The outpatients' area has an adolescent room with computer games and age-appropriate magazines. There was also a distraction station designed to take children's minds off procedures with toys and a micro projector so young people can plug in their mobile phones and listen to their own music.
- Parents with children with complex needs told us the staff manage their needs well and one mother told us "They don't treat her (the child) any differently to other children, even though they know she can't speak".
- Parents told us there were not always nappy changing facilities in all the toilets which they found inconvenient.
- Lack of car parking spaces was a consistently frustrating issue amongst parents with small children. Although the trust were aware of this and had plans for a further 150 spaces.
- The parents commented the facilities on a whole other than these issues were very good and that there was plenty to occupy children. Although, some televisions were not working on ward 217.
- Medical staff told us there had been an increase in admissions of children with mental health needs. We were told the County hospital received 120 admissions a year of children with mental health needs and County staff were concerned there would be an increase at the Royal Stoke site as County paediatric ward closes.
- There was little evidence for staff training around mental health and saw this was a gap in meeting the needs of this patient group. We were told the hospital do not have any mental health specialty beds therefore tend to liaise with hospitals that do and aim to transfer patients to these beds.
- The staff worked closely with 'Hospital@Home' which provides treatment, such as intravenous antibiotics, for children with chronic conditions, in their own home, saving them a hospital visit.
- NICU staff told us they used parent passports which explains parents' preferences and is used in transfers in order to maintain continuity of care for the parents as well as the baby.
- NICU family nurses supported teenage mothers on the unit teaching them how to care for their baby.

Learning from complaints and concerns

- We reviewed minutes of the meeting of the 'Child Health Patient Experience Group' for March where the matron reminded staff to bring feedback from parents and children to the meeting in order to share, learn and improve their services.

Services for children and young people

- The hospital had received four formal complaints about services from October 2014-February 2015 from children and young people's parents. Most of these complaints related to lack of communication. We were told the staff met with the families formally to resolve and discuss all issues.
- Leaflets detailing how to make a complaint were freely available. Staff were knowledgeable about the process and knew how to support people to make a complaint. Local resolution was preferred.

Are services for children and young people well-led?

Good

We found the management team were aware of their strengths and weaknesses and had a clear vision and plan for improvement, some of which had commenced. Staff were aware of the trusts vision and strategy. Staff told us they felt supported and that they enjoyed working for the hospital.

There were robust plans in place for the transfers of services from The County Hospital and staff told us they were well informed and involved in the service planning throughout. Although the medical staff at The Royal Stoke Hospital site told us they felt unprepared. Other

We saw evidence of innovation in the children's intensive care unit. Staff told us how they had been working with children on an international level bringing children who were on long term ventilation and working with them to improve their outcomes and wean to just night time ventilation which made a significant difference to the children's overall wellbeing, meaning they could live a more normal life.

Vision and strategy for this service

- There was a clear vision for the trust and the children's services. The majority of staff we spoke to understood the vision and strategy for developing the services, and said that they felt informed.
- The management team had developed an integration panel in order to strategically plan the move of County Hospital paediatric services and staff and integrate them into The Royal Stoke site. It involved staff from both hospital sites in order to ensure staff were engaged and informed. We saw the management team were eager to engage with staff.
- Medical staff from both sites did not feel involved. However managers told us senior medics were involved from both sites. The Royal Stoke medical staff told us they felt unprepared and it was not planned.
- The children's services have recognised the need to improve services for parents so had bid for Ronald Macdonald charity monies, which helps parents have a 'home away from home'.
- Children's Intensive Care Unit (CICU) had visions of employing more specialist consultants in order to be able to provide more specialist treatment and care. There were visions to 'grow' more advanced nurse practitioners amongst the children and young people directorate.
- There were plans for the new nurse educator; they planned to set up a 'skills stall' for staff to be able to interact with her on their own time. The objectives of the stall were to demonstrate basic essential skills such as 'how to wash a child'.

Governance, risk management and quality measurement

- Quality nurses were a relatively new strategy for the trust to improve quality on the wards. We saw quality nurse undertook audits to ensure skin integrity, medication management, pain and nutrition had been assessed and nurses had completed the relevant paperwork. The quality nurses then raised any issues of incomplete paperwork with staff at the time and any trends with the ward manager. The results were displayed in the ward for families to see and a newsletter is sent electronically to staff. There was one quality nurse for every ward/area manager.
- Staff completed an audit of records in September 2014 throughout the department and looked at a sample of five sets of notes per ward. We saw staff were complaint with record keeping policy in that records were signed, dated, in black ink, were legible and identifiable to the patient. They noted that pressure ulcers were documented 66% of the time, comfort round checks were completed 73% of the time, skin risk assessment was completed 73% of the time and observation charts were completed 100% of the time.

- The trust collated feedback from all staff around their training offered by the trust for April 2015. We saw staff rated the training medicine optimisation and end of life care as excellent and infection prevention and blood transfusion awareness as good. Although, it did not detail areas for improvement.
- We noted staff were unaware of their compliance with the NICE guidance as it was reviewed centrally and was not disseminated and therefore are missing out on learning or driving changes. We saw this as an area for improvement.

Leadership of service

- All medical staff felt well supported by their management. Nurses also felt supported however some areas and some staff told us they did not see the matron. The matron agreed it was a large 'patch' for her to have responsibility over. With the integration of County Hospital staff we were told another matron would be joining her in managing the children and young people directorate. Mostly all staff gave very good feedback about the matron's management style.
- The matron told us how she was planning an award programme for staff. The aim of the programme is to recognise and appreciate staff. The programme would include the new County site staff that would be joining them.
- Ward managers recognised they needed to improve appraisal rates although did not have plans in place for staff to have clinical supervision.

Culture within the service

- Staff told us that there was a positive culture within teams, and that staff supported each other well. We found that staff worked well together in multidisciplinary teams to provide holistic care to children.
- The staff described an open culture, where they were encouraged to report incidents, concerns and complaints to their manager. Staff felt able to raise any concerns.
- From talking to the management team we were able to see that they were aware of all the issues raised to us during inspection. We saw staff we able to discuss concerns with them and the management team would listen and take all their concerns seriously. Staff told us it was a great place to work and felt appreciated. We could see the culture was a positive one.

Public and staff engagement

- From the integration panel they developed the role of integration champions whose responsibility it was to answer questions, alleviate fears and disseminate information to other staff. This aimed to engage and involve as many of the staff as possible during the move.
- The trust had engaged with the public in the move of paediatric patients to The Royal, the public were disappointed with the move. We saw extensive evidence that staff were engaging with the public through community evenings, the media, visiting stakeholders and meeting with local GPs preparing.
- The children's services staff held an event with primary school children in order to eradicate negative fears of coming into the hospital. They had plans to develop further events.
- The service had developed a Child Health Patient Experience Group, the key purpose of the group was to engage with the children and parents who use the service.
- The 'Child Health Patient Experience Group' is developing a 'virtual tour' film which will show the journey of a child coming into hospital and follow the pathway from A&E/ Children's Assessment Unit (CAU) to the wards and discharge. The virtual film will then be accessible via the trusts website for children and parents coming into hospital.
- We saw they had plans for events, one being a 'thank you' to all the people who had supported the staff or had contributed to any charitable funds raised for the children's services.
- Staff were working with external professionals in order to develop a brand and 'app' for the children's services which will allow children to interact with the service in a more 'child friendly' way.

Innovation, improvement and sustainability

- The management team were passionate about improvement and wanted to continuously strive for better results and look for innovative ideas in which would better meet the needs of the local children.
- The respiratory nurse consultant told us how she was involved in influencing the national agenda and advises on the British Thoracic Society. She had been working with staff to implement recent guidelines.
- CICU employed the European medical lead specialist in congenital central hypoventilation syndrome. Staff told

us how they had been working with children on an international level bringing children who were on long term ventilation and working with them to improve their outcomes and wean to just night time ventilation which made a significant difference to the children's overall wellbeing, meaning they could live a more normal life.

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

End of life care was delivered across the hospital. There were no specific palliative care wards and patients who were palliative or at the end of their lives were cared for by their main treating physician within their wards.

Patients who staff believed required the input and support of the Specialist Palliative Care Team (SPCT) were referred to the service for their specialist input, usually for symptom control to ensure patients are comfortable. All staff had a responsibility to care for palliative or end of life patients and each ward had a champion who formed a link between the SPCT and the ward area.

There were 1761 deaths at Royal Stoke Hospital (April – December 2014). Referrals took place and were responded to by the SPCT within a day for urgent referrals and 48 hours for others. Thirty-eight percent of the referrals were for non-cancer patients.

During the inspection we spoke to 46 staff, visited 18 wards plus the chapel, multi-faith room, mosque, bereavement office and morgue. We reviewed patient notes and care plans including 40 Do Not Attempt Cardio Pulmonary Resuscitation records. We spoke with five relatives about theirs and their relative's experience.

Summary of findings

The hospital did not have safe arrangements in place regarding Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The completion of the forms was not always done as per trust policy.

Since the removal of the Liverpool Care Pathway, the hospital had failed to implement an individualised plan of care for the dying patient, with the trust still in the evaluation process.

The Specialist Palliative Care Team (SPCT) was adequately staffed, however it was not their responsibility to care for all the palliative and end of life patients; we saw that staffing challenges on the wards resulted in some people and families receiving care that was not optimum.

Caring within the service was good; staff were committed, compassionate and emotionally supportive. The SPCT team were expert communicators and demonstrated this during the inspection.

End of life care

Are end of life care services safe?

Requires improvement

Do Not Attempt Cardio Pulmonary Resuscitation forms were not filled in well, with much variation seen, in terms of medical staff answering all the questions contained on the form. We noted that the review process was not uniform - some people had identified review dates and others did not. Information was accessible for staff to ensure they had access to the most up-to-date information about patients.

The hospital had good arrangements regarding reporting and learning from incidents, although we observed one incident during our inspection which went unreported. We saw documents which contained the investigation detail which appeared robust. We also saw where learning from incidents had resulted in change of practice.

The Specialist Palliative Care Team (SPCT) was well resourced with only one vacancy for a palliative care consultant.

Incidents

- No 'Never Events' had occurred within the palliative care service since November 2014.
- Incidents which occurred were identified to ascertain if they involved any patients receiving palliative care. These were then reviewed further to identify if an investigation was required and any learning actions were to be taken.
- The incidents documented from November 2014 were recorded across both sites. We noted 48 incidents; eleven related to medication or equipment, four to discharge arrangements and eight to adverse staffing arrangements which either had, or had the potential of a negative effect on patients. For example, one pertained to a palliative care patient whose discharge was delayed because their take home medication had not been dispensed.
- We did see documentation of investigation following an incident which occurred before the formation of the new trust. The process demonstrated that a clear timeline of events was recorded which enabled the hospital to identify where there was deviation from protocol, or where additional learning opportunities needed to be offered. The investigation documents clearly described the actions required and delivered following the incident to reduce the likelihood of its repeat.
- All staff had access to the electronic form to enable them to complete incident forms. However, we did observe an incident which was not reported on the system at the time it took place. A patient who had been referred to the SPCT had had a medication omitted the day they were seen. It had not been coded on the patient's medication administration records (MAR), and the patient confirmed they had not had their medication. The CNS (Clinical Nurse Specialist) did not record it as an incident. The learning opportunity was lost as staff were not made aware that the medication needed 10-14 days to reach a therapeutic level.
- Staff told us of learning which had resulted from incidents; this involved the use of syringe drivers and the recommendations for priming them. We saw that written advice had been produced and shared with staff.

Environment and equipment

- Most wards had side rooms which could be used for patients who were dying. During our inspection we observed some patients who were actively dying being treated on main wards, as the side rooms were in use for other patients such as those who were infectious. We saw that in all cases families sat with their loved ones around the beds. On one ward the patient had two family members with them who we spoke to. They told us that more comfortable seating was required as they were visiting for long periods and the plastic visitor chairs were not suitable.
- Within the CDU they made provision for patients and families where the patient was expected to die within a few hours. They would set aside a room which was then called the 'Lily Room'. We spoke to staff about how they prepared and identified the room. The rooms they usually used were not too far from the nurse's station so family could access staff when they wanted.
- Common equipment used for palliative care patients were syringe drivers. The Graseby syringe driver had been discontinued for use and the hospital was using an alternative. We noted that a few times lack of syringe

drivers had been reported as incidents. Staff thought there were adequate numbers of syringe drivers to meet the needs of patients, local leadership felt more syringe drivers would be useful.
- Patients who were in the last few days of life were all cared for on a pressure relieving mattress.
- All equipment in use had been maintained and PA tested for their safe use.

Medicines

- The trust had identified the most commonly required medication for symptom control. We saw that the trust had produced guidance for staff to ensure that patients received the medication required. However, we did see that some patients who were at the end of their lives did not have anticipatory medications written up for them.
- We noted there was some confusion as to whose responsibility it was to prescribe them. We spoke to a pharmacist and a sister on one ward who both confirmed that one patient should have been prescribed anticipatory medicines. There was no consensus regarding who was responsible for this. However, we also spoke with the staff who were caring for the patient who confirmed that at the time of our inspection the patient was comfortable.
- There was one pharmacist who was part of the extended SPCT. General pharmacists were also available on each ward. Pharmacists did support the SPCT and patients requiring anticipatory medicines. We were shown a pre-populated discharge prescription form to support and expedite the discharge process.
- Some of the clinical nurse specialists (CNS) were nurse prescribers which enabled them to prescribe medications related to end of life care.

Records

- We reviewed the arrangements for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). Medical staff identified patients where this was an option to be considered. We also noted that if a patient had made that decision in the community it was discussed and continued within the hospital. This meant that some patients had two current DNACPR orders within their notes. The community one was red in colour but was not to be acted on if it was the only one in the patient's notes. In order to act on the wishes of the patient, family or doctors, the patients' notes had to have a Royal Stoke University hospital DNACPR form.
- We reviewed 40 DNACPR orders within the hospital, in the vast majority of cases we noted that discussions with families had taken place and were documented in the notes. The orders had been signed by appropriate senior medical staff. However where the patient appeared to lack capacity, the doctors completing the form would tick this option. The form then prompted them to complete three other Yes / No questions and in the vast majority of cases these were left blank. The questions related to whether an advanced decision had been made, whether a welfare attorney had been appointed and if any other person involved in the patient's welfare had been consulted. The hospital policy requires that if any of the questions are not applicable the form should be marked with N/A.
- There was inconsistency regarding reviews. Some DNACPR forms had associated documents indicating the date of the next review. The review dates were dependent on the acuity of the patient. Some forms had no dates indicating when the next review was due. An audit undertaken in May 2014 reported that 80% of DNACPR forms lacked a date of review.
- Notes were accessible, however we noted on the vast majority of wards that they were either unsecured or unlocked, or they were not able to be locked, being of a design which was not possible to lock. They were not always attended which meant that an information breach could occur.
- Risk assessments and care plans were kept either at the patient's bedside or just outside the bay areas. These were completed and reviewed. However we did note that the quality of the information contained within some care plans was limited. We did note that the narrative which nursing staff completed 2-3 times a day was comprehensive.
- When members of the SPCT visited patients they documented their visit and recommendations in the patient's notes.
- Documents used for safety rounds, handovers and ward rounds were in use and accurate. They contained up-to-date summary information about patients. These were updated on a daily basis and given to staff as they came on duty.
- There was an up to date resuscitation policy in place for review in 2016. This was accessible to staff via the intranet.
- The hospital was trialling an Individualised Care Plan (ICP) which at the time of the inspection was due for

evaluation. It was to be used in place of the Liverpool Care Pathway documentation as a care planning tool for patients in the last few weeks of life. The local leadership anticipated that the full implementation of the tool could take as long as 18 months.

- The AMBER care bundle had been launched on 11 wards; however on-going support was required to ensure its implementation. During the inspection we saw a number of patients who appeared to fit the criteria for the AMBER care bundle, but it had not been implemented for them. Staff had mixed understanding, ranging from staff that had no knowledge of it to those who did but told us it was not used on their wards. We saw very limited use of this tool. The AMBER care bundle is a simple approach used in hospitals when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live.
- The trust no longer used the Liverpool Care Pathway and had an interim measure in place implemented October 2013. It contained guidance for both medical and nursing staff of best practice of care and treatment for patients at the end of their lives. This consisted of a bullet point list of actions. It was unclear how it was best to be used by staff as it was not present in patient's notes, or in care planning documents. Staff who showed it to us retrieved it from folders on their units.

Safeguarding

- We spoke with two Clinical nurse specialists who were members of the SPCT. They confirmed that they had undertaken Safeguarding Adults training level 2. They were able to describe their responsibilities and actions they would take.
- There was 100% compliance with the protection of vulnerable adults training.

Mandatory training

- Documents supplied to us demonstrated that every member of the SPCT had undertaken all their mandatory training. Those that were slightly out of date had booked sessions for their updates.
- The trust had a policy which identified the different staff groups and the training they were to undertake. It had been ratified in 2013 and was not due for review until 2016. It still had as part of the training offered to medical, dental, nursing and midwifery staff end of life care including the Liverpool Care Pathway. Therefore it needed updating.
- The SPCT delivered part of the mandatory training to both nursing and medical staff.
- 513 staff received end of life mandatory training from November 2014 -March 2015.

Management of deteriorating patients

- Due to the patients' conditions, ceilings of care were identified and shared with all the staff involved in their care and treatment. Therefore interventions which control symptoms would always be offered, but more invasive treatment would not be offered.
- Modified Early Warning Score (MEWS) were maintained for patients and we saw evidence of escalation undertaken when scores indicated it necessary to do so.
- Risk assessments were in place for patients, and where these directed additional support it was provided. For instance, for patients who no longer took fluids orally, two to four hourly mouth care was administered.
- Patients and family we were able to speak with told us that they were kept comfortable. The hospital offered a pain management service but local leadership told us this service was predominantly used in surgery.
- The SPCT received referrals to offer additional advice to patients, family and staff. This was to help ensure the patients were kept comfortable during the end of their lives.

Nursing staffing

- The SPCT consisted of eight clinical nurse specialists; the team had one additional vacancy at the time of the inspection.
- Staff confirmed they were able to meet the needs of the patients and staff referrals with the current numbers.
- Most wards had at least one palliative care champion. These were not members of the SPCT but formed a link to that team and supported staff on the wards to recognise the dying patient.

Medical staffing

- The medical support was consultant led of which there was 3, which equated to 1.4 WTE in the team. They work across sites supporting patients at both hospitals. At the time of the inspection there was an outstanding vacancy for one full time consultant.

End of life care

Major incident awareness and training

- The hospital had a major incident planning policy. The chaplaincy team had a designated role within it. This is seen as good practice in line with the NHS Chaplaincy guidelines 2015.
- There were clear advice and guidance for mortuary staff regarding a major incident within the policy.

Are end of life care services effective?

Requires improvement

Since the withdrawal of the Liverpool Care Pathway, the trust used a guidance document which did not appear to be well embedded within the hospital. Both the AMBER care bundle and individualised plan of care had not been fully implemented, with the individualised plan of care still in the evaluation stage and only in use on five wards. This meant there was a risk that patients and family did not receive the full support they required and staff did not get the support to know what interactions should be in place.

The National Care of the Dying Audit results were mixed, but an action plan was in place to meet the short falls in future.

There was a lack of facilities to conduct difficult conversations with family members, however the bereavement office area was well designed and met relative's needs.

Evidence-based care and treatment

- The hospital achieved two of the seven organisational key performance indicators (KPI's) for the National Care of the Dying Audit results (NCoDA results May 2014). This included having board level representation for end of life care. The hospital met five of the ten clinical KPI's.
- An action plan had been produced to address the areas where the hospital had not achieved the NCoDA KPI's. The vast majority of these were due to be completed after the inspection.
- The trust did not use the Liverpool Care Pathway (LCP) since its withdrawal.
- The trust had developed the individualised care plan for the last days of life to replace the LCP. This was to be used in conjunction with the last days of life guidance. The care plan was in the evaluation stage after being trialled on five wards within the hospital. The guidance had not been implemented yet and was still in draft format.
- As an interim measure the trust used a guidance document for both medical and nursing staff, which was an aide memoire for the care and treatment needs of the dying person. However, we did not see these present in patients' care documents. When asked, staff retrieved them from folders and filing cabinets.
- AMBER care bundle pathways were in use in a minority of places. Patients who were palliative had their care identified and documented in the normal care plans used for all patients. Staff we spoke to thought this was the accepted practice. They did not think any other care pathway was required. However, we did see the vast majority of the patients' needs were met by nursing staff using the normal care plans. The downside of this was that it did not prompt them to consider additional care and treatment needs, such as spiritual needs and preferred place of care and dying.
- NICE quality standards number six relates to Holistic support- spiritual and religious for EOL care. We saw that the chaplaincy team felt they were well utilized. They received the vast majority of their referrals from the SPCT. However, the hospital did not achieve the KPI for assessment of spiritual needs achieving a score of 18% against the national average of 37% (NCoDA).
- The hospital did not use the gold standard framework.
- In documents supplied by the trust it described the intention to work within the NICE guidance for improving supportive and palliative care (2004).
- Documents supplied by the trust indicated that an audit of Opioids in palliative care had been undertaken 2014/15. The results demonstrated that the majority of patients were prescribed an appropriate opioid. Also about half of the patients were referred for a specialist assessment before opioids were commenced.
- Following the Leadership Alliance for the care of Dying People recommendation June 2014, the trust had adopted the five Priorities of Care. We observed some staff with an aide memoire on their person. We also observed a laminated leaflet with the five priorities on notes trolleys. We spoke with a nurse who was able to explain the five priorities.

End of life care

- We noted that each clinical area had an End of Life folder, these varied in the information which was contained within it. We also noted that some still contained the LCP protocol.

Pain relief

- Patients we saw appeared to be comfortable and pain free. When we spoke to family members they confirmed their relatives were pain free. However, one family did say they thought their relative had to wait too long for pain relief.
- The hospital scored higher than the national average for the prescribing of anticipatory medication, scoring 52% where the national average was 50% (May 2014 NCoDA).
- We saw that anticipatory medications were prescribed for most patients who were palliative or at the end of their life. We did see one patient who had not been prescribed these, and staff were not sure whose responsibility it was to implement them for this patient. However this patient did appear comfortable and staff confirmed this.

Facilities

- When doctors and/or nurses needed to inform families of the poor prognosis of family members, these difficult conversations took place mostly in offices on wards and day rooms and staff rooms. This was not ideal. We spoke to family members who did not think that staff offices and "quieter parts of the ward" were appropriate for this type of conversation.
- Families complained that when they were spending extended hours with their family members the seating available to them was uncomfortable.
- Rooms for families were shared across a number of wards. The family room contained two beds, bathroom facilities, refreshment facilities and a television.
- The hospital had facilities to meet patient and families spiritual needs, offering a chaplaincy service, a chapel, a contemplation room and a mosque. These rooms had regular services offered throughout the week.
- The bereavement office public area was well designed with dim lighting and comfortable chairs for families. There were two waiting rooms for families, one which was a viewing room and one for families who did not wish to view their deceased family members.
- The mortuary was large with nearly 200 fridges which included provision for bariatric patients.

Nutrition and hydration

- Assessments of patient's hydration and nutrition needs were assessed. Families were informed and understood when their relatives who were actively dying had a reduced interest in food and drink; this was included in medical notes.

Patient outcomes

- The hospital needed to improve the recognition of the dying person. Staff expressed that since the withdrawal of the LCP they felt they lacked guidance of what to do to support patients and families effectively.
- The NCoDA demonstrated that the hospital did not achieve the KPI of communicating the patient's plan of care in the dying phase, achieving 46% where the national average was 59%.
- The hospital did not support patients to achieve their preferred place of death as this was not routinely recorded, despite the SPCT using the Somerset software which had a place to record patient's preference regarding place of death. Staff told us they recorded preferred place of care, which was also recorded on the Somerset tool.

Competent staff

- Members of the SPCT were suitably qualified to meet people's needs. Documents supplied by the trust indicated that every member of the team was qualified to degree level. The majority of the SPCT had advanced communication skills training. All but one had also completed Level 2 Psychological Support. Clinical supervision was delivered on a monthly basis by the clinical psychologist/consultant neuropsychologist to maintain their competency.
- The SPCT delivered training on a quarterly basis to the end of life champions. They also delivered EOL training as part of the mandatory training to medical, dental nursing and midwifery staff.
- The SPCT saw their role as offering formal training to staff and delivering a preceptorship to newly qualified staff, but to also support staff informally whilst in the ward areas.
- Equality and diversity training was part of the training which was mandatory for all staff.
- Appraisal rate for medical division, nursing and midwifery was 18% April –December 2014.

Multidisciplinary working

End of life care

- The SPCT had within it medical palliative care consultants and CNS's. In addition to this the team had an occupational therapist, psychologist, anaesthetist, chaplains, social worker, bereavement staff and administrative support.
- We observed a weekly meeting of the MDT where patients referred to the SPCT were discussed. The Somerset Cancer database was used as a tool so that uniform information was collected and discussed at each meeting. Patients under discussion would include patients who were newly referred or those who had uncontrolled symptoms, or complex discharge needs. The minutes were shared with the treating physician and placed in the patient's medical notes.
- The hospital integrated with the local hospice which facilitated patient's wishes. The medical members of the SPCT also worked within the hospice to better support their patients.

Seven-day services

- The SPCT operated seven days a week between the hours of 9-5pm. Staff would visit all the patients referred to them in the ward areas. Outside of these times telephone support was offered by the local hospice. Staff on the wards had the contact details for the hospice and said they would use it if they needed.
- Consultant cover included weekends; we saw they were identified on an on-call rota which included weekends

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A current mental capacity assessment tool was available at the hospital via the intranet. However, we did not see this used as part of the DNACPR discussion where patient's capacity was in question. We spoke with local leadership where there were mixed views with regard to when a mental capacity assessment should be undertaken. One was very clear about that where the doctor had reason to believe capacity was lacking an assessment should be undertaken. The other thought it was the doctor's decision. CNS staff and quality nurses on site we spoke to thought that mental capacity assessments should be in place if the patient lacked capacity. In every case where the DNACPR had identified that the patient lacked capacity there was no associated mental capacity assessment.
- The trust supplied us with their current mental capacity act policy published April 2014 which stated "If there is evidence to suggest that a person may lack capacity then an assessment of capacity must be carried out."
- We observed staff prior to any interaction with patients gaining their consent where the patient was able to communicate.

Are end of life care services caring?

Good

We rated the care as good. We observed staff delivering their services to patients who had been referred. We saw that staff were respectful and maintained patients' dignity at all times. When interacting they demonstrated appropriate levels of compassion both to the patients and their relatives.

We observed that both relatives and patients were involved in aspects of the care and treatment. Their opinion was taken into account when planning treatment and care options.

Emotional support was available to both relatives and patients. Psychological and bereavement services were in place.

Compassionate care

- A trust-wide patient survey was undertaken in January 2015. It was a very small sample but this could be due to the cohort receiving palliative care or being at the end of their life. When asked the question; "Do you feel that you or your family were free to discuss any anxieties or concerns you may have?" 100% of responses agreed with the question.
- We observed members of the SPCT interacting with patients; they demonstrated exceptional communication skills, both verbal and non-verbal. Their listening skills were noted as very good. Staff on the wards we saw were respectful to both patients and family members. Family we spoke who gave positive feedback about staff interactions.
- One family of relatives we spoke to mentioned that they were offered drinks whilst visiting a dying relative for extended periods, but nurses would say we are not supposed to.

End of life care

- The bereavement team displayed compassion to relatives, but they were clear that they did not involve themselves with relatives outside of their remit as this would constitute counselling.
- When patients were receiving care and treatment, their privacy and dignity was maintained by the use of curtains. We noted that family members utilised the curtains when they wanted more privacy if they did not have a side room for their dying relative.

Understanding and involvement of patients and those close to them

- We saw in the notes that discussions with family members took place. Relatives we spoke to mostly felt well informed. However, we did speak with one family who said that communication needed to improve, as they wished they had one point of contact for information about their relative.
- Visiting times were open allowing relatives to spend as much time with their loved ones as they needed.
- We observed the CNS who sought the opinions of family members and explained planned approaches of care to both the patient and their relative, making sure they fully understood the care and treatment plan and the next steps.

Emotional support

- We noted that where patients had been referred to the SPCT they were routinely asked about spiritual support requirements and referred to the chaplaincy service.
- Counselling was available to patients if required.
- We observed that most patients who were actively dying had family members with them, so they could support both their relatives and start the grieving process.

Are end of life care services responsive?

Requires improvement

We found the service required improvement in terms of responsiveness to meet the needs of the patients. We saw that the referral process worked well in the majority of cases.

The fast track discharge process was not fast at all if patients wanted to go home or to a nursing home to die. It was complex and resulted in patients deteriorating in hospital which then prevented them being able to go home.

Additional support was given to relatives, such as parking concessions and open visiting, but these needed to be publicised more widely.

The identification and fast tracking to a ward area of palliative patients needed to improve as some patients who attended via Accident and Emergency waited for extended periods on trolleys before being moved to a ward.

Service planning and delivery to meet the needs of local people

- National care of the dying audit results were reviewed and the main points reviewed at the End of Life Operational Group. An action plan had been put in place in response to ensure that where they had not achieved the KPI's this could be addressed.
- The Registrar for registering a death was on site next to the bereavement office from Monday to Friday. This was utilised a great deal by grieving families.
- Parking passes and free parking was available for relatives which allowed them to visit for extended times. However, we did speak to some relatives who were not aware of this as they had not been informed.
- The SPCT received referrals from many specialities within the hospital with the medical division being the largest user. Of the 1682 referrals for April – December 2014 38% were for non-cancer patients.
- The trust did not record the number of patients dying in their preferred location. Staff said one of the reasons for this was that sometimes patients were not fully aware of their prognosis so staff did want to ask. Local leadership confirmed it was an area of improvement for the trust.
- We observed that clinical areas had End of Life folders with information/ guidance contained within for staff to use. However these folders were not uniform in the information contained. Some had information which was out of date and needed to be removed.

Meeting people's individual needs

- Patients admitted via accident and emergency were not identified as palliative or end of life and fast tracked onto wards. We received feedback from one family's experience in March and during the inspection we

observed a patient who had been in Accident and Emergency for an extended period waiting for admission to a ward. One was actively dying and the other had been identified as palliative, but they both spent 10 hours plus on trolleys

- We saw a very responsive service which met the needs of patients who were actively dying in the CDU. They identified one of the side rooms and described it as the Lily Room. Patients who had been identified as due to die within a few hours were moved to a side room fairly near the nurses' station.
- Both the patient and family were afforded some privacy but could access staff if they needed. One family described the experience of using the Lily Room compared to the emergency department and medical assessments unit like "stepping into a completely different hospital". They felt their relative received the care they deserved, although the person's wish had been to die at home.
- The SPCT received referrals and they were prioritised. Urgent referrals were responded to within one working day from Monday to Friday. Others were responded to within 48 hours.
- Anyone could make a referral to the SPCT and this included patients and their relatives, although most of the referrals came from staff. When we spoke to staff about the circumstances under which they would make referrals they described symptom controls and pain relief.
- Local leadership told us that the referrals had been coming in later so patients were closer to dying. This meant that interventions were limited for both the patients and families and the choices available were then also limited.
- We observed the CNS supporting patients who had complex needs and they utilised appropriate members of the SPCT to access specialist input for patients, such as counselling and occupational therapy.
- We saw that patients who were living with cognitive impairment had a "this is me" document in their nursing notes. This enabled staff to better understand their communication requirements to improve their experience of the hospital environment.

Access and flow

- The service referrals were continually rising since the service began in 2003/4. The SPCT monitor the referrals and in 2013/14 there were 2255. From April to December 2014 there were 1682 referrals. If the referral rate continued to April 2015 this would constitute a 12% increase in referrals within a year.
- During the inspection we did see one patient where the referral had been made over a week ago and the SPCT had not picked this up. Staff on the unit had failed to note that the referral had not been picked up. We drew their attention to the breakdown in the process.
- We saw another patient who appeared to be actively dying who had not been referred to SPCT. They had had an intervention which could indicate that a referral was appropriate.
- The discharge process was not very responsive where patients wanted to go home to die. We observed that patients waited up to a week or even more, even when they had been identified as requiring fast track discharge. The discharge process was complicated and involved another provider, but the result for patients was a delayed discharge process.
- If the patient needed to move to a new nursing home staff told us this could take weeks, as families needed to be happy with the choice offered.
- Discharges to the hospice care could be same day or next day, being a much more responsive service.
- When workload allows, members of the SPCT will check the wards for patients they think would benefit from the service.

Learning from complaints and concerns

- Complaints regarding end of life care was reviewed at the End of Life Operational Group. Minutes seen from the April 2015 meeting (which was attended by staff from both sites) identified one complaint relating to end of life care. The SPCT had an input in responding to the complainant. Local leadership confirmed that additional learning input had been implemented to reduce the likelihood of an occurrence.

Are end of life care services well-led?

Inadequate

Local leadership displayed some good characteristics, but overall we found the service to be requiring improvement.

The recognition of risk and quality measurement needed to be strengthened. There appeared to be a lack of timeliness

in the integration of both the AMBER care bundle and the individualised plan of care across the hospital. This resulted in staff not recognising the dying person and implementing the correct care pathway at the appropriate time. This situation was due to continue for some time as the wholesale integration of the pathways were not due for over 12 months.

More work was needed to address the practice of formal mental capacity assessments when a person's capacity was called into question.

The risk register did not have the major risks present within it, which meant that oversights and work to reduce and address the risks were not being monitored closely.

Although there was no current vision the SPCT were all working towards a common aim, which each member was able to communicate to the inspection team.

Vision and strategy for this service

- The strategy had not been fully agreed, due to the integration with County Hospital. An away day had been held in November and part of the reason for this was to achieve better integration. Members from both sites attended. It was agreed that policies needed to be harmonised and that both teams needed to work together.
- When we spoke to staff they told us there was no current strategy, but told us about their role and how this should improve the dying experience for patients and their relatives.

Governance, risk management and quality measurement

- July 2013 'More care, less pathway – An independent review of the Liverpool Care Pathway' recommended the phasing out of the LCP over the following 6-12 months and then the implementation of individual plans of care. At the time of the inspection this was not fully in use with the hospital having started a pilot in December 2014, with the evaluation stage starting 10 April 2015. The delay in the implementation of the individual plan of care meant that staff were not fully supported to deliver best practice care to patients who were dying. The leadership failed to apply enough urgency to have the plan of care in place.
- Within the minutes of a document supplied to us by the trust we noted that SPCT staff had misgivings about the implementation of the individualised plan of care being launched without being fully resourced to support staff acceptance and use. This could result in a barrier to use and patients could potentially not receive the standard of care required.
- The current practice regarding DNACPR and mental capacity was not uniform; the trust policy regarding DNACPR was not clear and could mean that both undertaking and not undertaking a mental capacity assessment is acceptable. However the trust Mental Capacity Policy was very clear that the expectation was that if capacity was in question a mental capacity assessment should be undertaken. We did not see any mental capacity assessments undertaken for the DNACPR decision.
- AMBER care bundle was not widely used within the hospital with staff expressing lack of knowledge of its benefits and implementation. Additional education support of staff was required to fully integrate this into the service.
- Each member of the SPCT worked well within the team and felt a level of autonomy within their role. We spoke with the CNS who was part of the team that identified the new practice to follow in the use of the syringe drivers following a few incidents. They developed a new protocol of use which has proven very successful, and this new protocol has been shared with the staff across the sites.
- Information governance risks were seen as most of the notes trolleys we saw were unlocked or not able to be locked. This meant the notes were vulnerable to being removed or tampered with.
- The risk register was a corporate document rather than local and site based. The risk is that patients may not receive the required amount of pain relief. An action plan was due to be produced for June 2015. The risk register had identified a number of controls which were already in place.
- We noted that a number of other risks were not present, such as further improvement of the fast track discharge process which could be classed as a moderate to high risk. However a potentially higher rated risk is the recognition and wholesale implementation of care pathways such as the individualised plan of care and the AMBER care bundle to ensure patients receive the highest quality of care.

Leadership of service

End of life care

- SPCT knew who the non-executive director and the executive lead was for end of life services within the trust. Local leaders confirmed that they felt very well supported by the trust leadership. However the leadership of the end of life care service had failed to recognise the urgency needed for implementing an individualised care plan for actively dying patients.
- The SPCT appeared to be a strong team; staff told us they felt supported by their local leadership and by the executive team.
- The End of Life champions on the wards we spoke to felt well supported by the SPCT also.

Culture within the service

- NHS Staff survey 2014 showed that staff within the hospital valued team work and felt well supported by their leadership.
- The hospital scored 81% compared to the national average of 82% having a team objective, which they all work to achieve.

Public and staff engagement

- The SPCT had not achieved the KPI for the NCoDA for obtaining feedback. We saw an action plan that the trust was planning to undertake feedback with patients and or their families in 2015 by taking part in the National Bereavement survey (VOICES). We did see a very small survey undertaken January 2015 where families and patients were happy with the service they had received.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department is open Monday to Friday between 8 30am and 6 00pm. Regular evening and Saturday clinics are also provided.

The trust offers a range of diagnostic imaging services including; general radiology, fluoroscopy, dental, ultrasound, CT and MRI scanning, breast scanning, orthopaedics, and obstetric ultrasound.

The Royal Stoke hospital has achieved ISAS accreditation and the trust is working towards incorporating this organisation wide in its re-accreditation in 2016.

The Royal Stoke site is a purpose built PFI and has access to outpatients and diagnostic imaging on both the ground and first floor. There are a high number of consulting rooms and sub waiting areas throughout the departments. There is also a dedicated A&E imaging department based in the A&E department.

Between July 2013 and June 2014 there were a total of 627,990 outpatient appointments at the former Royal Stoke University Hospital. The hospital had a lower than England average rate for patients who did not attend their appointment (DNA rate).

During the inspection the team attended a variety of clinics, including; fracture clinic, orthopaedics, ear, nose and throat (ENT), dermatology, surgery, medicine, ophthalmology, orthopaedic, plaster room, neurology and ophthalmic.

We spoke to a range of staff including, healthcare assistants, nurses, doctors, AHP, clinical nurse specialists, advanced practitioners, receptionists, administration staff, radiologists, manager in outpatients and diagnostic imaging and the medical records manager.

We also spoke to thirty patients accessing the services, five relatives/carers, and one hospital volunteer.

Outpatients and diagnostic imaging

Summary of findings

Systems and processes were not always reliable or appropriate to keep people safe. For example, records were not always kept confidential and secure.

Cancer waiting times were constantly fluctuating and referral to treatment time targets were not being achieved. The diagnostic waiting times had been higher than England average but were seen to be improving. A significant number of patients were waiting for follow up appointments.

The organisation of the outpatient services was not always responsive to patients' needs. There were numerous delays and clinics consistently over-ran.

Diagnostic imaging had nationally recognised accreditation in place.

Staff were suitably qualified and skilled to carry out their roles effectively, they were approachable, open and friendly. Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice.

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found that improvements were required in outpatients and diagnostic imaging to provide greater assurance about safety.

Incidents were reported but there was limited evidence that staff received feedback from incidents they had reported. Systems and processes were not always reliable or appropriate to keep people safe. For example, access to emergency resuscitation equipment in clinical areas and patients records were not always kept confidential and secure.

Incidents

- We found incidents in the outpatients department were reported in line with the trusts policy
- Nursing staff we talked to were familiar with the electronic reporting system to report incidents within the outpatient department. We spoke to healthcare assistants who said they had not had training to use the system but would report an incident to their line manager. There was limited evidence of feedback from incidents when talking to staff.
- No never events had been linked to outpatient specialities at the hospital.
- Between January and December 2014, no serious incidents had been linked to outpatient specialities at the hospital. There was one serious incident relating to a scanning incident.
- We saw that notifications of incidents relating to the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) were sent to CQC as required. These were usually incidents where a patient received exposure to radiation much greater than intended and greater than diagnostic reference levels. The incident notifications gave details of the action taken, including investigating the cause of the incident and explaining to the patients.
- There had been one reportable incident in diagnostic radiology in the last six-months. This was operator error due to adjustment of exposure factors in a paediatric case. The incident did not occurred on the Royal Stoke site. There was evidence that the incident was followed up and lessons were learnt and shared.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- We looked at all the areas in outpatients and diagnostic and found them to be clean and tidy. Cleaning schedules were seen on public notice boards and were up to date.
- Hand gel dispensers were well placed throughout the departments and in the visitor's toilets. We observed staff, patients and visitors using them.
- There was a named link nurse for infection control in both outpatients and diagnostic imaging. Their role is to promote infection prevention amongst staff and visitors to the department.
- We were shown evidence of hand washing and infection control audits. In the diagnostic imaging department, results for March 2015 showed 100% compliance with hand hygiene and disposal of sharps.

Environment and equipment

- In ENT outpatients that there was no resuscitation trolley. Access to another trolley was in either surgery or ophthalmic clinics. There was no emergency equipment seen for neck breathlessness and staff said they would just get a 'trachy tube' from the clinical nurse specialist's room in the clinic.
- We checked all cardiac resuscitation trolleys in outpatients and noted they had daily checks and logs were signed. All electrical equipment to support resuscitation e g suction machines were PAT tested and in date. The resuscitation trolley checks were seen also seen in diagnostic imaging. However we noted that the dating of checks in the log was not consistent.
- We saw that equipment was handled and cleaned appropriately. For example, plastic bags were used to transport used nasendoscopes to the dirty utility and clean bags used to return them to clinic rooms. The scopes were cleaned using the manufactures 3-step system.
- Staff were observed cleaning examination couches and applying clean covers between patients. There were no cleaning schedules observed in consultation rooms
- We observed that there were children's waiting area in clinics 1, 2 and 3 in outpatients. Fracture clinic also had a small play area and had just employed a play assistant.
- Outpatient areas were mostly spacious. However, we observed that the reception area in dermatology clinic was small and all conversations with the reception staff could be overhead and the booking screen seen.

Medicines

- We saw FP10 prescription pads were placed in consultation rooms before clinic started. Patients and visitors had access to these areas and the prescription pads and there was a potential risk that they could have been removed by anyone as the consultation rooms were open.
- All clinical areas and fridges were seen to be locked in outpatients. Botox has high usage with controlled monitoring and good documentation was seen.
- We were told that all radio-pharmacy was managed by the trust pharmacy and it was observed that drugs were stored in locked cupboards and fridges in the diagnostic imaging department.

Records

- Some patients may be required to access The Royal Stoke and County sites in the course of their treatment and/or care pathway. This meant that they had two sets of medical notes, for example stroke patients. This created patient safety issues when both sets of patient's notes were not available for each of the consultations at the different sites. Until the paperless system was rolled out to the outpatients department at the County hospital then this would continue to be a risk for patients
- Staff made us aware that they use "skinny notes" if a patients records are not available. Doctors can access patient's current letters, path lab results and imaging reports on line via GRAFNET. Once the patient records have been located the "skinny" notes are filed in the records.
- We found that records in outpatients were not always stored securely. Record trolleys with coded locks were found open and not attended by staff and a pile of records was found on the floor by the toilets in one clinic.
- We were made aware of an incident a year ago, where records collected by the driver fell off the van and were returned to the trust unopened by a member of the general public. It was reported that security and handling of records has been improved.

Outpatients and diagnostic imaging

- We observed patients' notes being transported around the hospital in open cages. We were informed by staff that notes were transported in locked cages to the central medical record store at Sutherland Library. Taxis are used to transport notes out of hours and at weekends for urgent requests.

Safeguarding

- Staff we talked to were aware of their role and responsibilities and told us how to raise matters of concern appropriately.
- Training records seen in outpatients for safeguarding showed 100% compliance for staff training in safeguarding.
- Paediatric imaging was seen by us to have good team working and staff were aware of safeguarding issues. They had all undergone safeguarding training.

Mandatory training

- We looked at the training records for all staff working in the outpatient department and noted that there was 100% compliance with mandatory training. Staff reported that they had online access to some training.

Assessing and responding to patient risk

- There were emergency procedures in each clinic to alert other staff and resuscitation equipment was available. Staff had received training in emergency life support.
- Staff carried out observations of patients as required, such as pulse and blood pressure. If patients were having treatment or tests.

Nursing staffing

- The trust employs 41.43 whole time equivalent nurses in the outpatients department. There are no vacancies for qualified nursing staff. The department does not use agency staff, if additional staff are required for extra clinics outpatients nursing staff covered them.
- Staff told us and we observed there were sufficient staff available during the clinics to provide a safe service.
- Staff told us there was some internal rotation of staff taking place between the two outpatient sites specifically in fracture clinic and imaging. This provided staffing flexibility as well as developing skills.
- The imaging department had a rota system in place for advanced practitioners working across the two sites.
- Diagnostic imaging is using agency and locum staff and staff expressed their concern that this was having a negative effect on patients' experiences. We were told that all locum and agency staff were mentored until deemed safe.

Medical staffing

- Outpatient clinics were arranged by consultants to meet the needs of their specialities.
- Consultants were supported by trainee colleagues in some clinics, where this was appropriate.
- We were told by staff that locum doctors do see patients in outpatients and their induction was organised by the speciality they were working for.
- Diagnostic imaging is using agency and locum staff to cover vacancies and sickness

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients' needs were assessed and their care and treatment was delivered following local and national guidance for best practice. Consent to care and treatment was obtained in line with legislation and guidance.

Staff were suitably qualified and skilled to carry out their roles effectively and in line with best practice. Staff felt supported to deliver care and treatment to an appropriate standard, including having relevant training and appraisal.

Diagnostic imaging had nationally recognised accreditation in place but there were concerns regarding some of the processes in place.

Evidence-based care and treatment

- Guidance from the National Institute for Health and Care Excellence (NICE) was used to determine the care and treatment provided to patients
- NICE and best practice guidance was available to staff through the trust's intranet.
- Staff were provided with regular updates when guidance was reviewed or practice changed.
- There were local protocols in place which were followed by staff.
- Diagnostic imaging services had received accreditation from the Royal College of Radiologists through the

imaging services accreditation scheme (ISAS). ISAS is a patient focused developmental scheme that helps imaging services improve continuously in four domains – clinical; facilities, resources and workforce; patient experience; and safety. The standard was developed, and is regularly reviewed and updated, by radiologists, radiographers and lay people. Imaging services join the scheme assess their own performance against the standards, make improvements where necessary and then be assessed against the standard to become accredited.

- During our visit and talking to staff in diagnostic imaging we found that there was a lack of awareness regarding the WHO checklist for interventions. Also changes in IRMER policy had not been effectively communicated across modalities. Staff reported they only found out by "word of mouth" and there were no formal arrangements for staff updates.

Pain relief

- Staff in the ENT and fracture clinic told us they could access appropriate pain relief for patients within the clinic setting. Prescriptions for pain relief were recorded in patients' notes and changed to meet patients' needs.

Patient outcomes

- In October 2014 the medical out-patients team reported on a patient survey they conducted during June and July, looking at waiting times in clinic and patient experience. 80% of respondents said nothing could have been added to improve their experience but would have like more information where clinics were running late.
- Since 1 November 2014, the out patients department overall Friends and Family results have scored well over 90%.
- In April, a survey of 40 patients attending the colorectal out-patients clinic demonstrated overwhelmingly that patients were satisfied with their experience.
- The Radionuclide Protection Audit Report from April 2015 noted there was a good standard of radiation protection within Nuclear Medicine and that the majority of action points from the previous report have been addressed.

Competent staff

- All new staff had a trust induction before they started working in the outpatients department and a local induction was arranged by a senior member of staff.
- Staff were trained in core subjects such as infection control, safeguarding and health and safety. Training records in both outpatients and imaging showed that staff were up to date with mandatory training.
- Staff in outpatients told us they had yearly appraisals. Clinical supervision is in its infancy and is informally carried out and not recorded.
- Band 6 and band 7 nurses reported that they had one-to-ones with their line managers monthly, and attended professional meetings in the trust.
- The imaging department had supervision in place and mentored locum staff until they were deemed safe

Multidisciplinary working

- We observed effective multidisciplinary working in both the outpatient and diagnostic imaging departments. Staff reported to us that they had team meetings, newsletters, and could ask for guidance from other professionals.
- Letters were sent to GPs regarding their patients and a summary of consultations, treatments and investigations for the outpatient clinics.

Seven-day services

- Diagnostic imaging run a six day service which includes diagnostic reporting by consultants. The department is working towards a seven day service. Staff rotas also cover the emergency department, seven days per week.
- The outpatient departments are open from 8:30 am to 6:00pm on the Royal Stoke site, Monday to Friday. They also provide regular evening and Saturday clinics.

Access to information

- The trust uses a bar coding system to track patients notes through the organisation. The records department also has a telephone "hot line" contact with each clinic on the day, to ensure they have all the records they require.
- The two patient administration systems across the two hospital sites for booking outpatients clinics do not communicate with each other. This presents challenges when patients are accessing clinics across both sites and patient's information is required. However, if a patients records are not available, doctors can access current information via the on line system.

Outpatients and diagnostic imaging

- Staff told us they had access to all policies and procedures on the trusts' intranet.
- X ray and diagnostic imaging results were available electronically which made them promptly and readily accessible to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated confidence and competence in seeking consent from patients. Verbal consent was observed in the plaster room and the orthopaedic outpatient clinic.
- Staff were aware of their duties and responsibilities in relation to patients who lacked mental capacity. Staff knew the procedures to follow, including involving other professionals.
- The trust had a vulnerable adult lead nurse for patients who may lack capacity, the lead nurse would carry out assessments on request by outpatients staff. Staff reported that most patients with lack of capacity issues usually attend with family or carers.

Are outpatient and diagnostic imaging services caring?

Good

People were supported and treated with dignity and respect and were involved as partners in care.

Staff were approachable, open and friendly. Staff were observed to be discreet and kind when individuals were upset.

Compassionate care

- Feedback from patients indicated that staff in outpatients and diagnostic imaging were kind and caring and did their best in very busy clinics.
- We had positive feedback from patients in diagnostic imaging and one patient was delighted there had only been a two week interim between results of test and seeing a consultant.
- We observed receptionists and staff in outpatients departments speaking to patients and visitors in a polite way.
- During our visit to outpatients we observed nurses leaving treatment room doors open while treating patients and the consultations could be heard by other patients sat in the waiting room.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved and well informed about their care and treatment.
- We talked to a patient and relative who had visited orthopaedic outpatients 19 times in the past two years and they said that waiting times had improved and staff had always been very helpful and gave good advice.

Emotional support

- Patients gave us examples of how staff had emotionally supported them through a diagnosis and treatment. Patients told us staff were caring, supportive and professional.
- Staff were seen by us to be supportive and explained what they were going to do.
- Patients told us staff were reassuring and kind.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Some people are not able to access services for assessment, diagnosis or treatment when they need to due to long waiting times. Cancer waiting times were constantly fluctuating and referral to treatment time targets were not being achieved. The diagnostic waiting times had been higher than England average but were seen to be improving. A significant number of patients were waiting for follow up appointments.

The organisation of the outpatient services was not always responsive to patients' needs. There were numerous delays and clinics consistently over-ran.

Car parking caused a great deal of anxiety of many patients, especially when clinics were running late as they had to pay on arrival, although the trust told us there were arrangements to mitigate this.

Service planning and delivery to meet the needs of local people

Outpatients and diagnostic imaging

- The trust provided a range of outpatient clinics to meet the needs of local people.
- Signage to outpatients and diagnostic imaging services was clearly displayed at the main reception and in corridors.
- During our visit senior management informed us about two innovation pilots. A consultant haematologist and paediatric consultant who run an allergy service telephone patients and parents in the evening to give results from tests and discuss treatments. This is then followed up by a letter confirming the discussion. The feedback is that the patients and parents like the process.
- We were told about a one stop clinic for patients with a **transient ischaemic attack (TIA) that was available** seven days per week. Patients referred by their GP, were seen, investigations carried out, the results would be confirmed and treatments agreed all during the same visit.
- Diagnostic Imaging outpatients supply a daily service and CT cover the service at weekends.

Access and flow

- The national standard for NHS trusts is that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral.
- The number of follow up appointments will have a bearing on how many new patients can be seen and so will have an effect on meeting the 18 week standard. For both of the predecessor organisations the ratio of follow up to new patients was consistently below the England average.
- The overall rates for the trust for patients who did not attend, (without prior cancellation) for their appointment was better than the England average. Patients who did not attend were referred to the consultant for a decision about whether to offer another appointment.
- Cancer waiting times were constantly fluctuating for all 2 week urgent GP referrals, 31 days and 62 day targets since 2013.
- Referral to treatment times (RTT) for patients with incomplete pathways have been consistently below England average since April 2013. RTT for non-admitted patients have also been inconsistent since April 2013.
- The Diagnostic waiting times have been high but are seen to be improving
- Between 1 November 2014 and 31 March 2015, 41,436 out-patient appointments were cancelled. This equated to 14% of all appointments during the same period. Data supplied by the trust showed that about half of these were cancelled by the patient themselves.
- At the time of our inspection, the trust had in the region of 28,000 patients who are waiting for a follow up appointment and that appointment is overdue. If these, approximately 10,000 are less than 4 weeks overdue (which the trust allows as a tolerance for patient choice of appointment). These leaves a backlog of 18,000 patients who have gone more than 5 weeks past their due appointment date. The trust have implemented a number of actions to address this including clinical validation led by the clinical leads and working with the local CCGs to facilitate a joint clinical review of selected patients.
- During our listening events with patients, we were told that some clinics book a number of patients for the same time; this is called block booking. During the inspection this was confirmed to us but our observations and from talking to staff. This means all the patients arrive at once, and provide a poor patient experience.
- Orthopaedic outpatient clinic had patients booked from 1 00pm. The consultants didn't arrive until 2 pm. The waiting area was small and patients were standing in the corridor
- The fracture clinic reception was busy during our inspection. Fracture clinic had eight patients booked at 10 00am and ten patients booked at 11 00am. Clinic delays were recorded as one hour on the information boards but one patient we talked to had an appointment at 10 00 am and was not seen until 12 00 pm.
- We noted that they had a 106 patients booked for the morning fracture clinic and had seven DNAs. We observed delays as patients waited for removal and application of plaster, X-rays to be completed and to see the doctors.
- In surgical outpatients it was observed that they had seven consultants and two were reported running late on the information board. Delay times on notice boards in the main waiting areas were not always correct and that they did not take into account sub waiting areas times. One patient told us they had been waiting over 90 minutes in the main waiting areas before being called through to a sub waiting area.

Outpatients and diagnostic imaging

- Staff told us that one of the consultants ran late for every clinic and they could go on until 6 00pm. This was confirmed by patients who commented that the consultant they saw always ran late.
- Staff were unable to provide us with data regarding percentages of patients waiting more than 30 minutes to see a clinician. We were told by staff that the issue of clinics repeatedly overrunning was being addressed with the directorates and the clinics were in the process of being audited.
- We observed lack of information regarding delays in CT scanning waiting area

Meeting people's individual needs

- The outpatient and diagnostic imaging departments had touch screen booking in systems, with six terminals in the main hospital reception area. During our visit we observed staff and volunteers helping patients use the new system and taking time to explain how it works. The patient is then given a number that will be called or displayed on a TV portal in clinic, rather than their name, to preserve privacy.
- We observed and were told by staff that the records of patients living with dementia had a butterfly printed on the front of the record to alert staff.
- We saw a quiet room in outpatients for patients to access when they had received bad news or needed time away from the busy department.
- We were informed by staff that they could access a translation service. This could be done over the phone or booking an interpreter to attend with patients for appointments. We observed no written information regarding this service and there were very limited leaflets in different languages.
- The outpatients has a dementia link nurse and information was displayed on notice boards in clinic areas. Staff we talked to said they had had dementia training and knew how to contact the nurse for vulnerable adults. Imaging staff reported that they have received no dementia training
- Car parking was an issue for patients and caused stress especially if clinics were running late as they had to pay "up front" for parking. We were told by management that if clinics were running late patients could ask receptionist to contact main reception giving their car registration and they would inform the parking attendant and they would not receive a fine. We were unable to find this information displayed in any of the outpatient clinics or diagnostic imaging. The patients we talked to were not aware of this process.
- Patients told us that spaces for disabled drivers had been relocated away from the hospital entrance and found it a long way from the car parking to the hospital especially in bad weather.
- We were told there were about 40 different information leaflets across diagnostic imaging and leaflets are sent out with appointments to ensure patients are fully informed of their treatment and care. However, we talked to a patient attending for a CT scan who was not aware of what they were to have done as no information was given with the pre procedure appointment. There is no regular audit of patients information to ensure its continued effectiveness.
- There was also limited post procedure information seen in the waiting areas. We also saw no patient feedback forms in the diagnostic imaging outpatient areas.

Learning from complaints and concerns

- There were nine complaints linked to the outpatients department at The Royal Stoke hospital since November 2014.
- Leaflets on how to make a complaint were available in the outpatient clinic areas. However, there were no such leaflets in the diagnostic imaging outpatient areas.
- We were told by staff in outpatients and imaging that written complaints went to PALs to be managed; however, verbal complaints were dealt with in the clinic or department setting if possible. This was not documented.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

There is a clear vision for the trust and the service. Staff in the outpatients department were engaged in developing services so that they understand the planned changes. There are integration champions as part of the service development across both sites and these have had a positive impact. Staff in diagnostic imaging had a good understanding of the departments approach and the role they played within that.

Outpatients and diagnostic imaging

Vision and strategy for this service

- The trust had a clear vision statement displayed in all areas of the hospitals, including outpatient clinics.
- Staff were aware of the strategy for their clinics or departments, but not of any specific objectives for the outpatients service as a whole. Staff felt they had been involved in some of the recent changes as part of the transition process.
- When talking to diagnostic imaging staff it was felt they had a good understanding of the department's vision and strategy and governance arrangements under the ISAS accreditation.
- Some staff we talked to felt that changes in policies in diagnostic imaging and feedback were not communicated well across modalities e g changes to IRMER policy.

Governance, risk management and quality measurement

- The outpatient management team had weekly meetings with the associate directors of each division to discuss issues.
- The outpatients risk register identified issues relating to clinic capacity, using two electronic clinic booking systems across the two sites and concerns relating to patient notes availability.
- Senior staff explained to us that the directorate had their own governance meetings and activities from outpatients were presented and discussed at the meeting, e.g. cancellations of clinics had been escalated to these meetings.
- We were told by staff that national audits were carried out as required to meet government targets. “In house” audits were carried out on a monthly basis e.g. family and friends, infection control, cancellation of clinic and clinic overruns.
- The diagnostic imaging department had 19 teams and each had their own governance team. There is also a patient’s experience group which is consultant led.

Leadership of service

- We saw evidence of the new management structure in outpatients and diagnostic imaging services. As the outpatient management team are based on the Stoke site, staff felt they could approach them with concerns and ideas to improve patient care.
- Some radiologists we talked to were not involved in the merger strategy but felt the service was well-led.
- Integration champions were put into place, before the merger took place, to support staff

Culture within the service

- We observed that staff supported each other and worked in multidisciplinary teams in both outpatients and diagnostic imaging.
- Staff we spoke with were proud to work at the hospital and were keen to tell us about their work and achievements.

Public and staff engagement

- Staff told us they felt up to date with changes being implemented in the outpatients department. They had regular e-mails, newsletters and team meetings. The spring newsletter included the new outpatients management structure.
- Staff told us that the integration champions had helped improve communication and awareness of changes occurring across the trust.
- Staff told us they were keen to engage with patients and the public to improve the patient experience and asked for verbal feedback.
- We observed patients providing feedback using an electronic tablet. This enables information about patient experience to be collected in real time and feedback to the outpatients management team.
- There was no patient feedback mechanism seen in diagnostic imaging.

Innovation, improvement and sustainability

- Diagnostic imaging services had received accreditation from the Royal College of Radiologists through the imaging services accreditation scheme (ISAS).
- We were told about the “one stop” TIA clinic and telephone clinic being carried out by consultants. Staff saw them as leading innovation in the departments.
- The Trust is working towards a 55% / 45% outpatients split between the two sites with non-urgent day surgery moving to the County Hospital

Outstanding practice and areas for improvement

Outstanding practice

- The trust Alcohol Liaison team had reduced hospital stay for patients with alcohol related issues by an average of 1 day per patient. This equated to 2762 hospital days saved during the last two years. In monetary terms this meant the trust saved over £4.25million during the same period. This was also seen as outstanding practice.
- A specialist one stop clinic had been developed for women with substance misuse issues where they could obtain the script for their medicines and then see the consultant and specialised midwife for their antenatal care. The rate of women who did not attend for antenatal care had reduced from 98% to 20%. We were told that the outcomes for women who attended the clinic had improved year on year.
- Development of a Frailty Passport to identify patients who require extra support during their stay in hospital.
- The trust was working in partnership with Teesside University to roll out the Excellence in Practice Accreditation Scheme (EPAS). The Elderly Care Wards, Emergency Department and the critical care Unit had all achieved the EPAS award at gold, platinum and silver levels respectively.
- There were a range of initiatives in the children's service:
  - Children on ventilators and having chemotherapy were taken on days out by staff.
  - Neonatal care staff had developed 'Helping hands', an online forum support group for parents with neonatal babies.
  - Oncology staff used a 'Beads of Courage' programme which is designed to support children going through their treatment. The beads are used as meaningful symbols of courage that commemorate different milestones.
  - Staff developed diaries for critically ill children to be able to take home with them when they leave. They recognised recent research that showed diaries were important for the psychological wellbeing of the parents and children after discharge. Staff wrote compassionate remarks in the diaries and added photographs to show the child's journey.
  - Staff in the children's intensive care unit have been working with children on long term ventilation to improve their outcomes and wean to just night time ventilation which made a significant difference to the children's overall wellbeing and quality of life.
- Diagnostic imaging services had received accreditation from the Royal College of Radiologists through the imaging services accreditation scheme (ISAS). ISAS is a patient focused accreditation scheme that helps imaging services improve continuously in four domains – clinical; facilities, resources and workforce; patient experience; and safety. The standard was developed, and is regularly reviewed and updated, by radiologists, radiographers and lay people. Imaging services join the scheme assess their own performance against the standards, make improvements where necessary and then be assessed against the standard to become accredited. The associate medical director has spoken at national conferences about their work on this.

Areas for improvement

Action the hospital MUST take to improve

- The trust must review the arrangements for patient flow through the emergency department at Royal Stoke to ensure the systems and processes in place throughout the hospital are contributing to moving patients through the hospital, especially referral protocols.
- The trust must review staffing arrangements in medicine and the emergency department at Royal Stoke to ensure there are sufficient numbers of nurses and that the planned and actual staffing levels for each shift are displayed.

Outstanding practice and areas for improvement

- The trust must ensure that resuscitation trolleys throughout the Royal Stoke hospital are appropriately stocked and are checked as regular intervals.
- The trust must review the capacity and adequacy of the critical care services at Royal Stoke to ensure that level 2 and level 3 patients are cared for in appropriate and safe environment by nursing staff with sufficient experience and qualifications as set out in the Intensive Care Core Standards and there are safe arrangements for responding to medical emergencies out of hours.
- The trust must continue to work with local stakeholders to reduce the backlog of patients waiting for follow up out-patient appointments and continue to work to assure themselves that patients are not affected by excessive waiting times for the appointment.
- The trust must ensure that the outreach team at Royal Stoke are sufficiently resourced to be able to response to deteriorating patients and support ward staff.
- The trust must implement the individualised care plan as soon as possible so that patients who are actively dying are supported holistically.
- The trust must improve the discharge process for patients who wish to go home to die so that fast track discharges can be completed within agreed timescales so that patient's preferences regarding place of death can be met. This information should be routinely recorded and monitored.
- The trust must ensure that arrangements for medicines that require storage in fridges are done so safely and effectively. All fridges must be maintained and/or replaced to ensure medicines are stored at the correct temperature. Plans should be in place in order to monitor the fridge temperature on a daily basis and clear actions taken when temperatures are not within agreed limits..
- The trust should ensure that all staff are suitably trained and knowledgeable about the Mental Capacity Act 2005 and their responsibilities around it to ensure that patients who lack capacity are protected from decisions being made about their care and treatment without their input and their capacity is appropriately recorded.

Action the hospital SHOULD take to improve

- The trust should review and reframe the 2025 Vision to ensure staff at all levels of the organisation can understand it and be clear how they fit into the wider plans for the new integrated organisation.
- The trust should ensure that all patient records are stored securely at all times to protect privacy and confidentiality
- The trust should ensure that the triage service in the emergency department is formally reviewed to ensure that robust clinical decisions are being made and that patients are being managed effectively.
- The trust should review arrangements for gynaecology patients to ensure they are provided with a safe service and are cared for by staff with the relevant skills and expertise.
- The trust should ensure they improve the children's oncology day unit in providing patient toilets and more space for staff to be able to provide treatment to children when lying down.
- The trust should ensure the Children's Assessment Unit (CAU) has cubicles for infectious patients.
- The trust should review arrangements for access to patient records and information across both sites to ensure staff are able to access records as needed and care is not compromised. The trust should also ensure that patient records are kept secure and confidential at all times.
- The trust should ensure that suitable arrangements are in place to address and when needed report mixed sex breaches of ward able patients in critical care.
- The trust should ensure that hazardous cleaning items are safely stored and kept locked away from vulnerable children and young people.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Care for patients at the end of their lives was not person-centred as care and treatment was not designed with a view to achieving their preferences and ensuring their needs were met. Regulation 9(2)(b) HSCA 2008 (Regulated Activities) Regulations 2010 Person-Centred Care

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way as the persons providing care or treatment did not all have the qualifications, competence, skills and experience to do so safely. Regulation 12(2)(c) HSCA 2008 (Regulated Activities) Regulations 2010 Safe Care and Treatment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems and processes in place to assess, monitor and improve the quality of services provided for patients who are cared for in facilities which are not intended for that purpose.

This section is primarily information for the provider

Requirement notices

The provider did not have systems and processes in place to assess, monitor and improve the quality of services provided for patients who are subject to delays in care and treatment.

Regulation 17(2)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Good Governance.