Worcestershire Acute Hospitals NHS Trust

Alexandra Hospital

Quality Report

Alexandra Hospital
Woodrich Drive
Redditch
B98 7UB
Tel: 01527 503030
Website: www.worcsacute.nhs.uk

Date of inspection visit: 22 to 25 November, 8 and 15 December 2016
Date of publication: 20/06/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Worcestershire Acute Hospitals NHS Trust was established on 1 April 2000 to cover all acute services in Worcestershire, with approximately 885 beds spread across various core services. It provides a wide range of services to a population of around 580,000 people in Worcestershire, as well as caring for patients from surrounding counties and further afield.

Worcestershire Acute Hospital NHS Trust provides services from four sites: Worcestershire Royal Hospital, Alexandra Hospital, Redditch, Kidderminster Hospital and Treatment Centre and surgical services at Evesham Community Hospital, which is run by Worcestershire Health and Care NHS Trust.

The trust was rated overall as inadequate and entered the "special measures" regime based on the initial inspection from 14 to 17 July 2015. Special measures apply to NHS trusts and foundation trusts that have serious failures in quality of care and where there are concerns that existing management cannot make the necessary improvements without support. Kidderminster Hospital was rated as requires improvement overall during this period.

As part of a scheduled re-inspection of the trust, we carried out a further comprehensive inspection of Worcestershire Acute Hospitals NHS Trust from 22 to 25 November 2016, as well as an unannounced inspection from 7 to 15 December 2016.

On 27 January 2017 we issued a section 29A warning notice to the trust requiring significant improvements in the trusts governance arrangements for identifying and mitigating risks to patients.

Overall, we rated Alexandra Hospital as inadequate, with two of the five key questions we always ask being judged as inadequate.

Our key findings were as follows:

- The flow of patients in the emergency department (ED) was often blocked by internal capacity issues, for example, a lack of available beds in the hospital. This resulted in ED becoming over crowded, and with patients waiting on trolleys in a corridor.
- In November 2016, only 50% of ambulance patients were handed over to ED staff within 15 minutes. There were not enough nurses to ensure that all patients were assessed within 15 minutes of arrival in the department, or to safely care for patients in the major treatment area and resuscitation room.
- There were not enough consultants to provide 16 hours of consultant cover within the ED each day, in line with national guidance.
- There was no privacy and little confidentiality for patients waiting on trolleys in the corridor of the ED. Staff did not always have line of sight of these patients.
- The department could not ensure that there was always as a senior doctor available who was qualified to resuscitate children. Staff had not been trained to use a new system to help staff recognise when a child's condition was deteriorating. The system had been introduced two days before our inspection.
- Staff did not complete venous thromboembolism assessments on patients in line with trust policy and national guidance.
- Appropriate systems were not always in place for the storage, administration and recording of medicines. Intravenous fluids for emergency use were stored unsecured in resuscitation trolleys on corridors in the ward areas. The trolleys were accessible to staff, patients and relatives which meant there was a risk of medicines being tampered with which could cause harm to patients.
- Safeguarding children training compliance was low throughout the hospital and not in line with national guidance.
- Staff were unaware of female genital mutilation and child sexual abuse. There was a risk that staff would not recognise when a child was being abused or exploited.
- There was a lack of radiation protection infrastructure.

Summary of findings

- Medical notes were not always locked away safely.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected.
- There was no policy in place regarding the management of medical outliers. Medical outliers are patients who are admitted to a non-medical ward. Doctors and nurses told us these patients were at greater risk because they were not cared for on a designated medical ward.
- Not all staff had completed mandatory training or received an annual appraisal.
- Not all staff cleaned their hands before and after contact with patients and some staff did not change their gloves or aprons after each task. This meant that infection prevention and control practices were not in line with trust policy or national guidance throughout the hospital.
- There was a high number of medical and nursing vacancies and unfilled shifts.
- The strategy for countywide management of emergency surgery was not fully implemented and some staff were unaware of the surgical plan.
- There was a culture of incident reporting and most staff said they received feedback and learning from serious incidents.
- Feedback from patients and those who were close to them was positive about the way staff treated them. We observed patients being treated with dignity, respect and kindness.
- Relatives of patients in critical care had access to facilities to enhance their stay on the unit; this included overnight accommodation, refreshments and information leaflets.
- Patients with a mental health condition who attended the ED were cared for by a responsive and effective psychiatric liaison service and specialist alcohol liaison nurse services were available.

There were areas of poor practice where the trust needs to make improvements:

Action the hospital MUST take to improve

- Ensure patients privacy, dignity and confidentiality is maintained at all times, particularly during handover.
- Ensure patients are always assessed and treated in line with the Mental Capacity Act 2005.
- Ensure that patient documentation, including risk assessments, are completed accurately and routinely to assess the health and safety of patients. This must include pain assessments, venous thromboembolism assessments and fluid balance charts.
- Ensure that patient weights are recorded on their drug charts.
- Ensure that there is clear oversight of all deteriorating patients and that the National Early Warning Score chart is completed accurately.
- Ensure there is an embedded risk assessment process to determine the criteria for patient moves to non-medical wards.
- Establish a female genital mutilation training programme for all staff working in children and young people's services.
- Ensure staff are aware of the Mental Capacity Act 2005.
- Ensure operating team brief is attended by all required members of staff, as per national guidance.
- A robust system must be in place to ensure that all electrical equipment has safety checks as recommended by the manufacturer.
- Ensure that all equipment is checked as per policy, particularly in midwifery services.
- Ensure that patients are cared for in a safe environment that has the appropriate equipment to facilitate care to a deteriorating patient.
- Ensure that medicines are stored within the recommended temperature ranges to ensure their efficacy and safety.
- Review arrangements for the storage of intravenous fluids for emergency use to ensure patient safety.
- Ensure that medicines are always administered to patients as prescribed.
- Ensure that there is a system in place in the emergency department to record medicines (including intravenous morphine) administered to patients by ambulance crews.

Summary of findings

- Ensure infection prevention and control procedures are always carried out as per trust policy and national guidelines.
- Ensure theatres and anaesthetic rooms are compliant with national guidance, Health Technical Memorandum 03-01: Specialised Ventilation for Healthcare Premises.
- Improve performance against the 18 week referral to treatment time, with the aim of meeting the trust target.
- Improve performance against the national standard for cancer waiting times. This includes patients with suspected cancer being seen within two weeks and a two-week wait for symptomatic breast patients.
- Ensure patient harm reviews are carried out on patients who breach the referral to treatment times and cancer waits in order to mitigate any risks.
- Ensure that incidents are accurately reported and investigated.
- Ensure all mortality and morbidity meetings are recorded and lessons are learnt.
- Ensure there are systems and processes established in surgical service to address identified risks, such as cancelled operations, bed capacity and access to emergency theatres.
- Ensure divisional management teams are aware of patient harm reviews.
- Ensure divisional management teams have oversight of the patient waiting lists and of initiatives and actions taken to address referral to treatment times and cancer waits.
- Develop a clear strategy for surgical services which includes a review of arrangements for county wide management of emergency surgery.
- Ensure children's and young people's service carry out clinical audits to identify effectiveness and areas for improvement.
- Ensure staff are aware of the strategy for diagnostic and imaging services.
- Ensure patient notes are stored securely and safely.
- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets the trust target of 90%.
- Ensure all staff receive an annual appraisal and that there is appropriate supervision for staff.
- Ensure that there are sufficient registered children's nurses in post so that the emergency department always has at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments.
- Ensure only appropriately trained staff members are left in charge of a ward to care for patients.
- Ensure all patients are clinically assessed by a competent member of staff within fifteen minutes of arrival in the emergency department.

In addition, the trust should:

- Ensure there are consistent mortality review group meetings in order to review the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) across the service.
- Ensure that clinical audits in the emergency department are reviewed to enable the findings to improve practice. Accurate performance data should be collected and discussed at relevant governance meetings.
- Ensure robust risk management processes are in place with defined action plans and regular reviews.
- Ensure governance meetings reflect their terms of reference.
- Ensure all staff use appropriate personal protective equipment and decontaminate their hands appropriately at all times, especially before and after every patient contact and when moving between clinical areas.
- Review the arrangements for the storage of intravenous fluids for emergency use.
- Ensure trust policies are up to date and reflect current national guidance.
- Develop documents that clearly identify where specific information should be recorded.
- Ensure record keeping systems are coordinated to enable staff access to all relevant patient information.
- Ensure there is an effective escalation process when the hospital is approaching full capacity.
- Ensure there are sufficient consultant emergency medicine doctors to keep patients safe.
- Ensure all new bank and agency staff receive thorough inductions and ward orientations before starting work.

Summary of findings

- Document and record all meetings where performance in the children's clinic is discussed.
- The provision of children's services should be clarified with external providers to ensure the safe care of children in the emergency department.
- Ensure all women are asked about domestic violence during their pregnancy in line with national guidance.
- Share results from national audits and action plans with all levels of staff to improve patient outcomes.
- The trust should improve its local audit schedule and consider more regular audits in documentation, the environment, equipment, surgical site infections and hand hygiene audits. Audit results should be followed up with improvement action plans where indicated.
- Ensure staff have knowledge of the key objectives within their service.
- Ensure all cancelled clinics and outpatient appointments are rescheduled in a timely manner.
- Review the high levels of unplanned medical admissions onto the surgical wards and implement steps to reduce the number of cancelled operations.
- Ensure all treatment areas where children and young people are provided with care and treatment, including adult services, are appropriate and child friendly environments.
- Ensure appropriate waiting areas are available for children and young people when sharing adult services.
- Take action to address the 'did not attend' appointment rate for new children and young people's services appointments.
- Ensure patients are discharged from the critical care unit within four hours of the decision to discharge, in order to improve the access and flow of patients within critical care.
- Investigate complaints within the timescales stated in the trust's complaints policy.
- Review the choices offered to patients about where they are discharged to for continuing care.
- Ensure information from the children's clinic flows to the board via effective governance processes.
- Engage and consult with all staff when considering any service reconfiguration and involve staff in the strategic plans to develop the surgical services across the three hospital sites.

Since this inspection in November 2016 CQC has undertaken a further inspection to follow up on the matters set out in the section 29A Warning Notice mentioned above, where the trust was required to make significant improvement in the quality of the health care provided. I have recommended that the trust remains in special measures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Inadequate 	We rated urgent and emergency services as inadequate because: • Safety systems and processes were not fit for purpose. There were significant delays for an initial triage assessment by emergency department (ED) staff. • Services were not planned and delivered to meet the needs of local people. There was not an adequate full capacity plan in place to address issues that the ED faced. • The flow of patients in the ED was often blocked by internal capacity issues in the hospital. This resulted in a severely crowded department with patients waiting on trolleys in a corridor. • The trust had not achieved the national target to admit or discharge 95% of patients within four hours of arrival, since October 2014. • In November 2016, only 50% of ambulance patients were handed over to ED staff within 15 minutes. There were not enough nurses to ensure that all patients were assessed within 15 minutes of arrival in the department, or to safely care for patients in the major treatment area and resuscitation room. There were not enough consultants to ensure a consultant presence in the department for 16 hours a day. • There was no privacy and little confidentiality for patients waiting on trolleys in the corridor and they were sometimes left in cold conditions. Staff did not always have line of sight of these patients and safety equipment was lacking. • Safety incidents were not always recorded correctly and little action was taken when repeated incidents took place. • Care and treatment did not always reflect current evidence based guidance. ED staff were unaware of best practice guidance on conditions, such as heart attacks, strokes and broken hips.

Summary of findings

- The department did not meet the requirements of the national "Standards for children and young people in emergency care settings". Children's emergency services were not always planned in conjunction with staff in the ED.
- The department could not ensure that there was always as a senior doctor available who was qualified to resuscitate children. Staff had not been trained to use a new system to help staff recognise when a child's condition was deteriorating that had been introduced two days before the inspection.
- The arrangements for governance and performance management did not always operate effectively. Until November 2016, there had not been an effective governance framework to support good quality care for over a year. There was no clear process for the escalation of risks to divisional directors or the trust board.
- Staff did not always feel actively engaged or empowered. They expressed frustration about the continuing delays in treatment and the conditions in which some patients had to be nursed.

However:

- Feedback from patients and those who were close to them was positive about the way staff treated them. We observed patients being treated with dignity, respect and kindness.
- The matron and lead consultant took an active part in daily clinical activity and were praised by staff for their supportive leadership skills.
- Patients with a mental health condition were cared for by a responsive and effective psychiatric liaison service and specialist alcohol liaison nurse.
- There had been good results from recent audits of sepsis treatment, recognition of deteriorating adult patients, measurement of vital signs in children and adult procedural sedation.

Summary of findings

Medical care (including older people's care)	**Inadequate**	
Surgery	**Inadequate**	We rated the surgery service as inadequate because: • Patient outcomes were generally below the England average. Not all staff were aware of patient outcomes, national audit results and performance measures. • There was a high number of medical and nursing vacancies in the service and unfilled shifts. • Not all staff cleaned their hands before and after contact with patients and some staff did not change their gloves or aprons after each task. • Medicines were not stored within recommended temperatures. • Venous thromboembolism assessments were not always completed in line with trust policy and national guidance. • Medical notes were not locked away safely. • Some junior staff did not have an awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and safeguarding procedures. Less than half of clinical staff had training in MCA and DoLS. • The five steps to safer surgery checklist was not always carried out in accordance with trust policy and national guidelines. • Not all patients had their temperature monitored during their operation and in line with national guidance. • The trust had mixed performance for the national Hip Fracture Database audit. • Theatre ventilation systems did not meet essential safety standards. • Not all staff had completed mandatory training or received an annual appraisal. • The admitted referral to treatment time and did not meet national standards. It was consistently below the England average of 80%. This meant some patients were waiting longer for their operation than in some other hospitals.

Summary of findings

- Patients had their operations cancelled more times than the national average.
- There were high levels of unplanned medical patient admissions to the surgical wards, resulting in some cancelled operations.
- Enhanced recovery pathways and care plans were not routinely used across surgery services to enable patients to go home as quickly as possible.
- Patients were not always offered a choice about where they were discharged for continuing care.
- Countywide management of emergency surgery was not fully implemented or understood by all staff.
- There was a lack of risk management.
- Staff satisfaction survey results for the surgical division were worse than last year.
- Less than a third of nursing and medical staff had received training in safeguarding children.

However:

- There was a culture of incident reporting and most staff said they received feedback and learning from serious incidents.
- Medical staffing was appropriate and there were emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.
- Treatment and care was provided in accordance with evidence-based national guidelines.
- Learning from complaints was evident.
- There was support for people with a learning disability and reasonable adjustments were made to the service. An interpreting service was available and used.
- Staff were caring and compassionate to patients. Patients spoke highly of the care they had received.
- Patient's pain, nutrition and hydration was appropriately managed and care was documented.
- The governance framework had improved since out last visit.
- Regular staff meetings were held at all levels and information was shared with staff.

Summary of findings

- There was evidence of patient and public engagement.

Critical care

Good

We rated critical care as good because:

- There was a positive safety culture. Staff recorded incidents, investigations were completed and staff received feedback. The service had a robust safety briefing in place, which was attended by all staff.
- Staff maintained and monitored patient safety through local audits which included infection control, patient harms and risks. Action plans were developed to address any issues.
- Patient records were contemporaneous, legible and stored safely. Evidence based assessment tools were used to monitor risk.
- Mandatory training was generally in line with trust targets.
- Medications were stored, prescribed and administered safely. There were systems in place to monitor safe storage and staff took appropriate actions in line with local protocol to address any concerns or anomalies.
- The service used evidence-based guidelines, policies and protocols to monitor patient outcomes. Results were used to compile service dashboards, which were used to present audit results and monitor trends. Clinical leads reviewed these for compliance and trends and discussed results as part of the divisional and trust wide service meetings.
- The service had a flexible approach to delivering patient care across both critical care units (Alexandra Hospital and Worcestershire Royal Hospital) to maintain patient safety.
- Patient outcomes were used to benchmark the service against similar organisations to identify areas for improvement.
- The service had access to additional specialists such as a pain specialist nurse, dietetics, microbiologists and pharmacy.
- Staff competence was monitored and maintained through annual appraisal and competency reviews. External training was available for staff.

Summary of findings

- There was evidence that the multidisciplinary team was inclusive and well organised.
- Patients were treated with dignity and respect, and in line with their individual beliefs and were involved with the care and treatment planning. Patients spoke positively about the care they received.
- Relatives had access to facilities to enhance their stay on the unit, this included overnight accommodation, refreshments and information leaflets.
- Patients were assessed appropriately for admission to critical care and received a full review by a consultant within 12 hours of admission to the unit.
- There were no formal complaints regarding the service.
- The service was well-led with strong local leadership, a service vision and robust governance systems in place.
- All staff were positive about their roles, enjoyed working for the service and were dedicated to improving the standards of patient care.

However:

- There were a small number of delayed discharges from critical care, which affected patient flow and experience.

Maternity and gynaecology

Requires improvement

We rated maternity and gynaecology as requires improvement because:

- Medical vacancy rates in obstetrics and gynaecology were high, leading to cancellations of clinics and some patients waiting more than 18 weeks to be seen.
- Limited use of local audit meant that some outcomes with regards to patient safety, care and effectiveness were not fully understood. This was especially noticeable with regards to documentation and assessment.
- Senior leaders were not always visible and some had limited capacity due to multiple roles.

Summary of findings

- Staff had a poor understanding of female genital mutilation, child sexual exploitation, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Leaders had told us that all staff had been trained in these areas.
- Multiple sets of patient notes led to gaps in information in some records we saw.
- There was no awareness amongst staff of major incident plans, or roles that individuals would take should there be a major incident.
- Midwives were not rotated to different areas, potentially resulting in loss of some skills.

However:

- All staff considered patients' needs and were respectful and caring in their interactions.
- Staff were valued and respected. There was open and honest communication between staff and managers. Local leaders were visible and approachable.
- Divisional leaders had a clear vision and strategy for maternity services.
- Incidents, comments and complaints processes were thorough, and lessons learned were disseminated well. However, the target to complete these was often missed.
- Nursing and midwifery leaders were always available by telephone or email.

Services for children and young people

Requires improvement

We rated services for children and young people as requiring improvement because:

- Staff were not aware of any guidance to support them in identifying what incidents should be reported. This created a risk that some incidents might not be recorded and therefore any learning from these would be missed.
- Incidents were not always graded. In addition, learning from incidents was not identified. This meant there was a risk in the service that staff would not learn from incidents.
- Recording templates for patient information were not always clear and did not contain columns on documents that clearly identified where height and weight should be recorded. This meant they were difficult to read and information could be lost.

Summary of findings

- Staff were unaware of female genital mutilation (FGM) and child sexual abuse (CSE). There was a risk that staff would not recognise when a child was being abused or exploited.
- Level 3 safeguarding children's training was not always face to face and was not updated annually; this was not compliant with the guidance on safeguarding training.
- There were some policies relating to safeguarding children that were not available on the trust intranet. This included the 'no allegations' policy, and the 'managing celebrity visits' policy. The 'safeguarding supervision' policy also stated that it was in development on the intranet safeguarding pages.
- There was no clinical audit plan for the children's clinic. There was little evidence that continual improvement of the service and compliance with best practice was identified or actions taken to address any shortfalls.
- The women and children's division had introduced a performance dashboard to monitor patient outcomes. There was little evidence that performance in the children's clinic was discussed.
- There was no formal clinical supervision for nursing staff. Supervision was provided by the outpatient's manager over the telephone. However, the manager also worked in WRH as an advanced nurse practitioner and could only offer staff telephone support when there were quiet periods at WRH.
- Multidisciplinary working between all the trust's hospital sites was not effective at all times.
- The 'did not attend' appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%.
- From September 2015 to August 2016 there had been three complaints about children's services at Alexandra Hospital. The hospital took an average of 31 days to investigate and close complaints. This was more than their complaints policy, which requires complaints to be closed within 25 days.

Summary of findings

- As a result of the emergency service reconfiguration, the children's service did not have a clear vision and did not have a long-term strategy for children's services. Staff were unaware of the vision and values in the children's outpatient service as these had not been defined.
- The governance framework was not effective. There was no evidence that information flowed between the directorate and divisional governance or quality meetings.
- Monthly divisional governance meetings were not consistently adhering to their terms of reference. This included, not focusing on themes and trends from incidents and safeguarding training performance. Compliance to level 3 safeguarding training was not recorded separately and therefore the service was unaware which staff had completed level 3 safeguarding training.
- The divisional risk register, focused on the number of risks recorded, rather than how they were being managed. The hospital had recently closed to paediatric inpatients and there had been little discussion around how the transitional period was managed.
- The outpatients manager had not been allocated any contracted hours for service leadership, which they had to fit around their other role at WRH. This meant it was unlikely that staff would receive timely supervision and advice.
- Some staff did not feel fully consulted about the service reconfiguration.

However:

- The environment in the children's clinic was visibly clean and staff followed correct cleaning protocols.
- Overall, care records were generally written and managed well.
- Staff had achieved the trust's mandatory training target of 90%.

Summary of findings

- There was no paediatric resuscitation 'bleep' in use at Alexandra Hospital. However, there were clear protocols describing how children should be transferred to WRH if they needed to be treated by a specialist paediatric doctor.
- Medical and nursing staffing levels were planned and reviewed in advance based on an agreed number of staff per shift.
- The trust had a major incident plan in place although some staff were unaware of the business continuity plan to deal with adverse weather.
- Staff who worked in the children's clinic took time to interact with patients and their parents in a manner which was respectful and supportive.
- The patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after.
- Feedback from the CQC's children and young people's survey 2014 was largely similar to other trusts including privacy, care and treatment and staff friendliness.
- Staff communicated with children and young people and their families in a way that they could understand.
- Children and young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of patient information available in the children's clinic.
- Staff understood the impact that a patient's care, treatment and condition had on them and those close to them.
- Services in the children's clinic took into account the needs of different children and young people. Consideration had been given their age, gender and any disability.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to the appropriate support.
- The trust regularly met its 95% target for referral to treatment time for non-admitted children and young people and most received an appointment within 18 weeks.

- Managers told us service reconfiguration was made with the objective of making improvements for patients and staff. However, at the time of our visit it was too early in the reconfiguration process to measure whether this would result in sustainable improvements to children and young people's care.

End of life care

Good

We rated the end of life care service as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. Incidents relating to end of life care were reviewed by the lead nurse for specialist palliative care. DNACPR (do not attempt cardiopulmonary resuscitation) records were generally completed well and the trust were making use of audits and learning from incidents to drive improvements.
- There was good identification of patients at risk of deterioration and those in the last days of life. There was clear evidence of the trust using national guidance to influence the care of patients at the end of life. There was consistent promotion of the delivery of high quality person centred care. Several audits had been undertaken to evaluate the service with associated action plans to address improvements identified.
- A comprehensive programme of end of life care training was available for the full range of staff within the trust. However, we were not able to establish compliance with mandatory training (including safeguarding adults training) for specialist palliative care staff, including their annual appraisals rates. Evidence for this was requested but not provided by the trust.
- There was good evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital including allied healthcare professionals as well as medical and nursing members. The specialist palliative care team provided a seven day face to face assessment service across the trust.
- The trust had taken action to improve the service since the previous inspection. This included the

replacement of fridges, flooring and improving the hot water facilities within the mortuary. Issues relating to obtaining syringe drivers had been addressed and appropriate anticipatory prescribing was used at the end of life.

- There was clear evidence of the trust using national guidance to influence the care of patients at the end of life. The trust had begun to record and audit preferred place of care and there were clear systems in place to make improvements in this area.
- The specialist palliative care team responded quickly to referrals and would see patients within a few hours if the need was urgent. The majority (92%) of patients were seen within 24 hours and there was a good balance between cancer patient and non-cancer patient referrals.
- Patients and relatives told us that the staff were caring, kind and respected their wishes. We observed staff communicating with patients and relatives in a manner than demonstrated compassion, dignity and respect.
- There was a clear vision for the service and a draft strategy was in place, highlighting the key areas the trust were focusing on in relation to end of life care.

Outpatients and diagnostic imaging

Inadequate

We rated outpatients and diagnostic imaging as inadequate because:

- There were long waiting lists for the majority of specialities and the trust had not met all cancer targets for referral to treatment times. The trust was failing to meet a range of benchmarked standards with regards to the time with which patients could expect to access care.
- Mandatory and safeguarding training levels did not always meet the trust's target and not all staff had received an annual personal development review.
- Incidents were not always categorised appropriately in terms of the level of harm caused. Incidents were not always reviewed in a timely manner and we were not assured that learning from incidents was cascaded to all staff.
- Complaints were not always responded to in a timely manner.

Summary of findings

- There was a lack of radiation protection infrastructure.
- Old and unsafe equipment across the trust was inadequately risk rated and there was a lack of capital set aside to fund replacement items.
- There had been two patient safety incidents in the trust involving unsafe x-ray equipment and which had resulted in patient injury.
- We were not assured the service had a robust, realistic strategy for achieving its priorities and delivering good quality care.
- Governance arrangements and the management of risk was insufficiently robust and further improvements were needed.

However:

- Patient records were stored securely and effective systems were in place to ensure clinicians had access to appropriate and up-to-date patient information.
- Patients were treated with kindness, dignity and respect and spoke positively about the care they had received.
- Care and treatment was delivered in line with national guidance.
- Some departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- There was effective multidisciplinary working across the outpatient and diagnostic imaging service.
- Local leadership was strong, supportive and approachable. However, staff did not feel directorate and divisional leads were visible.
- Staff were proud to work at the hospital and were passionate about the care they provided.

Alexandra Hospital

Detailed findings

Services we looked at
Urgent & 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 & Diagnostic Imaging

Detailed findings

Contents

Background to Alexandra Hospital

The Alexandra Hospital in Redditch was opened in 1985. It serves a population of approximately 200,000 and has over 300 beds.

The hospital is the major centre for the county's urology service. The hospital has eight operating theatres, MRI and CT scanners and has cancer unit status for breast, lung, urology, gynaecology and colorectal cancers.

In 2015/16, the trust had an income of £368,816,000 and costs of £428,732,000; meaning it had a deficit of £59,916,000 for the year. The deficit for the end of the financial year for 2016/17 is predicted to be £34,583,000.

This was the second comprehensive inspection of the trust. The first took place in July 2015, when Alexandra Hospital was rated as inadequate and the trust entered special measures.

Our inspection team

Our inspection team was led by:

Chair: Bill Cunliffe, Secondary Care Specialist, Newcastle Gateshead Clinical Commissioning Group

Co-chair: Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Head of Hospital Inspections: Bernadette Hanney, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultants and nurses from surgical services, critical care, outpatients, palliative care and general medicine; emergency department doctors and nurses, a paramedic, a consultant radiologist, paediatric nurses, safeguarding specialists and experts by experience. The team also included an executive director, a non-executive director and a governance specialist.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about Worcestershire Acute Hospitals NHS Trust and

Detailed findings

asked other organisations to share what they knew about the hospital. This included the Clinical Commissioning Group, NHS Improvement, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We held interviews, focus groups and drop-in sessions where staff shared their experience of services provided by Worcestershire Acute Hospitals NHS Trust. We spoke with people who used the services and those close to them to gather their views on the services provided. Some people also shared their experience by email, telephone or by completing comment cards.

We carried out this inspection as part of our programme of re-visiting hospitals. We undertook an announced inspection from 22 to 25 November 2016 and an unannounced inspection on 7 and 8 December 2016.

Facts and data about Alexandra Hospital

Hospital is part of Worcestershire Acute Hospitals NHS Trust.

In 2015/16, the trust had:

- 120,278 urgent and emergency care attendances.
- 139,022 inpatient admissions.
- 588,327 outpatient appointments.
- 5,767 births.
- 2,181 referrals to the specialist palliative care team.
- 51,444 surgical bed days.
- 1,945 critical care bed days.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Surgery	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Inadequate	N/A	Good	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Detailed findings

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (ED) at the Alexandra Hospital provides a 24-hour a day, seven day a week service and serves the population of Redditch and surrounding areas. There are approximately 56,000 attendances each year. Almost 11,000 (20%) of these are children up to the age of 16 years. The department has seen a decrease in attendances of 10% over the last year, which mainly relates to the reconfiguration of paediatric services to another site within the trust.

The ED consists of a minor's area with seating and five cubicles, a majors area consisting of 10 cubicles and three side rooms, and a resuscitation area consisting of three bays.

There is a five bedded observation ward known as the emergency decision unit.

During our inspection, we spoke with 30 members of staff, seven patients and two relatives. We also reviewed 15 associated patient care records. We undertook this announced inspection from 22 to 25 November 2016 and undertook an unannounced inspection on 8 December 2016.

Summary of findings

We rated this service as inadequate because:

- Safety systems and processes were not fit for purpose. There were significant delays for an initial triage assessment by emergency department (ED) staff.
- Services were not planned and delivered to meet the needs of local people. There was not an adequate full capacity plan in place to address issues that the ED faced.
- The flow of patients in the ED was often blocked by internal capacity issues in the hospital. This resulted in a severely crowded department with patients waiting on trolleys in a corridor.
- The trust had not achieved the national target to admit or discharge 95% of patients within four hours of arrival since October 2014.
- In November 2016, only 50% of ambulance patients were handed over to ED staff within 15 minutes. There were not enough nurses to ensure that all patients were assessed within 15 minutes of arrival in the department, or to safely care for patients in the major treatment area and resuscitation room. There were not enough consultants to ensure a consultant presence in the department for 16 hours a day.
- There was no privacy and little confidentiality for patients waiting on trolleys in the corridor and patients were sometimes left in cold conditions. Staff did not always have line of sight of these patients and safety equipment was lacking.

Urgent and emergency services

- Safety incidents were not always recorded correctly and little action was taken when repeated incidents took place.
- Care and treatment did not always reflect current evidence based guidance. ED staff were unaware of best practice guidance on conditions, such as heart attacks, strokes and broken hips.
- The department did not meet the requirements of the national "Standards for children and young people in emergency care settings". Children's emergency services were not always planned in conjunction with staff in the ED.
- The department could not ensure that there was always as a senior doctor available who was qualified to resuscitate children. Staff had not been trained to use a new system to help staff recognise when a child's condition was deteriorating that had been introduced two days before the inspection.
- The arrangements for governance and performance management did not always operate effectively. Until November 2016, there had not been an effective governance framework to support good quality care for over a year. There was no clear process for the escalation of risks to divisional directors or the trust board.
- Staff did not always feel actively engaged or empowered. They expressed frustration about the continuing delays in treatment and the conditions in which some patients had to be nursed.

However:

- Feedback from patients and those who were close to them was positive about the way staff treated them. We observed patients being treated with dignity, respect and kindness.
- The matron and lead consultant took an active part in daily clinical activity and were praised by staff for their supportive leadership skills.
- Patients with a mental health condition were cared for by a responsive and effective psychiatric liaison service and there was a specialist alcohol liaison nurse available.
- There had been good results from recent audits of sepsis treatment, recognition of deteriorating adult patients, measurement of vital signs in children and adult procedural sedation.

Are urgent and emergency services safe?

Inadequate

We rated safe as inadequate because:

- Safety systems and processes were not fit for purpose. There were significant delays for an initial triage assessment by emergency department (ED) staff.
- Severe crowding in the department resulted in ambulance patients waiting in a corridor for up to two hours. Staff did not have line of sight of some of the patients and safety equipment was lacking.
- Safety incidents were not always recorded correctly and little action was taken when repeated incidents took place. There were no safe processes for recording medicines given to patients by ambulance crews.
- When things went wrong, the approach to reviewing and investigating causes was insufficient. Serious incidents had not been thoroughly investigated and there had been no mortality and morbidity reviews for 18 months.
- Children were not treated in a secure environment. The doors to the resuscitation room were kept locked, meaning that ambulance crews and specialists doctors could not gain entry in an emergency.
- There were not enough nurses to look after the numbers and complexity of patients in the department. There were insufficient numbers of children's nurses. Consultant staffing did not meet national guidance of providing 16 hours presence each day.
- The department could not ensure that there was always as a senior doctor available who was qualified to resuscitate children. Staff had not been trained to use a new system to help staff recognise when a child's condition was deteriorating that had been introduced two days before the inspection.

However:

- National early warning scores were calculated correctly and appropriate action taken.
- Patients with sepsis were treated promptly.
- Medicines were stored and administered correctly.

Incidents

- There were no never events or serious incidents reported between October 2015 and September 2016. Never events are serious incidents that are wholly

preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

- There were two serious incidents in the department in the year ending August 2016. Although both had severe outcomes for the patients concerned, neither had been investigated using root cause analysis or the NHS serious incident framework. This meant that the fundamental causes of the incidents had not been identified and so no action had been taken to prevent a recurrence. Senior staff had received no training in carrying out a root cause analysis.
- Incidents and accidents were reported using a trust-wide electronic system. All staff had access to this and knew which incidents required reporting. We looked at incident reports from March to August 2016. They had been logged appropriately with a detailed description of the incidents. However, the seriousness of the incidents was not always recorded correctly. For example, an incident regarding a patient who had spent two hours waiting in the corridor and then had to be admitted to the critical care unit was recorded as "No harm" to the patient. In addition, the incident log did not allow any recording of actions taken to prevent a repeat of incidents.
- Nursing staff told us lessons were learnt from incidents. They explained that certain medicines brought to the department by patients were no longer administered following an error caused by incorrect labelling. However, there were three reports of repeat doses of medicines given to patients in error because medicines previously given by ambulance crews were not recorded clearly in the emergency department (ED) records. Little action had been taken to prevent this happening again. We observed four examples of medicines given to patients in ambulances not recorded in ED records, or not recorded accurately and completely. Two of these included intravenous morphine.
- Mortality and morbidity reviews were incorporated into departmental clinical governance meetings. However, there had been a period of 18 months when these had not taken place. During the November 2016 meeting, two deaths had been reviewed but it was discovered that these reviews had not been carried out using the method currently used by the trust. New documentation had subsequently been obtained and copies of reviews would, in future, be sent to the divisional quality governance manager.
- From November 2014, NHS providers were required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Staff that we spoke with were aware of their responsibilities regarding this duty and there was a process in place for the management of incidents that included the duty of candour.

Cleanliness, infection control and hygiene

- Infection control practices within the ED were not always in line with trust policy. Most of the ED was visibly clean and tidy. However, clinical waste bins and linen skips in the main sluice and in the emergency decision unit were rusty. There was a thick build-up of dust and cobwebs inside a radiator casing in the emergency decision unit. This can encourage the growth of bacteria and increase the risk of infection.
- The major treatment area had three rooms with doors so that patients with infectious conditions could be isolated. Staff spoke confidently about hospital infection prevention policies and the actions they would take to prevent cross-infection.
- Hand washing facilities were readily available and we observed staff wash their hands and use hand gel before and after patient contact. This helped to prevent the spread of infection. Gloves and plastic aprons were used appropriately.
- Sluices were well organised and clinical waste was handled and disposed of safely.
- The infection control audit that took place in August 2016 showed good compliance with hand hygiene practice but unsatisfactory cleaning of floors and some furniture.

Environment and equipment

- There was no separate treatment area for children. Although there were three rooms designated for

children at one end of the major treatment area, they were used for adult patients throughout the inspection. As a consequence, any child who needed to lie on a trolley was allocated to an adult trolley bay. Children with minor injuries were treated in the main minor injuries area. This meant that there was no audio/visual separation of children from adult areas. There was a separate waiting area for children containing age appropriate toys but it was not securely separated from adult areas.

- There was no separate resuscitation area for children. Instead, resuscitation equipment for children was kept on a trolley and wheeled to wherever it was needed.
- There was a system for checking equipment in the resuscitation room. We found that checks had been made daily to ensure that equipment was always ready for use. However, equipment for treating a pneumothorax (traumatic injury to the lungs) was not included in the checklists. This equipment was needed during the inspection and part of it was found to be missing. This delayed the treatment of one of the patients in the resuscitation room.
- There was a transfer bag containing equipment needed when transferring patients to critical care units. There was no list of the contents that should have been in the bag and so it was not possible to know whether the equipment it contained was appropriate.
- The doors of the resuscitation room were kept locked. They could be unlocked by means of a swipe card. However, non-ED staff did not have the correct swipe cards and could not gain access. We saw a senior specialist doctor repeatedly knocking on the door in an attempt to gain access in response to an emergency call. This delayed their attendance at the emergency. Ambulance crews also had difficulty gaining access.
- Severe crowding in the department meant that patients often had to wait on trolleys in a corridor. The corridor was narrow and when congested, it was difficult for staff and other patients to walk down. At one point the doors to the resuscitation room were blocked while an ambulance crew transferred a patient from the ambulance trolley to one belonging to the hospital.
- The ED was immediately adjacent to the main diagnostic imaging department. This meant that patients could be rapidly taken there for x-rays and scans.

Medicines

- The trust had a comprehensive medicines management policy and auditing process which staff described to us during our inspection. However, there was no robust system for recording medicines given to patients by ambulance crews. The crews recorded the medicines on their own computer system and verbally told nursing staff what had been given. Although the ambulance records could be printed out and attached to the ED record, this did not happen. There was no specific section of the ED record where these medicines could be recorded and we found they had been documented in a variety of different places. We found two examples of intravenous morphine that had either been incorrectly recorded or not recorded at all. This meant that doctors were unaware of the previous drugs that had been given and so there was a risk that repeat doses would be given in error.
- Medicines stored in the department were checked and found to be in-date and stored securely. Controlled drugs were stored securely and appropriately. A review of the controlled drugs register found that medicines administered had been correctly recorded and reconciled with the stock level.
- Minimum and maximum temperature recordings of medicine refrigerators in the resuscitation room were carried out daily. They were all found to be in the expected range.
- Patient allergies were recorded on the prescription charts we reviewed.

Records

- When a patient was registered their details were entered onto a computer system that showed how long patients had been waiting and the investigations they had received. Patient records and information stored on computer was protected by passwords and backed-up to keep it secure.
- The system produced patient records in a paper format so that staff could record care and treatment given.
- When not in use all paper documents were held in a file storage trolleys which were supervised at all times.
- When patients left the department the paper record was scanned on to the computer system to allow access to records for patients who had previously attended the department. Paper records were disposed of using a secure shredding service that ensured patient information was kept safe.

- We looked at 15 patient records which were accurate, detailed and easy to follow. However, in two records, doctors had not noted the date and time that they completed their entry.
- There was space to record appropriate assessments, including assessment of risks, such as pressure ulcers, infection, allergies and falls. Clinical observations, nursing care, advice and medication were all accurately recorded. Some nurses used name stamps so that their identity was clearly recorded.

Safeguarding

- There were systems and processes in place to ensure that patients were safe from abuse. However, we were not assured that all staff had the appropriate level of training to ensure they could recognise abuse.
- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. There were clearly documented procedures for responding to patients who had suffered from domestic violence and female genital mutilation.
- There was a paper copy of the child protection register which was kept in a locked drawer in the triage room. It was updated monthly and was checked by the triage nurse for all children up to and including the age of 17. However, it was difficult for staff in the major treatment area to access, and we noted that three children who had been brought by ambulance had not had their names checked against the register.
- All clinical records for children contained a brief risk assessment aimed at quickly identifying any concerns regarding child welfare. If this indicated a concern, a more detailed assessment would be carried out.
- We asked the trust to provide data regarding the percentage of staff that had completed annual training in adult safeguarding and children safeguarding. However, this was not provided. Therefore, we were unable to establish if staff were trained to an appropriate level of safeguarding to undertake their job roles and keep people safe from harm or abuse.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control, manual handling and conflict resolution.
- We asked the trust to provide us with information regarding the number of staff who had completed this training but this was not provided. As a result, we were unable to establish whether staff had received adequate safety training.

Assessing and responding to patient risk

- Patients who walked into the department, or who were brought by friends or family were directed to a receptionist. Walk-in patients rarely had to wait more than 10 minutes during the day but in the evenings, delays were longer. The trust produced live information on its website regarding the number of patients waiting in ED.
- Patients attending EDs should receive triage within 15 minutes of their arrival, in line with national targets. The Alexandra Hospital ED was not always meeting this standard. Figures sent to us by the trust showed ambulance patients waited an average of eight to 10 minutes for an initial triage assessment. However, during our unannounced inspections we saw ambulance patients waiting for up to 30 minutes to be assessed by an ED nurse. This meant that their treatment was delayed and their condition was at risk of deteriorating.
- Figures discussed at the October 2016 performance and business meeting demonstrated that, overall, only 79% of patients were triaged within 15 minutes in August 2016. In September 2016 this had dropped to 77%.
- The triage room was situated next to the waiting room and nursing staff were able to observe activity there. This helped to ensure the safety of patients when they first arrived.
- Patients that arrived by ambulance as a priority (blue light) call were taken immediately to the resuscitation room. Ambulance staff phoned through to the department in advance so that an appropriate team could be alerted and prepared for the arrival of the patient. We observed these calls being taken quickly and calmly with details being recorded on an ambulance record sheet. Specialist teams responded quickly and were in place before the patient arrived.
- Other patients arriving by ambulance were triaged by a senior nurse. This assessment was required in order to determine the seriousness of the patient's condition and to make plans for their on-going care. At the beginning of the day this process worked well with patients being rapidly assessed, appropriately prioritised and then

taken to a treatment cubicle. However, by late morning the department was usually full and ambulance patients had to remain in the corridor until a treatment cubicle became free. Because the triage nurse needed to care for patients in the corridor, it was not always possible to be available to immediately assess newly arrived patients.

- In order that ambulance crews were not delayed while their patients waited in the corridor, the local ambulance service had arranged for a hospital ambulance liaison officer (HALO) to work in the department. If the triage nurse was not available crews would hand over their patient to the HALO and then leave the department. This sometimes caused confusion when the information was subsequently handed over to the triage nurse as the HALO was not always sure that they had been given all of the facts about a patient's illness or injury. In addition, the time the patient was handed over to the HALO was entered as the time the patient was triaged by an ED nurse (there was not space on the computer to record both times). This meant delays in nurse triage were under-reported.
- ED staff told us that the triage nurse was responsible for looking after the first four patients waiting in the corridor and the HALO was responsible for a further six. We observed the HALO taking clinical observations, such as heartrate and blood pressure but it was not clear who decided how frequently these needed to be carried out.
- There were times during our inspection when there was no nurse or HALO visible in the corridor where patients were waiting. Should a patient's condition have worsened, there was no-one to respond.
- If an ambulance arrived when there was no triage nurse or HALO available the crew would sometimes handover to the nearest nurse that they could find. We observed that there was increasing confusion about which member of staff was responsible for which patients in the corridor. We sometimes observed HALOs taking observations for all of the patients in the corridor, not just the six for whom they were meant to be responsible.
- After 10pm there was no HALO and so the triage nurse looked after all of the patients in the corridor, as well as assessing newly arrived ambulance patients. During our unannounced inspection there was no triage nurse for ambulance patients. The nurse in charge of the department was trying to look after six patients in the corridor, triage new patients and run the department as a whole. This meant that, at times, there was no one observing the patients on trolleys in the corridor.
- The corridor was divided by a set of double doors. As more patients arrived some of them had to stay on the far side of the double doors, closest to the ambulance entrance. This meant that there were times that neither the HALO nor the triage nurse had line of site of the patient for whom they were caring. If a patient called for help in the outer corridor it was unlikely that they would have been heard.
- There was no medical suction equipment in either part of the corridor. We saw patients who had been spinally immobilised spending up to two hours in the corridor. If they had started to vomit there would have been no suction equipment readily available in order to clear their airway. Although such patients were at greater risk of harm than some others, staff told us that they would not be prioritised and that all patients were seen in time order.
- Despite ED staff's efforts to reduce delays for ambulance patients we observed some ambulances waiting with patients outside the department because even the corridor was full. In November 2016, 15% of ambulance patients had to wait for more than 30 minutes before being handed over to ED staff.
- The ambulance service recorded delays in patient handover of more than one hour (known as black breaches). Since October 2016, this had happened almost every day, with 40 patients being delayed for more than an hour in November 2016.
- The ED used a safety matrix to determine whether current conditions promoted patient safety. Information such as patient numbers, ambulance arrivals, complexity, and available staff, were entered into the matrix on a two hourly basis. Between 2pm and 10pm on 23 November 2016 the matrix showed that the department was "overwhelmed" due to large numbers of highly dependent patients in the department. However, the matrix did not contain guidance about what to do in these circumstances. We asked two experienced nurses about the actions they would take if the safety matrix confirmed that the department was overwhelmed. They had not been told that any action was expected and had been given the impression that the matrix was used for monitoring purposes only. They said that it was not unusual for the department to be

overwhelmed and that on the previous Friday (18 November) the safety matrix indicated that it had been overwhelmed for 24 hours. Records sent to us by the trust confirmed this.

- National early warning scores (NEWS) were used throughout the department. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Once a certain score was reached a clear escalation of treatment was commenced.
- Paediatric early warning scores were also used. However, the method of calculating these had recently been changed and staff had not received training in their use. Some nursing staff told us that they found them confusing and were doubtful about the methods used to calculate the score.
- There were no paediatricians (children's doctors) in the hospital after 5pm. For this reason, it was intended that the ambulance service would not bring children with severe illnesses or injuries to the ED. However, the guidance given to ambulance crews by the trust was not comprehensive. We saw children with potentially serious injuries, such as suspected cervical spine fractures, brought to the department. The matron told us that this had been raised with the head of children's services but no action had yet been taken.
- There were clear protocols describing how children should be transferred to the neighbouring hospital if they needed to be treated by a paediatrician. Senior doctors told us that, if a child needed to be resuscitated, this would be done by doctors from the adult intensive care unit. We were told by staff whilst we were on inspection that they had the necessary skills to do this. However, the trust did not provide data to evidence that there was always an intensive care doctor on duty in the hospital with an advanced paediatric life support qualification, if a child in ED needed resuscitating.
- All patients in the resuscitation room and major treatment area were screened for sepsis, (a life threatening condition caused by severe infection). We saw that patients with sepsis had intravenous fluids and antibiotics administered within an hour.
- The clinical decision unit (CDU) was used to accommodate patients who required a short intense period of investigation or a brief period of treatment and observation, typically lasting four to 12 hours. For example, uncomplicated head injuries, paracetamol overdose or low-risk chest pain. During our inspection all patients in the CDU had been referred appropriately.
- Staff did not always meet the individual needs of patients waiting on trolleys in the corridor. We observed a patient with a suspected spinal injury waiting for two hours in the corridor. The spine had been immobilised and the patient had to lie on their back and was unable to move. We asked staff if they would prioritise the treatment of such patients due to the discomfort that they were experiencing. We were told that all patients would be seen in time order, irrespective of their individual needs.

Nursing staffing

- Nurse staffing levels within the department did not always meet national guidance.
- We looked at nurse staffing for the four weeks immediately prior to the inspection and compared nurse to patient ratios with guidance issued by the National Institute for Health and Care Excellence (NICE). There were many occasions when nurse staffing levels fell below the NICE recommendations. For three or four days each week there were only two nurses looking after 13 patients in the major treatment area giving a ratio of one nurse to six or seven patients. NICE recommends a minimum of one nurse to four patients. An additional nurse came on duty at 11am to look after four patients in the corridor. However, when that nurse left at 7pm one of the nurses in the major treatment area had to look after the corridor patients as well.
- Throughout the four weeks, there was only one nurse allocated to three patients in the resuscitation room. NICE guidance recommends one nurse for two patients.
- There was only a band 7 sister in charge of the department for approximately 50% of the week.
- When the NICE guidance was published in 2015, it became clear to the matron that there were not sufficient nursing staff to look after the numbers of patients attending the department. The matron discussed this with the divisional director of nursing who asked for an in-depth staffing review to be undertaken. A well-known acuity tool called BEST was used and indicated a need for 15 more nurses. Discussions had taken place regarding the funding for these additional posts but, at the time of the inspection, it was not known when recruitment would start. We asked for the results of the 2016 nursing staff review but this was not provided by the trust.
- There was a band 6 sister who was the overall lead for children's care in the department. However, they were

the only children's nurse in the department and so it was not possible to have a children's nurse on each shift. There was at least one nurse with a children's resuscitation qualification on duty at all times. A second children's nurse had been recruited and was due to start in January 2017.

- On the majority of shifts during the previous four weeks, at least one nurse had been obtained from a temporary staffing agency. During the inspection there were usually two agency nurses on duty. Both had received a departmental induction when they first arrived and they both had worked frequently in the department. This meant that they were familiar with local working practices.
- Handover of patients' clinical details between nurses was methodical, detailed and efficient.

Medical staffing

- The hospital employed one full-time consultant in the ED and obtained three others from a temporary staffing agency. This was not sufficient to provide a consultant presence in the department for 16 hours a day as recommended by the Royal College of Emergency Medicine. Instead, there were two consultants from 9am to 5pm with one staying until 7pm. After that time they were on-call from home. The shortage of consultants was recorded on the divisional risk register but some of the controls to reduce the risk had not taken place. For example, robust monitoring of morbidity and mortality rates.
- The rota for junior doctors was not always clear and there was little continuity of shifts and several last minute changes. The majority of doctors only had one weekend off every eight weeks. After midnight, medical staffing consisted of middle grade doctors (ST4) and one junior doctor. Several doctors felt this was insufficient for the number of patients in the department and led to long delays in treatment for patients.
- Two of the five middle grade doctors and one of the junior doctors were from a temporary staffing agency. All had worked in the department for several months and were familiar with local working practices.
- Because of the lack of children's doctors in the hospital at night and at weekends we were told that all senior ED doctors were qualified in advanced paediatric life support (APLS). This ensured that they had the skills and knowledge needed to resuscitate children in the department. However, we found that one of the consultants and two of the middle grade doctors did not have this advanced qualification. In addition, some of the senior doctors had undertaken the European paediatric life support course which is shorter and less detailed than APLS.
- We observed the main medical handover session that took place at 2pm. This was consultant led and all patients were discussed. However, some of the discussion lacked focus and few clear treatments plans were agreed.

Major incident awareness and training

- It was unclear which major incident plan was currently used. One senior doctor showed us a copy of a plan dated 2002. Nursing staff told us that they would use the one on the trust intranet which was dated 2015. There were no paper copies immediately available and no action cards for staff to use. In the event of a major incident, staff were expected to print out lengthy documents from the computer system. This would delay preparation for potentially large numbers of casualties brought to the department.
- The emergency equipment that we were shown stored in the ED mainly related to Ebola emergencies and patients contaminated with hazardous substances, such as chemicals. There was very little major incident equipment stored in the ED that would be required to support the treatment of large numbers of patients that might result from a local coach or rail crash. For example, there was minimal intravenous infusion equipment, minimal large sterile dressings, chest drain equipment and emergency documentation.
- We were told that major incident training took place twice a year. However, most of the nursing staff that we spoke with could not remember the last time they took part in any training.
- ED staff told us that security staff made regular patrols of the department at night. However, they did not always respond quickly when they were needed. There were two incident reports to this effect. During our unannounced inspection there were two patients in the department who were verbally aggressive. Although the security officer was in the department they did not attempt to de-escalate the aggression or protect sick and injured patients who were nearby.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Requires improvement

We rated effective as requires improvement because:

- Care and treatment did not always reflect current evidence based guidance. Emergency department (ED) staff were unaware of how to access best practice guidance on conditions, such as heart attacks, strokes and broken hips.
- Clinical practice had not changed following an internal audit which showed deficiencies in the treatment of pneumothorax (a serious lung condition).
- Although nine internal clinical audits had been planned for 2016/17 none had yet taken place.
- Patient comfort rounds had not been fully implemented.
- There were delays when patients were referred to specialist teams. Only 47% of specialist doctors arrived within an hour.

However:

- There were good results from audits organised by the Royal College of Emergency Medicine regarding measurement of vital signs in children and for procedural sedation in adults.
- Monthly nursing audits showed good compliance with national early warning scores.
- The department employed an alcohol liaison nurse and there was an effective psychiatric liaison service.
- There were good training programmes for clinical staff.

Evidence-based care and treatment

- We found little evidence of the use of national guidelines in the department. There were no evidence based proformas or clinical pathways for serious conditions, such as heart attacks, strokes or broken hips. We asked a middle grade doctor and a junior doctor if these were available and both told us that they were not used in the department. One thought that they might be found on the departmental intranet, but after some searching, these could not be located. We were later told that national guidelines were available on the intranet but passwords had recently been changed so that staff could not gain access.
- There was no local guidance for doctors on the treatment of common conditions, such as acute knee injuries, wrist fractures or feverish children.
- We observed a discussion between a junior doctor and their senior regarding a patient with a transient ischaemic attack ("mini-stroke"). Although giving aspirin was suggested there was no mention of evidence based practice, such as scans of carotid arteries, CT scans of the head, or rapid referral to a specialist clinic.
- The department did follow the Royal College of Emergency Medicine (RCEM) standards for the treatment of sepsis, but did not comply with the standard for consultant sign-off. The latter required that certain patients, for example, those with chest pain aged 30 years and over or feverish children under one year old, are reviewed by a consultant or senior trainee doctor before discharge. We were told this was because the shortage of senior doctors meant that this was not always possible. We looked at the records of three patients with chest pain and none had been signed off before discharge by a consultant or other senior doctor. A review of sepsis documentation at the beginning of November 2016 showed that 100% of patients studied had had correct sepsis screening.
- We asked how the department had responded to recent NICE (National Institute for Health and Care Excellence) guidance on trauma care and emergency airway management. We did not receive any information about trauma care. Regarding the latter guidance, we received a submission from the critical care directorate because they had assumed responsibility for airway management in the ED. The information provided demonstrated that NICE guidance was followed.
- Although there was an extensive list of local clinical audits that had been planned by medical staff, no-one at the time of the inspection could show us results for any completed audits. Subsequently we were sent results of one audit which compared the treatment received by patients with a spontaneous pneumothorax (a serious lung condition) with guidelines published by the British Thoracic Society. The audit showed that only

45% of patients received the correct treatment. The conclusions of the audit included an action plan to improve treatment but it was not clear whether this had been implemented. Another audit was planned for 2017.

- Nursing staff undertook monthly audits of compliance with the National Early Warning Scores (NEWS). Results from April to August 2016 showed that NEWS was not always used or was used incorrectly. Subsequently, work processes were changed and results for November 2016 showed improvement in that 91% of audited records had NEWS recorded and 100% of the calculations were correct.

Pain relief

- Patient records showed that patients' pain levels were assessed and recorded. Appropriate pain relief was given and the effects monitored.
- We observed that nursing staff administered rapid pain relief when they assessed patients who had walked into the department and those who had arrived by ambulance.
- During our inspection we observed timely pain relief administered to children. The results of the pain relief were monitored in accordance with the RCEM Management of Pain in Children guidance.

Nutrition and hydration

- Following the assessment of a patient, intravenous fluids were prescribed, administered and recorded when clinically indicated.
- Although we occasionally saw staff offering refreshments during the course of our inspection, this was not done on a regular basis and was not always recorded in the patient record. A system of two hourly care rounds had been recently introduced aimed at ensuring that patients felt comfortable and had been offered food and drink. We found the implementation of care rounds was intermittent. Three patients who had been in the department for up to five hours had only been involved in a care round once, if at all.

Patient outcomes

- Although nine internal clinical audits had been planned, none had been completed. Discussion of audit results was a standing agenda item for departmental clinical governance meetings.
- From January to December 2015, the department had taken part in three national audits organised by the RCEM. These were; procedural sedation in adults, measurement of vital signs in children and assessment and treatment of venous thrombo-embolism (blood clots formed in deep veins). Results were published in May 2016 and were as good as, or better than, most other hospitals for measuring vital signs in children and for procedural sedation in adults. The audit for prevention and treatment of venous thrombo-embolism showed good treatment levels, although the quality of assessment was not as good as some hospitals.
- We observed patients being screened for sepsis and treated according to RCEM standards.
- The rate of unplanned re-attendances within seven days is often used as an indicator of good patient outcomes. At the Alexandra Hospital it had varied between 5.6% and 6.8% since April 2016. This was better than the national average of 7.5%.

Competent staff

- Both medical and nursing spoke positively about the annual appraisal process. We asked the trust for data to show how many ED staff had received an appraisal in the last 12 month but this data was not provided. Therefore, we were unable to establish if staff were receiving an annual appraisal and if the hospital was meeting the appraisal target in the ED.
- Nursing staff told us that there was a structured competency framework so that nurses and their managers knew when they were ready for increased levels of responsibility. Specific ED competencies included X-ray requests, application of plaster casts, cannulation, male catheterisation and taking arterial blood samples.
- We spoke with junior doctors who were complimentary about their training programme. They told us that they received regular supervision from the ED consultants, as well as weekly teaching sessions. Further ad hoc teaching took place during the afternoon handover session.
- Nursing staff that we spoke with told us that they had undertaken the Resuscitation Council's Intermediate Life Support course and others had also attended paediatric resuscitation training. This was confirmed by the training records. Some nurses had also obtained qualifications in trauma nursing.
- We asked the trust to provide us with information about the professional revalidation of senior doctors in the ED.

However, this was not provided. Therefore, we were unable to assess whether senior doctors satisfied the professional standards required by the General Medical Council of Great Britain.

Multidisciplinary working

- We observed good multidisciplinary working during the inspection. ED staff worked co-operatively with specialist teams to provide patient centred care and treatment.
- We were told that specialist teams gave good support to the ED and gave priority to emergency referrals. However, we observed a patient waiting for two and a half hours to see a specialist doctor prior to admission for a surgical procedure. On arrival, the doctor explained that two patients on a ward and two in out-patients had been seen before the patient in the ED. Data collected by the department showed that 53% of specialist doctors took more than an hour to see a patient.
- There was a trust-wide mental health liaison service which was based the ED. Staff numbers had been increased in the last year and senior ED staff described the quality of the service as "excellent". The service operated from 8am to 9pm, seven days a week and 95% of patients were seen within an hour of referral. Patients attending at night were contacted by a psychiatric liaison nurse the following morning. A care plan was developed for all patients and a copy given to any patient who was able to go home. On the back of the care plan there was a list of contact details for organisations who could give additional support. For example, the national self-harm network and MIND Line, a confidential service offering information, support and understanding for patients with a mental health condition.
- The department employed a specialist alcohol liaison nurse whose role was to help patients where alcohol had contributed to their attendance at the ED. All patients were screened for alcohol problems by a triage nurse and any who scored more than five were offered a referral to the alcohol liaison nurse. In August 2016, 530 patients scored more than five and 33% of them accepted a referral.
- Patients who had a severe psychiatric illness, or required treatment at night, were treated by the crisis psychiatric team provided by another NHS trust. A consultant psychiatrist was available for telephone advice throughout the night. If a patient needed immediate psychiatric treatment they would be taken by ambulance to a specialist unit at Worcestershire Royal Hospital.
- Although major emergency surgery did not take place at the Alexandra Hospital, there was an experience surgeon on-site at all times. This doctor would assess all surgical referrals and decide whether the patient needed to be transferred to Worcestershire Royal Hospital for surgery.

Seven-day services

- The department had access to radiology support 24 hours each day, with rapid access to CT scanning when indicated. There was always a senior radiology doctor available within in the hospital.
- The ambulatory emergency centre was only open from Monday to Friday.
- There was an on-call pharmacy service outside of normal working hours.

Access to information

- Access to treatment protocols and clinical guidelines on the trust intranet were limited. Although there was an electronic copy of a book aimed at informing junior doctors new to an ED, it contained basic, generalised information only. We asked three ED doctors to show us where they would find specific clinical guidance, such as local antibiotic protocols, and none was able locate them.
- All paper patient records generated during an episode of care were scanned onto an electronic record when the patient was discharged or transferred out of the department. This meant that there was immediate access to records for any patients re-attending the ED.
- Information about previous hospital admissions was available in paper and electronic formats.
- Access to all electronic records was protected with passwords.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed that consent was obtained for any procedures undertaken by the staff. This included both written and verbal consent.
- Consent forms were available for people with parental responsibility to consent on behalf of children.

- The staff we spoke with had sound knowledge about consent and mental capacity.
- Where patients lacked the capacity to make decisions for themselves, such as those who were unconscious, we observed staff making decisions which were considered to be in the best interest of the patient. We found that any decisions made were appropriately recorded within the medical records.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Feedback from patients and those who were close to them was positive about the way staff treated them. We observed people being treated with dignity, respect and kindness. Patient's privacy and confidentiality was respected whenever possible.
- Staff communicated information in a way that people could understand. Patients told us they understood their care, treatment and condition.
- Staff helped patients and those close to them to cope emotionally with their care and treatment. Nursing staff in the resuscitation room spend time reassuring patients and explaining their treatment.

However:

- There was no privacy and little confidentiality for patients waiting on trolleys in the corridor, although staff did move patients into a cubicle if urgent personal care was needed.

Compassionate care

- We saw patients being treated with compassion, dignity and respect. Staff spoke in a respectful but friendly manner and maintained patient confidentiality. We observed a nurse placing a call bell into a patient's hand and explaining how it worked. They encouraged the patient to use it as soon as they needed anything.
- We spoke with six patients and five family members. On the whole they reported a positive experience. One said "I cannot fault the care here. They have been marvellous." Another said "The staff here have been brilliant. Always have been." However, the relative of a sick child told us that they felt unwelcome in the department because they had overheard a nurse telling ambulance staff that they had brought the child to the wrong hospital.
- A patient with a suspected spinal injury was treated in the resuscitation room and was unable to move. We observed a nurse constantly reassuring the patient and explaining about the treatment that was taking place.
- We heard staff updating relatives about patients' progress whilst maintaining confidentiality.
- There was no privacy and little confidentiality for patients waiting on trolleys in the corridor. Staff frequently apologised for the crowded department and moved patients to a treatment cubicle as soon as one became empty. Patients could be moved to a cubicle temporarily if they required urgent personal care, such as an electrocardiograms or bedpan.
- The questions related to caring in the 2014 national accident and emergency survey indicated that staff at the Alexandra Hospital were as good as most others in England.
- The department took part in the national Friends and Family test. However, very few patients responded and from October 2015 to October 2016 the response rate was 4.9% and so the results did not represent patients as a whole.

Understanding and involvement of patients and those close to them

- We heard staff introducing themselves when they first met patients but very few of them wore name badges. Some of the patients we spoke with were not sure who was looking after them.
- One patient, who had been lying on a trolley in a corridor during the night, said that numerous members of staff had come to see them to apologise for the delay and the surroundings. They explained the problems that the department was experiencing and had always asked them if there was anything further they could do for them.
- Patients that we spoke with all said that they had been involved in the planning of their care and had understood what had been said to them.
- Privacy was maintained in the emergency decision unit by means of separate bays for men and women and separate bathrooms at each end of the unit.

Emotional support

Urgent and emergency services

- We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- Support was particularly strong for relatives of patients who needed to be in the resuscitation room. We observed nursing staff preparing relatives before they entered the resuscitation room and then carefully explaining what had happened and the details of the immediate treatment plan.
- There was a quiet sitting room where distressed relatives could sit in a private space. This was large enough to accommodate several people and was appropriately equipped. We observed staff making frequent visits to the room to make sure that relatives were comfortable.
- Multi-faith chaplaincy services were available day and night for people who requested spiritual support.

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

Requires improvement

We rated responsive as requires improvement because:

- There was no standard operating procedure for the diversion of ambulance patients from Worcestershire Royal Hospital to the Alexandra Hospital. Children's emergency services were not always planned in conjunction with the emergency department (ED). Guidance for ambulance crews was unsatisfactory and led to inappropriate patients being brought to the department.
- The flow of patients in the ED was often blocked by internal capacity issues in the hospital. This resulted in patients waiting on trolleys in a corridor before, and after, receiving a clinical assessment by ED staff.
- The trust had not achieved the national emergency access target to admit or discharge 95% of patients within four hours of arrival since October 2014.
- Services were not planned and delivered to meet the needs of local people. There was not an adequate full capacity plan in place to address issues that the ED faced.
- Patients' individual needs were not always met. Patients who were spinally immobilised were not prioritised for treatment and remained waiting in the corridor, unable to move, for up to two hours. Patients with dementia were rarely treated in a quiet, low-stimulus environment.

However:

- Learning from complaints was discussed at staff meetings and displayed on the noticeboard in the staff room.

Service planning and delivery to meet the needs of local people

- The emergency department (ED) staff told us that the neighbouring Worcestershire Royal Hospital ED was often full to capacity. When this happened, the ambulance service was asked to divert all ambulances to the Alexandra Hospital. However, there was no standard operating procedure in place to ensure that this process went smoothly. Staff at the Alexandra Hospital were not informed that additional patients were about to arrive and so could not make plans to accommodate them.
- The hospital full capacity protocol only described the actions to be taken during office hours. There was no plan if the hospital or ED became full during the evening or at weekends despite the fact that this had happened frequently. The hospital was full during every evening of the inspection. This resulted in patients waiting many hours to be admitted to a ward.
- Although there were plans to set up a frailty intervention team, aimed at treating frail, elderly patients at home, a date for the start of this initiative was yet to be agreed.

Meeting people's individual needs

- There was wheelchair access to all parts of the department and the reception desk had a hearing loop for those who had hearing impairments.
- Staff had received training in responding to the needs of people living with dementia. They described the care needed in a knowledgeable and sympathetic fashion. They knew, for example, that patients living with dementia should be cared for in a quiet part of the department in a low stimulus environment. However, because the department was frequently crowded, patients living with dementia were often placed in the only available treatment cubicle. During the inspection

we saw one patient living with dementia in a children's cubicle with brightly painted murals on the wall. Another was in the busiest part of the department with many people passing by, and telephones ringing regularly.

- We were told that patients with complex needs would be treated by a senior doctor who had the experience necessary to meet their requirements
- The outer part of the ED corridor sometimes became very cold because the doors to the ambulance entrance were constantly opening and closing. On two occasions during the inspection, we observed frail and elderly patients in this part of the corridor. Staff told us there was nowhere else in the department for them to go.
- The appointment of a trust-wide learning disabilities team had improved awareness and staff felt able to contact them for advice. Nursing staff told us that they encouraged the involvement of families and carers so that they could understand patient's specific needs.
- The department did not comply with NHS England's Accessible Information Standard by identifying, recording, flagging, sharing and meeting the information and communication needs of patients with a disability or sensory loss.
- Translators could be accessed via the telephone translation system provided by the hospital.

Access and flow

- The lack of available beds in the hospital had resulted in poor patient flow through the department and delays in treatment for patients.
- EDs in England are expected to ensure that 95% of their patients are admitted, transferred or discharged within four hours of arrival. This standard had not been met in any month during the last year. For year ending November 2016, 82% of patients were admitted or discharged within four hours. This was worse than the England average of 90%.
- It became apparent during the inspection that there was little sense of urgency with regard to admitting patients within four hours. We asked several members of staff about this and were told that managers who were responsible for ensuring there were empty beds for emergency patients could no longer achieve this within four hours. One member of staff told us "We have given up asking for beds within four hours because nothing ever happens."
- There were significant delays in admitting patients to a ward and this had become worse throughout the year. In July 2016, 11% of patients had waited for between six and 12 hours to be admitted to a ward, following the decision to admit. By October 2016, this had increased to 27%. ED staff were aware of this decline but felt powerless to make improvements. One experienced member of staff told us that the department at present reminded them of "the 1990's, before the days of the four hour target". No patient had waited more than 12 hours after the decision to admit had been made.
- Some patients had to wait for specialist doctors to see them before they could be admitted. We observed long delays in responses from surgical and medical specialists during our inspection. The department tried to monitor the time it took for specialist doctors to arrive in ED but they had only recorded it on 23% of occasions from April to October 2016. In that time, only 49% of specialists had arrived within an hour.
- The hospital had recently created an ambulatory emergency centre to help prevent unnecessary admission to a ward. The centre provided day case medical treatment. However, referral criteria for the centre were vague and it was not clear how many emergency admissions it prevented.
- A senior nurse from the department attended the bed management meeting twice a day. This was to update hospital managers on the capacity of the ED and to understand bed availability across the hospital. During our inspection there were a number of delays in admitting patients from the department but discussions at the bed management meeting were not able to provide any solution to the delays.
- There were fewer delays for patients with minor injuries and ailments. Despite this, an average of 3.4 % of patients had left the department without being seen in the year ending October 2016. This was worse than the England average of 2.5%.
- Poor patient flow through the department had been recorded on the ED risk register. The risk had been assessed as moderate.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If the concern was not able to be resolved locally, patients were referred to the Patient

Advice and Liaison Service (PALS), which would formally log their complaint and attempt to resolve their issue within a set period of time. Although PALS information was available on the hospital website we could not find any available for people in the waiting room or elsewhere in the department.

- Formal complaints were investigated by a consultant or the ED matron. Although all complainants were sent an acknowledgment within two days we were told that, earlier in the year, there had been delays in investigating complaints and sending a final response. Since then, additional resources were made available to investigate complaints and we were told that all new complaints were responded to within the trust target of 40 days.
- We saw that learning from complaints was discussed at sister/charge nurse meetings and also displayed on a noticeboard in the staff room. Complaints were discussed at governance meetings and figures compiled by the trust showed that the majority were about delays in treatment and admission to a ward.

Are urgent and emergency services well-led?

Inadequate

We rated well-led as inadequate because:

- Divisional leadership was not always effective in the emergency department (ED). There was no strategy and no clear plan to improve care or flow within the ED to allow safe patient care.
- The arrangements for governance and performance management were lacking. There had not been an effective governance framework to support good quality care for over a year. However, the clinical lead had recently become the governance lead and the first departmental governance meeting took place in November 2016.
- There was no clear process for the escalation of risks to divisional directors or the trust board.
- Staff did not always feel actively engaged or empowered. They expressed frustration about the continuing delays in treatment and the conditions in which some patients had to be nursed.

However:

- The matron and lead consultant took an active part in daily clinical activity and were praised by staff for their supportive leadership skills.
- Risks were clearly described on the departmental risk register and reflected the concerns described to us by staff.

Leadership of service

- The ED was part of the trust's medical division. Although the matron and clinical lead had regular meetings with divisional directors most ED staff had not met them and were unaware of any visits to the department. Some nursing staff had met the chief nurse and described them as approachable and supportive.
- Prior to the inspection, the trust told us that leadership of the department was shared between the matron, clinical lead and directorate manager. However, the directorate manager was shared between three sites and was based at the Worcestershire Royal Hospital. As such, it was only possible for them to spend a few hours a week at the Alexandra Hospital ED.
- The matron and clinical lead were highly visible in the clinical environment. They supported junior staff, led the treatment of the sickest patients and dealt with the more complex situations that arose. They had started to establish an effective governance framework in order to support the delivery of high quality care.
- One of the patients that we spoke with remarked on the leadership qualities of the matron. They were one of several patients, during the night, who had spent several hours on trolleys in the corridor because the department was full. When the matron arrived, immediate action was taken to move patients into treatment cubicles. They were seen to make decisions quickly and communicate them clearly. They were supportive of staff and sympathetic towards patients.
- Staff told us that they trusted the clinical lead and the matron and were certain they would be listened to if they raised concerns.

Vision and strategy for this service

- The future of the department had been uncertain for a number of years. A regional reconfiguration plan had been published five years ago with a suggestion that the ED would become a minor injuries unit. A more recent

report, published in January 2014, proposed that the department would become an emergency centre. However, details were few and staff were still unclear about the future.

- We reviewed a copy of the trust's patient care improvement plan for emergency and urgent care. This was created in 2015 with the aim of ensuring safe and responsive care and treatment. There were six work streams directly associated with the ED. The progress report dated November 2016 showed that none of the work streams had completely achieved the improvements in safety and responsiveness that had been planned.

Governance, risk management and quality measurement

- There had not been an effective governance framework to support good quality care for over a year. We were told that the governance lead had left the department 18 months ago and had not been replaced. As a result, governance activity had been minimal and there had been no departmental clinical governance meetings until a week before the inspection. Governance activity had now become the responsibility of the lead consultant (the only substantive consultant in the department), supported by the divisional quality governance manager. ED issues were discussed at divisional safety and risk review meetings but staff from the ED at the Alexandra Hospital were not included in the meetings. There was no record of patient safety issues being addressed in the five sets of minutes that we viewed.
- The department maintained a risk register which defined the severity and likelihood of risks in the department causing harm to patients or staff. It documented the measures to be taken to reduce the risk. The risks described reflected the concerns described by staff in the department but the seriousness of the risk did not. For example, the inability to triage all patients within 15 minutes and to admit or discharge patients within four hours had been entered on to the risk register. Staff thought these were very high risks but the register described them as moderate. There was space to address risk assessment scores on the agenda of the weekly divisional safety and risk meetings. We reviewed five sets of minutes sent to us by the trust but there was no review of the severity of risks.
- Senior staff were unclear about the process for escalating high risk issues to the trust board. The two issues with the highest risk scores were a lack of middle grade doctors and a severely crowded department. The latter had been on the risk register since 2010 but the risk had not been reduced. There was no information about when the board knew about the risks or who was monitoring risk reduction measures.
- The ED matron had not been involved in drawing up guidance for ambulance crews regarding which children to bring to the department. This had resulted in ambulance crews arriving with children who needed to be admitted to the Worcestershire Royal Hospital. The matron had escalated these problems to the head of children's services. Although a sympathetic response had been received, the guidance had not been changed.
- Performance monitoring, such as waiting times, was discussed at divisional quality assurance meetings and senior departmental meetings. Although concerns were raised and actions suggested, the actions were not followed up at subsequent meetings. No decisions were made in order to improve performance and patient safety.
- The senior staff we spoke with were clear about the challenges the department faced and they were committed to improving the patients' journey and experience. However, they felt that there was little more that they could do without the support of the wider organisation.
- Where national audits had demonstrated a weakness in clinical practice the senior clinical team ensured that action plans were developed. For example, the treatment and outcomes for patients with sepsis had improved over the last year.
- Monthly governance meetings were planned. We saw from minutes of the first meeting that complaints, incidents, audits and risks were discussed and acted upon. For example, ED consultants had recently been trained in the investigation of incidents and a decision was made to change and improve mortality reviews.
- Staff told us they were clear about their roles and felt fully supported by their clinical leads.

Culture within the service

- Staff told us that they felt respected and valued by their colleagues and the leadership team within the ED. One nurse said "I am proud to work with such a great team". Another said "The team here is like a family". However,

there was a sense of despondency about the long delays for assessment and treatment and about having to care for patients in a corridor. Senior staff were frustrated that they had been unable to improve the situation.
- A strong sense of teamwork in the ED encouraged candour, openness and honesty. Staff told us that the support they received from their colleagues helped them to cope with the pressures which resulted when the department was very crowded.
- Junior doctors reported good morale and high levels of support from senior doctors.

Public engagement

- The matron of the department kept copies of patient feedback and letters of comment or complaint. Details of the NHS Friends and Family Test were available around the department.
- The trust's website displayed live waiting time figures for the ED and neighbouring minor injuries units. This meant that people knew how long they would have to wait if they attended and also if there were any alternatives to the ED.

Staff engagement

- Staff did not always feel actively engaged or empowered. They told us none of the divisional directors or the trust board had been to see them to discuss the difficulties that the department had been experiencing. They were unaware of any cohesive plans to solve the problems of a severely crowded department.
- Communication to staff via divisional managers was sometimes lacking. For example, the process for accessing clinical guidance had recently been changed but ED staff had not been informed.
- We asked the hospital for results from the staff survey but these were not provided.

Innovation, improvement and sustainability

- All patients were screened for alcohol problems. Those found to be at high risk were offered referral to the department's alcohol liaison nurse.
- The psychiatric liaison team agreed a care plan with all their patients and a copy was given to patients to take home with them.

Medical care (including older people's care)

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

Information about the service

The Alexandra Hospital in Redditch opened in 1985. It serves a population of approximately 200,000 and has over 300 beds. The hospital is the major centre for the county's urology service.

The medical specialty provides cardiology, gastroenterology, haematology, and respiratory services. The hospital has nine medical wards including general medicine, gastroenterology, cardiology, respiratory and haematology wards. It also has a medical assessment unit (MAU) with male and female wards, a discharge lounge and a chemotherapy Garden Suite.

In July 2015, the Care Quality Commission (CQC) inspected the hospital and found that medical services required improvement for safe, effective, responsive and well led, and was good in caring. The service was required to complete a number of actions to ensure compliance with the Health and Social Care Act 2008, regulations and had produced a comprehensive patient centred improvement plan, which reflected these requirements as well as additional aims and objectives for the service.

During this inspection, we visited the following areas at the Alexandra Hospital; the chemotherapy Garden Suite, discharge lounge, medical assessment unit (MAU) and the medical wards.

We spoke with 34 members of staff including nurses, doctors, pharmacists, therapists, administrators and housekeepers. We spoke with 22 patients and relatives.

We observed interactions between patients and staff, considered the environment and looked at 35 care records. We also reviewed the trust's medical performance data.

Medical care (including older people's care)

Summary of findings

Overall, we rated the service as inadequate. We rated medical services at the Alexandra Hospital inadequate for safe and well led, and requires improvement for effective and responsive and good for caring. We found that:

- The National Early Warning Scores (NEWS) audit from September to December 2016 showed compliance to the escalation of NEWS above five was only 51%. This was below the trust target of 95%.
- Staff did not complete venous thromboembolism assessments (VTE) on patients in line with trust policy and national guidance. In the records we looked at it was difficult to establish the VTE re-assessment rate following 24 hours of admission. This meant that patients might not have the relevant re-assessment to manage their care appropriately.
- Appropriate systems were not always in place for the storage, administration and recording of medicines. The previous inspection identified the same concerns.
- Intravenous fluids for emergency use were stored unsecured in resuscitation trolleys on corridors in the ward areas. The trolleys were accessible to staff, patients and relatives which meant there was a risk of medicines being tampered with which could cause harm to patients.
- During the last inspection, the management of medicines was a concern. During this inspection, we found concerns with the storage of medicines and the timely dispensing of medicines.
- Most patient records were incomplete and not managed in a way that kept them safe. For example, pain levels, fluid and nutrition charts were not updated.
- Environmental audit action plans did not have targets or outcomes, which meant there were no systems in place to manage the potential risk to patient's safety.
- Medical staffing was in line with national guidance but was a concern for staff both in terms of effective recruitment and staffing level. Doctors said the level of medical cover in the evening and at weekends was not always sufficient. Senior staff reported delays in medical assessments at times of high demand. However, there were no reported incidents which affected patient care and treatment.
- Only 76% of nursing and medical staff had received all of their mandatory training. This was below the trust target of 90%. Safeguarding children's level 2 training was 30% for nursing staff and 11% for medical staff. Medicine management training was 36%.
- Staff appraisals were 75%, which was below the trust target of 85%.
- We found poor clinical supervision during our last inspection. During this inspection we found this had not improved and there was no clear structured approach for regular operational and clinical supervision. Managers did not provide regular formal supervision to staff. However, despite the lack of formal supervision, staff confirmed that managers supported them effectively.
- The service reported variable performance in a number of national audits relating to patients safety and treatment.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected. There were no embedded systems in place to review data and trends appropriately with regard to mortality and morbidity within the service.
- Care planning effectiveness was not consistent and care plans were not always person-centred, for example, for patients living with dementia.
- Staff showed awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the records showed training for medical staff was only 41%. This was below the trust target of 90%, which meant that staff might not have the appropriate skills to refer patients appropriately.
- The Friends and Family Test data response rate for medical care at the hospital was 17%, which was worse than the England average of 26%.
- There was no policy in place for the management of outliers (a patient admitted to a ward different from the medical ward). Medical and nursing staff considered the effectiveness of managing medical outliers a risk.

Medical care (including older people's care)

- The leadership, governance and culture did not promote the delivery of high quality person-centred care. The visibility and relationship with the management and executive team was not clear to most staff and they were unaware of the trust's strategy. Medical staff confirmed they were unaware of the key objectives to support the overall trust operational plan.
- The systems, processes and the operation of governance arrangements in place were not effective at identifying and mitigating patient risks. Not all risks identified were on the divisional risk register and local wards did not have their own risk register.
- The staff survey for 2015 showed that the trust was in the bottom 20% of acute trust for 23 of the 32 key findings and worse than average in four.
- Staff felt they were not involved in improvements to the service and did not receive feedback regarding any concerns.

However, we also found that:

- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally.
- The wards used the NHS safety thermometer system to manage risks to patients, including falls, pressure ulcers, blood clots, and catheter associated urinary tract infections. Service leads reviewed and identified areas of poor compliance or areas in need of improvement from the audit results.
- Nursing staffing levels met patient needs at the time of our inspection.
- Multidisciplinary team working was effective.
- Staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was generally good.
- Patients were supported, treated with dignity and respect, and were involved in their care. Patients told us that the staff were caring, kind and respected their wishes and we observed that staff were kind and caring to patients.
- Concerns and complaints procedures were established and effective and information was available for patients regarding how to make a complaint.
- Nursing and medical staff were positive about the teams they worked in and the services they provided.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Overall, we rated safety as inadequate because:

- The National Early Warning Scores (NEWS) audit from September 2016 to December 2016 showed the escalation of NEWSs was only 51% for scores above five. This was below the trust target of 95%.
- There was inconsistency in the management of deteriorating patients. For example, we saw two patients with a NEWS above who five were not being monitored regularly. This was not in line with the trust policy.
- Staff did not complete venous thromboembolism assessments on patients in line with trust and national guidance. We looked at 35 records and found it was difficult to establish the re-assessment of patients within 24 hours.
- Only 30% of nursing staff had completed safeguarding children level 2 training and 11% of medical staff. This meant that staff might not have the appropriate training to meet the needs of patients using the service.
- Not all staff had completed their medicines management training. The records showed a completion rate of 36% against a trust target of 90%. This meant that not all staff had up-to-date knowledge relating to potential risks associated with medicines.
- Staff reported delays to in medical assessments during busy periods. However, we saw no incidents had been reported which affected patient care and treatment.
- We found that patient's individual care records were incomplete and not managed in a way that kept patients safe. For example, fluid balance charts were incomplete in 12 of the 35 records we reviewed.
- There were no embedded systems in place to review data and trends appropriately with regard to mortality and morbidity within the service.
- The records showed that the administration of medicines was appropriate. However, we identified some concerns, including the appropriate storage of medicines and the timely dispensing of medicines. For example, medication that required cool storage was stored in fridges where temperatures were either below or above the manufacturers' recommended temperature. The previous inspection had also identified this concern.
- Intravenous fluids for emergency use were stored unsecured in resuscitation trolleys on corridors in the ward areas. The trolleys were accessible to staff, patients and relatives which meant there was a risk of medicines being tampered with which could cause harm to patients.
- All areas were visibly clean and tidy and the environment was regularly audited. However, the environmental audit's action plans did not have any targets or outcomes, which meant there were no systems in place to manage the potential risk to patient safety.
- There were inconsistencies in the storage of documents. We saw records stored in unlocked trolleys that were easily accessible to unauthorised individuals.
- The management of deteriorating medical patients on non-medical wards was not always effective. We found two records where a medical doctor had not reviewed a deteriorating patient who had been admitted onto a surgical ward.

However:

- Staff understood their responsibilities to raise concerns, to record safety incidents, near misses, and to report them internally and externally.
- Staff teams shared and reviewed the results of the safety thermometer to identify areas of poor compliance or areas in need of improvement.
- Good levels of cleanliness and hygiene standards were maintained.
- Nursing staffing levels met patient needs at the time of our inspection.

Incidents

- There was an effective system for the reporting of safety incidents. Staff described their roles and responsibilities in the management and reporting of incidents.
- Staff said they were encouraged to complete incident reports on the trust's electronic reporting system. Staff used the trusts policy and procedures when reporting incidents and there was clear accountability for incident reporting across the service.
- Nursing staff reported that they used reflective accounts to consolidate learning from incidents and were able to

give examples where this had happened. For example, a patient with a low potassium level had not been escalated for 24 hours (low potassium levels can cause serious side effects including, dehydration, low blood pressure, confusion, paralysis, and changes in heart rhythm. Following the incident, a study day was organised which trained staff to recognise and care for patients with a low potassium which helped keep patients safe and protect them from further harm.

- Medical services reported one never event at the Alexandra Hospital from July 2015 to August 2016 relating to medicine management. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The never event occurred in November 2015. The incident involved a patient that was prescribed zero to six units of insulin medicine and 60 units were administered via a non-insulin syringe. Because of the incident, new prescription charts had been implemented which included checking by two nurses. We saw the form in use and staff said this had improved learning. Following the never event, the trust implemented additional training in the administration of insulin.
- The band 7 nurses from the Alexandra Hospital liaised with their colleagues at the Worcestershire Royal Hospital regarding incidents, which they shared with staff at staff meetings. Staff confirmed they received feedback on incidents raised.
- In accordance with the Serious Incident Framework 2015, medical care services reported 38 serious incidents (SIs) which met the reporting criteria, set by NHS England, from July 2015 to August 2016. Slips/trips and falls (39%) and pressure ulcers (37%) accounted for 76% of all incidents reported. To help reduce the number of hospital acquired pressure ulcers the trust had implemented an increased training programme, which included improved staff awareness of risks.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw guidance within the service, which staff used as a reference. The records showed the duty of candour had been utilised regarding the never event and staff showed awareness and understood their responsibilities of when it would be used.
- Staff understood their role and responsibilities in relation to duty of candour. We saw minutes from staff meeting that reflected this practice.
- The trust established a mortality review process with its "buddy" trust in November 2016 to ensure they had the correct guidance and processes in place to manage the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results. The aim was to electronically record mortality reviews to ensure consistent evaluation of data and trends. However, we saw the service had not embedded this process and there were inconsistent mortality and morbidity review meetings.

Safety thermometer

- Each ward used the NHS Safety Thermometer (which is a national improvement tool for measuring, monitoring and analysing harm to patient's and 'harm-free' care). Monthly data collected displayed information on pressure ulcers, falls and catheter associated urinary tract infections (UTI) and blood clots (venous thromboembolism or VTE). Senior staff reviewed areas of improvement based on the audit results.
- The divisional quality governance team oversaw the completion of the safety thermometer and reviewed any actions regarding the non-completion of safety thermometer records.
- Staff teams shared the results of safety thermometer audits. Service leads reviewed areas of poor compliance and improvement.
- Across the medical service, the patient safety thermometer showed that the trust had reported 21 pressure ulcers, 15 falls and 22 catheter associated urinary tract infections between August 2015 and October 2016.
- We saw additional training implemented because of the increase in pressure ulcer results. Staff on Ward 5 confirmed they were working with the tissue viability nurse in trialling the "react to red" scheme. The aim of the scheme is to provide pressure ulcer prevention

awareness and training. It focuses on understanding and identifying risk, how to escalate and communicate effectively the knowledge around pressure ulcer prevention using the basics on the SSKIN bundle. The SSKIN bundle is a five-step model for pressure ulcer prevention and covers the following areas:
  - Surface: make sure your patients have the right support
  - Skin inspection: early inspection means early detection
  - Keep your patients moving
  - Incontinence/moisture: your patients need to be clean and dry
  - Nutrition/hydration: help patients have the right diet and plenty of fluids.
- The number of falls peaked in September 2015 (two per 100 patients). From October 2015 to February 2016, rates decreased but increased again from March to May 2016. However, from June to August 2016 the rates had decreased to zero because of additional training.
- From August 2015 to February 2016 the number of catheter UTI's had increased reaching its highest point in February 2016 at 0.8 per 100 patients surveyed. Rates decreased from March to May 2016 but were seen to be increasing from June to August 2016 (0.8 per 100 patients surveyed). However, we did not see evidence of an action plan to address the increase.

Cleanliness, infection control and hygiene

- We saw good cleanliness and hygiene standards across the service. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- Areas visited were visibly clean and sanitising hand gel was available throughout the wards.
- We saw current cleaning schedules displayed. Signed cleaning schedules were in accordance with trust policy to confirm that cleaning had taken place. Equipment had "I am clean" stickers that were visible and documented the last date and time of cleaning.
- We saw that infection prevention and control information displayed across all clinical areas detailed the correct procedures for hand washing, contact details for the trust's infection control and prevention team and audit results.
- The results of cleanliness audits, which include hand hygiene, were on display on noticeboards within the wards. For example, on Ward 5 they had achieved 97% and 95% on Ward 12. This was above and equal with the trust target of 95%.
- Senior staff for the areas visited confirmed that any patient with a potential infection was treated in a side room, if required. There were processes in place for areas to be deep- cleaned by the infection prevention control team.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons. We observed staff adhering to the trust's 'arms bare below the elbow' policy, applying gloves and aprons as required, and washing their hands and using hand sanitising gel following their time spent with patients.
- We observed staff cleaning chemotherapy trays and trolleys between each patient.
- All staff involved in decontamination had access to and wore the appropriate personal protective equipment including single-use gloves and aprons.
- There was evidence of Control of Substances Hazardous to Health (COSHH) risk assessments in place within the endoscopy unit.
- Patient led assessments of the care environment (PLACE) in 2016 showed a standard of 99% in the Alexandra Hospital for cleanliness. This was above the England average of 98%.
- From September to November 2016, there was one case of hospital acquired Clostridium difficile infection and one for MRSA within the service. In order to identify learning and any changes to practice the infection prevention and control team reviewed each case. Investigations were completed and shared with local teams and staff training targeted to address any findings.
- The endoscopy unit had effective processes in place to ensure the cleanliness of equipment and to prevent contamination. This was in accordance with the Health Technical Memorandum 01-06 guidance on the management and decontamination of flexible endoscopes. This included separate dirty and clean areas, and the use of designated staff for equipment cleaning. We saw endoscopes were leak tested, manually cleaned, and washed in washers between 45-50 minutes following a full wash cycle.
- The endoscopy team completed weekly water sampling for contamination. We saw evidence of sampling and

the results did not highlight any concerns. Staff told us that any incident of contamination resulted in resampling and "closing" the unit until confirmed as clear of contaminants. We saw stringent infection control measures in the endoscope washrooms.

- There were processes and procedures in place for tracking each endoscope used; decontamination records were in the relevant patient notes to ensure the traceability of equipment, including details of the staff members who were responsible for operating and decontaminating them.
- Staff adjusted treatments lists for patients attending appointments with a potential risk of a communicable infection. This enabled additional cleaning times for equipment between patients.
- Patient records we viewed had discussions with microbiologists recorded regarding the management of infections to minimise any risks.

Environment and equipment

- The design of most areas and the maintenance of the facilities and electrical equipment protected people from avoidable harm. There were systems and arrangements in place to review and check equipment. However, actions plans seen regarding the environmental audits did not have any target dates or outcomes to manage any potential risk to patients.
- Guidance on the planning and designing of in-patient facilities for adults, including the layout of bedrooms and bathrooms was in line with the Health Building Note 04-01: Adult in-patient facilities.
- The security department within the hospital had carried out an assessment of the environment. The recommendations included a new security contract that had been agreed and commenced. Staff confirmed they were happy with the security arrangements at the hospital.
- The coronary care unit's patient environment audit for October 2016 had an overall score of 93%. This was above the trust target of 90%. They scored 97% for cleanliness, 90% for condition/appearance of the environment, 100% for equipment cleanliness and 60% for both safety and temperature of the environment. The audit raised three areas of concern which included; are fire doors fully functional and uncompromised, has all electrical testing been done and is it up to date and was the ward temperature appropriate for the patients. We saw all the concerns reported to the service manager. However, the action plan linked to the audit did not have any outcomes or targets, which meant we were unassured as to the systems in place to manage the potential risk to patients.
- The environmental audits for Wards 2, 3, 4, 5 and 6 completed in September and October 2016, showed the overall scores ranged from 89% to 94% with cleanliness, condition/appearance of the environment, equipment cleanliness, safety and temperature between 75% and 100%. Examples of identified actions included; emergency exits free of obstacles and fire doors closed. We saw all concerns reported to senior staff. However, the action plan did not have any outcomes or targets, which meant there were no systems in place to manage the potential risk to patients.
- The endoscopy's environmental audit for September 2016 had an overall score of 94%. They scored 96% for cleanliness, 90% for condition/appearance of the environment and 100% for equipment cleanliness, safety and temperature of the environment.
- Emergency equipment for resuscitation for all areas visited was in date. For example on the Garden Suite and Ward 12, emergency equipment was stored on dedicated trolleys, which was available for immediate use. This included for example; a defibrillator, oxygen cylinder and a reusable resuscitator, all of which were in date.
- We saw the checklist appropriately completed for Ward 12. The Garden Suite completed their checklist for each weekday; however, for the months of November and December none of the weekends were completed. We addressed our concern with the nurse in charge.
- The resuscitation trolley, within the discharge lounge, was taken away each day for checking by the medical care team. During our visit on 08 December 2016, there were no records on the trolley for us to verify authenticity. This meant that we were unsure as to the effective systems and processes in place to manage the checking of resuscitation equipment.
- Nursing staff said there was adequate supply of equipment to meet the needs of the patients. This included alternating air mattresses (which were used to minimise the risk of patients acquiring pressure ulcers) and infusion pumps (a medical device that was used to deliver fluids or medicines into the body in a controlled manner).

- All equipment checked was labelled as being suitable for use, for example, fire extinguishers on each ward had been checked to ensure they were safe and appropriate to use.
- We saw the identification of regular testing of portable electric equipment with clear dates for the next test date on them.
- Dirty utility rooms (or sluice room) were observed to be clean and tidy with appropriate storage for clinical waste and chemicals.
- The Joint and Advisory Group (JAG) (a quality improvement and service accreditation programme for gastrointestinal endoscopy) had identified in their August 2016 report concerns regarding the location of the decontamination equipment and environment within the endoscopy unit. A business case had been approved which would involve the replacement of equipment and the possible relocation of the unit. During our inspection, staff explained the forthcoming developments and the prospect of getting new equipment. Staff told us how they were looking forward to relocating to a new environment. Staff explained how they were mitigating the areas identified within the report, which included the isolation of male and female patients to ensure they complied with the mixed sex legislation. We saw curtains in place to isolate patients and a restructure of the reception area implemented. The risk register report for October 2016 had identified a target date of April 2017 for works to be completed.
- Equipment used for endoscopy procedures was appropriately tracked. This was in line with best practice.
- Within the endoscopy unit there was:
  - Designated and dedicated decontamination areas
  - Allocated entry and exit points
  - Separate dirty, clean and storage areas
  - The appropriate flow for equipment used
- Endoscopes were stored so that residual fluid did not remain in the channels, which prevented the risk of environmental contamination.
- The endoscopy completed weekly cleaning audits with no concerns or anomalies identified.
- Manufacturer maintenance contracts maintained specialist equipment. There was an asset register, which identified the equipment and the maintenance dates. We found no issues or concerns identified within the register.
- Nursing staff reported that they had access to sufficient equipment for the clinical needs of each department. This included the endoscopy unit, chemotherapy Garden Suite and wards.
- We saw that all sharp boxes for the disposal of needles were appropriate to the clinical area and detailed the date, time, and person responsible for assembling them. We saw sharp boxes had been assembled correctly.
- Clinical areas used the appropriate coloured disposal bags. General waste and recycling facilities were available to staff, patients and visitors.
- In order to maintain the security of patients, visitors were required to use the intercom system outside the wards to identify their arrival before they were able to access the area. Staff had the appropriate access codes.
- Staff disposed of cytostatic medicines (any drug that has a toxic effect on cells such as chemotherapy treatments for cancer, which kill off the cancer cells) appropriately. Equipment requiring incineration and contaminated cytotoxic waste, a bi-product of chemotherapy and radiotherapy treatment, was disposed of in accordance with trust policy in purple bags. Used needles and syringes following administration of chemotherapy were disposed of appropriately in purple-lidded sharps boxes.

Medicines

- The records showed that the administration of medicines was appropriate. However, we did identify some concerns. Appropriate systems were not always in place for the storage and timely dispensing of medicines.
- During the last inspection, the management of medicines was a concern. Since the previous inspection, the pharmacy team had remained actively involved in medicine management from the point of a patient's admission through to their discharge. However, we found concerns with the storage of medicines and the timely dispensing of medicines.
- The chemotherapy fridge within the Garden Suite showed that for November 2016, the maximum temperature for the whole month was above 10º Celsius. This exceeded the recommended average temperature of between 2-8º Celsius. We addressed our concern with the nurse in charge who confirmed they would attend to the matter.
- The clinical room on Ward 18 showed a mean temperature above 26º Celsius which was above the

recommended 25º Celsius. Although staff were aware of the risk regarding the potency of patient's medicines when stored above the recommended room temperature there were no processes in place to manage this risk to patients. We also found the fridge temperature on Ward 18 was below the recommended 2º Celsius for the month of December with the exception of one day. We addressed our concerns with the nurse in charge who arranged for the destruction of all affected medicines.

- Emergency medicines for resuscitation were stored on dedicated trolleys, which were accessible and available for immediate use. However, some medicines including intravenous fluids stored on the resuscitation trolleys were unprotected with a tamper evident label or seal to provide visible evidence that they were safe to use. This contravened the Resus Council November 2016 guidance. We addressed out concerns with senior staff during our visit.
- The discharge lounge had access to a drug cupboard to support patients who may require medicines such as insulin, blood thinning medicine and analgesia. During our visit on 08 December 2016, this was inaccessible to the health care assistant working in the department as they did not have the correct competencies to administer medicines. Staff confirmed they usually had access to a registered nurse. However, due to the shortness of staff on the day of our visit they did not have access to a registered nurse in the event of medicines being required to patients. This meant there was a risk of patients not being able to access the required medicines in order to maintain their care and welfare.
- We looked at five medicine administration records (MAR). Arrangements were in place for the recording and administration of drugs. A coding system used explained the non- administration of any missed doses. All MAR had the patient's allergy recorded. However, we found inconsistencies in the recording of the patient's weight or VTE reviews. We looked at five drug charts across the service and found that only one had the patient's weight recorded. Recording patient weight is important as it is sometimes required in order to calculate the appropriate medicine dosage.
- The MAR identified the accurate reporting of missed medicines. However, we found two drug charts whereby the patient missed their medicines due to it not being available. There was no system in place to ensure that staff acquired the relevant medicine for the care and welfare of their patients in a timely manner. This was brought to the attention of the nurse in charge who immediately phoned pharmacy to ensure the appropriate medicines would be dispensed.
- There were good governance processes in place to ensure that learning from medicine incidents was undertaken and action taken to prevent them reoccurring. Medicine incidents discussed at the Medicine Optimisation Expert Forum were distributed and discussed at the clinical governance group meetings. The medicine safety officer had a well-developed system of reporting across the trust.
- Medicine management link-nurses helped to ensure that learning from medicine incidents were cascaded back to the ward teams. For example, due to an increased reporting of medicine incidents relating to allergies, all penicillin related antibiotics were stored separately from all other medicines. Following a never event with insulin, changes were made to the whole process of supply and delivery of insulin which was followed up with training. Medicine safety bulletins, posters and newsletters were available in clinical areas as well as on staff notice boards.
- The treatment room within the chemotherapy Garden Suite had limited space that was not adequate for the level of activity. There was potential for distractions during drug preparation. However, the service recorded no medicine errors. Senior staff confirmed there were plans to move the location within the acute oncology ward. However, there was no timescale for the implementation of this work.
- Nursing staff wore a red tabard during medicine rounds, which indicated that the staff member should not be disturbed. Nursing staff were aware of medicine policies and relevant assessments, including self-medication. We observed nurses administering and following the required medicines' protocol on Ward 8. This ensured patients received the correct medicines at the correct time.
- Within the clinical room all supplies were neatly stored and within date. All intravenous fluids were within date and correctly stored.
- We saw omitted medicines clearly recorded with an appropriate code as to the reason why.
- The pharmacy visited the wards daily, reviewed the patient's medicines and ordered additional medicines as appropriate.

Medical care (including older people's care)

- The trust participated in a Commissioning for Quality and Innovation (CQUIN) baseline audit. The pharmacy department conducted a 'missed medicine administration due to the medicine not being available (code 3)' audit in March 2016. The aim of the audit was to assess the current level of missed medicine administration and to discover methods of preventing these to optimise patient care. The pharmacy audited a sample of 20% of the occupied beds on each ward. The total percentage of code 3 was 0.40%; this was lower (better) than the CQUIN baseline audit of 0.96%. The highest number of missed medicine doses occurred on the medical assessment unit (0.83% based on 484 number of doses prescribed). However, we did not see any evidence of an action plan outlining how the service would monitor or manage the shortfall.
- The ward pharmacist visited the wards daily and monitored the prescribing of drugs, and offered prescribing advice. They also completed drug reconciliation, which was a process of checking drugs prescribed against those previously taken by a patient. All drug charts checked had a completed drug reconciliation record. We saw evidence of completed reconciliation with comments recorded in patient notes and on drug charts. We observed the pharmacist discussing a patient's medicine history with them on admission to the ward. In addition, the pharmacist answered any other questions the patient may have about their medicines.
- All drugs were stored safely behind locked doors and only accessible to appropriate staff. We saw all controlled drugs (CDs) were stored appropriately. CDs are prescription medicines controlled under the Misuse of Drugs Legislation 2001. On checking the CD register, we found no issues or concerns.
- Nursing staff were observed administering patients' medication in line with the Nursing and Midwifery Council Standards for medicines management 2007. This included checking the drug, its expiry date, dose and time due. All nursing staff checked the patient's identity prior to administering any medicines.

Records

- We found that patient's individual care records were incomplete and not managed in a way that kept patients safe.
- We looked at 35 records across the service and found inconsistencies in the completion of charts, assessments and care plans in all wards visited. We notified senior staff of our concerns. Examples included:
  - Intentional rounding, which should have been completed two hourly, did not have a time indicated on the records (seven records)
  - Incomplete skin assessment (seven records)
  - Incomplete fluid charts (12 records)
  - Incomplete NEWS charts which included blood sugar monitoring and pain management (nine records)
  - Nursing assessments including biographical details and contact details for next of kin were only partially completed (six records)
- There were inconsistencies in the storage of documents. For example, we found records within the Garden Suite securely locked away behind the reception desk, while records on a trolley on ward 12 were open and unlocked.
- We observed patient information left on display on the desk by the nurse's station on ward 12. We informed the nurse in charge of this and they immediately addressed our concerns.
- Computer terminals were secure and locked to prevent non-authorised persons accessing patient information.
- The wards used a patient passport document called "About me" to support care planning for patients with dementia. Screening for dementia assessments was being carried out in the wards we visited.

Safeguarding

- There were systems, processes and practices that kept patients safe. Staff understood their responsibilities and knew how to identify potential abuse and report safeguarding concerns. However, the training records showed that the medical service did not have the appropriate level of training for safeguarding children.
- Safeguarding adults was part of the mandatory training programme for all staff. There was different levels of training provided for different job roles. Medical staff had a training completion rate of 94% for safeguarding adults (level 2), thereby exceeding the trust target of 90%.
- Senior medical staff at the Alexandra Hospital confirmed they did not treat children but confirmed staff had completed their children's safeguarding awareness training. However, data provided by the trust showed that the safeguarding children level two completion rate

was 11%. This was below the trust target of 90%. The Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document 2014, states, "adult nurses in acute/community settings and adult physicians should be trained to at least level two". Senior staff confirmed they were aware of the shortfall and identified electronic learning was being allocated to medical staff. This meant that nursing and medical staff may not have the relevant qualifications to meet the needs of other patients should they be relocated. Therefore, we could not be sure that all staff had the sufficient knowledge and skills to safeguard people.

- Nursing staff had a training completion rate of 99% for safeguarding adults. The records provided by the trust showed that only 30% of staff had completed safeguarding children level two training. Senior staff confirmed they did not treat children but were aware of the shortfall and we saw arrangements in place for staff to attend safeguarding e-learning training. We saw training dates assigned on staff notice boards.
- Safeguarding information, including contact numbers for the trust leads were kept on the wards in folders and on staff notice boards and staff were aware of how to access these. Safeguarding concerns were discussed at handovers to ensure staff were updated on any ongoing issues.
- The adult safeguarding lead confirmed that female genital mutilation (FGM) training formed part of the safeguarding children and safeguarding adults' training at all levels. All new staff received FGM awareness as part of their safeguarding level one training.
- There were clear systems, processes and practises in place to keep patients safe. Staff knew who the named safeguarding lead for the service was and how to contact them for support. There was safeguarding information, including contact numbers on display on staff notice boards and staff knew how to access the trust policy on the intranet.

Mandatory training

- Staff received mandatory training in safety systems, processes and practices.
- The trust had set a target of 90% for completion of mandatory training. However, the records showed that the medical staff had not reached its target with the exception of manual handling. For example, information governance had a completion rate of 60% whilst fire awareness, health and safety, infection control and resuscitation had a training completion rate of between 83% and 85%. Equality and diversity training had the lowest completion rate at 20%, followed by conflict resolution (29%) and medicine management (36%).
- Nursing staff had a training completion rate of 90% to 93% for fire awareness, infection control, resuscitation and information governance, thereby meeting and exceeding the trust target of 90% in these specific modules.
- Mandatory medicine management training occurred twice a year. However, across the nursing staff, medicine management had the lowest training completion rate of 27% followed by conflict resolution (39%) and equality and diversity (39%) training. This meant that staff were not up-to-date on the safe administration of medicines, which could pose a potential risk to patients.
- Staff knew how to access the management of violence and aggression policy and confirmed they had received training in conflict resolution and personal safety. However, the training records provided by the trust did not reflect this, which showed that only 39% of staff had completed this training across the medical services
- The risk register did not record training. However, the patient centred information plan tracked all training. In response to the training deficit, the service had developed online training and a review of roles to ensure that training was specific to the needs of the role.
- Training timetables were on display on the wards visited as well as the cardiology and endoscopy units so staff could clearly see what training was outstanding. Ward managers confirmed they followed up staff who had failed to complete their training, or were having difficulties in attending their allocated sessions.
- New starters completed their mandatory training during induction. Staff told us they had undertaken mandatory training relevant to their role.
- Ward managers had access to an electronic system for recording and monitoring staff training records and they planned ahead to ensure staff received the appropriate training.
- Staff had undertaken sepsis awareness training. Within the cardiology service, we saw posters on display outlining the procedures and processes to be completed when sepsis was suspected in a patient.

Assessing and responding to patient risk

- Comprehensive risk assessments were not always compliant and completed in line with national guidance.
- Assessments for patients covered all health needs (clinical, mental health, physical health, and nutrition and hydration needs) and social care needs. Although patient's care and treatment was planned and delivered in line with evidence-based guidelines, we found areas which the service were not monitoring effectively. This included venous thromboembolism (VTE) (blood clots) assessments and National Early Warning Scores (NEWS) charts.
- All patients on admission received an assessment of VTE risk using the clinical risk assessment criteria. This was in line with the National Institute for Health and Care Excellence (NICE) QS3 Statement 1. Although the trust assessed and responded to patient risk, there were shortfalls in the completion of VTE assessments and NEWS.
- During our unannounced visit on the 07 December 2016, we visited the discharge lounge. The trust guidelines stated the area should be staffed by "one trained nurse and one health care assistant (HCA)." During our visit, this area only had one bank HCA in situ. This resulted in the discharge lounge only taking patients whose discharge was complete and did not require any medicines due to the HCA not having the appropriate competency to dispense medicines. This meant there was a risk that staff may not be able to assess and respond to patient risk in a timely manner.
- During our visit on 07 December 2016, staff within the discharge lounge confirmed they would bleep the matron in charge or phone the ward should a patient become unwell and deteriorate. This was in accordance with trust policy. However, during our visit, staff called the bleep holder, the matron in charge and the bed manager twice, over a 20-minute period, with no response. This meant there were inappropriate processes and support in place to manage the care and welfare of patients appropriately should their health deteriorate in the discharge lounge.
- Identified systems, processes and practices essential to keeping people safe were incomplete. For example, the service used a VTE and risk of bleeding assessment tool. Patients should have the tool completed on admission and a re-assessment within 24 hours of admission. We saw that the service did not always follow the NICE (QS3 Statement 4) reducing venous thromboembolism risk in hospital patients' guidelines on all wards. For example, of the 35 records seen it was difficult to establish the re-assessment of patients within 24 hours. This meant that patients might not have the relevant re-assessment to manage their care appropriately.
- The VTE audit provided by the trust was undated, but highlighted the following based on 10 admissions at the hospital:
  - VTE prophylaxis (a measure taken to maintain health and prevent the spread of disease) was understood well by clinicians
  - Many incidents where VTE assessments had not been completed
  - Although initial assessments were completed, none of the re-assessments had been completed within 24 hours of admission.
  - Nurses had been reluctant to given medicines where there was no evidence of a VTE assessment, which could place patients at risk.
- The medical service recognised this as an area for improvement. Areas/actions identified included the carrying out of monthly auditing of VTE assessment completions and the implementation of additional training for both medical and nursing staff. However, we did not find any timescale for the implementation of the identified actions. Senior staff said they were aware of the recommendations and confirmed this was a work in progress.
- The review of VTE ensured that patients received the appropriate medicine to prevent deep venous thrombosis, a condition in which harmful blood clots form in the blood vessels of the legs. For example, on Ward 12 we looked at six medicine records, which identified the use of a preventative clotting medicine, only two had received the appropriate VTE review. We spoke with medical staff who confirmed awareness of the shortfall and told us that there was arrangements in place to improve compliance. However, during our unannounced inspection, we found three new patients who had not received the appropriate assessment.
- The medical services used the NEWS system for identifying and escalating deteriorating patients. The NEWS audit for November 2016 identified staff not escalating patients with an average score of five appropriately. This resulted in all patients with a NEWS of five or above being reviewed by doctors. This system alerted nursing staff to escalate patients for review if routine vital signs were outside of normal parameters.

Medical care (including older people's care)

- Senior staff and doctors confirmed they used a stamp that highlighted the date and time of review of the NEWS charts. We saw stamped NEWS charts within the records. However, during our inspection, we looked at 35 records and found nine NEWS charts were incomplete which meant there was a risk to deteriorating patients and the stamping of the NEWS chart had not been fully embedded within the medical team.
- Medical patients on non-medical wards such as surgical wards did not always have a medical staff review, especially at weekends. For example, two patients at risk of deteriorating due to a NEWS above five had not had their symptoms escalated to the medical team and were not seen. We spoke with senior staff who confirmed that these patients had increased NEWS levels, which were acceptable. However, there was no evidence in the patient records to confirm this. This meant there was a risk of deteriorating patients not being appropriately referred and seen by the medical team.
- Senior staff attended a multidisciplinary safety meeting on the ward each morning. This assessed and reviewed patient risk. Each patient was RAG (red, amber, green) rated to determine what intervention was required.
- We saw evidence of discussions between the trust and the ambulance service regarding the transportation of patient presenting with or developing signs of upper gastro intestinal (GI) bleeds which included the transfer of patients to Worcestershire Royal Hospital, once diagnosed by the Alexandra Hospital. We saw the action plan (September 2016) which included the drafting of a standard operating procedure for integration of the ambulance service pathway for upper GI bleed. We saw this had a target completion date of December 2016.
- There was an escalation policy for patients who required immediate review.
- Staff at the Alexandra hospital had access to a "just in case" pack. This ensured that patients receiving systemic anti-cancer therapy (SACT) had antibiotics that could be administered to them on presentation to the emergency department prior to a blood result/medical review being available.
- During our visit to Ward 9, we observed the speech and language therapist conducting an in-depth risk assessment. We saw the therapist was calm, took time to explain what they were doing and obtained good interaction and feedback from the patient.
- The critical care outreach service was available to all staff from 7:30am to 8pm seven days a week. The aim of the outreach service was to improve patient outcome and avert unnecessary admissions. Ward staff at night had support from out of hour's nurse practitioners. At the beginning of each shift, staff discussed any patient considered to be "at risk." This ensured that they had up to date knowledge of patients in their care.
- Medical care services had access to levels two and three critical care wards, required if a patient deteriorated. This was in line with the National Institute of Care and Health Excellence (NICE) critical care guidance 2015.
- The hospital provided four beds for patients requiring non invasive ventilation (NIV) on ward 5. A band 6 registered nurse or above attended to these patients. Patients received treatment and clinical decisions from respiratory registrars and doctors trained in NIV management. Specialist consultants saw patients daily and the respiratory medicine offered a seven-day service for patients requiring NIV. Consultants reviewed patients that may require transfer to a critical care bed due to potential resuscitation concerns. This was in line with current guidance published by the British Royal Thoracic Society.
- Patients identified as at risk of skin damage due to underlying or admitting clinical conditions, were nursed using pressure relieving mattresses and seat cushions.
- Intentional rounding charts used across the service included staff signatures for all care provided. Intentional rounding is a structured process where nurses in acute and community hospitals and care homes carry out regular checks with individual patients at set intervals, typically hourly. During these checks, they undertake scheduled or required tasks to ensure the fundamental aspects of care are delivered. In eight of the 35 records we looked at, there was no time recorded when the intentional rounding took place.
- All patients admitted to the service received a falls risk assessment using a national falls risk assessment tool. Nursing staff informed us that patients identified as being at risk of falls were placed in view or as close to bathrooms as possible. This prevented patients from walking long distances.
- Consultants confirmed they saw all urgent or un-planned medical admissions as and when required and within the specified timeframe. We saw no issues or concerns in the records reviewed. The trust policy

specified that consultants should see all urgent and un-planned admissions within 12 hours or within 14 hours of the time of arrival at the hospital. This was in line with the London Quality Standards.
- Patients who became unwell during outpatient procedures such as endoscopy or during outpatient clinical appointments were admitted to the service through the medical assessment unit.

Nursing staffing

- The trust utilised the safer care nursing tool for their staffing levels' acuity and dependency reviews along with NICE guidelines and professional judgement. Following a workforce review in January 2016, the trust's outcome was to continue with their current establishment of one nurse to eight patients across all general wards. However, staffing levels could change on a shift-by-shift basis if a patient was identified as being a higher risk. For example, if at risk of falling or they required increased nursing observations.
- To ensure the safe care and treatment of patients, the rotas we was identified appropriate staffing levels. On most wards one nurse and one healthcare assistant were responsible for one bay of patients, which usually had six to eight patients. Staff measured patient acuity and managed rotas to match patient dependency.
- Actual staffing levels were comparable to the planned levels for the wards we visited. Wards displayed their planned and actual staffing numbers at the entrance to each ward, which reflected the actual number of staff on duty. We observed previous duty rosters, which confirmed staffing levels were appropriate to clinical need.
- The nurse co-ordinator reviewed nursing rotas daily with allocations to department areas. This ensured the allocation of staff was appropriate in accordance to their skill and patient need. This took into account nursing students and any supernumerary staff (staff who are in excess of the normal number), who did not feature as part of the establishment. Staff escalated identified gaps to the bleep holder who deployed any extra available staff on a shift-by-shift basis.
- During busy periods, escalation processes ensured the redeployment of corporate nurses and specialist practitioner nurses into the role of delivering patient care.
- There was a staffing escalation policy and processes in place whereby the matron or the clinical site supervisor had awareness of any unfilled shifts. We observed the ward matrons attending clinical areas to review the staffing levels, ward activity and to offer support to the ward teams. Senior staff confirmed that nursing staff were often moved to support other wards but said that they were replaced by either agency or bank staff to ensure the correct numbers on each ward.
- In August 2016, the trust reported that their staffing numbers for medical care at Alexandra Hospital was 107.8 whole time equivalent (WTE) staff against a requirement of 134.12 WTE staff. This equated to a shortfall of 29.32 WTE staff.
- The trust reported an overall vacancy rate within the hospital of 30%. For example, the MAU, wards 2, 5 and 6 had a vacancy rate of between 20% and 36%.
- In August 2016, the hospital reported a turnover rate of 16% within the medical service. The discharge lounge had the highest turnover rate of 50%, followed by MAU (22%), ward 6 (21%) and the respiratory unit (18%). The chemotherapy garden suite, ward 2 and ward 5 all had a turnover rate of 14% whilst ward 12 had a rate of 6%. Dermatology and medicine administration had a 0% turnover rate.
- From April 2015 to March 2016, the Alexandra Hospital reported a sickness rate of 10%. This was higher than the trust target of 5%. Medicine administration reported the highest rate at 36% followed by the discharge lounge (23%). The chemotherapy garden suite had a sickness rate of 10%, ward 5 (8%) and MAU and ward 12 (5%). Dermatology reported a 0% sickness rate.
- From September 2015 to August 2016, Alexandra Hospital reported a bank and agency usage rate of 13% in medical services. This was higher than the trust average of 6%. The highest agency and bank usage was reported for the discharge lounge (31%), ward 9 (30%) and the overspill ward (25%). Six of the 13 units had an agency and bank usage rate of between 9% and 18% while four units reported a 0% agency and bank usage.
- The trust had an ongoing recruitment programme. Where practicable, agency staff were block booked to ensure continuity and rotas were re-organised where possible to ensure suitable skill mix on each shift.

Medical staffing

- The records showed that staffing levels had taken into account the needs of the patients' safe care and treatment. This was in line with relevant tools and guidance, where available.

Medical care (including older people's care)

- There was general medicine consultant cover seven days a week. This ensured there was sufficient consultant trained cover for the medical service. Senior medical staff confirmed they could access the hospital within the required 30 minutes. Cover at the Alexandra hospital was from 8am to 8pm weekdays and post take ward rounds at weekends. A post take ward round is primarily a medical round which is consultant led. These rounds usually take place in the morning.
- There was 24 hour on-call registrar cover and FY2 (foundation doctor)/registered medical officer (RMO) cover across the hospital. In addition, there was an FY2 on a late shift in the medical assessment unit and a late FY2 for the wards from 3pm to 1am and Monday to Thursday additional FY2 cover from 4pm to 4am.
- Night cover on the wards was from a registrar, a FY1 (house doctor) and an advanced nurse practitioner (ANP). The role of the ANP was to be a link between medical and nursing teams. There were no ANP facilities at weekends and the nurse in charge undertook the assessment of patients.
- The risk register had identified the lack of a consultant physician gastroenterologist as a concern. This resulted in the placement of a locum doctor at the hospital to assess and respond to patients when required.
- In September 2016, the Alexandra Hospital reported a vacancy rate of 37% in medical care, which was higher than the trust average of 32%. Dermatology and the postgraduate medical centre had a vacancy rate of 100%; histology had a vacancy rate of 58% whilst older people medicine and respiratory medicine both had a vacancy rate of 37%. General medicine had a vacancy rate of -20% indicating that the division was overstaffed. Gastroenterology reported a rate of 10% and ear, nose and throat (ENT) reported a vacancy rate of 0%. Cardiology and diabetic medicine both had a vacancy rate above 25%
- The vacancy rate for consultants was 44%, whilst the rate for other medical staff was 30%.
- The trust had an ongoing recruitment programme. Where possible, locum doctors provided additional cover to support the care and welfare of patients at the hospital.
- From April 2015 to March 2016, the service reported a sickness rate of 2% in medical staffing which was lower than the trust target of 3%. General medicine reported the highest rate of 12% whilst cardiology and respiratory medicine reported a 1% sickness rate. Consultants reported a 0% sickness rate and other medical staff a sickness rate of 3%.
- From September 2015 to August 2016, the service reported a bank and locum usage rate of 61% in medical care. The agency and locum usage for this hospital was higher than the trust average of 27%. This was on the trust's risk register as an area of concern. However, both locum and bank staff confirmed they had received an appropriate induction to the wards and felt competent in their role.
- The proportion of consultants (42%) reported to be working at the trust was higher than the England average (37%). Middle career (5%) and registrar doctors (28%) was lower than the England average of 6% and 35% respectively. Junior doctors (25%) working across the trust was higher than the England average of 21%.
- Medical locum staff reported that they had excellent support from substantive staff members including 24-hour support from consultants.

Major incident awareness and training

- The trust's winter plan for 2016/2017 summarised how the trust would provide an integrated approach to deliver services across Worcestershire. Four common factors were identified which may exacerbate winter pressures. These included:
  - Norovirus
  - Adverse weather conditions
  - Seasonal illness such as flu and other respiratory illness
  - Staff shortages due to the above
- The hospital had a service contingency plan in place for staff to use in the event of interruption to essential services such as electricity and water supply.
- Regular testing of generators occurred in case there was a failure of the electricity supply to the hospital.
- There were procedures for managing major incidents, winter pressures and fire safety incidents on the trusts' intranet that staff could easily access.

Medical care (including older people's care)

Are medical care services effective?

Requires improvement

Overall, we rated effective as requires improvement because:

- The service reported variable performance in a number of national audits relating to patient safety and treatment. We requested action plans from the trust which were not provided.
- The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) results were worse than expected.
- The patients' National Early Warning Scores (NEWS) showed that pain levels were incomplete in nine of the 35 records reviewed.
- There were no systems or audits to monitor effectively the hydration needs of patients.
- There were no systems in place to monitor the Waterlow score of patients. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. Of the 35 records seen, seven had incomplete Waterlow scores. This meant there were ineffective systems and processes in place to monitor patients at risk of acquiring pressure sores.
- The trust did not have action plans in place where the service had scored worse than the England average in national audits such as the Myocardial Ischaemia National Audit Project (MINAP) and heart failure audit.
- The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training records showed poor compliance (41%). This meant that staff might not have the relevant skills to refer patients appropriately.
- Following a never event, the trust instigated additional training in the administration of insulin on medical wards. The records received showed that from December 2015 to November 2016, only 16 (11%) nurses had completed their training. This meant that nurses deployed to other wards might not have the necessary competency to manage a patient's diabetic need.
- The last inspection identified clinical supervision as an area for improvement. During this inspection, we found there continued to be no clear structured approach for regular clinical supervision.

However:

- Evidence based guidance, standards, best practice and legislation ensured the planning and delivery of patients' care.
- Specialist advisors provided additional support and treatment plans in the management of pain control.
- Patient's nutritional needs were regularly assessed and monitored.
- There was evidence of effective multidisciplinary team meetings.
- The service offered a seven-day service to oversee the care and welfare of patients.

Evidence-based care and treatment

- Evidence based guidance, standards, best practice and legislation ensured the planning and delivery of patients' care.
- Policies were relevant and accessible by staff via the trust's intranet system. This included guidance, such as National Institute for Health and Care Excellence (NICE).
- All staff demonstrated awareness of trust policies and guidelines, which were available on the intranet
- Patients transferred to inpatient wards received daily consultations from either consultant or registrar led ward rounds Monday to Friday. Patients requiring continued assessments or reviews at weekends saw on-call consultants. Medical notes confirmed weekend assessments were completed.
- The service had a series of care bundles in place based on national guidelines, such as NICE and Royal College of Physicians. This included guidance for the assessment and treatment of medical conditions such as dementia care, chronic obstructive pulmonary disease, hyperglycaemia (high blood sugar), sepsis (blood infection) and acute kidney injury.
- Staff understood appropriate NICE guidelines and understood how these supported discussions about patients' care and treatment.
- We looked at the trusts' guidelines for the management of sepsis and septic shock in adults and found it had been updated in August 2016. This reflected the new sepsis definitions found in NICE guidance and the Worcestershire Acute Hospital NHS Trust (WAHT) 'Suspected Sepsis' screening process. An infection in any part of the body could cause sepsis.
- The Joint Advisory Group (JAG) on gastrointestinal endoscopy found that the endoscopy services met the accreditation standards framework such as policies, practices and procedures. JAG accreditation is the

formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale Standards. However, the June 2016 report highlighted concerns with the decontamination unit and the environment at the hospital. This resulted in the approval of a trust business plan. A target date of April 2017 had been set for the completion of the plan, which included the installation of new equipment and the proposed relocation of the unit.

- The service participated in the Commissioning for Quality and Innovation (CQUIN) framework, which encourages care providers to share and continually improve care, how it is delivered and to achieve transparency and overall improvement in healthcare. This ensured a better experience, involvement and outcomes to patients.
- We saw the service participated in the sepsis CQUIN and the record showed that FY1 and FY2 doctors (foundation doctors) had received an induction into the programme. Areas covered included the recognition of sepsis, the use of the sepsis six tool (the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis) and National Early Warning Score (NEWS) charts.
- Endoscopic procedures, for example, diagnostic upper and lower gastrointestinal examinations were carried out in line with national guidance. We reviewed the endoscopy care pathways, which included the World Health Organisation (WHO) 'Five steps to safer surgery' checklist.
- We saw effective treatment planning recorded in nursing and medical notes for the implementation of care and treatments in line with national guidance. For example, we reviewed eight patients' records from the chemotherapy and endoscopy unit and found that the information captured and treatment implemented was in line with national guidelines.
- Staff provided patients with a telephone contact number as well as advice regarding any side effects or any signs or symptoms post chemotherapy.

Pain relief

- We found there was not a consistent approach to assessing and managing pain.
- The trust used the NEWS chart to assess a patients pain levels. In October 2016, the trust used the Abbey pain control scale to measure the pain in people living with dementia or delirium and for people who were unable to express ideas or feelings in words. However, staff said they were unaware of the new tool and were currently using the scale within the NEWS chart.
- The service confirmed they did not audit the pain score, which was part of the monthly NEWS audit conducted by the critical care outreach team. We saw that the recording of pain levels for patients was inconsistent across the service. For example, nine of the 35 records seen did not have evidence of pain scores. This meant that patients might not have access to the appropriate level of pain relief to manage their symptoms. However, during our inspection, we observed staff asking patients about their pain which was confirmed by five patients spoken with.
- Pain management commenced in the pre-assessment clinic where actions to deal with pain management were discussed.
- The patient's medicine administration records (MAR) charts showed appropriate pain evaluations with suitable medicines prescribed.
- Staff referred patient's concerns with pain management to the anaesthetist or consultant for re-assessment. We saw MAR charts amended accordingly. Additional as required medicines prescribed to patients meant that patients had medicines relevant to their needs.
- Patient controlled analgesia (pain relief) equipment used for some patients post-operatively was available and staff felt they had sufficient quantities to meet the needs of the patients.
- Staff had access and contacted the pain team as required who provided support and advice as required.
- Staff and medical handovers discussed patient's pain when appropriate.
- The endoscopy unit recorded patient's pain scores appropriately. This was in line with the requirements set out by the Joint Advisory Group (JAG) guidelines.

Nutrition and hydration

- There were inconsistent processes in place to identify and support patients that needed assistance with eating and drinking although we saw drinks offered to patients to promote hydration.
- Staff used fluid balance charts to monitor patients' fluid intake. However, we saw that the input and output charts were incomplete and not always totalled. For example, of the 35 records reviewed, 12 had incomplete fluid balance charts. We enquired with senior staff as to

what audits/monitoring of patients hydration charts took place. They confirmed they were unaware of any audits/monitoring of patients to manage the risk of dehydration. This meant the service did not have systems in place to monitor effectively the hydration needs of patients.

- The trust used the Malnutrition Universal Screening Tool (MUST) for screening patients who may be underweight or at risk of malnutrition. Patients in the discharge lounge waiting for relatives or arranged transport to go home, had access to sandwiches and hot lunches if required. There was access to tea and coffee throughout the day.
- The hospital used nationally recognised risk assessments such as MUST and Waterlow score. MUST is a five-step screening tool to identify patients, who are malnourished, at risk of malnutrition (under nutrition) or obese. The Waterlow score gives an estimated risk for the development of a pressure sore in a patient. Patients identified at risk had care plans and frequent monitoring by staff to reduce the risk of harm. We looked at 35 records and found incomplete Waterlow scores in seven of the records. This was highlighted the appropriate nurse in charge of the wards. This meant there were ineffective systems and processes in place to monitor patient's risk of acquiring pressure sores.
- Staff confirmed they referred patients to a dietitian if required. We saw referrals within the records with no issues or concerns highlighted with the timeliness of access. Senior staff also confirmed patients who may be obese had access to a dietitian to support their needs.
- Nursing staff were able to access dietetic support at weekends via a telephone call to the on call team.
- Nursing staff used a red tray system to identify patients who required additional support to eat and drink. This was a visual aid to highlight to staff the need for additional support and assessment of intake. We observed patients had access to jugs of water by their bedside tables to promote hydration.
- We saw patients who were unable to eat or drink provided with alternative hydration through intravenous fluids (infusion into a vein).
- We spoke with 17 patients and most thought the food was edible. However, three patients said their food was cold when it arrived and was not appetising.

Patient outcomes

- The hospital participated in all national audits they were eligible to enter in order to monitor patient's outcomes, such as the heart failure audit and the national hip fracture audit. The trust reported their findings to the trust board.
- The heart failure audit result for 2015 showed the hospital was worse than the England and Wales average for two of the four standards relating to in-hospital care, and worse for five of the seven standards relating to discharge. For example; discharge care standards for referrals to heart failure liaison officers were 40% and referral to heart failure liaison officer (left ventricular systolic dysfunction only) were 53%. Both much worse than the England average of 59% and 69% respectively. We requested an action plan from the trust to verify what actions they had taken to manage the outcomes. However, the trust did not provide us with this information.
- The hospital took part in the Myocardial Ischaemia National Audit Project (MINAP). MINAP is a national clinical audit of the management of heart attacks. The hospital scored better than the England average for one of the three metrics. However, Non-ST-elevation myocardial infraction (a type of heart attack) admitted to a cardiac unit or ward was much worse at 12%, than the England average which was 56%. The score for this metric was worse for 2013/14 than it was in 2012/13. We requested an action plan from the trust to verify how they were managing the outcomes. However, the trust did not provide us with this information.
- The Summary Hospital-level Mortality Indicator (SHMI) is a nationally agreed trust-wide mortality indicator that measures whether the number of deaths both in hospital and within thirty days of discharge is higher or lower than would be expected. In September 2016, the trust reported a figure of 106, which was higher than the expected 100. However, this was lower than in 2015 when it was 110.
- The Hospital Standardised Mortality Ratio (HSMR) is an indicator of trust-wide mortality that measures whether the number of in-hospital deaths is higher or lower than would be expected. The quality account report for 2015/2016 stated the HSMR value for the rolling 12 months to January 2016 was 105. The comparable peer group figure is 100.

- The trust embarked on four work streams because of the HSMR and SHMI data to identify and address avoidable lapses in care as part of the trust improvement programme. These included:
  - Routine review of the care of those dying whilst an in-patient
  - Reduction in avoidable cardiac arrest
  - Ensuring patients with sepsis are identified and treated within an hour of presentation
  - Ensuring all patients presenting with a fractured neck of femur (broken hip) receive rapid treatment, specifically surgery within 36 hours of arriving at the hospital.
- From March 2015 to February 2016, patients at the Alexandra Hospital had the same expected risk of re-admission for non-elective admissions based on 100 patients, and a lower than expected risk for elective admissions. Non-elective readmissions for geriatric medicine and respiratory medicine were lower than expected at 75 respectively against a value of 100 patients. Elective readmissions for clinical oncology was 75, gastroenterology 65 and clinical haematology 75, which were all lower than expected.
- The hospital took part in the 2015 National Diabetes Inpatient Audit (NADIA), which scored better than the England average in all 17 metrics. The indicator regarding "seen by the multidisciplinary diabetic foot team within 24 hours" had the largest difference versus the England average (42% better). The hospital also scored much better than the England average for insulin errors, 23% versus 15%, and there was a large difference in the percentage of medicine errors at 20%, against an England average of 38%.
- Endoscopy services at the hospital were JAG accredited for gastrointestinal endoscopy. However, there were conditions stipulated in June 2016 involving the decontamination unit and the environment. We saw an approved business case with a view of implementing the required changes by April 2017. This meant that the service met the accreditation standards framework for aspects such as policies, practices and procedures.
- Matrons carried out audits that had patient safety goals showing performance regarding falls, pressure ulcer prevention, complaints and patient feedback. Matrons received the results of these audits monthly, which they cascaded to staff. Staff confirmed they received feedback on their ward performance during staff meetings.

Competent staff

- Staff had the appropriate clinical skills, knowledge and experience for their roles and responsibilities within the clinical area worked. The service had processes in place to identify training needs and compliance, and implemented changes to practice to address any identified issues.
- During the last inspection, there were no clear mechanisms in place to ensure appropriate levels of formal supervision of all staff. During our recent inspection, we found there continued to be no clear structured approach for regular operational and clinical supervision. Senior staff confirmed awareness of the shortfall and told us this was a work in progress.
- From April to August 2016, 75% of nursing staff within the medical service had received an appraisal compared to a trust target of 85%. Appraisal rates for medical staff had declined to 83% between April and August 2016. However, appraisal rates for non-medical staff had improved from 76% to 82% during the same period.
- The infection prevention and control team (IPCT) provided educational sessions for housekeepers and porters. The consultant microbiologist provided antimicrobial prescribing updates to medical and non-medical prescribers. The IPCT also contributed to doctors induction workshops and provided infection prevention guidance and training for maintaining asepsis, peripheral cannulation, central vascular device management, blood culture sampling and phlebotomy.
- Junior doctors said senior support was effective and that generally, the quality of teaching was very good. However, some junior doctors felt the pressures within the service meant there were insufficient opportunities for gaining clinical experience.
- Nursing staff had received relevant training in the management of non-invasive ventilation (NIV) patients. Ward 5 had a four-bedded bay for high dependency unit patients requiring NIV. NIV refers to the provision of ventilated support through the patient's upper airway using a mask or similar device. The British Thoracic Society (2008), states that "there should be a minimum staffing ratio of one nurse to two NIV patients for at least the first 24 hours of NIV." However, most staff we spoke with were unclear as to the level of staffing required for their NIV patients as well as their understanding of what constituted being an NIV patient. For example, during our visit, we observed only one patient required NIV

support whilst the other three were able to access their airway device as and when required. This was brought to the attention of senior management during our inspection.

- The phlebotomists visited the wards daily and carried out the insertion of cannulas (a thin tube inserted into a vein or body cavity to administer medication, a surgical instrument or to drain off fluid) and blood tests. Their training was up to date which meant they were competent to be a bleep holder and support doctors as required throughout the hospital.
- Senior staff on ward 5 confirmed they had a rolling programme for all nurses and senior health care assistants to attend a respiratory learning day to ensure they had an understanding of how to support patients with respiratory problems. Staff said they found the training very helpful.
- There was a rolling programme for the management of sepsis training. The records showed most staff at the hospital had completed their training in September 2016. The trust was unable to define the number of medical staff who had received this training. However, staff we spoke with had a good understanding of sepsis.
- Following a never event, the trust instigated additional training in the administration of insulin on medical wards. The records received showed that from December 2015 to November 2016, only 16 (11%) nurses had completed their training. This meant there could be a risk of staff attending a diabetic patient without the necessary skills to administer insulin. This meant that nurses deployed to other wards might not have the necessary competency to manage their diabetic needs.
- New nursing staff worked as supernumerary team members for a short period on commencement to post, usually a minimum of two weeks which could be extended according to each individual's needs to ensure competency.
- We saw that nursing staff within specialist clinical areas had additional competencies to ensure they were able to manage patients safely. Examples included, heart rhythm recognition, performance of electrocardiograms (ECG - tracing of the heart) and heart failure recognition and management.
- Each ward had allocated link nurses to topics such as dementia awareness, infection control and falls. Link staff attended extra training and held meetings to share learning across the clinical areas.
- Professional development nurses offered planned study days and drop in sessions for nurses and medical staff to help with staff professional revalidation requirements. Nursing and medical staff could attend local team meetings and the trust's intranet page provided further links to relevant information, including the Nursing and Midwifery Council.
- All new staff attended a trust induction programme that covered topics which included the trust values, information governance and clinical skills such as basic life support. Staff we spoke with confirmed they received adequate inductions.
- To ensure their competency and induction, all staff worked a supernumerary period within the clinical areas. The time was flexible and dependent on each individual's development needs.
- We saw evidence throughout clinical areas that agency staff received appropriate induction to the wards, to ensure they were aware of layout, call bell systems and team working. The service used induction checklists to complete this task, which we saw in use during our inspection. We saw completed induction booklets in place for bank and agency staff within the wards.
- Throughout the induction period, a named mentor and ward sister supported the staff member. We observed this in practice on ward 12 whereby supernumerary staff managed the care of patients under the supervision and guidance of another registered nurse. Staff reported that this system worked well and enabled them to develop at their own pace.
- Student nurses were also supervised during their placement on wards, and depending on their level of training would take their own caseload of patients (under supervision) to develop their skills.

Multidisciplinary working

- We saw good multidisciplinary team (MDT) working throughout the medical wards, including daily board rounds.
- There was daily communication between nursing and medical teams, physiotherapists, occupational therapists, discharge coordinators and pharmacy. The meetings observed were well structured and inclusive. All staff in attendance at ward rounds and meetings contributed to discussions and all team members were open to suggestions from others.
- We observed that the MDT reviewed all patients within 24 hours of admission to the hospital, which identified

baseline conditions to formulate treatment plans. This included a review from the ward pharmacist and if appropriate the physiotherapist or occupational therapist.

- Medical staff within the medical admissions unit (MAU) reported excellent working relationships with the emergency department (ED). Staff stated that they worked collaboratively to manage patient flow through both departments.
- Staff reported good multidisciplinary team working, with effective links to specialist services such as tissue viability, infection control and diabetes specialist nurses. Nursing staff told us that they knew how to contact specialists and felt supported by them.
- We saw evidence of referrals to specialists recorded within patients' records. Senior staff informed us that they followed all written referrals with a phone call to the individual directly to ensure they were aware of the referral.
- Staff undertook daily ward rounds seven days a week. This involved medical and nursing staff together with physiotherapists and/or occupational therapists as required.
- Discharge coordinators attended the wards daily to assist with the movement of patients across wards and assist with tasks to promote early discharge. This included arranging transport, liaison with relatives and care placements. Staff knew how to access the discharge co-ordinators when required.
- Nursing staff told us that relationships with medical staff and other professionals were inclusive, positive and promoted multidisciplinary working. Ward sisters reported that the working relationship with the speciality consultants was strong.

Seven-day services

- Consultants were on call seven days a week for patients in their care. Staff we spoke with confirmed that consultants reviewed all new patients at the weekend as well as all patients in the high dependency ward for non-invasive ventilation. Overall responsibility for the patient remained with the named consultant who was responsible for the care and treatment.
- The discharge lounge was open Monday to Friday from 8am to 8pm. Staff confirmed they reviewed weekend opening on the Friday but this was dependent on the availability of staffing.
- The endoscopy unit operated a weekday service with two or three sessions per day. Additional weekend clinics were included to reduce waiting lists and any demands on urgent referrals.
- The medical consultants provided weekday cover between 8am and 6pm, with on call facilities overnight and at weekends. All wards reported that at weekends, patients would continue the treatment plans identified by their consultant unless they became acutely unwell. The consultant on call would then review the patients and advise on any changes to clinical treatment.
- The medical consultants oversaw all new medical outliers on surgical wards during weekdays and weekends. A medical outlier is a patient admitted to a ward different from the medicine wards for example surgical. During the weekends and overnight, consultants saw their existing patients if they became acutely unwell.
- The pharmacy provided was available Monday to Thursday 8:30am to 5:30pm, 8:30am to 5pm on Friday's, with a limited service on Saturday and bank holidays (10am to 12:30pm). There was no pharmacy service available on Sunday. Staff could access pharmacy out of hours when required. There was an out of hour's emergency drug cupboard, which was accessible to nursing staff, for any medications prescribed that were unavailable on the wards.
- The medical assessment unit did not operate a GP referral service direct to MAU for patients out of hours at the weekends. Patients were admitted direct to the emergency department.
- Diagnostic services were available over the weekend and out of hours.

Access to information

- Staff reported that they had access to all information required to review patient's conditions and plan safe care and treatment. For example, when patients transferred to other wards, staff gave comprehensive handovers to the receiving nursing staff.
- Trust policies and guidance was available on the trust intranet, and staff demonstrated how they accessed the information.
- All clinical areas had access to patient records. Notes such as risk assessments and observation charts were by the patient's bedside whilst medical notes were stored in lockable trolleys at either the nurse's station or

the entrance to bays. However, not all medical notes were locked away which meant there was a risk of records being accessible to unauthorised personnel. We raised our concern with senior staff on duty.
- All clinical staff had access to hospital computers, which were password protected. During our inspection, we observed computers when not in use being locked.
- Staff accessed diagnostic results such as blood results and imaging, electronically. This enabled them to support the safe care of patients when required.
- Patient's notes recorded the equipment used during clinical procedures within endoscopy along with details of the staff that carried out the procedures. This ensured the traceability of equipment.
- Patients GPs received copies of discharge letters to ensure awareness of changes to patients' admission and treatment plans.
- Staff had access to relevant files within their departments. For example, within the endoscopy suite we saw information about Control of Substances Hazardous to Health (COSHH) with built in risk assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of their responsibilities regarding the Mental Capacity Act 2005 (MCA) and knew what to do when patients were unable to give informed consent. However, in September 2016, only 41% of staff across the medical service had completed their MCA and Deprivation of Liberty Safeguards (DoLS) training. This was below the trust target of 90%. There was a training programme in place to manage the shortfall and staff confirmed they had been allocated e-learning time to complete their MCA training. This was also evident on the training schedule within the staff rooms.
- Staff confirmed familiarity with the consent policy and showed us how they could access the information on the trust's intranet.
- The mandatory electronic learning provided to staff included safeguarding, information about the MCA and DoLS. Staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff said they would seek advice from a senior member of staff should a formal assessment of mental capacity require completing.
- Both nursing and medical staff understood consent, the decision-making requirements and guidance. The hospital had four nationally recognised consent forms in use. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent for their operation or procedure and another for procedures under a local anaesthetic. During our visit to the chemotherapy Garden Suite, we observed staff obtaining and completing consent form 3 (patient agreement to investigation or treatment).
- Medical and nursing staff understood when to use the forms and whether the consent provided was implied, verbal or written. Implied consent is "consent which is not expressly granted by a person, but rather by their actions and the facts and circumstances of a particular situation". Verbal consent means that patients read a verbal version of a consent form, such as an information sheet and give their verbal consent rather than a written consent.
- Endoscopy staff understood their responsibilities in relation to gaining consent from patients, including those who lacked mental capacity to consent to their care and treatment. Staff confirmed all patients discussed consent with their consultant who used the relevant consent form prior to any endoscopic procedures.
- We saw the appropriate consent forms completed within the endoscopy unit.

Are medical care services caring?

Good

Overall we found the service good for caring because:

- We observed staff providing kind and compassionate care to patients.
- Patients received care and treatment, which ensured their dignity and respect.
- Staff assisted patients and relatives in decision-making to ensure they had all the relevant information to make an informed decision.
- Staff understood the impact that a person's care, treatment or condition would have on their wellbeing and on those close to them both emotionally and socially.

- Chaplaincy services were available to provide people with appropriate emotional support.

However:

- The Friend and Family Test response rate for medical care at the hospital was 17%. This was worse than the England average of 26% from August 2015 to July 2016.

Compassionate care

- During our inspection, we visited all ward areas and discharge lounge. We spoke with 22 patients and their relatives. Patients were positive about their experience within the inpatient services. We observed staff spoke in a kind and considerate manner with patients. The majority of patients were positive about the care they received on the wards.
- The Friend and Family Test response rate for medical care at the hospital was 17%, which was worse than the England average of 26% from August 2015 to July 2016. We requested an action plan from the trust to verify what the service had taken to manage the outcomes. The trust did not provide us with this data.
- The trust participated in the National Cancer Patient Experience Survey 2015, (published in July 2016). Patients were asked to rate their care on a scale of zero (very poor) to 10 (very good). The trust achieved a rating of 8.7. For example, from October 2015 to March 2016, the trust sent 1,278 surveys to eligible patients with 888 returned completed. This represented a response rate of 70%, which was better than the national rate of 66%. Ninety two percent (482) patients said the hospital had told them whom to contact if they were worried about their condition or treatment after they left hospital and 77% (850) patients said that they were involved as much as they wanted to be in decisions about their care and treatment.
- All patients said they received care and treatment with kindness and dignity and most said staff were compassionate and respected their needs.
- We saw that staff respected their patients and their individual preferences, which included habits, culture, faith and background. During a visit to the Garden Suite, we observed good rapport between staff, the patient and their relative when explaining what they were doing.
- We observed staff being courteous over the telephone and when discussing patients between staff members.
- We observed staff used the "Hello, my name is" campaign. The aim of the campaign is to encourage all staff to introduce themselves to patients and visitors to improve their hospital experience. Patients confirmed staff had introduced themselves and spoke to them appropriately.
- Nursing and administration staff ensured patient confidentiality at all times and were observed asking patients permission to share information with family members.
- Before entering a patient's room, we observed staff knocking on doors. We saw staff closing curtains to protect patients' privacy.
- Patients and relatives we spoke with said they were happy with the care they received. Comments from patients included; "staff are wonderful", "I couldn't ask for better care" and "staff look after me very well and attend to my needs."

Understanding and involvement of patients and those close to them

- We saw that staff involved patients and their relatives in discussions held relating to care and treatment.
- Staff communicated in a way that patients could understand which was appropriate and respectful. Staff ensured that patients fully understood plans, taking time to explain treatment processes and what to expect. This enabled patients to be involved with making choices and informed decisions about their care and treatment.
- Patients said consultants discussed their treatment and the risks and benefits involved, and said they felt they could ask questions in any decision making.
- We observed staff assisting patients with meals and drinks if they were unable to manage by themselves.
- Wards had a named nurse system so patients and their relatives knew who was looking after them.
- We observed medical staff taking time to explain to patients and their relatives the effect or progress of their medical condition which meant that people understood why rehabilitation or changes of arrangements were required prior to safe discharge.

Emotional support

Medical care (including older people's care)

- Patients at the Garden Suite confirmed they were happy with the service provided and had been visiting the unit for many years. Patients also confirmed it was nice that they could have their relative with them to provide support.
- Patients reported staff always introduced themselves and were very respectful and showed kindness.
- We observed how staff appeared to understand and show how they supported the emotional and mental health needs of patients and said they were able to access specialist support if necessary.
- During our visit, we observed a student nurse sitting with a patient in the Garden Suite offering support and asking them about their "journey" in the chemotherapy services.
- Staff knew how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- Patients and their relatives told us the clinical staff were approachable and had "no complaints about the care" received.

Are medical care services responsive?

Requires improvement

Overall we found the service for responsiveness as requires improvement because:

- There were significant problems in terms of home care and placement capacity across the region. Some patients had been on the wards for up to 64 days.
- The records showed that 45% of patients moved once and 9% of patients moved wards twice or more during their admission.
- Staff transferred over 12% of patients outside of the recommended hours (between 10pm to 6am) as outlined by the trust.
- The patient flow centre was not operating effectively to improve discharge within the hospital. Staff reported inaccessibility to the service and unavailability of assessors involved with the discharge process.
- Assessments and care plans did not support patients living with dementia. We found most care plans were standardised and lacked an individualised approach.
- Complaints were not reviewed and completed in line with trust policy.

However:

- The hospital planned and delivered the services that meet the needs of local people. The services provided reflected the needs of the population.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services has been the same as the England overall performance.
- Senior medical staff reviewed patients admitted to non-medical wards as outliers each weekday
- The average length of stay for elective general medical was just below the England average whilst non-elective medical was the same.
- Wards had allocated discharge coordinators who assisted with discharge planning.
- Patients could access interpreters as required.
- Information leaflets could be requested in different languages; audible tapes or braille as required.
- The service had mechanisms in place, which provided patients with additional support due to their complex needs.
- Additional waiting lists were organised across the service to ensure patients received timely treatment.
- The hospital had systems in place to ensure that patients, relatives and/or their representatives knew how to make a complaint or raise a concern.

Service planning and delivery to meet the needs of local people

- The delivery and planning of care met the needs of local patients.
- We observed an integrated approach to care delivery across all the wards involving nursing staff, therapists, medical staff, pharmacy and a commitment to timely, safe and person-centred discharges for patients.
- The medical services worked with local commissioners and external providers to plan delivery of patient care. The MAU had a function in place that allowed GPs to refer patients who were low risk direct. The MAU service was available from 9am to 9pm. Patients could present to the dedicated nurse in MAU at these times. After 9pm, GP referred patients would have to present to the emergency department. This concern was not on the risk register.
- The hospital had Joint Advisory Group (JAG) on gastrointestinal (GI) endoscopy accreditation. The JAG accreditation scheme is a patient centred scheme based on the principle of independent assessment against recognised standards, which included; the provision of a knowledge base of best practices, continuous

improvement in processes and patient outcomes, and to provide comparisons with self and others. We saw a copy of the approved business plan to support the delivery of care that would meet the needs of local patients.

- Patients we spoke with felt the service met their needs. Relatives confirmed the service was flexible and provided choices. This meant the service had reviewed the continuity of care which best met the needs of the patients.

Access and flow

- We saw that all clinical areas completed daily board rounds, which included nursing, medical, therapy staff, and discharge coordinators. The board rounds reviewed all patients and the actions required to enable a safe discharge.
- From August 2015 to July 2016, the trust's referral to treatment time (RTT) for admitted pathways for medical services has been the same as the England overall performance. The figures for July 2016 showed 87% of patients treated within the trust's target of 18 weeks. And the following specialities were just slightly above the England average:
  - gastroenterology 96% against the England average of 95%
  - geriatric medicine 100% against the England average of 99%
  - rheumatology 100% against an England average of 97%.
- Across the trust there were around 1,000 patients waiting for a colonoscopy (a test that allows the examination of the inner lining of your large intestine (rectum and colon). The trust had a waiting list initiative to manage the risk of patients on the waiting list, which included additional clinics at weekends. Staff confirmed they were aware of the initiatives and had participated in weekend working as appropriate. Three patients we spoke with said they had not waited very long for an appointment, only a few weeks, and had no concerns.
- The records showed that from August 2015 to July 2016, 47% of patients did not move wards at the Alexandra hospital during their admission, 45% moved once and only 9% of patients moved wards twice or more during their admission.
- From April to November 2016, the number of patients on medical wards that transferred to another ward from 10pm to 6am at night was 1947 across all medical wards, with average bed moves of 242 (12%) per month. The trust had a patient transfer policy, which stated that internal transfers between wards should only occur between 7am and 9pm. Out of hours internal transfers should only occur if clinically indicated. Information showing the reasons why these moves had taken place during the night was not available. The service was monitoring the number of moves within the departments. However, the trust's target around bed moves was unclear and it was unclear how the trust was planning to improve this.
- From April 2015 to March 2016, the average length of stay for medical elective patients at the hospital was 4.4 days, which was slightly worse than the England average of 4 days. For medical non-elective patients, the average length of stay was 7 days, which was the same as the England average.
- We saw the average length of stay from July to December 2016 across the MAU was 2 days, which was better than the England average of 4 days.
- The risk register report submitted by the trust showed they had recognised the risks with regard to patients' length of stay if there were blockages in the pathways. We saw a target date of December 2016 regarding this. Actions included working with the commissioners to access the relevant pathways.
- The MAU managed GP referred medical patients who were low risk. The unit had assessment beds in a defined area and served a clinical decision support function. The GP received notification of discharge together with all relevant clinical details and care plans. From July to December 2016, the MAU discharged 72% of patients within 48 hours and 82% within 72 hours. The rate of re-admission within 28 days of discharge from MAU was 6% for the period July to December 2016. This was below the national re-admittance rate of 7%.
- The trust had a programme to improve discharge from acute hospitals through three pathways:
  - Pathway 1 – home with support
  - Pathway 2 – community hospital for rehabilitation
  - Pathway 3 – discharge to access
- Discharge plans commenced on admission and patients had estimated dates of discharge documented in their records. On wards, designated discharge coordinators would oversee discharge arrangements and discharge plans during MDT rounds.

- The service regularly reviewed patients. Once patients had their package of care, transport arrangements and tablets to take away (TTAs), they could be discharged. This meant that patients did not have unnecessary long waits in hospital.
- The hospital had a bed management strategy and escalation policy to respond to short term bed shortages across the service to support the admittance and discharge of patients. We observed bed monitoring discussed during staff huddle meetings.
- We visited the discharge lounge as part of the inspection. This lounge was open from 8am to 8pm Mondays to Fridays. Weekend openings were dependent on staffing levels.
- In response to concerns of delays of up to three hours in the discharge of patients waiting for their medicines, a pharmacy service was set up in discharge lounge. Supplies of pre-labelled medicines ready for discharge were available. This meant that medicine charts remained in the discharge lounge and medicines were available to give to patients if they needed them. This also ensured there were no missed doses of medicines. The time waiting for discharge had significantly reduced to 37 minutes.
- Wards had allocated discharge coordinators who assisted with discharge planning. These individuals would ensure that discharge letters were completed, relatives informed, transport booked and referrals completed. Ward staff reported that this worked well, as the discharge coordinators completed all discharge related tasks, such as notifying relatives, care/ nursing homes and arranging transport. Nursing staff told us that this allowed them to spend more time providing care and treatment and not making phone calls.
- The integrated discharge leads told us that there were significant problems in terms of home care and placement capacity across the region. The service reviewed delayed discharged weekly. We saw two inpatients on Ward 5 had been in hospital for 32 and 19 days and on Ward 2, we saw five patients had been on the ward for 64, 63, 56, 55 and 21 days. Staff described the reasons for the delays, which included the waiting of relevant care packages and community beds.
- To improve patient flow within Worcestershire, the trust had agreed with other organisations to support a systematic process for dealing with capacity and demand issues. The aim of the patient flow centre (PFC) is to collect, review and act on all data from across the whole health and social care system related to bed and service capacity and demand. The purpose of the PFC is to provide accessible admission, transfer and discharge data. However, senior staff on the medical wards said the patient flow centre (PFC) had not improved discharge within the hospital. Staff said it took multiple phone calls to access the PFC and often they did not get through to the assessors involved with the discharge process. Senior staff confirmed they had not received any feedback regarding their concerns.
- The service provided a senior nurse on call out of hours. This role rotated through the senior nursing staff across all medical specialities. Their role was to attend the bed management meetings and assist with the management of flow through the hospital, offering clinical advice and support to staff. The senior nurse on call during the inspection reported cover from 5pm to 10pm, but often individuals would remain on site later. Each senior nurse completed a templated report for the night's activity, which included any staff moves, details of any clinical emergencies and reasons for opening of escalation areas.
- The bed management team managed patients that needed to stay in hospital and identified suitable beds within the inpatient wards.
- All wards had named consultants, so when patients were transferred to the inpatient area, care was transferred to that consultant. Where possible, patients requiring specialist treatment were referred to the most appropriate clinical area
- There was an escalation policy for on-call bed utilisation. The policy outlined the action staff took when activity increased which included the opening of additional clinical areas. The policy identified whose responsibility it was to ensure patient safety. When the policy became active, staff understood and identified their roles and responsibilities.

Meeting people's individual needs

- The hospital took into account the needs of different patients.
- The hospital provided dementia and learning disability link nurses on most wards to help support effective care for people living with dementia or learning disability. The hospital used the "About Me" passport documentation. Patients and families completed the passport whilst ensuring relevant information enabled staff to provide person centred care. However,

assessments and care plans did not support patients living with dementia or learning disability. We found most care plans were standardised and lacked an individualised approach.

- The wards used the "butterfly" scheme to help staff recognise when someone is experiencing memory problems or confusion. This ensured staff knew to take more time when communicating with patients who have difficulty understanding information and offer additional help, or support with tasks where needed, such as eating, drinking, going to the toilet and being accompanied off the ward.
- We observed that disabled patients could easily access the hospitals. All clinical areas were accessible for wheelchair users and disabled toilets were available in public areas.
- Patients who required additional support or whose first language was not English had access to language interpreters, specialist advisors and/or advocates as required. Staff knew how to access the interpreting services and said they had prior knowledge of the patient's individualised needs.
- Leaflets were available for patients about services and the care they were receiving. Staff knew how to access copies in an accessible format, which included audible tapes and braille.
- Nursing staff reported that they had access to bariatric equipment such as specialist beds, chairs and mobility aids when necessary, although none were observed during inspection.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital. Patients had access to a chapel and multi faith room on site.
- Patients had good access to occupational therapists, physiotherapists and speech and language therapists when required. This ensured that services had been planned, delivered and co-ordinated taking into account patient's individual needs.
- Staff completed intentional rounding throughout the patients' stay. The aim of the rounding is to ensure staff visited patients regularly for example; two hourly to check if call bells and a drink were in reach, if the patient required repositioning, if the patient had pain or had any other requests. However, of the 35 records seen, seven had incomplete time of when the intentional rounding had taken place.

Learning from complaints and concerns

- From September 2015 and August 2016 there were 35 complaints about medical care services at the hospital and it took an average of 54 days to investigate and close complaints. This was not in line with the complaints policy, which states that 90% of complaints should be closed within 25 days. Clinical treatment accounted for 29% of all complaints received, and admissions, discharge and transfers and the values and behaviour of staff, accounted for 1% each. At the end of August 2016, there were seven complaints still open at Alexandra Hospital, three received in June, one in July and three in August 2016.
- The trust had addressed the shortfall in response time to complaints. Staff discussed complaints during team meetings to ensure action taken to improve the quality of care and learning opportunities were cascaded to staff.
- We saw evidence of identified learning opportunities through investigating complaints. For example, a complaint regarding a patient with a grade three-pressure ulcer was difficult to track due to multiple moves. This resulted in changes to the care and comfort carried out and documented. For example, pressure ulcer prevention plans supported patient's individual needs.
- Patients we spoke with were aware of the complaints process and knew how to raise concerns.
- Complaints procedures and ways to give feedback were in place. Patients were supported to use the system using their preferred communication method, such as by telephone or email. Patients were informed about the right to complain further and staff encouraged patients to use the patient advice and liaison service.
- We saw literature about the complaints procedure and information about the patient advice and liaison service (PALS) on display on most wards.
- We saw many compliment letters and thank you cards displayed in ward areas, which enabled patients, relatives and staff to see feedback.

Medical care (including older people's care)

Are medical care services well-led?

Inadequate

Overall, we found that the service was inadequate for well-led because:

- The leadership, governance and culture did not always promote the delivery of high quality person-centred care. Known concerns such as the inadequate storage of medicines and lack of compliance with mandatory training continued to be areas which required improvement.
- The systems, processes and the operation of governance arrangements in place were not effective in identifying and mitigating risks to patients. The National Early Warning Score (NEWS) was a system used by the trust to identify deteriorating medical patients. This system was not working effectively as NEWS charts were incomplete in nine of the 35 records reviewed. This meant that there was not clear oversight on the deterioration of those patients.
- The governance system in relation to the management of risk did not operate effectively to ensure that senior leaders and the board have clear oversight of the risk of harm to patients suffering a VTE due to lack of appropriate assessment and re-assessment within 24 hours.
- There were unidentified issues regarding records management, which included for example, in the completion of fluid charts and skin assessments.
- Not all risks identified were on the divisional risk register and local wards did not have their own risk register.
- Staff reported senior management rarely visited the service and had not met any of the executive team.
- Staff felt that communication from the trust executive team was not always timely.
- Medical staff confirmed they had no awareness of the key objectives to support the overall trust operational plan.
- There was poor oversight of the service which included medicine management, environmental outcomes and actions.
- There was inconsistent oversight of mortality and morbidity meetings.
- There was a lack of safeguarding children level 2 training for all grades of staff.
- The NHS Friends and Family Test results from August 2015 to July 2016 rated the service's response rate as worse than the England average of 26% at 17%. However, all responses received were positive regarding patient care and treatment.

However:

- Staff felt supported within their working environment where openness and honesty was encouraged.
- Staff were proud to work for the trust and they were enthusiastic in their work.
- The trust had a leadership programme which enabled senior staff to learn from each other's experience and share ideas on how they could manage clinical areas.
- Most staff knew of the trust's values.
- Staff, patients and relatives were generally positive about the services provided.
- Staff took steps to capture and share comments and learning with different teams and they worked collaboratively. Staff said they felt supported in their role.

Leadership of Service

- Local leaders were visible and approachable and ward managers understood some of the challenges at a local level within the medical service.
- Staff said that more input from senior management would be beneficial and said senior staff rarely visited the service. Staff also had very little awareness of who the senior nursing team was within the trust.
- Nursing staff reported that the local leads encouraged development and took ownership of the services provided.
- The trust had developed a leadership programme, which included options for accredited courses. We spoke with two senior nurses who confirmed they were on the programme which had enabled them to learn from each other's experience and share ideas on managing clinical areas.
- Nursing staff reported that clinical leads within specialities were visible and easily accessible. Nurses said that doctors were responsive to their needs and were always available to help with patient care.
- Clinical leads and matrons told us that they were proud of their teams and recognised that staff worked hard within their roles.

- Staff reported that communication from the trust executive team was not always timely although they felt this had improved since the implementation of new management.
- Staff felt they had good training and development opportunities and found their managers friendly and supportive.
- We observed that ward staff worked well together and supported each other. On occasion's staff across medical wards reported feeling pressurised by the bed management team. During our inspection, we overhead several phone calls requesting updates of patient discharges. Ward managers felt that bed management was too much of a priority and to the detriment of patient care.
- Staff felt supported by their matrons. We saw ward matrons working clinically and included in ward staffing numbers. However, this was as a co-ordinator or supervisory role. All ward matrons we spoke with told us that the recruitment of new staff had enabled them to balance managerial tasks and clinical workload.

Vision and strategy for this service

- The trust's values were based on PRIDE which were:
  - Patients at the centre
  - Respect for everyone
  - Improve and innovate
  - Dependable
  - Empower
- Staff awareness of the trust's values was evident and they directed us to posters within the hospital.
- The service had clear aims and objectives for their continued development, which included the redevelopment of the endoscopy area in order to obtain Joint Advisory Group (JAG) accreditation.
- Medical services had key objectives to support the overall trust operational plan. However, staff confirmed they had no awareness of these objectives. This meant that communication was not effective and not disseminated to the staff team.
- Attracting doctors and nurses who had a particular interest in individual specialities was identified as an area of concern by both medical and nursing staff and was on the service risk register. The recruitment programme was specific to the specialities' needs, with matrons, consultants and ward sisters all involved in the recruitment of staff.

Governance, risk management and quality measurement

- The service had a governance structure. However, there were no clear escalation processes from ward to board, and board to ward. We saw information was shared across the division, the trust quality and safety group and trust executive boards. We saw minutes from these meetings during the inspection with information disseminated to the multidisciplinary team.
- Although there was a governance framework to support the delivery of the strategy and good quality, it did not always promote the delivery of high quality person-centred care. For example, ineffective medication storage at recommended fridge temperatures was identified during our last inspection and remained a concern during this inspection, which meant the trust did not have adequate systems in place to rectify these issues.
- The systems, processes and the operation of governance arrangements in place were not effective in terms of identifying and mitigating risks to patients. For example, NEWS charts were incomplete in nine records reviewed. This meant that patients might be at risk due to the poor oversight of patients' NEWS charts.
- The arrangements for identifying, recording and managing risks in the service were not robust. For example, there was lack of oversight of venous thromboembolism (VTE) assessments and re-assessments within 24 hours. There was a risk of patient harm due to these VTE assessments not identified on the divisional or corporate risk register. This meant that the trust's governance system in relation to the management of risk did not operate effectively. There was no assurance that senior leaders and the board had clear oversight of the risk of harm to patients of VTE, due to the lack of an appropriate assessment.
- Some patients were moved to non-medical wards with no actions taken to mitigate risk. Even though the service had an escalation policy, there was not a robust process in place to determine the criteria for these patient moves.
- The trust had a risk management strategy to ensure it complied with its statutory and NHS duties. The aim of

the strategy was to ensure the service delivered was safe and as effective as possible. However, we found no evidence that the strategy had been disseminated to staff at team meetings.

- There was an inconsistent approach to governance and risk management within the medical specialities. We found poor oversight of outcome measures, which included patient records management and environmental audits.
- The risk register highlighted risks across medical services and actions were identified which included a recruitment and retention strategy to mitigate the risk. Ward managers were able to tell us what the key risks for their wards were. However, not all risks identified were on the divisional risk register and local wards did not have their own risk register. Staff across the medical service acknowledged that recruitment of qualified and experienced medical staff was a risk.
- The divisional risk register highlighted some risks across medical services and some actions were in place to address these concerns. For example, failure to meet National Institute for Health and Care Excellence (NICE) guidelines. We saw the divisional risk register identified key areas of service risk which included staffing levels and the risk that JAG accreditation in endoscopy would not be achieved.
- Minutes of the monthly medical services governance and quality group meetings showed that there were discussions and actions planned around safety and quality improvements, clinical effectiveness and patient experience. However, the action plan did not identify any outcomes or targets. This meant that there was no clear oversight in relation to risk, for example, the risks in medicine management.
- Senior staff attended monthly meetings within the medicine division that reviewed safety and quality issues, including for example, complaints and the risk register. The wards did not maintain their own risk registers and not all risks were included on the divisional risk register. Senior staff confirmed the main risks identified for the service focussed on staff pressures and patient flow concerns.
- Each speciality group held monthly clinical governance meetings. We reviewed the minutes of three meetings across the specialities and saw there was good attendance from the multidisciplinary teams. Areas reviewed included; incidents, infection control, key performance indicators and patient feedback.
- Ward sisters held monthly meetings that included discussion on; a review of complaints and compliments, details of incidents including falls and medication omissions, clinical effectiveness audit results, staffing and recruitment, training and risks. We saw evidence of these meetings and found that they were structured and inclusive.
- The trust board papers published in September 2016, identified a visit had been undertaken to another hospital to learn from their experiences. This resulted in new systems. For examples, commencing morality reviews and a focusing on sepsis management. We saw a planned completion date of November 2016. However, during our inspection, we found inconsistent mortality reviews and poor understanding of sepsis management within the nursing teams.
- Staff had a clear understanding of their roles and understood what they were accountable for and to whom.

Culture within the service

- Staff felt listened to but did not feel engaged in key decisions about their service, which included, for example, deployment onto an escalation ward.
- Staff described a supportive and encouraging working environment and one in which openness and honesty was encouraged.
- There was evidence of collaborative working throughout the service and a shared responsibility to deliver good patient centred care.
- All staff spoke positively about the service, and clinical area they worked in. This included clinical and non-clinical staff.
- Staff when asked confirmed they felt respected and valued at local level. They said there was an open and transparent culture within the service where staff were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.
- Teams worked collaboratively, with support and advice provided as necessary. On the wards, we observed senior staff mentoring junior staff in their tasks. Mentoring staff explained processes and procedures to new staff to ensure they understood correct processes.
- Nursing staff reported that ward sisters and matrons were accessible and supportive. We observed matrons

attending the clinical areas and discussing activity and any issues that had arisen. The matron on ward 12 was observed offering support to the ward sister to complete a task involving a dementia patient.
- Nursing staff were very positive about the contributions they made to patient health and wellbeing. This was particularly evident in the care of elderly patients.
- There was effective multidisciplinary working within the service. This involved patients, relatives, therapists, and nursing staff working together to achieve good outcomes for patients.
- Patients acknowledged a positive and caring culture within the services and were happy with their care.

Public engagement

- Staff within medical services recognised the importance of gathering the views of patients and actively sought comments and feedback on the services provided.
- The NHS Friends and Family Test gathered patient's views. We saw most comments were positive. However, the results from August 2015 to July 2016 rated the service's response rate as worse than the England average of 26% at 17%. Senior staff confirmed they were aware of the low response rate and were looking at ways to improve this.
- The trust had recently embarked on a plan to co-produce a refreshed patient and public engagement strategy. The aim of the programme is to build a stronger and more dynamic collaboration with patients, and public by developing the way the trust works and communicates with the communities and partners it serves. However, staff said they were unaware of the strategy or of its implementation.
- The trust informed us they supported patient and carer involvement in a range of committees and forums. We saw the public forum completed the patient-led assessments of the care environment (PLACE) visits, which involved quality review visits and tests and commenting on patient information.
- The trust worked alongside a range of voluntary agencies including Age UK, Worcestershire Health and Care Trust and Healthwatch. The trust actively gathered and acted on the feedback provided from these stakeholders in order to shape and improve the services and culture.
- We saw thank you cards, expressing the gratitude of patients and relatives for the kindness and support they had received.

Staff engagement

- Staff engagement was primarily through team meetings, training events and email and intranet services.
- The staff survey identified some staff had personally experienced or had witnessed bullying or aggressive behaviour. Staff we spoke with said that although they were aware of the staff survey results they had no evidence regarding any bullying. However, they confirmed they felt supported by their local leaders and would not hesitate to make the relevant concern in line with the trust's whistleblowing policy.
- We saw effective team working across all clinical areas. We observed the links between administration staff, nursing staff and the unit nurses in charge to be very good, with staff offering support to each other regularly. Nursing staff reported that individuals performed beyond the requirements for their role.
- All nursing and medical staff we spoke with told us that clinical leads helped develop the service and were dedicated to their roles.
- During our inspection, we observed evidence of regular team or ward meetings and weekly trust newsletters and bulletins detailing key information about the service. Examples included, safeguarding, updates on complaints, incidents and learning opportunities.
- Staff morale across medical wards was good although there were occasions they felt stressed due to staffing levels and work pressures. However, this was not apparent during our visit to the service.

Innovation, improvement and sustainability

- The trust had recruitment events planned for the next 12 months rotating around the trusts' three sites. The trust said they were working alongside NHS professionals regarding targeting increase of staff numbers on their books.
- A dedicated helpline was available for haematology and cancer treatment patients.
- Following the last inspection the trust had made improvements in the following:
  - The reporting of incidents to ensure lessons learnt were cascaded to staff.
  - A review of the referral process to ensure the service was meeting its18 week pathway in accordance with national standards.

Medical care (including older people's care)

- Improve the access and flow of patients to reduce delays for patients being admitted and discharged from wards.
- Responding to patient complaints in a timely mannerThe trust had made some progress with the following:
  - The recruitment and retention of nursing and medical staff in order to maintain patient safety.
  - Review of medical outliers and devise a trust wide policy to improve their management.
  - Ensuring that staff received annual appraisals.

Surgery

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

Information about the service

Surgery services provided by Worcestershire Acute Hospitals NHS trust are located on four hospital sites. Worcestershire Royal Hospital is the main site with Alexandra Hospital, Kidderminster Hospital and Treatment Centre and Evesham Community Hospital as additional sites. The trust provides services to a resident population of 550,000 people in Worcestershire.

Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre were visited as part of the inspection process and each location has a separate report. Evesham Community Hospital was not visited. Services on all four hospital sites are run by one management team and are regarded by the trust as one service, with some staff working at all sites. For this reason it is inevitable there is some duplication contained in the reports.

The Trust provides services to a resident population of 550,000 people in Worcestershire. This report relates to surgery services provided at Alexandra Hospital which provides planned (elective) and emergency surgery and consists of six surgical wards (wards 10, 11, 14, 16, 17, 18), a day unit and seven theatres. There are 146 surgical inpatient beds. The day unit, which has 10 beds, provides surgical care for patients who are admitted and discharged on the same day as their operation. In addition, there is a six bedded surgical decision unit open from Monday to Friday between 7am and 9.30pm. Surgical specialities include general surgery, trauma care, vascular surgery, breast surgery, oral and maxillofacial surgery and head and neck surgery.

From April 2015 to March 2016, there were 15,014 surgical admissions, 45% of these were day surgery, 20% were elective surgery and 35% were admitted for emergency surgery.

We visited all surgical services as part of this inspection and spoke with 29 staff, including nurses, theatre staff, health care assistants, doctors, consultants, therapists and managers. We spoke with eight patients and reviewed 24 sets of medical notes.

The Care Quality Commission carried out an inspection at Alexandra Hospital in July 2015 and found that overall surgical services required improvement.

Surgery

Summary of findings

Overall, we rated the surgery service as inadequate.

We rated surgical services as good for caring and as requires improvement for effective and responsive and inadequate for safety and for being well-led because:

- Patient outcomes were generally below the England average. Not all staff were aware of patient outcomes, national audit results and performance measures.
- There was a high number of medical and nursing vacancies and unfilled shifts.
- Not all staff cleaned their hands before and after contact with patients and some staff did not change their gloves or aprons after each task.
- Medicines were not stored within recommended temperatures.
- Venous thromboembolism assessments were not always completed.
- Medical notes were not locked away safely.
- Some junior staff did not have an awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and safeguarding procedures. Less than half of clinical staff had training in MCA and DoLS.
- The five steps to safer surgery checklist was not always carried out in accordance with trust policy.
- Not all patients had their temperature monitored during their operation and in line with national guidance.
- The trust had mixed performance for the national Hip Fracture Database audit.
- Theatre ventilation systems did not meet essential safety standards.
- Not all staff had completed mandatory training or received an annual appraisal.
- The admitted referral to treatment time was consistently below the England average of 80%.
- Patients had their operations cancelled more times than the national average.
- There were high levels of unplanned medical patient admissions to the surgical wards, resulting in some cancelled operations.
- Enhanced recovery pathways and care plans were not routinely used across surgery services to enable patients to go home as quickly as possible.
- Patients were not always offered a choice about where they were discharged for continuing care.
- Some staff were not aware of the plans for the county wide management of emergency surgery in inpatient services. However, the trust told us this related more to the centralisation of all in-patient emergency general surgery rather than the county wide service.
- There was a countywide strategy for surgical services but not all staff were aware of it.
- There was a lack of effective risk management.
- Staff satisfaction survey results for the surgical division were worse than last year.
- Less than a third of nursing and medical staff had received training in safeguarding children.

However, we found that:

- There was a culture of incident reporting and most staff said they received feedback and learning from serious incidents.
- Medical staffing was appropriate and there were emergency cover arrangements. Consultant-led, seven-day services had been developed and were embedded into the service.
- Treatment and care was provided in accordance with evidence-based national guidelines.
- Learning from complaints was evident.
- There was support for people with a learning disability and reasonable adjustments were made to the service. An interpreting service was available and used.
- Staff were caring and compassionate to patients. Patients spoke highly of the care they had received.
- Patient pain, nutrition and hydration were appropriately managed.
- The governance framework had improved since out last visit.
- Regular staff meetings were held at all levels and information was shared with staff.
- There was evidence of patient and public engagement.

Surgery

Are surgery services safe?

Inadequate

We rated safe as inadequate because:

- Theatre ventilation and laminar airflow systems failed to meet required safety standards.
- Safeguarding children training was below the trust's target of 90%. Less than 10% of medical staff and 23% of nursing staff had completed safeguarding children at levels one and two. Some staff could not demonstrate an understanding of safeguarding.
- Venous thromboembolism assessments were not always completed in a timely manner or in line with national guidance.
- Doctors did not follow the guideline to record all patient temperatures regularly during surgery.
- There were a high number of vacancies for nursing staff in surgery. Safe staffing levels were achieved most of the time but there was high use of bank and agency staff.
- Staff did not always follow the trust policy on infection control and there was variable compliance with hand hygiene and the use of personal protective equipment.
- Medicines were not always stored at the recommended temperature.
- Patient medical notes were not locked away safely.
- White electronic boards displaying patient details were visible to all ward visitors.
- The Five Steps to Safer Surgery checklist was not always completed appropriately, or steps followed.
- There was in sufficient storage space in the theatre department and some operating kits had damaged covers as a result of this.
- Mandatory training was below the trust target of 90%.
- Emergency equipment was not always checked in line with the trust policy.
- Pre-operative risk assessments were sometimes scheduled too close to a planned surgery.

However:

- Staff were encouraged and confident to report any incidents and serious incidents were discussed at team meetings. Staff were aware of the importance of duty of candour.
- The service had procedures for the reporting of new pressure ulcers, and slips, trips and falls. Action was being taken to ensure harm free care. Some of this information was displayed within the wards and clinical areas.
- Patient care records were appropriately completed with sufficient detail.
- Nursing and medical handovers were well structured within the surgical wards visited.
- The environment was visibly clean. Equipment was clean with an 'I am Clean' sticker placed on to it.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, and near misses, and to report them internally and externally.
- A system and process for reporting of incidents was in place. Staff understood how to report incidents, this was confirmed verbally, both at junior and senior level. The incident reporting form was accessible via an electronic online system.
- There were six serious incidents reported via the Strategic Executive Information System for surgery services at the Alexandra Hospital, from October 2015 to September 2016. The most common category related to pressure ulcers.
- During the last inspection, from April 2014 to May 2015, there had been 24 reported serious incidents and 18 of these were grade three pressure ulcers. During this inspection, we saw there were nine reported pressure ulcers from September 2015 to September 2016. This meant that measures the trust had undertaken to reduce the number of pressure ulcers had been successful. For example, the introduction of turning charts for patients who were unable to reposition themselves in bed.
- There was one never event reported at the Alexandra Hospital from August 2015 to August 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorized as a never event. The never event related to a patient undergoing surgery for a

hip replacement and the wrong sized prosthesis (part of the replacement hip) was inserted. Following this event, an investigation identified actions to prevent similar mistakes, which included ensuring a 'stop' moment for final checks, prior to all implant surgery.

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff understood their responsibilities with regard to the duty of candour legislation and described a working environment in which any mistakes in a patient's care or treatment were investigated. Staff discussed mistakes with the patient and their representatives and provided them with an apology. We saw evidence that the duty of candour had been applied following the never event.
- We saw that each surgical speciality held regular mortality and morbidity meetings where individual cases were discussed. Lessons learned included checking discharge medicines, ensuring blood tests were carried out promptly and the involvement of specialist nurses whenever possible.

Safety thermometer

- The NHS safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free care'. Information was displayed in the ward corridors for patients, relatives and staff. This included information about patient falls, pressure ulcers and infections. Staff we spoke with were aware of the data and how it was used to improve patient safety.
- From September 2015 to September 2016, there were nine pressure ulcers reported. Staff were able to describe changes that were made because of learning from pressure ulcer incidents. For example, heel guards were available and used for patients at high risk of developing pressure ulcers.
- There were nine incidents of falls, and 13 reported urinary catheter related infections for the surgical division, which included Alexandra Hospital. There were no new MRSA infections in the past year.
- Venous thromboembolism (VTE) assessments were not always documented on admission although all patients reviewed had preventative treatments prescribed. We looked for evidence of VTE assessments in 24 sets of medical records and we found nine did not have a documented VTE assessment (38%). We did not see any notes where a reassessment of VTE risk had been carried out within 24 hours of a patients' admission. We were therefore not assured the trust was following NICE clinical guidelines: venous thromboembolism: reducing the risk for patients in hospital (2015). We brought this to the attention of senior staff during our inspection who told us they would address the issue.

Cleanliness, infection control and hygiene

- The environment and equipment in the wards and theatres was visibly clean and tidy.
- Staff had received training about infection prevention and control during their initial induction and during annual mandatory training updates. We saw that in September 2016, 85% of nursing staff had completed their training in infection prevention and control.
- There was a specific cleaning schedule in place and this was displayed on each ward. Cleaning staff told us that the standard of cleanliness and compliance with the schedule were checked by their supervisor and we saw evidence that regular checks had been completed.
- We observed staff were not always following the trust's policy regarding infection prevention and control. Some staff wore long sleeve shirts, stoned rings and wristwatches and were not 'arms bare below the elbow'. We also saw some staff failed to clean their hands prior to contact with patients and their environment, for example while carrying out a medicine round. Staff of all grades entered and left wards and bay areas without cleaning their hands. Some staff wore gloves and aprons while carrying out different tasks in the general ward areas without changing these. For example, we observed, after assisting a patient with washing, a healthcare assistant left the patient bedside to collect more equipment without removing their gloves and aprons. We raised this with senior staff at the time of the inspection and they carried out their own hand hygiene audit, which showed compliance ranged from 65% to 100%. The trust provided us with an action plan to address this issue and this included further hand hygiene education and weekly audits by the infection

prevention control team. On our unannounced visit, all staff were compliant with 'arms bare below the elbow' and there was an improvement in compliance to hand hygiene before and after patient contact.

- Hand hygiene training was carried out regularly. In surgical services overall, 87% of staff were up-to- date with their hand hygiene training.
- Hand hygiene gels were available at the entrance and exits of the wards, bays, theatres and the pre assessment clinic. Not all patient bed spaces had individual hand gel available. Some nursing staff had bottles of alcohol hand gel attached to their uniform. There was access to hand-wash sinks in each bay, side room and clinical area.
- Personal protective equipment (PPE), such as gloves and aprons was readily available on the ward but we saw that its use did not always comply with the trust's PPE policy. Some staff wore the same gloves and aprons to carry out multiple tasks.
- Waste management was handled appropriately with separate colour coded arrangements for general waste and clinical waste. Sharps bins were stored safely and were not overfilled.
- We saw audits of environmental cleaning and decontamination of clinical equipment had been completed from May 2016 to August 2016 with an average compliance score of 83%. Feedback to cleaning teams was the main action following audit results.
- From August 2015 to August 2016, there had been no reported cases of MRSA and one reported case of Clostridium difficile on the surgical wards at the Alexandra Hospital.

Environment and equipment

- The ward areas and theatres were spacious and well-lit and corridors were free from obstruction to allow prompt access.
- Large equipment and some supplies were stored in theatre corridors due to a lack of space. Systems were in place to ensure the areas and items were cleaned regularly and ready for use at all times.
- There was insufficient storage space in the theatre department to store sterile instrument trays adequately and trays were stacked on trollies in the theatre corridors. Although the trays had three layers of wrapping, incidents had been recorded where the wrappers had become torn and so the instruments could not be used. One incident resulted in an operation being cancelled because the instrument set had a torn wrapper and was no longer sterile. We were told about plans to improve theatre storage but these had not been commenced at the time of our visit. We saw outer boxes had been obtained to store more specialised equipment as a temporary solution.
- Resuscitation equipment, for use in an emergency, was checked daily in most clinical areas. However, in theatre recovery and on ward 11, there were three occasions from October 2016 to December 2017 where the equipment was not checked every day. This meant staff were not always following the trust policy on checking emergency equipment. This was raised with staff during our inspection and we were told a new checklist of jobs had been introduced which listed every job for each day, including checking of the resuscitation equipment.
- Not all emergency drugs on the resuscitation trolley were stored securely or protected with a tamper evident label or seal to provide visible evidence that they were safe to use. We raised this with the trust management during our inspection, who said they would review the storage of medicines on emergency trolleys.
- There was a difficult airway trolley available in theatres. Staff told us this was checked every day. However, we saw it had not been checked on three occasions from October 2016 to December 2016. We were therefore not assured that emergency equipment was always in date and fit for purpose.
- There were three theatres with laminar flow air systems suitable for orthopaedic surgery. Staff told us the airflow systems were revalidated regularly by an external organisation and met standards set out in the national guidance, Health Technical Memorandum 03-01: Specialised Ventilation for Healthcare Premises. Data provided by the trust showed checks carried out in November 2016 had identified problems with the airflow in several of the theatre and anaesthetic rooms and this included two 'immediate' safety concerns and nine 'urgent' safety concerns. This meant that there was a risk inadequately filtered air would contaminate the wounds of patients during their operation. When we returned to theatres on our unannounced visit, staff did not know if these issued had been resolved. However, subsequent to the inspection the trust provided us with an action plan which indicated the risks had been assessed and some measures had been implemented with further actions to reduce the risk planned for January 2017.

- There was sufficient equipment on the wards and in theatres to maintain safe and effective care, including hoists for assisting patients, anaesthetic equipment, theatre instruments, blood pressure and temperature monitors, commodes and bedpans.
- Most electrical appliances and equipment had been electrical safety equipment tested to ensure they were safe to use and had stickers with appropriate dates. We found some items where the electrical safety tests were overdue, including two physiotherapy motion machines (due June 2015 and January 2016) and a bladder scanner due in July 2016.
- Some equipment had been standardised, such as the provision of anaesthetic machines. The same machines were used in every anaesthetic room and operating theatre throughout the trust. This improved safety as it ensured staff were familiar with the equipment wherever they worked.

Medicines

- The pharmacy department was open between 9am and 5.30pm and out of hours, medicines could be obtained through the on-call pharmacist service.
- The pharmacy team visited the wards each weekday and a pharmacist was available out of hours. The pharmacist recorded information on the prescription chart to help guide ward staff in the safe prescribing and administration of medicines.
- Medicines were stored in a secure temperature controlled room that had suitable storage and preparation facilities for all types of medicines such as controlled drugs and antibiotics. However, on wards 14 and ward 11 we saw records indicating that the ambient temperature in the medicine storage room had been regularly above the recommended range. For example, on ward 11 we saw temperatures recorded over 25 °C for three consecutive days in November 2016 and the maximum temperature had been above 30 °C for eight consecutive days without any actions recorded to rectify this. Staff did not record room temperatures every day on every ward. On ward 11 the temperatures were not recorded for September and October 2016 because the thermometer was broken. Staff on ward14 had escalated high temperatures to the estates and pharmacy departments but we were not aware of any actions because of the escalation.
- Medicines that required refrigeration were kept at the correct temperature on most wards and we saw daily checks of fridge temperatures were recorded. The checklists indicated the acceptable temperature range should be between 5°C and 8°C. However, on one ward the temperature had been recorded above 8°C for three consecutive days without any action to address this. Additionally, temperatures were not recorded for eight days in October 2016 and six days in September 2016. On our unannounced inspection in theatre two, the fridge temperature had been recorded as between 8°C and 12°C for seven consecutive days in December 2016. Staff told us when temperatures went out of range they reset the thermometer but did not take any further action or report the incidents. We were therefore not assured that medicine inside all fridges remained safe and effective for use or that staff were aware of the actions to take when the fridge temperature went outside safe parameters. We raised this with the trust during our inspection. In a response provided by the trust on 11 January 2017, after we raised this as a significant concern, the trust told us that they would review and assess all medication areas and fridges. A new document to monitor temperature was introduced and audits would be ongoing throughout January. The trust told us that a medicines optimisation group would review the audit results and that this information would be used to plan trust's next steps. The storage of medications outside manufactures recommended temperature ranges had not resulted in any reported incidents.
- Controlled drugs (CDs) were stored in a locked unit and the keys held separately from the main keys. Staff checked the CDs daily in each area. The CD cupboards were tidy and only used to store CD medication.
- Staff made entries in the controlled drug register as required. Administration was related to each patient and this was signed appropriately. Staff checked new stock delivered and signed to record any destruction of old or unwanted medicines.
- There was a medicines management policy, which included information on the safe administration of medication and staff could access this via the hospital intranet.
- All medicines, including intravenous fluids were stored behind locked doors and only accessible to appropriate staff.

- Staff recorded medicine administration accurately. We observed the preparation and administration of intravenous infusions. These were administered safely and in accordance with the hospital's policy.
- Nursing staff wore red aprons during medication rounds to prevent disturbances and reduce drug errors and we saw staff using these.
- Staff had access to up to date medicines information such as British National Formularies and the trusts medicines policy.

Records

- During our last inspection, the quality of medical record keeping was variable. However during this inspection we found records were kept in good order and information was easy to access.
- We looked at 39 sets of patient notes. We saw records included admission documentation, risk assessments, records of therapies, consent forms, theatre records and medical and nursing notes. Records were legible, accurate and up to date. Daily care records such as fluid balance records and care plans were stored in folders at the patient bedside. The samples we reviewed were fully completed, legible with entries timed, dated and signed.
- The nursing and medical notes were stored in trolleys in the ward corridors and were not away from public view. During our inspection, we found that the lockable notes trolleys were unlocked and therefore we were not assured of the security of medical records.
- White electronic boards were used to display patient name and location on the wards, which included some care and treatment information. These were visible to staff and visitors to the ward, therefore we were not assured that patient confidentiality was maintained.

Safeguarding

- There were systems, processes and practices in place to keep patients safe. The hospital had safeguarding adult and children policies and procedures available to staff on the trust intranet. There was a lead nurse for safeguarding.
- Training was provided in the safeguarding of vulnerable adults and children. However, not all staff were fully aware of their responsibilities towards safeguarding vulnerable people. Some staff told us they did not have safeguarding concerns because their patients were 'surgical' or 'elective' patients.
- Some staff told us the trust policies were difficult to find on the intranet. This was demonstrated by two members of staff who had difficulty in finding safeguarding information on the intranet when asked by the inspection team.
- The trust reported in September 2016 that 95% of medical staff and 100% of nursing staff had up to date training in adult safeguarding level one and level two. However, less than 10% of medical staff and 23% of nursing staff had completed safeguarding children at levels one and two. The trust's target was 90%. This meant we were not assured all staff had the necessary skills to identify and respond to safeguarding concerns involving children.

Mandatory training

- Mandatory training was provided for staff including for example infection control, fire, moving and handling patients and health and safety. Some training was delivered by face-to-face sessions and some training was on line.
- There was an induction programme for new staff and this included the mandatory sessions as well as any required local training. New staff said that the programme met their needs.
- The trust's training record for September 2016 showed that for the surgical division, 70% of nursing and 63% of medical staff had completed their mandatory training against a trust target of 90%. This was similar to last year. This meant that we were not assured all staff had the necessary training to carry out all of their roles effectively. More on line training sessions had been made available to improve mandatory training compliance and ward administrators booked nursing staff directly onto outstanding training sessions.

Assessing and responding to patient risk

- Staff told us they were aware of risks to patient safety and said they knew how to escalate any concerns. However, not all patients had been appropriately risk assessed or monitored and we were therefore not assured that systems to keep patients safe were adhered to at all times.
- Some risks were not always assessed and this included VTE assessments, which we saw had not been documented on admission. We checked 24 sets of notes for a VTE assessment and found nine (38%), did not

have one recorded. We did not see any patient notes where a reassessment of VTE risk had been done within 24hours of admission. An audit carried out by the service in May 2016 looked at ten patients admitted to the trauma and orthopaedic wards, found 0% of patients been reassessed within 24hours. We observed one patient going into theatre without a completed VTE assessment. We saw two sets of notes where a patient was ready for discharge after a stay of five or more days and no VTE assessment had been carried out. We were therefore not assured the trust was following National Institute for Health and Care Excellence guidelines: venous thromboembolism: reducing the risk for patients in hospital (2015). This was raised with senior staff following our inspection. In a response provided by the trust on 11 January 2017, after this was raised as a significant concern, the trust told us matrons ward visits would now include checks to patient documentation to ensure VTE assessments were carried out on all patients. We saw a specific action plan, which included training for staff on completion and recording of VTE assessments and a review of funding to recruit specialist VTE nursing staff.

- Audits of the 'five steps to safer surgery' checklist had been carried out regularly from August 2015 to August 2016 and trust compliance was recorded as 100%. Observational audits had also been carried out, which highlighted the need to improve staff engagement and that all staff involved in each theatre case should be present at team brief. The World Health Organisation (WHO), recommend both a team brief and a team debrief are carried out to improve team performance and patient safety. Briefings are also an opportunity to share vital information about patients and potential safety issues both before and after procedures. During our inspection, we saw that theatre teams did not always adhere to the WHO recommendations. We observed a theatre case where the operating surgeon was not present at team brief. We brought this to the attention of senior managers at the time of our visit. On our unannounced visit, we saw that the consultant surgeon was present for team brief but his registrar was not. Therefore, some staff involved in the procedure may not have been aware of any current issues prior to the commencement of surgery.
- Patient temperatures during operations (intra-operative temperatures) were not recorded in line with NICE guidance, Hypothermia: prevention and management in adults having surgery (2008), which recommends all patients have a temperature recorded before anaesthesia and every 30mins during their operation. Patients who suffer from hypothermia feel greater discomfort and have poorer outcomes. This was raised with staff during our inspection and they told us that temperatures were recorded on the ward prior to surgery and in the recovery room following surgery only. A trust audit carried out on 93 patients, showed compliance to intra-operative temperature monitoring was 30%. Following this audit, in August 2016 adaptations were made to the anaesthetic chart to guide anaesthetists to the requirement to record intra operative temperatures in line with NICE guidance, every 30mins. On our unannounced inspection, we saw two out of five patients had temperatures recorded on admission to theatre only.
- Patients having elective surgery attended a preoperative assessment clinic where essential preoperative tests were carried out, including MRSA screening, electrocardiogram monitoring and blood tests. Patients were reviewed by an anaesthetist if necessary during a dedicated appointment. Access to an assessment by an anaesthetist was not routinely available to all patients during the pre-assessment clinic but staff explained how they could arrange this if it was required.
- Not all patients received a preoperative assessment appointment in a timely manner. Some patients were given an assessment appointment the day before their surgery and this had led to some operations being cancelled. For example, if the patient required anticoagulation medication (a drug to thin the blood) prior to their operation. The trust told us 43 patients had their operations cancelled following identification of issues at pre assessment from September to November 2016.
- Risk assessments were recorded to assess the patient's risk of, for example falls, malnutrition and pressure ulcers. These were documented in the patients' records and included actions to mitigate the risks identified.
- Staff used the National Early Warning Score (NEWS) in accordance with NICE clinical guidance CG50 to record routine physiological observations including blood pressure, temperature, heart rate and respiratory rate. There were clear directions for actions to take when NEWS increased and indicated a patient was deteriorating. We reviewed 18 NEWS charts and found

they were all completed regularly and accurately. However, an audit carried out by the hospital critical care outreach team in August 2016 found NEWS were not always accurately documented. One ward was 77% compliant and only two out of six wards achieved the trust threshold of 95% accuracy. The trust provided us with an action plan to improve accuracy of NEWS and this included increased staff training and competency assessments plus monthly audits with results reported to senior staff.

- The trust had an outreach team who provided extra clinical support with deteriorating patients. The hospital at night team provided this support out of hours.
- Patients were checked at regular intervals using an 'intentional rounding' tool, which enabled staff to manage individual care needs. The checks included the use of a Waterlow risk assessment tool to estimate risk for the development of a pressure ulcer.
- Sepsis awareness training had recently been carried out and staff were aware of the procedure to be followed for deteriorating patients suspected of having sepsis. Instruction posters were on ward notice boards and stickers were available on most wards for patient notes.
- There was 24-hour access to emergency surgery teams, theatres and doctors. During the night, there was a senior house officer who covered the surgical wards, supported by the on call consultant for surgery.
- We observed a patient's admission to theatre. Staff introduced themselves to the patient and carried out thorough checks, including identification of the patient, any known allergies, the procedure to be undertaken and verification of signature on the consent form.

Nursing staffing

- Nursing staff numbers, skill mix review and workforce indicators such as sickness and staff turnover were assessed using an electronic rostering tool. The surgical directorate used an acuity tool, dependency reviews, NICE guidelines and professional judgement to assess and plan staffing requirements. There was a staffing review in January 2016 when amendments and adjustments to levels were made.
- Vacancy rates in surgical services at the Alexandra Hospital in September 2016 were 19%. There was 125 whole time equivalent staff in post against a requirement of 174. The nurse vacancy rate was documented on the surgical risk register and actions to address this included the use of bank and agency staff and monthly reviews of recruitment. Further initiatives included offering rotational placements to newly qualified nurses, which allowed them to work in several surgical areas before deciding on a preferred speciality. Staff were also hoping to attract student nurses by keeping in contact with them throughout their training. Matrons were assisting with nurse interviews to ensure appropriate candidates were selected and the trust were attending recruitment fairs and university open days.
- From May 2016 to November 2016, there were 27 reported incidents of staff shortages. These incidents were investigated and the need to forward plan was identified as a lesson learnt. However, some incidents were recorded as unplanned staff absence due to sickness or agency staff cancelling at short notice.
- From May 2016 to October 2016, the surgical directorate reported 133 unfilled nurse shifts and 79 unfilled healthcare assistant shifts.
- The planned and actual staffing numbers were displayed on the wards we visited. Staffing levels were appropriate to meet patients' needs during our inspection. On our unannounced inspection, we saw three out of four wards checked had less actual staff than planned. For example, one ward reported their actual staffing to be three nurses and three healthcare assistants compared with a planned staffing of four nurses and four healthcare assistants.
- Staff worked extra shifts and bank and agency staff were used to cover nursing vacancies. Some agency staff were blocked booked for shifts in advance. This assisted with safe staffing levels and continuity of care. In theatres, an in-house nurse bank had been established to allow permanent staff to work extra shifts. This had reduced the reliance on external staff.
- New temporary staff received an induction to each area. This ensured staff were familiar with ward layouts and emergency procedures. In theatres, staff showed us an induction booklet used for new agency staff and we saw copies of signed induction sheets.
- From September 2015 to August 2016, the Alexandra Hospital reported a bank and agency usage rate of 10% trust wide. The day surgery unit and Ward 18 overspill had the highest agency and bank usage rate over the period at 75% and 67% respectively.

- Staff turnover in September 2016 was 16%. Staff leaving the service were offered an exit interview. We were told findings from these interviews indicated most staff left for a promotion.
- The sickness rate in September 2016 was 4% against a trust target of 3.5%. This was better than during our last inspection, when the average sickness rate for nursing staff in the surgery team was 4.9%.
- We observed two nursing handovers and they were well structured and used printed information sheets. The information discussed included patients going to theatre, patients requiring appointments for investigations, discharges, pain management, medication, personal care requirements and home circumstances. The handovers occurred in the bays at the end of each patient bed and on the corridors outside of single rooms. We were not assured that patient privacy, dignity and confidentiality were maintained due to the location of these handovers.

Surgical staffing

- During the last inspection staff reported that during out of hours (weekends and nights), there was a lack of experienced doctors to cover the trauma and orthopaedic service. During this inspection, most doctors and consultants said they had sufficient cover for their specialities. Staffing levels were appropriate to meet patients' needs during our inspection.
- In September 2016, the overall vacancy rate for medical staff at the Alexandra Hospital was 10%, with 8% being consultant vacancies and 17% for other medical grade staff. From September 2015 to August 2016, Alexandra Hospital reported a bank and locum usage rate of 31% for the whole hospital. It was not possible to separate the number of bank and locum doctors used purely in surgical services. Medical staff vacancy rates were documented on the surgical risk register. Actions included the use of long-term locums and changes to rotas to improve recruitment.
- Medical staffing levels were similar to the national average, at 49% consultant grade staff, which was higher than the England average of 44%. Middle career group (doctors who had been at least three years as a senior house officer or a higher grade within their chosen speciality) was 12% against an England average of 10%. Registrar grades were 24%, which was lower than the England average of 35%; 16% were junior doctors against the national England average of 11% junior doctors.
- We observed a doctors handover, which was well attended, consultant led and appropriate information was shared. This included new admissions overnight, patients waiting to be reviewed in the emergency department and patients of concern on the wards. The consultant discussed the workload and allocated actions.
- Doctors ward rounds occurred daily on each ward. There was good interaction between doctors and nursing staff.
- Surgical consultants worked weekends and carried out ward rounds to ensure the provision of consultant led care. A consultant was on call for emergencies 24 hours a day.
- Nursing and medical staff told us they felt supported by their consultants and that they were accessible, approachable and available when required.

Major incident awareness and training

- Staff were aware of the major incident policy in place relating to all services within the trust including surgical services.
- Some staff told us there had been fire evacuation exercises and were able to explain the actions to be taken.
- There was a major incident file for staff to refer to, detailing communication arrangements and different staff roles in relation to an incident.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff were unaware of the results from national audits and unaware of any action plans to improve performance.
- Less than half of nursing and medical staff had received training in Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff had a poor awareness of the MCA and the DoLS.
- Not all staff used the appropriate consent form for patients who lacked capacity to consent to treatment.

- Not all staff had received an annual appraisal.
- Care pathways or enhanced recovery pathways were not used to improve outcomes for surgical patients including general surgery and urology.
- The national Hip Fracture Database audit showed the trust had a mixed performance against the England average results. The trust had improved in some measures since the previous year but they remained not compliant with some of the national standards.

However:

- The trust participated in national and local audits, for example the Patient Reported Outcome Measures (PROMS) which overall showed the trust was similar to the England averages for PROMS measures for hips and knees.
- Policies and procedures were accessible to staff and most staff were aware of how to find relevant information.
- Patient's pain, nutrition and hydration were appropriately managed.
- The surgical service had a consultant-led, seven-day service with daily consultant ward rounds.

Evidence-based care and treatment

- Patients received care according to most national guidelines. Clinical audits demonstrated the trust monitored its care against the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons guidelines. For example, this included re-excision rates for breast cancers treated with breast conservation surgery (NICE CG80) and NICE CG124, treatment for patients admitted with a hip fracture within 36 hours of admission.
- Trust policies were current and we saw that the hospital had systems in place to provide care in line with best practice guidelines. For example, the service used an early warning score to alert staff should a patient's condition deteriorate (in line with NICE CG50 Acutely ill patients: Recognition of and response to acute illness in adults in hospital 2007).
- The trust recorded medical device implants on the National Joint Register to ensure outcomes for patients undergoing joint replacement surgery were monitored.
- Local policies such as the falls prevention and management policies were written in line with national guidelines. Staff we spoke with identified these policies and knew how to access them.
- Assessments for patients were comprehensive, covering all health and social care needs including clinical needs, mental health, physical health, and nutrition and hydration needs. However, we saw not all patients who required a mental capacity assessment or a dementia screen received this in line with the trust policy.
- Surgical services did not use pathways or enhanced recovery programmes for all patients. Pathways help patients to recover quickly post-operatively because they are evidence based and focus on holistic patient assessments, pain relief and the management of fluids and diet.
- When patients attended pre assessment clinic they received advice on smoking cessation and reducing alcohol consumption to ensure that they were supported in being as fit as possible for their surgery.
- The pre-operative assessment clinic assessed and screened patients in accordance with NICE guidance: Routine preoperative tests for elective surgery (NG45) (2016). Examples included MRSA testing and electrocardiograms tests for patients over 65 years old.
- Peripheral intravenous cannula and urinary catheter care bundles were used to improve the quality of care. A care bundle is a set of individual evidence based steps which, when used together, give patients a better outcome. For example, by reducing their chance of getting an infection.
- An ice machine was available for clinical use to improve outcomes for surgical patients.

Pain relief

- Patient's pain was assessed and managed appropriately. Patients received information on pain relief during their pre-operative assessment.
- Patient care records showed that pain relief had been risk assessed using consistent and validated tools, such as the pain scale found within the National Early Warning Score (NEWS) document. Results were recorded alongside other vital signs. Handovers discussed patient's pain when appropriate.
- We observed staff asking patients if they were in pain and patients told us they were provided with pain relief in a timely manner.
- Staff carried out 'intentional rounding' observations at two-hourly intervals. The check sheet included a prompt for staff to ask patients about pain to identify those who required pain relief.

- There was a consultant led pain team to help staff and patients manage pain. This included dedicated staff to help with epidurals during working hours. Out of hours, advice was available from senior site managers and anaesthetists.

Nutrition and hydration

- Patient's nutrition and hydration status was assessed and recorded using the Malnutrition Universal Screening Tool (MUST). During the last inspection, this was not consistently completed for all patients. During this inspection, we found all patients had an up to date MUST assessment.
- Patients at risk of malnutrition or who had specific dietary needs were referred for review by a dietitian and we saw evidence of these reviews documented in patient notes. We also saw evidence of food diaries used to record daily intake.
- We checked the fluid balance charts in eight patient records and observed that fluid intake and output had been recorded and that the charts were used effectively to monitor patients' hydration status.
- Pre-operative drinks were provided when appropriate to patients having elective surgery in order to aid their recovery following their operation. Patients who had their operation cancelled were removed from the 'nil by mouth' list and advised in a timely manner. Healthcare assistants checked and monitored patients were taking regular drinks and we saw them providing extra drinks on request.
- There were processes in place to ensure patients who needed assistance with eating and drinking were identified and supported. Staff used a red tray system to alert staff that particular patients required support with diet.
- Patients who presented with nausea and vomiting post-surgery were given antiemetic medicines (a medicine to prevent vomiting and nausea) where appropriate. We saw these medicines had been prescribed and administered appropriately.
- The patients we spoke with told us that they were offered a choice of food and drink and spoke positively about the quality and portion size of the food offered. Meals were available for special diets including halal meals and Indian food.
- Day surgery patients said they were offered drinks and snacks post operatively.

Patient outcomes

- During the last inspection, there was no evidence of how information was cascaded and shared at all levels of the organization to improve care and treatment and patients' outcomes. During this inspection, we found staff were still unaware of patient outcomes following audits.
- Trust guidance indicated emergency laparotomy surgery should not be carried out at the Alexandra Hospital. This formed part on the trust's emergency surgery plan. Emergency laparotomy is a term used to describe the group of abdominal surgical procedures that are commonly performed at short notice to treat certain conditions. However, we saw in September and October 2016, two emergency laparotomies had been carried out. Although both procedures had been carried out in an emergency, trust guidance provided at the time of our inspection, required patients to be transferred to Worcestershire Royal Hospital using a medical escort. This meant that the trust was not following their own guidelines for emergency surgery.
- During the last inspection, there were delays in the transfer of patients requiring emergency acute abdominal surgery from the Alexandra Hospital of up to 10 hours, which meant the patient's condition, could deteriorate prior to transfer for treatment. During this inspection, we found no evidence of delays or of patient harm due to transfer.
- The hospital participated in the National Hip Fracture Database (NHFD), which is part of the national falls and fragility fracture audit programme. A review of the 2015 report indicated that the mortality rate was 10% which falls within expectations. The proportion of patients having surgery on the day of or day after admission was 69%. This did not meet the national standard of 85% but had seen improvement on the previous year which was 58%. The perioperative surgical assessment rate was 90% which did not meet the national standard of 100%. The length of stay was 17.5 days which is an improvement of previous performance. We saw a corrective action plan, which included prioritising fracture neck of femur cases on the trauma lists plus daily reports on the achievement of the 36 hours target.
- PROM audit measures health gain in patients undergoing hip and knee replacement and groin surgery in England. The patient related outcome measures for the hospital for groin hernia showed fewer patients'

health improving and more patients' health worsening than the England averages. The Oxford hip score and Oxford knee score were in line with the England averages.
- From March 2015 to February 2016, patients at Worcestershire Acute Hospitals NHS Trust had a lower expected risk of readmission for non-elective admissions and a lower expected risk for elective admissions. The elective specialty for general surgery has the largest relative risk of readmission.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- There was a specific induction programme for all new staff. This included both a trust wide induction and local orientation. Staff told us the inductions were useful. The trust wide induction included information governance, infection control and fire safety. The local induction included orientation to the department and local competencies.
- Nursing staff (both agency and permanent) said they felt well supported and adequately trained in their local areas.
- Medical and nursing staff told us that they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely.
- Newly qualified nurses had support through a preceptorship programme, which offered role specific training and support. Nursing and theatre staff were offered opportunities to rotate within the surgical departments to improve their knowledge of different surgical specialities.
- Agency staff had a local induction in the ward and theatres area where they worked. This included a tour of the area, introduction to staff and details of the equipment used. Theatre areas used an induction booklet but the ward areas did not. We saw completed induction booklets for theatre agency staff which were comprehensively completed and signed.
- Junior doctors within surgery reported good surgical supervision and they each had a specific personal development plan, which they said enhanced their training opportunities. Junior doctors had specific personal development plans, a mentor and clinical support.
- Staff said they were able to access study days relevant to their area of work, both internally and externally and told us about recent days they had attended, for example in pressure area care. Extra skills training was also available for example in cannulation.
- Some healthcare assistants had recently undergone training to become phlebotomy assistants for surgical services.
- During the last inspection, appraisal rates were below the trusts target of 85%. During this inspection, we found appraisal rates in July 2016 were still below the trust target at 80% for all staff working within the surgical division.

Multidisciplinary working

- There was daily communication between the multi-disciplinary teams within the elective surgical pathway.
- Surgical wards undertook daily ward rounds, which included medical and nursing staff together with physiotherapists and occupational therapists as required. We observed a ward round and saw good working relationships between ward staff, doctors and therapists.
- The relevant staff, teams and services were involved in assessing, planning and delivering patient care and treatment and worked collaboratively to understand and meet the range and complexity of patient's needs. For example, we saw dietitians, speech and language therapists, pharmacists, and physiotherapists had contributed to patient assessments and care records. There was access to a discharge team if patients required assistance or extra support to enable them to go home.
- During the previous inspection, staff reported there was lack of support from medical staff responsible for the care of medical outliers (these are medical patients admitted to surgical beds when beds on medical wards were not available). During this inspection, on review of notes and discussion with staff, we found most medical patients (outliers) were reviewed daily and staff could access doctors for advice when required.
- Staff could access the learning disability lead, critical care team, pain management team, social workers and safeguarding teams who were able to provide advice and support to the surgical staff when required.

- There was dedicated pharmacy support to the surgical wards. This helped to speed up patient discharges in relation to take home medicines. In addition, advice and support to medical and nursing staff was provided when required.

Seven-day services

- Consultant ward rounds occurred daily, including at the weekend.
- Sufficient out of hour's medical cover was provided to patients in the surgical wards and this included access to on site and on call consultant cover. Consultants could be contacted out of hours by junior staff if required.
- Theatres, anaesthetics, and recovery staff were on duty out of hours and at weekends to cover emergency surgery.
- Imaging (for example x-ray and CT scans), pharmacy, pain teams and physiotherapy services were available at weekends and an on call service out of hours.
- The critical care outreach service operated from 8am to 8pm**,** seven days a week. Patients deemed 'at risk of deteriorating' were handed over between these teams at the commencement of each shift. Nurse practitioners were available at night to provide clinical advice and support to ward staff.

Access to information

- Computers were available in all clinical areas for staff to access patient information and trust policies and procedures. Staff were able to demonstrate how they found patient test results and how they accessed guidelines.
- Staff used printed handover sheets, which included details of each patient's current diagnosis and care needs to handover care between practitioners each shift. The handover sheets were available to the multidisciplinary team.
- Nursing staff ensured that when patients transferred between theatres and the wards, a comprehensive handover was provided. This ensured that staff were aware of the patient's condition, relevant medical and social history and on-going care needs and plan of treatment.
- GPs were sent copies of discharge letters to ensure continuity of care within the community. The summary included the surgeons' contact details so the GP knew whom to contact if further information was needed.
- The hospital used paper-based patient records however, some information was stored electronically, for example, pre assessment records and any test results. Agency nursing staff did not have access to the electronic system and required a permanent member of staff to access the system on their behalf.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Staff we spoke with understood consent, decision-making requirements, and guidance. There was an up to date consent policy for surgical treatment.
- The hospital had four nationally recognised consent forms in use and staff were able to describe the different uses for these. For example, there was a consent form for patients who were able to consent, another for patients who were not able to give consent and another for procedures not under general anaesthetic.
- Not all patients who required a mental capacity assessment or a dementia screen received this in line with the trust policy.
- Not all patients were consented using the correct form. We found two examples where the incorrect consent form had been used. This included a patient who had signed a 'consent one' form (a form for patients who have mental capacity) and had a DoLS in place but was without an MCA. Patients under DoLS have been deprived of their liberty in their best interests because they are deemed at risk of harm. In order to instigate a DoLS, patients should first have their mental capacity assessed. A second patient had been consented for theatre using a 'consent four form' (a form used for patients who are deemed not to have capacity and therefore the procedure is carried out in their best interests). However, this patient did not have a mental capacity assessment documented. Therefore, we were not assured that consent to care and treatment was always obtained in line with legislation and guidance, including the MCA. This was raised with the trust at the time of our inspection who told us this issue would be investigated.
- The consent forms we reviewed showed evidence that the possible risks and benefits of surgery had been identified. Patients confirmed they had received clear explanations and guidance about the surgery and said they understood what they were consenting to.
- There was a trust policy to ensure staff were able to meet their responsibilities under the MCA and DoLS.

However, we found not all staff were fully aware of these responsibilities. For example, some staff were unaware of the procedures to be followed when a patient lacked capacity. We saw a patient had a DoLs in place but they had not received a mental capacity assessment. Another patient had a consent form completed on their behalf because there were deemed unable to do so themselves, yet no mental capacity assessment had been undertaken.

- Pre-operative assessment clinic staff advised us they communicated to surgeons and anaesthetists any concerns they had about a patient's mental capacity and they flagged the notes using the electronic flagging system. Pre assessment staff referred patients identified as requiring MCA or DoLS assessments to the dementia team for follow up upon admission.
- Records for August 2016 showed that within surgery, 44% of medical staff and 37% of nursing staff had received training in MCA and DoLS.
- Junior nursing staff told us they would contact senior nurses for help if they were required to make an application for a DoLS for patient.

Are surgery services caring?

Good

We rated caring as good because:

- Staff were caring and compassionate to patients' needs. Patients spoke highly of the care they had received.
- Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.
- Patients were kept up to date with their condition and health progress.
- Information was shared with patients and their relatives and opportunities were provided to ask questions.
- The NHS Friends and Family test response rates were better than the England average.

However:

- Privacy, dignity and confidentiality was not always maintained.
- During our inspection, we observed that staff did not introduce themselves, including at the beginning of their shift. Staff did not knock on side room doors prior to entering.

Compassionate care

- We saw staff respected patients' privacy and dignity during personal care. For example, while assisting patients with personal washing, staff pulled the curtains around the bed space. However, nurse handovers were carried out at the end of patient bed spaces and in the corridor outside of the side rooms. This meant personal, private and confidential information could be overheard. We also saw that staff did not knock on side room doors before entering and we were therefore not assured that patient privacy and dignity were always respected.
- Staff responded compassionately to patient's pain, discomfort, and emotional distress in a timely and appropriate way. We observed staff providing comfort to a patient in pain, for example by obtaining more pillows and helping them reposition in bed. We saw staff holding hands with a patient who was very anxious while going into theatre and they talked to the patient about their life outside hospital in order to distract them while they waited.
- Patients told us that staff were kind and caring when they answered their call bells.
- Comfort rounds (where nursing staff regularly check on patients) were undertaken and recorded.
- The NHS Friends and Family Test (FFT) showed that from September 2015 to August 2016, over 90% patients who completed the survey said would recommend the trust to family and friends. The FFT response rate was 36% against the national average of 29%.
- We received positive comments from the patients and relatives we spoke with about their care. One patient said 'the nurses here have been fantastic and I cannot fault any of the care from them'.
- Patients told us that they had managed to rest and sleep because staff were as quiet as possible at night.

Understanding and involvement of patients and those close to them

- Patients we spoke with felt informed about their care and treatment. However, most said they were not aware of their discharge plans.
- Patients told us they were aware of their treatment plans and that doctors had explained different options,

which were available to them. Patients said they felt involved in the decisions made about their care and said they felt comfortable asking questions. They told us staff took time to explain and answer their queries.
- Patients and relatives were given the opportunity to speak with their consultant prior to their surgery and ask any questions. Ward staff arranged extra appointments for patients who wished to speak to doctors when their relatives were available.
- Staff were able to recognise when a patient required help with understanding their treatment and they had access to interpreters.

Emotional support

- Clinical nurse specialists were available to provide emotional support and advice to patients, such as stoma care.
- Patients and those close to them were able to receive support to help them cope emotionally with their care and treatment.
- Staff showed an awareness of the emotional and mental health needs of patients. They told us they were able to refer patients for specialist support if required.
- Staff had access to an on call chaplain and other spiritual advisors could be arranged to meet patient's needs.
- A team of volunteers were available and provided assistance and support to patients and their visitors when requested. For example by getting newspapers from the shop or providing directions.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- The admitted referral to treatment (RTT) time was 68% which was consistently below the England average of 80% in all specialities at 68%, apart from eye surgery, which was 86%.
- The number of operations cancelled and not treated within 28 days was 14%. This was higher than the national average which was 6%.
- There were high levels of unplanned medical patients admitted onto the surgical wards, resulting in some cancelled operations.
- Patients were not always offered a choice about where they were discharged to for continuing care.
- Some information leaflets and consent forms were not available in other languages.
- Complaints in surgical services were not always responded to within the trust target of 25 days.

However:

- Service planning generally met the needs of the local people and the community.
- The average length of stay was similar to the national average.
- There was support for people with a learning disability and reasonable adjustments were made to the service provided.
- Arrangements were in place to support patients living with dementia or a learning disability.
- Pre-assessment documentation identified patients who were living with dementia or a learning disability.
- Translation services were available to support patients, which ensured they could access relevant information about their care.
- The hospital held regular bed capacity meetings attended by representatives from the service.

Service planning and delivery to meet the needs of local people

- The service was planned and designed to deliver the different needs of the people using it.
- Services were planned and delivered in a way that ensured there was a range of appropriate provision to allow people to access care as close to their home as possible. However, some patients told us they were not treated at their local hospital or their preferred location.
- The use of theatres was monitored to ensure that they were responsive to the needs of patients. Theatre utilisation at Alexandra Hospital ranged from 68% to 92% from June to August 2016.

Access and flow

- During the last inspection, some people were not able to access services for assessment, diagnosis or treatment when they needed to. There were frequent delays or cancellations. The number of surgical patients trust wide whose operation was cancelled on the day of surgery and were not rebooked to be treated within 28 days was 20% in 2015. During this inspection, 14% of

patients had their operation cancelled on the day of surgery and they were not treated within 28 days compared to the England average of 6%. Staff told us this was mainly due to a lack of surgical beds.

- Local actions to improve theatre efficiency had been implemented following a theatre review by independent analysists. This included daily huddles to ensure potential problems were identified early, weekly lookback and look forward meetings attended by senior teams to discuss significant events and plans for the forthcoming week, and the use of white boards, which identified actions and those responsible for ensuring their completion. Staff spoke very positively about the new measures although their impact could not be measured because they had only just started.
- During the last inspection, medical patient outliers affected bed capacity and patients were not always reviewed by their medical teams in a timely way. During this inspection, we found medical patients were reviewed regularly and nursing staff said they could access the medical team for advice whenever required. However, the high demand for medical beds still affected surgical bed capacity and resulted in cancelled operations. Although this was documented on the surgical risk register, there did not appear to be robust plans in place to resolve this.
- From April 2015 to March 2016, the average length of stay for surgical elective and non-elective patients at the trust was similar to the England average.
- During the last inspection, the theatre dedicated for emergency surgery, had insufficient capacity to meet the increasing workload. This resulted in delays to the treatment of emergency surgical patients. This had been added to the theatre risk register. During this inspection, we were not made aware of any delays to emergency surgery at this site.
- From September 2015 to September 2016, the trust's admitted referral to treatment time within 18 weeks (RTT) for surgery was 68%, which was worse than the England average of 80%, apart from ophthalmology, which was better at 86%. Although this was on the surgical risk register, we did not see any action plans to improve waiting times.
- During the last inspection, patients and their relatives were not always offered a choice of location for continuing care in the community. This was sometimes located a long distance away from family and friends. During this inspection, we found this remained the same. Staff told us that due to bed shortages, patients had to go to wherever a community bed became available.
- There was a six bedded surgical decisions unit (SDU) which accepted direct general surgical referrals from GPs and provided surgical day care and assessments, for example assessment for patients who required removal of a catheter. The unit was not designed for, or staffed, to provide a 24 hr day service. However, senior staff told us it often remained open overnight due to bed shortages in the hospital. On our unannounced inspection, staff working in the unit told us it had been open 24 hrs for the previous six days and that some medical patients had been cared for on the unit. This meant that surgical patients requiring admission to the decision unit might have to go elsewhere for treatment if there was no bed available on the SDU.
- An on call theatre team facilitated emergency surgery. Consultants in each speciality were on call at night and weekends and carried out any emergency procedures as necessary.
- From March 2015 to February 2016, the risk of readmission following surgery at the trust was better than England average for both elective and non-elective surgery.
- We spoke with one patient who had had their operation cancelled on three previous occasions. They described to us the emotional and practical impact this had had on them, including making arrangements for time off work, arranging transport home from hospital and caring for pets while they were away.

Meeting people's individual needs

- Surgical services were planned to take into account the individual needs of patients.
- Staff told us they had link nurses for specific areas, for example infection control and diabetes. The link nurses received extra training and were able to support ward staff and share information.
- There were arrangements in place to respond to patients with specific needs, for example by allowing carers to escort patients into theatre.
- Patients who had specific needs, including those living with dementia, could have a carer or friend accompany them to theatre prior to their operation.

- Some wards had a dementia box, which contained some aids, games and a computer to access black and white films, games and music. Staff said these helped in caring for patients living with dementia.
- An interpreting service for patients who did not speak English was available and staff knew how to access it. However, consent forms were only available in English.
- Staff who worked in pre-assessment clinic advised patients on healthy weight loss where required and gave patients information on how to get advice and support.
- Patient information leaflets were available including, wound care, pain management and skin care. Leaflets were not available in other languages but staff said they could be obtained through the Patient Advice and Liaison Service (PALS) service.
- There was a prayer room for use by patients and their families.
- Patient call bells were answered promptly.

Learning from complaints and concerns

- There was a complaints policy for staff to follow. Some complaints were not handled in line with the trust's policy because they were not resolved within the required timeframe.
- Staff directed patients and relatives to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly. Information was available in the main hospital areas on how patients could make a complaint. The PALS provided support to patients and relatives who wished to make a complaint. Literature and posters were also displayed within the ward areas, advising patients and their relatives how they could raise a concern or complaint, either formally or informally.
- During the last inspection, patients told us they were worried about raising concerns or complaints and said when they did complain they received a slow or unsatisfactory response. During this inspection, patients told us they were not worried about complaining and would feel confident in making a complaint if it was necessary.
- From April 2015 to March 2016, 58 complaints were received in the service. Of these, 18 complaints were not responded to within the trust's target of 25 days including four, which took more than 45 days to be investigated. Complaints were discussed at the surgical quality governance meetings and the identified themes were communication with patients and relatives, and care and clinical treatment.
- Senior staff told us about their recent complaints and what actions they had completed to ensure learning occurred from them. This included communication training and improving awareness of individual differences, for example in dietary requirements. Complaints were also discussed at sisters meetings and shared with ward staff.

Are surgery services well-led?

Inadequate

We rated well-led as inadequate because:

- Some staff were not aware of the plans for the county wide management of emergency surgery in inpatient services. However, the trust told us this related more to the centralisation of all in-patient emergency general surgery rather than the county wide service.
- There was a countywide strategy for surgical services but not all staff were aware of it.
- There was a lack of updated action plans to address the ongoing risks on the risk register.
- Senior leaders did not have oversight of all risks, for example the lack of compliance to trust policy for venous thromboembolism screening.
- Staff told us there was disengagement between consultants, department managers and the surgical divisional leaders.
- Clinical staff said the executive team was not visible.

However:

- The governance framework had improved since our last inspection, although senior managers were not cited on all risks.
- There were regular staff meetings at all levels and information was shared with staff.
- Local department leadership was good, matrons, ward and theatre managers were visible and supportive to staff.

Leadership of service

- The surgical division was led by a divisional director, a divisional manager and a director of nursing who lead

the surgical services care division. We met some of the management team and they told us how they were dedicated to their roles and responsibilities. Various grades of staff told us there was disengagement between the department managers, consultants and divisional managers and the trust board. Some clinical staff did not feel listened too and were unaware of the plans for the surgical division, especially in relation to bed capacity and countywide emergency services.

- Each ward and the theatre department had a manager who provided day-to-day leadership to staff members.
- There were matrons for the different surgical specialities who staff said were responsive and supportive. Matrons kept staff informed of trust wide developments through ward manager meetings and provided guidance where required.
- We saw evidence of good local leadership with commitment and support from the ward managers and theatre managers. Locally, senior staff were responsive, accessible and available to support staff during challenging situations such as managing deteriorating patients or to provide support to distressed relatives.
- Junior surgical doctors reported consultant surgeons to be supportive and encouraging.
- Most staff were aware of the chief executive officer (CEO) and the chief nurse. However, junior staff said they had not seen them visit their area. Some ward managers had attended a breakfast meeting with the chief nurse, which they found useful. The meeting provided an opportunity to obtain hospital updates and share urgent messages.

Vision and strategy for this service

- The trust's values were Patients, Respect, Improve, Dependable, and Empowered (PRIDE) and most staff were familiar with these. Staff had an understanding of the values and were able to explain briefly what they meant.
- During the last inspection, plans for a countywide management of emergency surgery were not implemented. During this inspection, we found these had still not been fully implemented and some staff told us they were confused about the countywide plans such as which surgical services each hospital would provide. However, this related more to the centralisation of all in-patient emergency general surgery rather than the county wide service which had not been achieved due to a lack of capacity at Worcestershire Royal Hospital. The trust told us they had pathways in place to help mitigate any risks.
- Some senior staff raised concerns with lack of engagement, planning and decision making with the surgical leaders and trust board.
- There was a countywide strategy for surgical services but not all staff were aware of it. We saw a surgical division control plan for 2016/17, which had identified risk areas within the surgical division and priorities. This included vacancies, treatment times, compliance with fractured neck of femur pathways and theatre utilisation. Each risk had a specific action plan, for example reviewing of job plans and the recruitment of ward administrators to assist with vacancy rates and weekly monitoring of theatre utilisation.

Governance, risk management and quality measurement

- The trust had a divisional framework for governance arrangements in surgical services. During the last inspection, sharing of information was not established at ward level. During this inspection, we found this had improved in some areas and ward managers attended divisional meetings to enable the sharing of some information. However, senior leaders did not always have oversight of some risks. For example, venous thromboembolism (VTE), assessments were not done in line with trust policy. This demonstrated that the trust's governance system in relation to the management of VTE risk did not operate effectively to ensure that senior leaders and the board had clear oversight of the risk of harm to patients. Similarly, robust action following the reporting of high fridge temperatures was not evident. This shows that there are not effective processes in place to ensure that the trust policy on medicines management was being adhered to, and this had not been recognised as a risk. Senior leaders and the board did not have oversight of the risk of patients receiving medication that had been stored at incorrect temperatures.
- Surgical services had regular surgical divisional quality governance meetings with management representation from all surgical areas including consultants, matrons, and directorate managers. We saw minutes of meetings where quality issues such as complaints, incidents and audits were discussed. Each specialty within surgery

held their own clinical governance meetings. We reviewed minutes of these meetings, which included incidents, complaints, audits, policy update and training. The meetings were attended by the multi-disciplinary team and the minutes were available to those who could not attend. Surgical ward managers and sisters had meetings with the matrons to discuss, vacancies, incidents, complaints and local audits.

- The department managers held team meetings within specific wards and theatres to cascade information. We saw minutes of meetings where items such as incidents, complaints and staff training were discussed.
- The trust completed local and national audits. For example, environmental audits and compliance with the safer surgery checklist was monitored in line with the trust's policy and national standards. However, there was a lack of consistent follow-up and improvement when issues had been identified. This included VTE assessments where the trust's own audit data had indicated non-compliance.
- The trust had systems in place to identify risks. The surgical division held its own risk register and clinical leads we spoke with were able to identify the top risks. Risks included, staffing levels, bed capacity and managing cancelled operations. However, we did not see robust action plans in place to address the risks and some had been on the risk register for two years with little improvement, such as managing cancelled operations.

Culture within the service

- Staff were frequently moved to other wards when there was staff shortages to help maintain patient safety. Staff sometimes did not feel comfortable working in other areas as they felt they did not have the specific skills required such as surgical nurses caring for new acute medical patients with complex needs.
- Across all disciplines, staff consistently told us of their commitment to provide a safe and caring service, and spoke positively about the care they and their colleagues delivered.

Public engagement

- Trust board meetings were held in public and the venues rotated round the three main hospital sites. Minutes of the meetings were also published on the trust website.
- The trust held patient and public forums, were patient representatives and staff would meet to discuss working collaboratively to enhance patient experience. We saw minutes of meetings, which discussed complaints, pre-operative assessment services, patient information and the discharge process.
- The service used feedback from patients to improve services including for example the use of 'you said we did' notice boards.

Staff engagement

- All staff we spoke with were focused and committed to providing a high standard of safe care and were proud of the services that they provided.
- Within the surgical division, 49% of staff who responded to a staff survey reported work related stress and dissatisfaction with staffing levels. Action plans were in place to address work related stress by improving recruitment and retention of existing staff and improve the culture.

Innovation, improvement and sustainability

- Urological theatres had recently implemented new equipment and systems for destroying kidney stones to improve efficiency.
- The breast unit worked in partnership with a breast cancer charity, which provided free complementary therapy for breast cancer patients, enhancing patient experience.
- An internal staff bank had been commenced by theatre staff. The bank registered all theatre staff automatically, which enabled them to work extra shifts without using an agency.

At this inspection, there had been the following improvements noted since our inspection in July 2015:

- Staff were recording incidents and receiving feedback on action plans and lessons learnt.
- There was a reduction in pressure ulcers from 18 in the previous year to nine in this year.
- Our observation of practice and discussion with staff confirmed that communication had improved between the managers and staff.
- Documentation of patient care had improved including the use of the MUST tool.
- Medical outliers were reviewed regularly and nurses said they could access medical staff for advice when required.

Surgery

- There were daily consultant ward rounds, including weekends.
- The governance framework had improved.
- There was regular staff meetings at all levels and information was shared with staff and across all four hospital sites.

There were areas highlighted where there had not been any changes since our inspection in July 2015. These included:

- A lack of risk management. The risk register had captured the main surgical risks; however, there were no specific plans for most risks such as reduce the number of cancelled operations, review of bed capacity or emergency theatre utilisation.
- Vacancy rates for nursing and medical staff were still high.
- There was no clear strategy for a countywide surgical service. County wide management of emergency surgery had not been fully implemented.
- The admitted referral to treatment time (RTT) was consistently below the England average of 80%, in all specialities at 68% apart from ophthalmology, which was 86%.
- Cancellations of operations were still high at 14% compared to the national average of 6%.
- There were still high levels of unplanned medical admissions onto the surgical wards, resulting in some cancelled operations.
- There was insufficient capacity in emergency theatres.
- Patients were not always offered a choice about where they were discharged to for continuing care.
- Staff told us there was disengagement between consultants, department managers and the divisional leaders.

Critical care

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

Information about the service

Critical care services at the Alexandra Hospital consist of an eight bedded specialist unit, which is led by a clinical director and critical care Matron. The service forms part of the theatres, anaesthetic and critical care division

The critical care unit is managed in conjunction with the critical care unit at the Worcestershire Royal Hospital to provide a countywide service. This enables the service to manage the flow of patients across both sites and enables the service to flex to meet demands.

The unit can care for up to eight patients requiring intensive care (level three) or high dependency care (level two). Level three refers to patients requiring multiple organ or advanced support such as respiratory ventilation, whereas level two care refers to patients requiring support for a single organ such as renal replacement therapy. Patients were admitted to the unit for treatment and care following complex operations or following a clinical emergency.

In addition to the critical care beds, the service managed the critical care outreach team, who provided support across the hospital for the management and monitoring of acutely unwell patients. The service was operational between 7.30am and 8pm daily.

The service admitted 406 patients from November 2015 to November 2016.

We previously inspected the service in July 2015 and found that safe, effective, caring and well-led were rated as good and responsive rated as requires improvement.

During inspection, we found three inpatients on the unit, one of which was discharged within the first half hour of arrival on the unit. This limited the availability of patient records for inspection but enabled us to observe additional activities such as ad hoc training.

During inspection, we spoke with a range of staff, including consultants, different grades of nurses, healthcare assistants and a member of the housekeeping team. We met with the clinical leads for the service at the Worcestershire Royal Hospital although spoke with the Matron during our visit on site. We met with a patient who was able to talk, checked the clinical environment, observed care and looked at records and data.

General critical care services provided by this trust were located on two hospital sites, the other being Worcestershire Royal Hospital, Worcester. Services at the Worcestershire Royal Hospital are reported on in a separate report.However, one critical care management team ran the critical care services on both hospital sites. As such, they were regarded within and reported upon by the trust as one service, with many of the staff working at both sites. For this reason it is inevitable there is some duplication contained in the two reports.

Critical care

Summary of findings

Overall we rated the service as good because:

- There was a positive safety culture. Staff recorded incidents, investigations were completed and staff received feedback. The service had a robust safety briefing in place, which was attended by all staff.
- Staff maintained and monitored patient safety for infection control, patient's harms and risks using national and local audit tools and developed action plans to address any findings.
- Patient records were contemporaneous, legible and stored safely. Evidence based assessment tools were used to monitor risk.
- Mandatory training was generally in line with trust targets.
- Medications were stored, prescribed and administered safely. There were systems in place to monitor safe storage and staff took appropriate actions in line with local protocol to address any concerns or anomalies.
- The service used evidence-based guidelines, policies and protocols to monitor patient outcomes. Results were used to compile service dashboards, which were used to present audit results and monitor trends. Clinical leads reviewed these for compliance and trends and discussed results as part of the divisional and trust wide service meetings.
- The service had a flexible approach to delivering patient care across both critical care units (Alexandra and Worcestershire Royal Hospitals) to maintain patient safety.
- Patient outcomes were used to benchmark the service against similar organisations to identify areas for improvement.
- The service had access to additional specialists such as pain specialist nurse, dietetics, microbiologists and pharmacy.
- Staff competence was monitored and maintained through annual appraisal and competency reviews. External training was available for staff.
- There was evidence that the multidisciplinary team was inclusive and well organised.
- Patients were treated with dignity and respect, and in line with their individual beliefs and were involved with the care and treatment planning. Patients spoke positively about the care they received.
- Relatives had access to facilities to enhance their stay on the unit; this included overnight accommodation, refreshments and information leaflets.
- Patients were assessed appropriately for admission to critical care and received a full review by a consultant within 12 hours of admission to the unit.
- There were no formal complaints regarding the service.
- The service was well-led with strong local leadership, a service vision and robust governance systems in place.
- All staff were positive about their roles, enjoyed working for the service and were dedicated to improving the standards of patient care.

However we also found that:

- There were a small number of delayed discharges from critical care, which affected patient flow and experience.

Critical care

Are critical care services safe?

Good

We rated safe as good because:

- There was a positive safety culture, with staff escalating concerns appropriately. Incidents were reported, investigated and learning shared across the clinical team. Safety briefings were completed daily.
- The service had positive safety thermometer data, which showed no patient harm. Audit results were shared with the team.
- Staff maintained safe infection control and prevention practices and used personal protective equipment appropriately and carried out regular auditing to monitor compliance.
- There were processes in place to ensure that medicines were stored and administered safely in line with guidance.
- Patient's records were found to be complete, with details of author, treatment plans and diagnostic results. Records were contemporaneous and stored securely.
- Staff received mandatory training and the unit was compliant in seven out of nine mandatory topics.
- Staff used evidence based assessment tools to monitor patient's condition and assess risks. Audits were completed to ensure compliance and reported on dashboards, which were reviewed, by clinical leads and the trust board. The service completed and reported on the use of the national early warning scores across the trust.
- The service provided a trust wide nursing and medical team, which enabled staff to work between the Alexandra Hospital and Worcestershire Royal Hospital to maintain safe staffing levels for the number of inpatients at each site.

However:

- There was a small amount of evidence to suggest that patient epidurals were not always managed effectively.

Incidents

- The safety performance of the service was good, with evidence that staff reported any incidents, low numbers of unit acquired infections and errors leading to patient harm. During our previous inspection we identified that the service was categorising incidents incorrectly with some classed as "near misses" when the reports showed that incidents had actually occurred. During this inspection, we saw that there had been four near misses reported from September 2015 to August 2016. Two near misses referred to issues with staffing, one referred to broken emergency drug ampoules and one to a delay in referral. On review of the incidents reported, all could have been determined as near misses, due to no patient harm being sustained.
- Staff were aware of their roles and responsibilities to raise concerns, report incidents, concerns and near misses. There were 52 reported incidents from October 2015 to September 2016. The two main categories were bed management (14) and pressure tissue damage (such as pressure sores) (14). The remaining incidents reported related to topics such as patient falls (2), medication administration (2) and security (1). During the same period, no incidents were categorised as a serious. One incident was categorised as moderate and referred to threats being made to a member of staff by a visiting relative when police were called to intervene. A further 27 incidents resulted in minor harm such as pressure tissue damage, patient falls, accidental line removal and a broken unit door lock.
- Service data confirmed that there had been no never events from October 2015 to September 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic barriers are available at a national level, and should have been implemented by all healthcare providers.
- Consultants led a daily safety briefing on the unit which included an overview of patients, planned activity and any incidents or NHS patient safety alerts. The consultant followed a set agenda. We saw that the medical team, the critical care outreach team, unit nurse in charge and the physiotherapist, attended the meeting. Staff were encouraged to discuss any concerns or investigation outcomes.
- Nursing staff told us that they recorded any incidents on the hospitals electronic incident reporting system and in the patients notes; however, we did not see this during inspection.
- The service completed two safety meetings per month. The critical care governance forum reviewed issues relating to patient safety, patient safety alerts, mortality

and morbidity and changes to guidelines. Meeting minutes were detailed with evidence of discussion and actions. Minutes were shared across the team to ensure staff were aware of issues discussed.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.
- Staff understood their responsibilities with regard to the duty of candour legislation. Staff told us that incidents and mistakes were openly discussed within team meetings and at safety briefings to ensure key learning was cascaded across the team. However, we did not see any examples of where duty of candour had been used.
- Nursing and medical staff were fully aware of the duty of candour and described a working environment in which any mistakes in patient's care or treatment would be investigated and discussed with the patient and their representatives and an apology given whether there was any harm or not.

Safety thermometer

- The services completed the monthly point prevalent safety thermometer audit, which is a national audit, which captures patient harms on one specific day each month. The audit captures harms associated with new pressure ulcers; patient falls with harm, urinary infections and venous thromboembolism (deep vein thrombosis). Service data confirmed that there had been no patient harms from September 2015 to September 2016.
- In line with best practice, we saw that safety thermometer data was displayed for staff and visitors to view in the main corridor. Historical data remained on display to enable staff to observe trends.

Cleanliness, infection control and hygiene

- The service had systems in place to prevent and protect people from a healthcare associated infection. This included robust cleaning schedules, auditing and monitoring.
- Rates for unit-acquired infections were low. Service data supplied to the Intensive Care National Audit and Research Centre (ICNARC) supported this evidence. All rates of infection had been better than the national average over the past five years.
- We saw that the services audited compliance against cleaning schedules and trust policy for areas such as uniform, hand hygiene and surgical site infections. Data was displayed for staff to review. Data collected confirmed that critical care achieved 100% compliance in all infection control audits from April 2015 to October 2016. This data was displayed for staff and visitors to view in the main corridor.
- We observed staff completing thorough cleaning of equipment after a patient discharge. Nursing staff cleaned all equipment such as pumps and ventilators, prior to the domestic team attending to clean the environment. Nursing staff confirmed that they were responsible for completing the initial bed space clean and cleaning equipment. The domestic team then completed a deep clean and changed the curtains. Once this was completed, the bed space was prepared for the next admission.
- Staff used "I am clean stickers" to identify equipment that had been cleaned ready for use. We saw equipment in storerooms labelled or sealed in bags to ensure they did not become soiled whilst waiting to be used.
- All staff were observed wearing personal protective equipment (PPE), such as aprons and gloves for all patient centred activity and contact. Nursing staff were observed washing their hands after the removal of gloves and disposing of PPE in the appropriate bins.
- We saw that all staff washed their hands before and after patient contact, and before completing any other tasks. Staff were observed using hand gels when entering and leaving the unit and between patient bed spaces during the ward round.
- Nursing staff has access to colour coded aprons for activities in line with trust policy. This included green aprons for issuing food and white aprons for patient contact. We did not see coloured aprons in use during our inspection.
- Patients with suspected communicable infections were nursed in side rooms. Critical care had two rooms with laminar flow capabilities; however we saw that the

doors contained large openings for ventilation. This was not identified specifically on the service risk register, however, the register does detail estates improvements required to meet requirement.
- There had been no MRSA cases attributed to the service since May 2015.
- Examination of patient records confirmed that MRSA screening was completed on admission and rescreened weekly.

Environment and equipment

- The critical care unit was on the first floor of the hospital, situated in close proximity to the theatres. The unit provided up to eight bed spaces (including two side rooms). Each bed space had an individual sink, nursing desk and equipment trolley. There was sufficient room at each bed space for additional equipment and staff to attend patient's needs, although the size of bed space did not meet recommendations.
- The Health Building Note (HBN) 04-02 Critical care units, sets out the requirements for location and environmental features of critical care units and can be used to assess the suitability of services environments. The clinical lead for critical care completed an HBN 04-02 audit in February 2016, which identified that the service was compliant with 35 out of 65 reference points. The service was non-complaint with 15 reference points including the size of bed space, no ceiling pendant for equipment and no wall mounted dialysis water. The service was partially compliant with a further 10 reference points including access to equipment such as tilting chairs and the ability to adjust ambient temperature. Five reference points were not applicable to the service. Audit results were shared with the clinical leads and partial and non-compliance reference points placed on the service risk register.
- Patient observation charts required equipment and environment checks to be recorded three times daily (each morning, afternoon and at night). For example, oxygen, suction, the ventilator, monitors, pumps, the bed and patient bed space were checked for different safety elements. Pumps were checked to ensure that they had an electrical supply and alarm settings were set correctly plus whether they were clean and within service date.
- All equipment was stored locally to enable access when required. We saw that the storeroom was secure and well organised. We were told that all equipment was serviced annually to ensure that it was suitable for use. This included the servicing of specialist equipment by the manufacturer. However, we did not see any stickers on equipment that confirmed this. We saw that one manufacturer had planned attendance in all clinical areas to complete maintenance work. The maintenance log for equipment in critical care referred to all equipment across both hospital sites, this contained details of serial numbers, date of servicing and expiry.
- Each staff member received training in equipment used across the service and we saw training taking place and competencies confirming individual's abilities. To promote safety, the service had introduced the same equipment across both sites. This meant that when staff worked at the Worcestershire Royal Hospital, they were familiar with equipment used. The exception to this was the monitors, which were manufactured by different companies, but worked similarly. We were told that a business case had been prepared requesting the provision of the same monitors on both sites.
- Nursing staff told us, that equipment was occasionally shared between the Alexandra Hospital and the Worcestershire Royal Hospitals critical care units. During periods of high activity on one site, equipment was transferred between sites using secure transport.
- The service had systems in place to manage waste. We saw that single use items were disposed of appropriately in either clinical waste or sharps bins. All staff used appropriate clinical and general waste bags that were segregated and removed at regular intervals by the domestic team. Domestic services were contracted to another provider.
- All sharps bins were assembled and labelled correctly with the date, time and name of assembler. Sharps bins were secure, elevated on stands, and found to be below the recommended fill level.
- We saw that equipment on the resuscitation trolley was not secure, although due to its location and nature of the unit, unauthorised access would be difficult. Medication and intravenous fluids were accessible in sealed paper or bags. The resuscitation council suggests that medication can be stored in this manner providing they are sealed, tamper evident paper or bags. This meant that the service was compliant with guidance.

- We saw that all clinical areas completed daily checks of emergency equipment. The exception to this was the paediatric emergency trolley on critical care, which was checked monthly. The policy relating to this was requested, but not provided by the trust.
- The service attended the medical devices meetings, which were held every two months. We saw minutes from the July 2016 meeting, which included details of equipment purchases, training needs, appliance testing and including details of sharing information in the patient safety bulletin and intranet.
- The service maintained an equipment replacement log, which we saw during our inspection. Equipment was identified by serial numbers and a log maintained detailing the date of service, date for next service and planned date for replacement.
- We saw that the unit was secure with key code access door and CCTV cameras. We saw that all doors were locked and staff did not permit any tail gating checking identity prior to allowing admission.

Medicines

- The service had systems in place for ensuring the safe management, prescribing and administration of medications. We reviewed two medication prescription charts and found them to be legible. All charts were appropriately labelled and detailed patients consultant, weight and allergies. We saw that all medications had been given as directed or appropriate records were completed to detail reasons for omissions.
- All medications were stored securely in locked cupboards within the locked treatment room. Intravenous fluids were stored on raised shelving or in locked cupboards. The treatment room was located behind the nurse station with two entrances from behind the unit corridor. A large window looked out onto the nurse station and across the whole unit enabling patients to be observed when medication was being prepared.
- Controlled medications (those requiring extra checks and special storage arrangements) were stored in a locked cupboard. Staff maintained a controlled drug record, which detailed stock levels, usage and any wastage. We saw that the stock level was checked daily by two nurses and audited quarterly by the pharmacy department staff. We cross-referenced usage of controlled medication against patient prescription charts and saw that these accurately reflected each other.
- There were two medication fridges in the treatment room. The fridge containing medications such as eye drops, oral supplements was locked. However, the fridge containing the emergency medications was not locked. Nursing staff reported that this was to prevent possible delays in accessing emergency medication whilst locating keys. Fridge temperatures were checked and recorded daily. Three months data showed that the temperature had been consistently within recommendations with one exception. On one occasion, the upper fridge temperature reading had been recorded at 17 degrees Celsius. We could not see any evidence that actions had been taken, although the temperature was recorded within normal limits for all following occasions. On discussion with the matron, we were told that staff followed the protocol for raised temperatures, which identified the resetting of the temperatures and continued monitoring. We saw that the printed protocol was displayed on each fridge.
- Since our last inspection, critical care staff had commenced the daily recording of the ambient treatment room temperature. We saw three months of data and saw that actions had been taken to address fluctuations on any occasion that the temperature was elevated. This included increasing the ventilation and using fans.
- A designated pharmacist was allocated to critical care. They attended the unit regularly to assist with treatment planning and medication reviews. We saw the medication stock being reviewed during inspection. This enabled a top up of regularly used medications.

Records

- Nursing staff used a standardised format to record patients care and treatment. Staff used a large daily patient proforma, which detailed assessments of clinical condition, blood results, patient agitation scores and care plans. The nurse caring for the patient completed the proforma with details of clinical observations and any interventions. All records were legible and found to be up to date with contemporaneous data entries.
- Consultants used yellow paper to record their notes which enabled identification of critical care documentation. Medical notes were held separately and

were stored at the patient bed space, in a drawer to enable access in an emergency. Although the notes were not locked in cupboards, access to the unit was by request, and patients supervised at all times, which would prevent any unauthorised access.

- Medical notes confirmed that patients were reviewed a minimum of twice daily. We saw that records detailed clinical assessments and treatment plans devised during each review. All patients' records demonstrated personalised care and multidisciplinary team input. Data entries were in chronological order and were signed dated and detailed staff contact numbers.
- We saw that patient's notes included decisions regarding admission to the critical care unit and ceilings of treatments. This was in line with the National Institute for Health and Care Excellence (NICE) guidelines: acutely ill adults in hospital: recognition and response to acute illness in adults in hospital. There was also evidence that the decisions were discussed with family members as close to the time of decision as possible.
- We saw that computers were not visible from patient's bed spaces and screen savers were used to prevent unauthorised persons from seeing personal identifiable information.
- We were told that the service completed record keeping audits however; we did not see evidence of their completion.

Safeguarding

- Staff had access to the trust policies and procedures for the management and escalation of suspected safeguarding concerns. This included a local lead contact number. Safeguarding posters were also displayed across the site detailing contact numbers for relevant team members.
- With the exception of one consultant, staff within the service did not complete safeguarding children level 3 training which was not in line with the Royal College of Paediatric and Child Health (RCPCH) guidelines or the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for the assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.
- The trust provided staff with mandatory online safeguarding adults and safeguarding children level two training. This was the recommended level of training for staff who have contact with patients and is designed to enable staff to identify anyone who is vulnerable and details on how to escalate concerns. Safe child training had been completed by 89% for nursing staff, and safe adult training completed by 100% of nursing staff.
- Staff we spoke with were able to describe incidents that would prompt them to consider a referral to the safeguarding team. They were able to demonstrate how to access the trust intranet and report an issue to protect the safety of a vulnerable patient.
- Critical care did not admit children under the age of 16 and all cases were transferred to a specialist hospital. In an emergency, the on call consultant would assist with the management of a sick child whilst waiting for the specialist team to collect the child. However, we found one reported incident that referred to a 13-year-old patient being cared for on the unit due to delays in collection by the specialist hospital. The incident does not state if the patient was ventilated, but indicates that the transfer to critical care was for patient safety after a long period waiting for the collection team. No harm to the child was recorded as a result of this incident.
- Trust data confirmed that the service admitted six, 16 to 18 year olds from November 2015 to November 2016.
- The trust did not provide female genital mutilation (FGM) training. Staff we spoke with were aware of FGM, but this was through individual professional development.

Mandatory training

- The service monitored mandatory training compliance across both the Alexandra and Worcestershire Royal Hospitals. This was in response to the service providing a trust wide service.
- The trust had nine core mandatory training topics, which included clinical and non-clinical skills. Training included topics such as basic life support, infection control and prevention, manual handling and health and safety. Trust targets for compliance were 90%.
- Critical care achieved compliance with all training with the exception of information governance (87%) and health and safety (75%). We were told during inspection that staff were aware of the needs to complete their mandatory training and attendance had been planned.
- All consultants and nursing staff were trained in advanced life support and paediatric life support.

- Training records were updated every two weeks, and were displayed in the unit office. Staff received an automated email-detailing expiry of training three months prior to expiry date. This enabled staff to plan training sessions and maintain compliance.
- All staff completed an induction-training programme when they commenced post. Following the trust induction, staff were offered a period of supernumerary practice which enabled them to familiarise themselves with the unit, local processes and policies. This was usually completed for four weeks, but could be flexed according to experience and abilities. Throughout this period, staff were allocated mentors/ supervisors who assisted with assessment of skills.

Assessing and responding to patient risk

- Ward rounds were conducted twice daily, in the morning and evening, and led by the consultant on duty. There was input to the ward rounds from unit-based staff including the doctors and the nurses caring for the patient. The senior nurse (sister or charge nurse) would attend the whole ward round.
- Patients were closely monitored to enable a response to any deterioration. Staffing levels were in line with recommendations. Patients classified as needing intensive care level three, were nursed by one nurse for each patient. Patients classified as requiring high dependency care, level two, were nursed by one nurse for two patients. Where possible nurses would be placed with the same patient throughout the patient's stay to ensure consistency.
- Staff completed comprehensive risk assessments based on national guidance for all patients. This included venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- We saw that VTE assessments were recorded on admission to hospital. A tick on patient's drug charts and records within the clinical assessment documentation evidenced this.
- The majority of patients within the critical care unit required respiratory support for an underlying clinical condition. Ventilation was provided using specialist equipment, which included non-invasive ventilation through a mask or hood for awake patients and full ventilation for sedated unconscious patients. Full ventilation was performed using either an endotracheal tube (tube from the mouth or nose into the lungs) or a tracheostomy (a tube inserted into the windpipe), usually used for patients requiring longer periods of respiratory support. We saw that ventilation was assessed regularly and changed according to patients clinical conditions. Nursing staff recorded ventilation checks a minimum of hourly noting any changes when they occurred. We saw that any changes were recorded and discussed with the doctor.
- The consultant intensivist on duty would review any potential patients prior to admission to the unit. Admissions were generally planned following operations; however, the unit did admit patients following an emergency or sudden deterioration in condition. Patients across the hospital who were deteriorating were referred to the critical care outreach team. The team worked trust wide and had one staff member on site from 7.30am to 8pm daily. Out of hours, referrals were managed by the hospital at night team.
- Critical care outreach staff tracked all critical care discharges to ensure stability on discharge to the wards. This was particularly important, as there was no high dependency units based at the Alexandra hospital. The outreach team supported ward staff with the management of acutely unwell or deteriorating patients' offering advice and completing investigations to determine clinical condition. Where necessary the outreach nurse would liaise directly with the consultant on call for critical care, however all referrals for admission were consultant to consultant.
- At night, the critical care outreach team handed over the service to the hospital at night team. All patients identified as being acutely unwell or at risk of deterioration were discussed along with any staffing or capacity issues that may affect patient care. The service did not use an electronic patient handover process. We were told that the hand over was conducted to the whole night team, although we did not see this in practice.
- Since the last inspection, the trust had introduced the National Early Warning Scores (NEWS) system for monitoring patients in line with NICE guidance CG50. This system enabled the recognition of deteriorating patients through point allocation to clinical observations such as blood pressure and pulse. The NEWS charts outlined actions to be taken for abnormal readings and escalation processes. The service completed a trust wide NEWS audit, which was reported

on the unit dashboard, reviewed by the service leads, and escalated to trust board. Ward sisters were required to complete action plans to address any non-compliance and the audit repeated.

- The trust had implemented a sepsis bundle in September 2016. Patients with a suspected sepsis were treated in line with national guidance and a sticker was inserted into medical notes to highlight the pathway. To assist with awareness, the critical care outreach team told us that they had introduced sepsis awareness as part of all training programmes completed by the team. We did not see this during inspection.
- There was a process in place to monitor the use of antibiotics. A sepsis pathway had been introduced and patients identified as having suspected sepsis were commenced on a standardised treatment regime. This included commencement of antibiotics within 2 hours of diagnosis, discussion with microbiology and continued monitoring. Antibiotics were reviewed after 72 hours of commencement. We saw that drug charts detailed when reviews should take place however; as neither inpatient was receiving antibiotics at the time of inspection, we did not see this in use.
- We saw that nursing staff were quick to respond to alarms from equipment and check patient's condition. We saw that any changes were escalated to the nurse in charge or consultant.

Nursing staffing

- The matron ensured that staffing levels were in line with requirements to meet the demand of the service and national guidance for level two and three patients. Nurse staffing were moved between the Alexandra and Worcestershire Royal Hospitals critical care units to maintain safe staffing levels on both sites. The service found that it was beneficial to patients if staff moved rather than transferring patients, between sites. To facilitate this, the roster was highlighted in advance, to identify staff members that may be required to move if activity was higher in the Worcestershire Royal Hospital. The move was confirmed prior to the shift to ensure that staff attended the right location for their duty. This process enabled staff to move across the service to meet the demands at any point. Nursing staff told us that they did not mind working between two sites, and transport was provided for those who did not have access to a car.
- Duty rosters were completed for the whole service. We saw that the roster was updated regularly with any changes and accurately reflected the number of staff on duty. The previous three months off duty was reviewed and confirmed that staffing numbers were maintained and met the Guidance for the Provision of Intensive Care Services 2015. Staffing was in line with the core standards throughout the inspection with level three patients (intensive care) cared for on a one to one basis, and level two patients (high dependency) had one nurse for two patients.
- The vacancy rate for critical care nurses was 6%. There was a 3% sickness rate, which was in line with the trust upper limit.
- The service did not use bank or agency staff, with substantive staff members choosing to either move their shifts or completed additional hours to maintain ward cover. Off duty and trust data, confirming nursing fill rates confirmed this. We saw trust data confirming that the staffing levels on critical care were maintained at 100% from May to August 2016.
- The nurse in charge completed a verbal handover to the next shift at the end of the working day. All oncoming staff attended a handover in the staff room on the unit. This handover included the patients name, age, diagnosis and any changes in condition or planned activity. Once this was completed, nurses were allocated a patient (or patients if level 2), and then received a detailed handover about their allocated patients by the patient bedside. The nurse in charge received a detailed handover for all patients following the initial shift handover and maintained a written record of the details. We did not see the nursing handover at the Alexandra hospital, although were told that the process was the same across both sites.
- Nursing staff used a discharge checklist to facilitate the discharge process from critical care. The nursing, critical care outreach and therapy staff jointly completed this. The checklist had been devised by the team to enable accurate records of clinical condition, treatments and details of follow up care. We saw this checklist in use across the trust.
- We observed and were told that the nurse in charge of the critical care unit was always supernumerary to numbers, which enabled them to coordinate activity

and offer support to staff when activity increased. During our inspection, the nurse in charge was seen contributing to the medical ward round, covering staff breaks and assisting with staff training.

- The critical care outreach team provided a trust wide service and consisted of one band seven nurse and a small team of band six nurses. Posts were substantive and did not rotate into critical care, however, we were told that critical care staff had the opportunity to rotate out of critical care into the outreach service. The band 7 would attend both the Alexandra and Worcestershire Royal Hospitals during their working week whereas the band 6 nurses were rotated between sites at monthly intervals to ensure that all staff experienced the variety of care provided at each location.
- The service had a dedicated physiotherapy team who attended the unit daily to assist with the management of patients and the completion of therapies including chest physio and passive movements.
- A pharmacist visited the critical care unit regularly to assist with the planning of medications and treatment.
- Patients were continuously monitored to enable any changes in clinical condition to be identified immediately.

Medical staffing

- The service had 16 designated consultant intensivists (consultants trained in advanced critical care medicine) who completed a trust wide service covering the Alexandra and Worcestershire Royal Hospitals. The level of experienced consultants in critical care was in line with the Faculty of Intensive Care Medicine (FICM) recommendations and promoted continuity of care. From Monday to Friday, one consultant provided cover during the day from 8am to 6pm. A registrar and junior doctor supported them as part of rotational posts.
- Out of hours, a designated consultant was responsible for the service, supported by another consultant on call. The service had a resident medical officer core trainee (year two or above) who was also supported by the on call anaesthetic team for clinical emergencies. The critical care on call service was not responsible for any other services across the trust, which met the Intensive Care Society standards. Consultants were accessible to attend the unit within 30 minutes of a call for assistance.
- Weekend cover was provided by one on call consultant who attended the service during the day and provided on call support out of hours. Medical staff told us that weekends were often split into Saturday and Sunday on calls.
- The service reported that there were two consultant vacancies at the time of inspection, however this did not affect patient care or service provision as current staff covered any gaps in service cover.
- In line with recommendations, critical care did not have any foundation year one-trainee doctors working outside normal hours. This enabled junior doctors to complete training and supervised practice. During the week, there was a specialist registrar on duty with a foundation year two doctor or other specialist registrar. This reduced to one registrar supported by the consultants out of hours and at weekends. The doctors completed 12 hours shifts from 8am to 8pm or 8pm to 8am. The specialist registrar would also attend any emergency calls across the hospital. Although the registrar was supported by the on call, consultant and anaesthetist this was below the recommended safe staffing levels.
- We observed the medical staff handover. This was found to be robust, with systems in place to ensure relevant information was shared. The consultant completing the handover used a template, which detailed areas to be discussed, which included patients' treatments, any local or trust news, details of pressures such as staffing and bed availability, incidents and any feedback or alerts. Ward rounds were completed a minimum of twice daily, which was in line with national guidance. Handover was completed at the patient bedside, and led by the consultant. All staff were involved with the patients care and were able to contribute to discussions, including junior doctors, nurses and allied healthcare professionals.

Major incident awareness and training

- The trust had a major incident policy, which was accessible to staff on the trust intranet.
- Staff within critical care were able to detail what actions should be taken in the event of a major incident. Action cards were available for staff to use in the event of a major incident.

Are critical care services effective?

Critical care

Good

We rated effective good because:

- Care was provided for patients in line with evidence-based practice, with where possible, policies and procedures based on current guidance.
- The service had close links to the pain specialist team, who tracked patients from admission to critical care to discharge from the unit and resolution of symptoms.
- Nutrition was regularly assessed using national tools, with additional support being provided by nutrition specialists.
- Patient outcomes were monitored and benchmarked against other organisations. Audit results were as expected.
- All staff were competent to complete their roles, with additional training and support through designated practice development nurses, external training and supervised practice.
- The service showed strong multidisciplinary team working, which was inclusive and well organised.
- The service provided seven-day care, with access to specialists and diagnostics out of hours and at weekends.
- Information was readily available for staff to support treatment planning. This included access to patient records, diagnostics results and medical and nursing notes.
- Staff were aware of the Mental Capacity Act (2005) and were able to describe situations where capacity needed to be assessed.

Evidence-based care and treatment

- Patients' needs were assessed on admission and their care planned in line with best practice and national guidance. Critical care admitted patients according to their needs and within timescales outlined within guidance from the Department of Health and Faculty of Intensive care Medicine (FICM). The service policy outlined the processes for elective and emergency admissions, transfer between departments and guidance on caring for patients.
- Patients were treated without discrimination through the use of staff training and policies assessed and approved for equality and diversity. This included no barriers to patients on the grounds of age, disability, gender, race, pregnancy and maternity status, religion or belief and sexual orientation. There was no evidence of any discrimination on any grounds when speaking with nursing and medical staff.
- We saw that the service had a number of standards, which related to staffing (nursing, dietetics, medical and therapists) and operational standards. These outlined actions to be taken to ensure safe evidence based practice, for example the use of a standardised approach to the identification of a deteriorating patient through the use of the national early warning score system, and admission to critical care within four hours of decision to admit.
- The service followed the trust policy for suspected sepsis. Patients with suspected sepsis were discussed with the microbiology team and reviewed regularly for effectiveness. First choice antibiotics were accessible.
- We saw that the patient's daily record had been amended to include a delirium score, which was completed for all awake patients. This was in line with the core standards for intensive care (2013) guidance that requires all patients to be screened on admission for delirium.
- The pain service had amended and introduced the Abbey Pain Scale for patients with delirium or dementia across the trust. This is a national tool that enables the identification of pain through patient appearance or behaviour and not reliant on vocalised complaints.
- The service contributed to a number of internal and external audits, which included data collection for the Intensive Care National Audit and Research Centre (ICNARC). A designated ICNARC data clerk uploaded collected information onto the national database. This process enabled the service to track activity, quality of care and compare results to similar organisations. Data collected from April 2015 to March 2016 showed that the trust performed in line with England average and as expected.
- We saw action plans relating to the development of standards across critical care. This included an action plan relating to medical and nursing staffing, operational standards and therapy and dietitian standards. The action plans were robust and based on national guidance. We saw that these were regularly reviewed and actions had completed.
- The service did not provide a designated follow-up clinic, staffed by doctors and nurse who work within

critical care. This was not in line with NICE CG83 standards. The service offered patients a follow up telephone call after three months of discharge. The critical care outreach team using a template questionnaire completed these. We did not see any completed templates during inspection. The service had no current plans to develop the service further.

- Critical care staff followed NHS guidance for monitoring sedated patients. Sedation is necessary to help deliver care safely and try to ease patients though a distressing time. Maintaining light sedation in stable adult patients has shown advantages to patient outcomes, their length of stay, evaluation of neurological conditions, and reduced levels of delirium. Critical care staff assessed patients daily using the Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the assessment of patient responses, such as alertness (scored as zero) and then behaviours either side of that (positive scoring) to levels of sedation (negative scoring). Any scores below the baseline of zero (or below the score outlined by the prescribing doctor) would indicate the need for a discontinuation of the sedation infusion (termed a 'sedation hold') to monitor the patient's response. Sedation was then withdrawn, continued or adjusted dependent upon how the patient reacted. Results were recorded on the patient's daily chart and in their notes. The policy followed best practice and referred to research and guidance to provide the optimal level of sedation for the patient in all circumstances.

Pain relief

- The pain specialist team were based within the critical care unit, which enabled all patients to be assessed prior to discharge and tracked on the main hospital wards. The service had a medical clinical lead and was supported by a band 7 nurse. Since our previous inspection, the team had implemented a number of changes, which included a trust wide administration charts for patient controlled analgesia and epidurals. The team had also developed a teaching and pain competency package, which was in use across the trust. The service was available daily from 8am to 8pm.
- We saw that pain was assessed regularly using a standard pain scoring tool. Patients received regular analgesia as prescribed. Nursing staff responded to complaints of pain quickly and we saw evidence of referrals to the pain specialist team for additional support.
- We reviewed service data and found that there were two reported incidents relating to pain management. One referred to an epidural being stopped and disconnected by theatre staff without alternative analgesia being administered prior to transferring the patient to critical care. The second incident referred to an epidural, which was not being monitored in line with best practice, resulting in ineffective pain control. Staff reported that this incident was escalated upon admission and pain control managed effectively. The pain control specialist nurses were completing training with staff to ensure they were aware of safe practice with epidurals.

Nutrition and hydration

- The service had appropriate policies, support and guidance to ensure that patients received specialist-feeding regimes safely.
- All patients were assessed for the risk of malnutrition using the Malnutrition Universal Screening Tool. We saw that initial screening was completed on admission, and then repeated at regular intervals.
- Patients identified as being at risk of malnutrition were referred to the dietitian who attended the units regularly. The dietitian assisted with the planning and implementation of feeding regimes for nasogastric feeding (tube inserted into the stomach via the nose) or artificial intravenous feeding. The dietitian worked closely with the multidisciplinary team, which was in line with Guidance for the Provision of Intensive Care Services 2015.
- Nursing staff used an evidence-based protocol for the administration of nasogastric feeding, which could be commenced prior to an assessment by the dietitian. This enabled patients to receive nutrition upon admission and not wait until a full assessment had been completed.
- Staff were competent at administering intravenous fluids. We saw nursing staff assessed patient's fluid balance and hydration status, taking into account electrolyte results and discussing changes to treatments accordingly. This met the requirements of the National Institute for Health and Care Excellence (NICE) QS66 statement 2: Intravenous therapy in hospitals.
- We saw two patients' records and found that all fluid balance charts were accurately recorded with hourly data entries.

- Patients who were awake and able were offered oral fluids and diets in addition to any intravenous fluids. A meal of choice could be accessed from the kitchens.

Patient outcomes

- Around 95% of adult, general critical care units in England, Wales and Northern Ireland participate in ICNARC the national clinical audit for adult critical care; the Case Mix Programme. Following rigorous data validation, all participating units received regular, quarterly comparative reports for local performance management and quality improvement. Critical care had a designated data clerk, who collected performance and outcome measures for critical care patients and uploaded information into the database.
- The ICNARC annual report for 2015/16 showed that the service performed as expected or slightly better than similar organisations in all indicators. This included the number of high-risk sepsis admissions, unit acquired blood infections, out of hours transfer, bed delays, unplanned readmissions and non- clinical transfers. Non-clinical transfers are those that are performed due to the lack of bed.
- The ICNARC 2014/15 annual audit reported that the risk adjusted hospital mortality ratio for the Alexandra Hospital critical care unit was 0.8, which was within the expected range.
- The ICNARC 2014/15 annual audit data reported that for the Alexandra Hospital critical care unit, mortality ratio for patients with a predicted risk of death less than 20% was 0.5, which was within the as expected range.
- The service had a robust annual audit programme for evidence based national care bundles. This included monthly audits for the safe placement and maintenance of invasive lines, such as peripheral, arterial and central cannula, urinary catheter, enteral feeding care and ventilation associated pneumonia. We saw audits displayed showing 100% compliance in all topics for July to October 2016.
- The service completed the national care bundles audit (evidence-based procedures) monthly. This audit enabled the service to evaluate the effectiveness of care delivery. We saw audit data referring to the care and management of central, peripheral and renal dialysis catheter lines, surgical site infections, ventilator-associated infections, wound care and enteral feeding. Audits were completed monthly and showed 100% compliance from April 2015 to October 2016.Audits and results were displayed in the unit corridor.

Competent staff

- Staff within the service had the appropriate skills, qualifications and knowledge to complete their roles safely. Staff commencing new roles were expected to complete a trust wide induction programme, which included all mandatory training. A local induction consisted of a four-week supernumerary period. Staff were issued with competency handbook, which were based on the critical care network competencies. These included theoretical learning of physiological systems, and observed practical assessments. Staff were supported to complete the competencies.
- Critical care had three designated practice development nurses (PDN) who worked across both sites to assist with staff training. We saw posters detailing planned training sessions and saw an ad hoc training session completed on the unit during inspection. This was in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- In addition to supporting competencies, the PDNs offered planned and ad hoc training sessions. Training was developed and offered to staff within critical care and across the main hospital. Training topics included clinical skills such as ventilation methods, sepsis and analysing blood results. This was in line with the GPICS. During inspection, the outreach nurse completed trust wide training on respiratory support. All planned training events were advertised.
- We saw that over 57% of nursing staff had gained the post registration award in critical care nursing which was in line with the GPICS. Additional nurses were booked to attend the course in the near future.
- Junior doctors reported that they were supported to learn during their placement within critical care. They reported that practice was supervised appropriately and they were involved with personal development plans to enhance their experience.
- Critical care outreach staff were trained to complete extended roles, such as requesting x-rays, male catheterisation, advanced life support, patient transfer training and arterial blood gas sampling. These skills were competency based or completed in line with training programmes.

- We saw that staff were assessed annually for their competency, skills, and development. This was completed in conjunction with annual staff appraisals. Staff were aware of the appraisal system and who was responsible for performing and completing the review. Appraisal dates were recorded electronically. Reports could be produced at any time and this included a list of all staff who were due for appraisal. Critical care nursing staff had 98% compliance with annual personal development appraisals. The trust target was 85%.

Multidisciplinary working

- We saw that all necessary staff were involved with the planning, assessing and delivery of patient care.
- Consultants led the daily multidisciplinary team meetings which included open discussions of patient condition and planned treatment. We saw that staff were able to raise any concerns or ideas openly. Throughout our inspection, we saw the consultants on call communicating with all staff to achieve the best possible care for individual patients.
- The unit had designated physiotherapy and occupational therapy staff who assisted with the management and treatment of patients. Therapists became increasingly involved with patients as their clinical condition improved assisting them to start to mobilise out of bed and prepare for transfer to a ward.
- We were told that the critical care outreach team assessed patients within 24 hours of discharge from the unit. In preparation for this, the critical care outreach team reviewed patients prior to the move and a checklist completed as to ongoing needs and treatment plans. Upon discharge, patients were assessed the consultant intensivist and the critical care outreach team. This was in line with the NICE CG83 guidance for rehabilitation after critical care. This was an improvement since the last inspection when we identified that the discharge of patients from critical care to a ward was sometimes suboptimal.
- Consultants discussed each referral and identified ceilings of treatment where necessary. We did not see an admission criterion, and were told that patients were assessed according to their individual conditions.
- Microbiologist attended weekly ward rounds to review patient's treatments offering advice on antibiotic regimes. We did not see this during inspection.
- All staff reported that they were supported by their colleagues and were able to share ideas for team or service development.
- There was a multidisciplinary team approach to the weaning of patient ventilation. Weaning is the gradual decrease in ventilation support with the aim for the patient to become independent as quickly and safely as possible. We saw the team discussing weaning plans and safe parameters for the patient's condition.
- The service worked with other providers to ensure that patients' needs were met. This meant that on occasion, when a clinical speciality bed was required, the service would liaise with the critical care network to identify the nearest speciality bed. Patients would then be transferred to the accepting trust as necessary.

Seven-day services

- Consultants on call completed twice daily ward round daily across the service. This was supported by the nursing and medical team on duty, the physiotherapist and where necessary the pain specialist nurse and outreach team. This was in line with the core standards for intensive care (2013).
- A consultant assessed patients admitted to the service within 14 hours of admission, which was in line with national guidance.
- Physiotherapy services provided an on call and weekend service for patients requiring treatments such as chest physio. Patients were handed over to the weekend therapist to ensure that treatment plans were followed. On call provision was usually required for respiratory therapy as part of emergency treatment.
- The occupational therapist, dietitian and pharmacist provided additional support Monday to Friday.
- Trust data showed that the pharmacist attended the unit more frequently than the contracted hours, spending approximately 45% of their working week on the unit. An on call pharmacist was accessible out of hours.
- Doctors were available on critical care 24 hours per day. This included access to consultants. Junior doctors told us that on call consultants were accessible and supportive out of hours, answering queries and attended the unit if they required.
- Diagnostic services were available 24 hours per day, which enabled treatment plan to continue.

Access to information

- Staff had access to all relevant information required for the delivery of effective care and treatment during their stay within all units. The critical care unit had administration staff that could coordinate the provision and supply of patient records. Including obtaining historical notes and accessing current test results and reports.
- Consultants and the allocated nurse reviewed patients' notes on admission to the unit, to determine a full understanding of the patient's condition and treatment history.
- We saw that the service had implemented a discharge pathway, which captured key information for discharge planning. This was a template initially completed by the nurse caring for the patient and reviewed by the outreach team and therapists prior to discharge. This meant that all members of the multidisciplinary team were aware of the treatment plan and were able to track the patient to the ward. This promoted the continuity of care and was in line with National Institute for Health and Care Excellence CG50 guidance.
- The discharge pathway was used as a standardised handover template for all discharges from critical care.
- All clinical areas had access to computers, which were password protected. Staff were able to and demonstrated accessing patients diagnostics, test results and personal information retained on the trusts electronic databases. Staff reported no issues with accessing information.
- We saw that notes of patients discharged from critical care included a discharge summary, which was shared with the receiving ward, and the patients named specialist consultant.
- We observed medical and nursing handovers, and noted that information shared contained details of current condition, treatment and any planned care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff we spoke with were aware of the policy and their roles and responsibilities in the escalation of concerns.
- We saw that staff recorded patient consent to treatment where possible. When consent was not possible, staff completed treatment in line with best interests and the MCA, for treating unconscious patients, or in an emergency. For example, patients who were sedated were unable to give consent for personal care; however, staff completed these recording details within the patient records.
- Staff were able to describe the differences between lawful and unlawful restraint and what this meant for patients being cared for on critical care.
- MCA training compliance data was not made available by the service.

Are critical care services caring?

Good

We rated caring as good because:

- All patients were treated compassionately whilst taking into account their individual beliefs, any concerns and maintaining privacy and dignity.
- Patients spoke positively about the care received.
- We saw that staff involved those close to the patient in care planning. Patients and loved ones were kept up to date the clinical condition and progress.
- Staff provided additional services and support mechanisms for loved ones. Providing opportunities for asking questions and speaking to the consultant.

Compassionate care

- We saw that all patients and their relatives were treated with dignity, respect and compassion throughout the clinical areas.
- We spoke with one patient who told us "care could not have been better", and staff were "very attentive".
- We saw staff members spent time with the patients, interacting about everyday activities and not just treatment. We saw that staff explained all tasks, explaining the reasons why they were being completed and how they would affect care and treatment plans.
- We saw one patient accompanied by their relatives awaiting discharge home. The patient had regularly attended the unit and staff spoke to the patient and their relative in a friendly manner, offering advice and support regarding their clinical condition. Staff enabled some privacy, allowing time for them to be on their own.
- We saw that curtains were used across all clinical areas to ensure privacy during treatments and personal care. Staff were reminded to knock before entering areas when curtains were closed.

- Patient confidentiality was maintained throughout. We saw that patient's names were not displayed and medical notes were stored in drawers. Conversations with relatives were held in quiet rooms adjoining the unit. Quiet rooms were also used for multidisciplinary team meetings to prevent conversations taking place on the main ward area and being overheard.
- We saw that staff responded quickly to any signs of patient's distress or discomfort.
- Complaints of pain were responded to appropriately. Medication charts confirmed pain medication had been administered in line with records of patient complaints of pain or discomfort.

Understanding and involvement of patients and those close to them

- Relatives told us they were involved with care planning and had regular contact with consultants caring for their loved ones. We saw the consultant on call talking to relatives and planning family meetings to discuss ongoing care.
- Staff introduced themselves to patients and their relatives or loved ones at all contacts, offering time to answer any questions.
- Staff informed relatives that they could stay on site as there were a number of waiting and relatives' rooms available.

Emotional support

- Staff showed awareness to the emotional needs of patients and relatives offering support or referral to specialist services if necessary. We saw that one patient was offered additional support for their psychological needs following repeated admission to the service.
- We saw that visitors attending the unit were greeted in a polite and friendly manner, and accompanied to the appropriate bed space and introduced to the nurse caring for their relative.
- Patient's relatives were able to complete a diary, which recorded events and treatments. Nursing staff also used these to record information, which was used when patients woke up to inform them of what had happened whilst patients were unconscious. We saw a blank copy of the diary, which gave clear instructions on how it should be used.
- A follow up service was not established; however, the outreach team completed a telephone call questionnaire after discharge. This was a new initiative during inspection and results of the initial three months had not been analysed.
- A multi-faith chaplaincy service was available 24 hours, which enabled staff to access additional support for relatives and patients.

Are critical care services responsive?

Good

We rated responsive as good because:

- The service used a trust wide flexible approach to meet the demands on critical care beds.
- There were systems in place to meet patient's individual needs. This included access to translation services, specialist support for patients with learning disabilities and access for wheelchair users.
- There was a variety of facilities available for relatives, which included overnight accommodation, refreshments and information leaflets.
- A consultant reviewed patients admitted to the service within 12 hours of admission to the unit, with treatment plan outlined on admission.
- Staff were aware of the systems in place to manage formal and informal complaints.

However:

- There were some delays in discharge from critical care.

Service planning and delivery to meet the needs of local people

- The provision of critical care beds had been reviewed by the service to ensure that beds were available where needed. This resulted in the trust wide approach to service needs. Staff and equipment moved between the units at the Alexandra and Worcestershire Royal Hospitals to meet clinical demands. This enhanced the services ability to reduce non-clinical transfers, improving patient safety and experience.
- The unit admitted elective patients following procedures within the theatres. This was usually prearranged as part of the patient's treatment plan. The

service also admitted patients following a clinical emergency; this could be following admission through the emergency department or a sudden deterioration on the wards.
- Visiting times had been changed the week prior to inspection to 12midday to 8pm. This had been in response to lengthy ward rounds in the morning. Visiting outside these hours was permitted for relatives following discussion with the nurse in charge.
- Relatives were able to access hot, cold drinks within the critical care relative is rooms, and we observed staff asking visiting relatives if they would like refreshments.
- Patients requiring home ventilation were cared for on the critical care unit until discharge could be secured. We did not see this during inspection and staff reported that bespoke care packages for long-term ventilated patients were rare.
- Patients requiring home ventilation were kept on the unit until an appropriate care package could be arranged by the local care services.

Meeting people's individual needs

- Staff reviewed patients daily to ensure that they were being cared for in the most appropriate clinical area. We saw that patients were assessed for stability prior to discharge or transfer to the ward.
- Due to the nature of the unit, staff were not able to provide a single sex ward, however they used the available side rooms to provide privacy for those patients who were awake during their stay in critical care. When patients were receiving treatment in line with level two care, staff were not required to report the mixed sex accommodation as an incident. However, when patients became level one, the mixed sex occupancy should be reported. Nursing staff told us that patients were transferred to wards as soon as possible after becoming a level one to prevent a mixed sex breach. We saw no reported incident for mixed sex breaches within critical care from September 2015 to August 2016.
- Patients, who were mobile, were also able to use the relative's room washroom facilities for additional privacy.
- We previously identified that the service did not provide specialist support for patients in critical care with psychological problems or anxieties. Although the critical care team acknowledged that, this was important. During this inspection, it was noted that there remained a deficit in psychological specialist support for both patients and their relatives.
- The bed space curtains had posters attached stating "do not disturb". We saw these in use throughout our visit.
- Trained and experienced staff supported patients with learning disabilities. The service had access to a trust wide learning disability liaison nurse who assisted with support and advice. To assist with promoting a calm environment the service used a "hospital passport" which contained details of the patients past medical history, their relatives, contact details, their likes and dislikes. In addition, the patient's relatives or carers were able to stay on the unit to provide additional support or comfort.
- All waiting rooms were supplied with hot and cold drinks for relatives and visitors.
- The waiting room displayed a variety of information leaflets, which referred to the service, explaining aspects of care such as sedation, ventilation and discharge.
- We were told that the service provided translation services, and were able to access interpreters to attend planned meetings without any difficulty. In addition, we were told that some translation was completed by multilingual staff working across the organisation.
- We saw that entry to the critical care unit was via an intercom. Visitors were given access from the nurses station and greeted by either the nurse or ward clerk on entry to the unit. We saw that visitors attending the unit were greeted in a polite and friendly manner, and were accompanied to the appropriate bed space and introduced to the nurse caring for their relative.
- Critical care provided several relatives areas both on and off the unit. This included a small room with washroom and kitchen facilities. This ensured that relatives had privacy during their stay on the unit and enabled them to stay for a longer period.
- Critical care had a large number of information leaflets available for patients and relatives. We were told that staff could provide large print or translation to different languages if necessary.
- All areas and facilities were accessible and suitable for wheelchair users.

Access and flow

- During the last inspection, we identified that the service had issues with the flow of patients leaving the unit,

with a higher proportion of delayed transfers and transfers overnight. During inspection, we identified that the service had minimal transfers at night. In addition, the Intensive Care National Audit Research Centre data showed that 4.4% of patients were delayed greater than 8 hours after decision to discharge. This was slightly better than the national average of 5.2%. One reason for the potential change to patient flow could relate to the type of patients admitted to the unit. Following relocation of trust wide services, a larger portion of patients admitted to critical care were planned admissions following surgery.

- Service data showed that critical care had 2,920 available bed days. Data showed that bed occupancy for critical care was better than the England average for seven out of twelve months from September 2015 to August 2016. Bed occupancy was higher than the England average for the remaining five months.
- Admission to the service was following a consultant-to-consultant referral. During the initial discussions for referral, consultants would discuss the patients underlying clinical condition, treatment plans, possible outcomes and any ceilings of treatment. If patients were not suitable for admission to the service, this was clearly recorded with a rationale in patient's notes. During inspection, we saw evidence of consultant referrals and discussions in all patients' notes.
- Nursing staff told us that patients requiring a critical care bed were cared for on the referring ward or clinical area by the critical care outreach team, consultant and when necessary the resuscitation team up until admission to the critical care unit. This ensured that patient's safety was maintained whilst awaiting a bed. Admission to critical care was within four hours of decision to admit and in line with the core standards for critical care (Guidance for the Provision of Intensive Care Services 2015). We saw a standard for the admission process, which detailed timelines and actions to be taken by all staff.
- The critical care outreach team monitored activity relating to the number of referral, reviews and patient checks for devices such as central lines and tracheostomies. Data for September to November 2016 showed that the service had 221 referrals, completed 450 reviews and completed 544 device checks.
- Consultants reviewed all new admissions to the critical care unit within 12 hours of admission. However, all patients had treatment plans in place on admission.
- The service admitted 406 patients from November 2015 to November 2016. This consisted of 255 unplanned emergency admissions, 116 planned post-operative cases and 22 planned medical cases.
- Trust data showed that the critical care unit discharged between one and three patients out of hours each month from January to June 2016.
- We saw five incident reports relating to a delay in beds for discharge from September 2015 to August 2016. These detailed delays up to four days. Trust data showed that of the 341 discharged patients, 84 were transferred to a ward within 4 hours of the decision to discharge, 167 discharged within 24 hours and 90 discharged after 24 hours.
- Trust data showed that there were 44 cancelled operations due to the lack of an intensive care bed from November 2015 to November 2016.
- The service performed in line with similar organisations for the transfer of non- clinical transfers. Non-clinical transfers are those transferred between units due to a lack of an available appropriate bed.
- We saw a patient discharged home from critical care. The discharge was managed smoothly with the patient and relatives received advice for ongoing care and treatment. We saw that a number of patients were discharged home from critical care. These were frequently patients who required a short stay on the unit for treatment following, for example, an overdose. These patients were routinely discharged home directly from critical care following a mental health assessment.

Learning from complaints and concerns

- Patients and relatives we spoke with told us they knew how to make a complaint or raise concerns.
- Nursing staff told us they would try to address any concerns raised locally to ensure resolution. If resolution was not possible, staff directed patients and relatives to the patient advice and liaison service (PALS).
- We saw that the service received two concerns regarding diagnosis recorded on death certificates. There were no other formal complaints or concerns raised from September 2015 to August 2016. The team did not share the learning from these concerns during inspection.
- The service used the trust policy for managing complaints. The most relevant person would investigate any concerns, for example, complaints about nursing staff attitude were investigated by the matron, or treatment concerns investigated by the lead clinician.

Critical care

Are critical care services well-led?

Good

We rated well-led as good because:

- There was strong local leadership from the ward sisters, matron and clinical director.
- Local leads, such as the ward sisters, matron and clinical director demonstrated capability, awareness of needs and dedication to developing the service. Locally staff reported that leads were visible and accessible.
- The service had a vision that reflected the trust vision and strategy.
- There was a robust governance and risk management process in place, with regular reviews of risk and mitigation implemented to reduce the risks of harm.
- Critical care staff were positive about their roles and the team.
- All staff were dedicated to providing a high standard of patient care.

However:

- Clinical leads reported uncertainty about and lack of progress in reconfiguration of services as a result of the lack of permanent executive team.

Leadership of service

- Locally the service was led by the consultant intensivist (clinical director) and critical care matron. This was in line with the Guidance for the Provision of Intensive Care Services 2015 (GPICS).
- The service escalated and reported into the specialised clinical services division, which consisted of the sterile services, pathology, haematology, oncology, palliative care, radiology, breast screening and endoscopy bowel screening services.
- Clinical leads reported uncertainty and lack of progress in the reconfiguration of services. Staff reported that this related specifically to the lack of permanent executive team and perceived poor executive planning.
- Staff within critical care were happy with the local leadership, stating that speciality leads were visible, approachable and supportive.
- We were told that the executive team were not visible across the organisation, although staff had attended the listening in action sessions arranged by the trust.
- Leadership of patient care and treatment was good by nursing and medical staff. Throughout our inspection we saw that the nurse in charge was supernumerary and therefore able to coordinate activity. This was in line with the Faculty of Intensive Care Medicine (FICM) standards.
- Locally we saw strong leadership, commitment and support from senior staff. Nursing and medical staff were responsive, accessible and offered support to staff during challenging or emergency situations.
- Junior doctors reported that consultants were supportive and they felt appropriately supervised.

Vision and strategy for this service

- Staff were aware of the trust vision and values, which were to work together for the needs of the patient and to place the patient at the centre of care.
- The service leads told us that the service had its own service values, which were supported through education and embracing new ways of working. Staff we spoke with confirmed these values stating that the team were “working differently to provide a trust wide service”.

Governance, risk management and quality measurement

- The trust had a robust governance structure in place. Clinical leads reviewed performance captured in dashboards, at the bi-monthly critical care directorate and monthly divisional meetings. Representatives from this meeting would also attend the trust wide safety meeting to discuss any actions, plans or trends. Minutes from all meetings were made available to staff.
- Clinical leads for all divisional specialities attended the monthly divisional meetings, which were conducted against a set agenda. The meetings used service dashboards to identify trends in quality of care and patient outcomes.
- Ward staff told us that they completed monthly team meetings, which included details of trust news, local changes, training, incidents and feedback. Staff that were unable to attend the meetings were kept informed by the meeting minutes being displayed in staff areas.
- The critical care outreach team reported into the critical care division and patient data was reflected in the critical care dashboards.

- We saw various minutes from meetings, which showed discussions of business plans, learning from incidents, the review of policies, updates on current work or action plans and feedback from the critical care network. Minutes showed good attendance.
- Critical care contributed data to the Intensive Care National Audit and Research Centre Case Mix Programme for England, Wales and Northern Ireland, which was in line with the Faculty of Intensive Care Medicine (FICM) core standards. This enabled the trust to show patient outcomes and other quality data benchmarked against other similar units.
- The service had an audit calendar in place to monitor patient outcomes, infection control practices and standards of care. National guidance was used to develop the audits and to identify areas for improvement.
- The service had a robust risk register, which covered both the Alexandra and Worcestershire Royal Hospitals. Service leads described the three main risks as the ability to transfer patients to tertiary centres, patient discharges and the allocation of patients to medical consultants.
- Additional risks identified included the replacement of mattresses, exposure to hazardous substances, access to records and the negative impact of hospital flow on patient admission and discharges. We saw that risks were reviewed frequently and updated and amended when mitigating actions were completed.
- As the service introduced the sepsis pathway in September 2016. The clinical lead and the outreach team were responsible for cascading training and understanding of the pathway. We did not see any audits relating to the effectiveness of the pathway.

Culture within the service

- There was a strong supportive culture within critical care. Staff were friendly and reported that teamwork was excellent.
- All staff reported that they were committed to providing safe effective patient care.
- Staff across critical care generally reported that they felt able to provide a high standard of patient care and they enjoyed coming to work. Good practice was shared across the critical care team through a local system called “Greatix”. We saw that this was completed during departmental meetings to celebrate good practice and achievements.

Public engagement

- Due to the nature of critical care, there was no general public involvement with how the service developed. However, patients and their families were asked to comment on care received.
- We saw a selection of thank you cards displayed on critical care from patients and relatives who had used the service. The unit reported on the number of compliments received monthly.

Staff engagement

- Locally staff were encouraged to share their thoughts and ideas. Ward sisters and matrons spent time with staff explaining rationale for changes and thanking staff for their work.
- The service had participated in the trusts listening into action meetings and staff reported that the events had been interesting and given them the opportunity to see the executive team.
- Staff across critical care generally reported that they felt able to provide a high standard of patient care and they enjoyed coming to work.

Innovation, improvement and sustainability

- Clinical leads encouraged all staff to be innovative.
- Due to the flexibility of staffing across both sites, the service was able to sustain increased activity at one site and reduce activity at the other.
- Critical care had introduced a system to alert staff to the noise generated on the unit. The unit had a device, which lit up green for acceptable noise, amber for above acceptable noise and red for too loud. The device was situated at the back of the nurse’s station and easily visible to the majority of bed spaces. Nursing staff told us this was a visual reminder that equipment and staff make a lot of noise. The service had introduced a rest period to facilitate a quiet time for patients to rest. During inspection, we noticed that lights were turned off and treatment activities were reduced as able.

Maternity and gynaecology

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

Information about the service

Maternity and gynaecology outpatient services provided by Worcestershire Acute NHS Trust (WAHT) are located on three hospital sites, the Worcestershire Royal Hospital (WRH), Alexandra Hospital (AH) and Kidderminster Hospital and Treatment Centre (KHTC). Services at WRH and KHTC are reported on separately. However, services on all three hospital sites are run by one maternity and gynaecology management team. They are regarded within the trust as one service, with some of the staff working across the different sites. For this reason it is inevitable there is some duplication contained in the three reports.

The AH in Redditch serves a population of approximately 200,000 people and has over 300 beds. The maternity services provided at the AH are antenatal outpatient clinics from Monday to Friday, providing various consultant and midwifery led clinics. There are phlebotomy and scanning services available during these clinics. There is a maternity day assessment unit on ward 15, with two beds and two chairs. This is staffed by one midwife and two maternity support workers (MSW). This is open on weekdays only. There is a women's orthopaedic trauma and gynaecology ward; ward 14, open 24 hours a day. Ward 14 has two gynaecology beds. Nursing on this ward is provided by general surgical nurses. There is an early pregnancy unit for planned admissions, staffed by one gynaecology nurse and one MSW. There is no labour suite or facilities to give birth at this site.

The gynaecology outpatient service has various consultant led gynaecology clinics, Monday to Friday. There is a colposcopy clinic open during the week for planned patients. The surgical day case unit cares for women who need to have gynaecological operations and procedures such as laparoscopic hysterectomies, diagnostic laparoscopies and laparoscopic sterilisation. (Please see the surgical part of this report for this service).

We inspected the maternity and gynaecology service from 22 until 25 November 2016. During our inspection, we looked at the facilities and environment spoke with seven members of nursing and midwifery staff, six service leaders, five patients and looked at six sets of patient records. We collected data about the services provided, policies and patient outcomes.

We revisited the hospital on the 7 December 2016 and spoke with a further five members of staff and three patients. We looked at three more sets of records and looked further at the environment.

Maternity and gynaecology

Summary of findings

We rated this service as requires improvement because:

- Medical vacancy rates in obstetrics and gynaecology were high, leading to cancellations of clinics and some patients waiting more than 18 weeks to be seen.
- Limited use of local audit meant that some outcomes with regards to patient safety, care and effectiveness were not fully understood. This was especially noticeable with regards to documentation and assessment.
- Senior leaders were not always visible and some had limited capacity due to multiple roles.
- Staff had a poor understanding of female genital mutilation, child sexual exploitation, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Leaders had told us that all staff had been trained in these areas.
- Multiple sets of patient notes led to gaps in information in some records we saw.
- There was no awareness, amongst staff, of major incident plans or roles that individuals would take should there be a major incident.
- Midwives were not rotated to different areas, potentially resulting in loss of some skills.

However:

- All staff considered patients' needs, and were respectful and caring in their interactions.
- Staff said they were valued and respected. There was open and honest communication between staff and managers. Local leaders were visible and approachable.
- Divisional leaders had a clear vision and strategy for maternity services.
- Incidents, comments and complaints processes were thorough, and lessons learned were disseminated well. However, the target to complete these was often missed.
- Nursing and midwifery leaders were always available by telephone or email.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

- Not all incidents were investigated and closed within the trust's own target time of 20 days.
- Staff had a poor understanding of female genital mutilation and child exploitation.
- Hand hygiene practices were not embedded in every day activity.
- Multiple records were in use for obstetric patients. This meant that information was available in some and not others and increased the risk of not all information being available quickly and easily for all patients.
- Record keeping audits were not routinely carried out.
- Not all staff were up to date with mandatory training.
- Not all staff were up to date with safeguarding training or had an awareness of all safeguarding issues. However, we were told that the service aimed for 90% compliance by March 2017.
- There was a 24% vacancy rate in doctors for the service.
- Staff had not received training and did not know their roles in case of a major incident.

However:

- When incidents had been investigated, lessons learned were shared.
- Safety measures were recorded and used to inform areas for improvement.
- Patient assessment tools were comprehensive and thorough.
- Medications were safely stored.

Incidents

- Staff we spoke with understood their responsibilities to raise concerns, record safety incidents, concerns and near misses, and to report them. Staff were confident in using the trust's electronic reporting system and gave examples of incidents which they had reported, for example a poorly labelled blood specimen.
- Between October 2015 and September 2016, the trust reported no never events for maternity and gynaecology. Never events are serious incidents that are wholly preventable, where guidance or safety

recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

- Two serious incidents (SI) in maternity and gynaecology met the reporting criteria set by NHS England between October 2015 and September 2016. The two incidents were reported as diagnostic incidents including delay meeting SI criteria (including failure to act on test results) and both incidents were reported within gynaecology. Both incidents had undergone thorough investigations, and had associated reports and recommendations with time specific actions in place. Changes were made because of the incidents, including the development of an automated pathology alert system for the escalation of abnormal results.
- In May 2016 the trust introduced a standard to investigate and close incidents within 20 days. Incidents were allocated to a specific manager to investigate, report and feedback on. In the maternity and gynaecology services, 67% of incidents were dealt with and closed within 20 days. We were told that the division monitored the compliance every two weeks and would write to individuals whose incidents are open for over 20 days.
- We saw in the reports that Duty of Candour was used. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For NHS bodies, the duty came into force in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Most staff we spoke with knew about the duty of candour. However, they were unable to tell us in detail about the process involved.
- Lessons learned from incidents, comments or complaints were used to inform and improve services. Lessons were shared via newsletters emailed to staff, in weekly effective handovers, in team meetings and when necessary by individual discussion and support. For example, recently an incident occurred on another site where blood samples had not been correctly labelled before being sent to the laboratory for testing, which meant that they could not be used and the patient had to have a repeat test. The incident was investigated, causes found and measures put in place to help prevent future similar occurrences. This was done across all sites.
- Mortality and morbidity meetings were not formally minuted. In addition, there was no information arising from this meeting. This meant that there was a lack of documented learning. We were told that a governance administrator had recently been appointed and that learning from events would be formally recorded in the future.

Safety thermometer

- The maternity safety thermometer is a national tool that has been designed to measure commonly occurring harms within maternity care. It integrates measurement for improvement into daily routines and supports improvement in patient care. The maternity safety thermometer collects data on the following harms; maternal infection, perineal trauma, post-partum haemorrhage, term babies, Apgar score, (a simple assessment of how a baby is doing at birth, which helps determine whether the baby requires additional medical assistance), term baby treatment, mother and baby separation and women's perception of safety. In maternity outpatients or in the community, there was no maternity safety thermometer in use.
- A maternity safety dashboard was on display in the maternity outpatient manager's office. Two of the staff we spoke with in maternity were aware of the dashboard and what it was used for. This provided monthly, maternity specific data. Goals were set to ensure patients received safe care. The data was used to monitor, understand, analyse and improve safety and services to patients. For example, weekly monitoring by the governance team had reduced the number of incidents that remained open. An email prompt was sent out if targets were not being met. We were told that recently one of the targets regarding the number of babies born before arrival (of a midwife) had been removed from the dashboard. However, data we saw

showed that there had been no babies born before arrival (of a midwife) from December 2015 to November 2016. This site does not do deliveries, all are diverted to WRH.
- There was no specific gynaecology safety thermometer because patients are treated in mixed speciality wards. Safety thermometers are reported on a ward level, not speciality. For gynaecology inpatients, please refer to the surgery part of this report.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean. The design and use of facilities and premises allowed ease of cleaning and maintenance.
- Waste disposal was managed appropriately with different types of waste and laundry separated. Sharps boxes, for the disposal of needles, were assembled and dated.
- Waste disposal, was managed by the outpatient department. Appropriate bags for different types of waste were available throughout the antenatal and gynaecology clinic as well as the maternity assessment unit (MAU) and early pregnancy assessment unit EPAU. Sharps boxes were labelled and sealed appropriately.
- There were no MRSA or Clostridium difficile reported in the maternity or gynaecology services in the year to November 2016.
- Personal protective equipment was available for staff to use in all areas we visited.
- There had been 2573 gynaecology procedures performed at the hospital in the year to November 2016. However, there had not been an audit of surgical site infections within the gynaecology department. This means that we did not know how many women have had surgical site infections in this speciality.
- In the antenatal and gynaecology outpatients, maternity assessment unit and early pregnancy assessment unit staff complied with the "arms bare below the elbow" policy. However, some staff did not decontaminate their hands at all times and in all areas when moving from one area to another. In the maternity assessment unit, we observed one member of staff taking blood from a patient wearing just one glove. This did not follow personal protective equipment guidelines. We raised this with the manager immediately. Later the same morning we observed the same member of staff repeating the procedure, again without appropriate protection. This was not in accordance with National Institute for Health and Care Excellence (NICE) guidance (QS61 statement 3).
- Audits of hand hygiene in the antenatal outpatient department were provided by the trust. From April 2016 to November 2016, the compliance in the antenatal outpatient department was 100% with both hand washing and "arms bare below the elbow" policy.
- Hand hygiene audits were carried out in the antenatal clinics and the Elias Jones unit (where colposcopy, a procedure to treat cell changes on a woman's cervix and hysteroscopy, a procedure to observe a woman's uterus with a camera inserted vaginally were carried out). A score of 100% was recorded in all cases. However, there were no hand hygiene audits carried out in the MAU or EPAU.
- In most areas we visited, there was appropriate washing and hand hygiene facilities. However, in the colposcopy room one sink had an overflow hole. This did not comply with requirements for hand washing facilities.
- All pregnant women were offered the influenza (flu) vaccination and pertussis (whooping cough) vaccination during their antenatal appointments after 20 weeks. We saw posters displayed in the antenatal clinic emphasising the benefits of these vaccines.
- For gynaecology inpatient services please refer to the surgery section of this report.

Environment and equipment

- Please see the outpatients section of this report for details about resuscitation equipment.
- All areas we visited were visibly clean. Floor coverings were non slip. Window restrictors were used in all patient accessible areas to reduce the risk of falls from windows and the blind cords were not a ligature or strangulation risk.
- The early pregnancy assessment unit and maternity assessment unit were very small and cramped. The early pregnancy assessment unit was disorganised and cluttered, with inadequate space for equipment. However, plans were in place to move the maternity antenatal outpatient clinics, gynaecology outpatient clinics, the maternity assessment unit, the early pregnancy assessment unit and sonography services

two weeks after our inspection to the former delivery suite and neonatal unit. All staff we spoke with were optimistic about the new arrangements and design of the space.

- In the outpatient departments, infection control and prevention nurses carried out four environmental audits in 2016. The department scored between 86% and 91% in the four audits. In all cases, actions to be taken from findings of the audit were recorded and allocated to specific individuals, however there were no dates specified for completion.
- The cardiotocography (CTG) and scanning equipment was all maintained and serviced by the manufacturer. All machines were observed to be clean and up to date with maintenance.
- Curtains in the outpatient department were visibly clean. Housekeeping staff maintained records of when these should be cleaned and changed. Logs were up to date.
- All equipment was visibly clean. However, we saw no evidence that equipment was cleaned between patient use.
- Some equipment was labelled with in date electrical testing stickers. However, we found four sonic aids (devices for listening to a baby's heartbeat) that required electrical testing. We raised this with the manager at the time, who told us that steps would be taken to correct this.
- In the MAU we found a blood pressure monitoring machine which was out of date for electrical testing. We raised this with staff and it was immediately taken out of service, replaced and the estates department was informed.
- Environmental cleaning schedules were on display in the outpatient department and fully completed.
- The resuscitation trolley for use in this area was stored on ward 14 and reported on in the surgical section of this report.
- Community emergency bags containing equipment to assist in delivering a baby were carried by on call community midwives. A contents list was laminated and with the bag at all times. A weekly check was carried out to ensure all contents were present and in date. The checklist was thoroughly completed and changes made to the bag were recorded.
- Please see the surgery part of this report for more information regarding gynaecology inpatients on ward 14.

Medicines

- Please see the surgical section of this report for inpatient and day case patients.
- Arrangements were in place for managing medicines.
- No medicines were stored in the maternity and gynaecology outpatient department.
- On the MAU and the EPAU, medicines were stored securely in a locked cupboard. No controlled drugs were used in these areas.
- Medicines were stored according to temperature limits set by the manufacturers.
- Women having home births were responsible for storing their own pethidine or Meptazinol which was prescribed by their GP if required.
- There were no prescription pads visible anywhere during our inspection.

Records

- Records were not always accurate, up to date and complete. However, they were detailed, legible, and stored securely. Maternity patients were issued with patient held maternity records at their booking appointment. If a patient attended a clinic in the hospital, a paper hospital obstetric record was used to record the details of the visit. Any test results, such as blood tests or scans, were filed in the hospital obstetric record. A copy was sent to the community clinics and given to the patients for insertion into their patient held records. If a patient had risk factors identified, or highly confidential information in their record, a pink envelope was inserted in the front of their hospital records to store sensitive information and to alert the relevant member of staff to any specific issues. There were two electronic records systems in use. One was for recording information about patients seen in any other part of the hospital, for example by a cardiologist. The other was a system used in maternity when monitoring a woman and her baby either as an outpatient or an inpatient. The quantity of record keeping systems was a known risk and had been highlighted in our previous inspection. However, the trust still had this recorded as a risk to the safety of patients, with a limited plan for improvement in place.
- Hospital records not in use were stored safely in locked cabinets in a locked room. Records for clinics were in a locked trolley.

- We viewed five sets of hospital records in the maternity outpatient department. All records were legible, signed and dated where required. However, one set of notes had highly sensitive confidential information that was not stored in the pink envelope provided. Some assessment information had not been transferred from the patient held records to the hospital records. For example, local policy dictates that "women must be asked twice during their pregnancy if she is, or ever have been, a victim of domestic violence. "This is based on the domestic violence and abuse: multi-agency working public health guideline [PH50] (2014). In three of the records there was no second domestic violence question recorded as having been asked. In two records there was no indication as to whether the patient had been offered a flu vaccine. In two records there was a pink envelope but no indication as to why this was inserted.
- There was no record keeping audit performed by the outpatient and community midwifery services. This meant that there was no awareness of how well records were kept over time and by different teams or individuals.
- One member of staff approached an inspector in order to identify what paper work was being viewed, in order to protect patient confidentiality.
- Personal child health records or "red books" were issued to parents following the birth of their baby in hospital. Red books were issued to parents who had home deliveries by the community midwives.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. The trust set a target of 90% for completion of mandatory safeguarding training. Nursing staff within maternity and gynaecology exceeded the trust target of 90% for safeguarding adults although completion rates for safeguarding children level 2 (44%) and safeguarding children level 3 (51%) did not meet the trust target.
- Medical staff within maternity had not met the trust target of 90% for any of the three safeguarding training modules. Safeguarding adults had a completion rate of 86%, safeguarding children level 2 had a 0% completion rate and safeguarding children level 3 had a completion rate of 19%. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.
- An action plan was in place to improve compliance with their safeguarding training. This focused on completing the training for community midwives, with a target date of 31 December 2016 for full compliance. A target date was set of 31 March 2017 for hospital based midwives. Plans were in place for all medical staff to be booked on to complete the training by 19 December 2016. A one day 'hot day' teaching session was held in September 2016 and email reminders sent to all junior doctors in November 2016.
- Some staff told us that they were booked onto safeguarding training in the coming weeks.
- We were not provided with the safeguarding training rates for the gynaecology service.
- A safeguarding named midwife, who also had responsibility for other vulnerable patients including substance misusers, was employed by the trust. All staff we spoke with knew how to contact the safeguarding named midwife.
- Safeguarding policies and guidelines were available on the intranet and contained clear, up to date and evidence based instructions on what to do if a member of staff was concerned about a child.
- Staff generally understood their responsibilities and followed safeguarding policies and procedures. Whilst staff had a good knowledge of general safeguarding principles, we found that there was poor awareness of Female Genital mutilation (FGM) or child sexual exploitation (CSE). Midwives of all levels told us that they had not received any training in FGM identification or awareness and that they did not know of any FGM lead within the service. Although we were told by service leaders that this was part of safeguarding training, some staff told us they had not had any training at all. We did not see any leaflets available regarding CSE or FGM or details of contact details of support groups. We reviewed the FGM and CSE policies, which were part of the safeguarding children pathway. This policy directed staff to report concerns to their line manager and gave a list of possible indicators of abuse. However, it did not refer to section 5 Sexual Offences Act 2003 or the fact that a child under the age of 13 is legally unable to consent to sexual activity.

- Under section 5 Sexual Offences Act 2003, children under the age of 13 are unable to consent to sexual activity. If a child under the age of 13 presents to the maternity or termination of pregnancy service disclosure to social services is usually required in the best interests of the child. Staff were not able to tell us their specific responsibilities in relation to this but said they would always refer to the safeguarding leads for advice.
- The service's FGM guidance was thorough and contained both descriptions and diagrams to aid staff in identifying FGM.

Mandatory training

- The trust had set a target of 90% for completion of mandatory training. Nursing staff within maternity and gynaecology failed to meet the trust target of 90% for all of the nine mandatory training modules. Fire awareness, resuscitation, infection control, information governance and health and safety training had a completion rate between 82% and 87%. Manual handling had a completion rate of 74% and conflict resolution, medicine management and equality and diversity training had a completion rate between 19% and 38%.
- Medical staff within maternity and gynaecology failed to meet the trust target of 90% for all of the nine mandatory training modules. Manual handling, resuscitation and infection control training had a completion rate between 80% and 87%. Health and safety, fire awareness and information governance training had a completion rate between 64% and 78%. Medicine management, conflict resolution and equality and diversity training had the lowest completions rates of between 22% and 33%.
- Mandatory training specific to maternity had a compliance rate for midwives of 95% and 97% for medical staff. Cardiotocography (CTG) online training for midwives had a compliance rate of 92% and for medical staff of 94%.
- Community midwives had an annual "escape day". This was used to provide up to date training with essential emergency skills. However, midwives told us that this had been reduced to once every two years due to staffing or financial constraints.

Assessing and responding to patient risk

- For gynaecology inpatients, please refer to the surgery section of this report.
- Risk assessments were carried out for patients and risk management plans were developed based on NICE national guidelines.
- Community staff were responsible for carrying out full assessments of women at their initial booking visit. These included social, medical and mental health assessment and referral as necessary. Other assessments included tobacco use, drug use, family history and previous pregnancies. Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it is known as deep vein thrombosis. A blood clot in the lungs is called pulmonary embolism. Assessments of VTE and of immunisation history were also recorded.
- Risk assessments were used to help patients choose their preferred place of delivery, recommend further investigations and inform a plan of care. This included whether a patient should have midwife or consultant led care or be referred to other professionals within the multidisciplinary team.
- Nationally, patients seen and assessed before the end of the 12th week of pregnancy have better outcomes than those who were seen for the first time later on in pregnancy. The Within the service overall, 87% of women in the year to September 2016 booked their care before 10 weeks and 6 days. This is against a service target of 90%.
- The use of nursing early warning scores was introduced trust wide in July 2016. This was a tool that allowed nurses to assess a patient's condition, identify indications that the patient may be deteriorating and escalate appropriately.
- The World Health Organisation (WHO) surgical checklist "Five Steps to Safer Surgery" was in use within the trust. From August 2015 to July 2016 100% of obstetrics and gynaecology surgeries complied with the use of the tool. Audits were carried out in February and March 2016 to monitor quality of the compliance. This audit recommended actions including; that surgery staff should having human factors training; scenario based training should be introduced and visits to other trusts arranged to observe how they conducted the WHO process. All actions were due to be completed by March 2017.

Midwifery staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment, in line

with relevant tools and guidance. The service used "Birth Rate Plus", a nationally recognised tool for planning staffing levels. In all areas we visited there was a mix of qualified staff and support workers to care for patients. In the outpatient area, we saw details of the names and numbers of staff in clinic displayed.

- In the community, midwives held an average caseload of one midwife to 117 patients. This was above recommended levels and the trust had agreed plans with the Clinical Commissioning Groups to reduce this to one midwife to 98 patients by 2018 to 2019.
- In September 2016, AH reported a vacancy rate of 6% in maternity services. The antenatal clinic had the highest vacancy rate of 11%, while the day unit colposcopy gynaecology unit had no vacancies.
- In September 2016, AH reported a staff turnover rate of 24% in maternity services. The antenatal clinic had a high staff turnover rate of 53%. The gynaecology colposcopy day unit had no turnover. The midwifery turnover rate was 18%.
- From April 2015 to March 2016, AH reported a sickness rate of 3% in maternity. The day unit for colposcopy reported a rate of 3%. Midwifery reported the highest rate of 5%.
- From September 2015 to August 2016, AH reported a bank and agency usage rate of 4% in maternity. Midwifery services reported the highest bank and agency use of 9%. This was mainly due to 100% bank usage in May 2016. However, when asked about induction and orientation processes for bank and agency staff, service leaders told us that bank and agency were not used in maternity services.
- On ward 14 in July 2016 during the day, there was an average staff fill rate of 94%. At all other times in June and July the average fill rates for both registered staff and care staff was above 100%. We were only supplied information for these two months. We were not supplied fill rate figures (that is the number of planned verses actual number of staff) for the outpatient services provided.
- Community midwives were used to provide assistance in maternity services in WRH if required due to low staffing levels. However, community midwives we spoke to told us that they would not feel confident to work on the delivery suite. Staff told us that there had never been a time when this had compromised the care of patients in the community. Teams across the county worked together to support safe levels of care.

Medical staffing

- The medical staffing skill mix was similar to the England average. The service had 37% consultants, 7% middle grades, 48% registrars and 8% junior doctors. In contrast, the England average was 40% consultants, 8% middle grades, 45% registrars and 7% junior doctors. Obstetrics and gynaecology medical rotas were organised so that they all worked in multiple locations within the trust. The proportion of consultant and junior (foundation year 1-2) staff reported to be working at the trust were about the same as the England average.
- The service had a middle grade vacancy rate of 40% and reported that recruiting doctors to these posts, especially within gynaecology, was difficult. Applications had been limited. As a result, the service relied on locum staff to cover gaps in the medical rotas. From September 2015 to August 2016 the trust used 6% bank or locum staff. Locum doctors received an induction letter and pack. They were appointed a supervisor to ensure induction processes were adhered to. A policy was in place for management of locum doctors.
- In October 2016, the trust as a whole reported a vacancy rate of 24% in maternity and gynaecology. This risk was on the divisional risk register. There was a maternity patient care improvement plan in place; one action within the plan was plans was to monitor rotas on a weekly basis. Consultants would act down and support in extreme circumstances.
- Four new consultants had recently been appointed which meant that there were no current vacancies at consultant level.
- An obstetrician or gynaecologist was in the hospital either in the operating theatre or in the outpatients department during clinics on weekdays. They were called on for review of inpatients and day case patients if necessary. Leaders told us that this was under review and job plans would be revised to formalise daily ward rounds for gynaecology patients in early 2017.
- There was no dedicated gynaecology service out of hours. However, junior general surgical doctors were available to review gynaecology patients. A consultant was on call from home when post-operative gynaecology patients remained in hospital overnight.
- From April to October 2016, the trust reported a staff turnover rate of 9% in maternity and gynaecology.

Maternity and gynaecology

- From September 2015 to October 2016, the trust reported a sickness rate of 1% in maternity and gynaecology.
- From September 2015 to August 2016, the trust reported a bank and locum usage rate of 6% in maternity and gynaecology.
- Locum doctors received an induction letter and pack. They were appointed a supervisor to ensure induction processes were adhered to. A policy was in place for management of locum doctors. This was monitored and mentioned on the risk register for women's services.

Major incident awareness and training

- A major incident plan was in place for the trust. However, none of the staff we spoke with knew what their specific role was within this, nor had they received any major incident training.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement because:

- Local audits were limited which made some areas of patient care and treatment difficult to monitor and change if required.
- No documentation audit was carried out. Therefore, we did not know the overall quality of record keeping in the maternity service.
- Four record keeping systems were in use. This meant that not all information about patients was always for staff at one time.
- Some areas of the service were cramped and lacked privacy. However, they were due to be moved soon after the inspection.
- Midwives were not routinely rotated between areas. This meant that some midwives may have lost some skills over time.
- Staff had limited understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

However:

- Information was collected and benchmarked against national targets.
- Robust treatment pathways to ensure patients were treated by the right person at the right time were in place for all maternity patients.
- Specialist midwives were based at Worcestershire Royal Hospital (WRH) and visited the Alexandra Hospital (AH) when required.
- They had achieved level 3 in the UNICEF Baby Friendly awards.
- New clinical pathways were introduced two weeks before our inspection. However, due to the newness of these, they were not yet embedded and staff awareness of how to access these were limited.

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered. At the time of our inspection the service had recently changed their policies and guidelines to pathways. The pathways referenced National Institute of Health and Care Excellence (NICE) and Royal College of Midwifery guidance appropriately. As they had only been introduced two weeks before our inspection staff awareness of how to find the correct pathway was limited.
- Policies, guidelines and pathways were available via two systems on the trust wide intranet. All staff we spoke with knew this. However, the older system was difficult to navigate and users had trouble locating policies. The newer system was easier to navigate but there were no reference documents attached to the new pathways. This meant that there was no indication of when the pathways had been written, reviewed or by whom, or if they were based on appropriate, up to date evidence and guidance.
- Patient treatment assessments and plans were documented on patient held records. These assessments were based on up to date relevant NICE Excellence Quality Standards (QS). They included antenatal care (QS22) and antenatal and postnatal mental health quality standards (QS115).
- There was a diabetes antenatal clinic, ran by a diabetes link midwife. Women at the clinic were offered glucose tolerance testing, in line with NICE guidance (NG3).
- New domestic violence assessment guidelines had been introduced and the assessment documents had been recently changed to reflect this. Staff were being trained on the use of this new assessment. An audit of the use of

the guidelines on asking patients about their experiences of domestic violence had taken place between January and March 2016. The results of this had been used, along with CQC recommendations about making the domestic violence question part of routine enquiries, to produce a plan of action. The actions included; discussion at midwifery forum to community midwifes, cascaded of information from community team leaders to community midwifes and information sharing via effective handovers. Also the domestic violence pathway had been updated to include the routine use of the question, specific mandatory training was being considered for all the women's services and there audit was planned to be repeated to track progress with changes.

- However, there was no general documentation audit carried out within the maternity services. This meant that we were not assured that all the other assessments were being used as intended.
- Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, including "safer childbirth" were used for the organisation and delivery of care in labour.
- Services were being developed to provide a "hub" model of care for antenatal and gynaecology services in the gynaecology and antenatal unit. This was in line with the national maternity review report (2016). The concept of a community hub is that it is a local centre where women can access various elements of their maternity care. They could be located in a freestanding midwifery unit. Different providers of care can work from a community hub, offering midwifery, obstetric and other services easily accessible for women. These might include ultrasound services, smoking cessation services or voluntary services providing peer support. Women may also be able to meet professionals who will be involved with them after childbirth, for example, their health visitor.
- Various audits were in progress or planned that included services provided at the hospital for maternity and gynaecology patients. These included; serious incidents a two week wait for referral for post-menopausal bleeding, colposcopy, third and fourth degree tears and intrauterine growth retardation detection.
- Technology and equipment was used to enhance the delivery of effective care and treatment. The midwife was employed who was a specialist in scanning. There were plans in place to train three more. Obstetric scanners were available in the antenatal clinics and the maternity assessment unit.
- Growth of babies in the uterus was monitored from 24 weeks by measuring and recording the symphysis fundal height (from the top of the mother's uterus to the top of the mother's pubic bone) at each midwifery appointment. This was in accordance with MBRRACE-UK 2015 and NICE CG62 guidance. If concerns arose regarding foetal growth the patient was referred to triage for a full assessment.
- Midwives and obstetricians emphasised to women during antenatal clinics the importance of foetal movements at each antenatal contact in accordance with MBRRACE-UK 2015 and RCOG guidance. We saw posters displaying this information in the antenatal clinic.
- Maternity dashboards provided data and information to set targets, which were benchmarked against national targets. These targets and the pathways to achieve them were produced by using on evidence-based guidance, standards, and legislation. The dashboard was on display in the maternity offices.
- Several electronic record systems were in use throughout the trust sites. They allowed doctors and nurses to access information in a timely manner to help make clinical decisions. However, they did not always contain all the information that was also in patients' paper records and vice versa. This had been recognised as a safeguarding risk at our previous inspection.

Pain relief

- Please refer to the surgical section of this report regarding gynaecology patients treated on ward 14.
- There had been no pain audits carried out at the Alexandra Hospital with regard to perinatal patients in the community.
- If a patient was in pain in early pregnancy, they would be directed immediately to the maternity assessment unit at WRH.
- Patients in early labour in the community were assessed by either a community midwife or a midwife over the telephone in WRH. Pain relief advice would be given according to pathways of care developed for use in the trust.

- For patients choosing a home birth pain relief options were Entonox (gas and air) or Meptazinol (an opioid pain killer). Women were given advice when choosing a home birth that no other medical pain relief would be available to them at home.

Nutrition and hydration

- For gynaecology patients on ward 14 please see the surgery part of this report.
- The service had been awarded the UNICEF Baby Friendly Initiative level three. The baby friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. We saw posters displayed in the waiting areas promoting the importance of breastfeeding and stickers were placed in women's hand held maternity notes highlighting the health benefits associated with breastfeeding. The infant feeding coordinator was qualified to divide tongue tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems.
- Infant feeding support services were widely available in the community. Patients were given a card with links to multiple providers of support, including the NHS, charity and private groups and individuals. Midwives and infant feeding support workers were available to support babies and their mothers who had feeding difficulties in the community.
- The service had a plan in place to ensure that the most up to date advice and services were used to support women who wished to breast feed their babies.
- Babies who had lost weight were referred to the paediatric service at WRH or another local NHS trust following the appropriate pathways. Babies who were jaundiced in the community could be tested at home by midwives and referred when necessary to the paediatric service at WRH or other local hospitals.

Patient outcomes

- Information about the outcomes of patients' care and treatment was routinely collected and monitored. National audits were contributed to so the trust could bench mark their performance against others in England. However, the majority of this data was in relation to hospital care.
- The trust stopped delivering babies at the Alexandra Hospital on 5 November 2015. There were 60 home births delivered by the community team in the area covered by the community midwives from 1 December 2015 to 30 November 2016.
- The service performed poorly in relation to antenatal detection of intrauterine growth restriction (IUGR) (a condition where an unborn baby does not grow at a normal rate). From April to July 2016 the service identified this in 16% of cases, significantly lower than the target of 40%. This was acknowledged by the trust and a clear plan was in place to gather accurate data, work with commissioners, continue with staff training and offer additional services to women who have higher risk of IUGR.
- The number of patients who were still smokers at delivery in the year to July 2016 was 11%. This was less than the national average of 12%.
- From January to March 2016 four audits were due to be completed. These were; an audit of pregnancies in women with complex social issues; foetal heart oscillation; an audit in response to CQC recommendation around the asking of the routine enquiry question and the disclosure of domestic abuse and an audit in response to CQC recommendations around risk assessment in pregnancy. Of these audits, as of September 2016, only the audit of pregnancies in women with complex social issues had been completed. All other audits had outstanding action plans.
- The service audited its compliance with the UK National Screening Committee's standards for screening programmes. The audit considered 26 pairs of women's hand held and newborn notes and assessed whether they had evidence of screening for sickle cell and thalassaemia (SCT), infectious diseases (IDSP), foetal anomaly (FAS), newborn blood spot (NBBS), newborn infant physical examination (NIPE) and newborn hearing (NHSP). The audit found that in almost all (25 out of 26) records reviewed, screening information was provided to women. It also found that between 24 and 26 records had documented offers of screening tests for SCT, IDSP, FAS and NBBS. However, none of the 26 records reviewed had documented offers of screening for NIPE and NHSP.

Competent staff

- For further information about staff on ward 14 and the day case unit please see the surgery part of this report.

- There were four safeguarding supervisors within the trust that provided safeguarding supervision. Out of the 75 community midwives employed, 30 received safeguarding supervision every two months. All specialist midwives also received safeguarding supervision every two months from the named midwife for safeguarding.
- Staff generally had the right qualifications, skills, knowledge and experience to do their job. Maternity teams comprised of both qualified and unqualified staff so that patients received the appropriate level of care as required. However, gynaecology patients being treated and cared for on Ward 14 were not cared for by gynaecology trained nurses. Senior managers told us that during daytime hours there was an obstetrics and gynaecology consultant on site who was allocated to normal duties in theatre or in clinic. They were available to review gynaecology inpatients and/or referrals from other specialities. Job plans were being reviewed to build in a daily consultant ward round (0.125 additional sessions) in order to formalise the process.
- Out of hours, surgical junior doctors provided first line cover for elective gynaecology patients. A consultant was on call from home when gynaecology elective patients remained in hospital overnight.
- From April 2015 to March 2016, 87% of staff within maternity and gynaecology at WAHT had received an appraisal above the trust target of 85%. From April to August 2016, 88% of medical staff and 82% of non-medical staff had received an appraisal.
- All the staff we spoke with had either had their appraisal, or were due to have one in the near future. Appraisals were used to identify individual learning needs. Staff we spoke with gave us examples of learning needs that had been identified and courses that had been done or were planned in the future.
- The maternity service had a practice development midwife who was responsible for identifying individual and service learning needs.
- Midwives were allocated supervisor of midwives (SoMs) who would meet with individual midwives and assess on going competencies. SoMs were experienced midwives who have had additional training to enable them to help midwives provide the best quality midwifery care. They supervised the work of the midwives and met with them regularly to ensure that high standards of care were provided. They also guided and supported midwives in developing their skills and expertise. SoMs were also responsible for investigations into poor staff performance or incidents. The service's supervisor to midwife ratio from July 2015 to July 2016 was one supervisor to 20 midwives, worse than the national target of one supervisor to 15 midwives. All midwives had a supervisor allocated who supported them in their clinical practice.
- Other ways of supporting and managing staff were provided through team meetings, providing information by email and newsletters.

Multidisciplinary working

- Please see the surgical section of this report regarding gynaecology patients on ward 14.
- The maternity service promoted multidisciplinary working. Laboratory, pharmacy, physiotherapy, sonography, diabetic and endocrinology services were all available to patients at the Alexandra Hospital during the week. Senior midwives told us that patients could be referred directly to these services.
- Good links were available between medical disciplines when patients needed them. For example, we saw records that showed referrals and appointments with mental health professionals, endocrinologists and cardiologists.
- One senior midwife told us there was collaboration between the microbiologists, midwives, GPs and obstetricians to develop new guidelines for the treatment of streptococcus B (strep B) infection. This is a bacterial infection that can be passed from mother to baby. As newborn babies have a poorly developed immune system, strep B bacteria can quickly spread through their body, causing serious infections such as meningitis and pneumonia.
- As antenatal patients had hand held records, they were able to take these to all their appointments, including their GP, community midwives, mental health professional or physiotherapists. However, not all relevant professionals had access to patient's electronic record or hospital records.
- When patients were discharged from hospital services, a discharge summary was sent to the GP by fax.
- Some staff told us that joint working with GPs could be variable. Some GPs were fully engaged and the services worked well together. Relationships with other GPs were

less well developed. For example, some GPs would be reluctant to prescribe recommended medications for pregnant women such as ferrous sulphate (iron) or antibiotics for a urine infection.
- Service level agreements existed between the trust and other trusts to provide maternity services for women who chose to book their delivery closer to home. Midwives told us that at times there was limited information received from other trusts, for example blood results or discharge summaries.
- Patients with multiple and complex needs had information within their records which demonstrated coordinated care. For example, when the woman had additional medical needs, the relevant speciality consultant was involved. When safeguarding concerns had been identified multidisciplinary, multi-agency safeguarding meetings were held and plans put in place to protect people.
- Community midwives worked seven days a week and were able to see patients at the weekends to discharge them if necessary. Care was coordinated with the health visiting team and infant feeding specialists as required. Patients with complex needs had either detailed handovers or discharge planning meetings to ensure the right support was in place prior to discharge.
- Community midwives were employed by the acute trust and based at seven locations around the county. One team was based at the AH. Community teams were able to access all the same services available to the hospital based services as well as additional community services such as children's centres.

Seven-day services

- Antenatal clinics were held Monday to Friday from 8.30am to 4.30pm.
- There were gynaecology outpatient clinics held during the week.
- No early gynaecology or early pregnancy assessment services were available at weekends.
- No maternity assessment unit services were available at weekends.
- When women presented out of hours, they were directed to services at the Worcestershire Royal Hospital.
- Imaging (x-rays and scans) were available from 9am until 6pm, Monday to Friday.
- Pathology services were provided from 9am to 5pm, Monday to Friday.
- Physiotherapy and occupational therapy services were available for maternity patients from 8.30am to 4.30pm, Monday to Friday.
- Please refer to the surgery section of this report for gynaecology day case and inpatients.

Access to information

- Information needed to deliver effective care and treatment available to relevant staff was usually available in a timely and accessible way.
- Maternity patients had paper obstetric records for the duration of each pregnancy; these were kept at the hospital for staff to complete when a patient attended an appointment. Patients also had hand held records to take to each maternity appointment which were also completed. A separate electronic record was used for all other medical conditions treated in the trust. In addition when maternity patients had foetal heart rate monitoring and were in labour, records were kept in a specific maternity electronic system. Service leaders told us that the maternity service had to continue with the obstetric paper record system because the ante and postnatal electronic records programmes were not available at the time of purchase. Since they became available, the maternity division had not been successful in bidding for the financing of the programmes. The maternity division was working with partners in the wider area to plan for an alternative system in the financial year 2016 and 2017.
- We saw examples of how doctors had accessed hospital electronic records and noted in the paper hospital obstetric record that a treatment decision had been made based on all the available information. However, other speciality doctors, based on other sites, were unable to quickly view the obstetric records of patients at the AH, as they were paper and not electronic. We were told that patients were encouraged to always have their hand held records with them.
- Information is sent by fax to GPs when a patient was discharged from midwifery services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had limited understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of

Liberty Safeguards (DoLS). However, they were aware that they could seek advice from the safeguarding midwife or relevant line managers, who more often dealt with these issues.

- WAHT reported that as at September 2016 MCA and DoLS training had been completed by 37% of staff in within maternity and gynaecology. Medical and dental staff had a training completion rate of 44% while nursing staff had a completion rate of 31%.
- Two members of staff we spoke with told us that patients under the age of 16 would usually be accompanied by their mother to appointments and therefore a suitable adult would be available to support with decision making. Staff were unable to explain to us Gillick or Fraser competency guidelines for patients under the age of 16. Gillick competency is where a child under 16 can consent to a procedure, without parental knowledge or consent, if they meet the criteria of sufficient maturity. The Fraser guidelines relate to contraception only, and provides a test for whether a medical professional should provide contraceptives to under 16s without parental knowledge.
- Staff we spoke with were aware of referral pathways to mental health professionals.
- Assessment records provided an area to complete regarding past or present mental illness. However, we saw no evidence of assessment of capacity to consent to treatment.
- Community midwives were aware of their responsibility to make best interest decisions.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

- Surveys of care consistently showed high levels of patient satisfaction.
- Staff were consistently observed to be respectful, kind and caring.
- Additional measures were taken to protect privacy and dignity where possible.
- Patients told us that staff were always kind.

However:

- Facilities meant that conversations could be overheard at times. However, plans were in place to move to a new unit soon after our visit.

Compassionate care

- All interactions we observed between staff and patients were respectful, kind and considerate. This included reception staff, nurses, midwives and doctors.
- Women we spoke with were positive about the care and treatment they had received. Patients told us that they could not fault the staff and that they had been attentive to all of their needs.
- Staff told us that they were aware of the culture of the majority of the local population.
- All staff told us that they felt comfortable raising concerns about disrespectful, discriminatory or abusive behaviour or attitudes.
- Measures that were in place to protect women's confidentiality and dignity were sometimes used. Additional screening was in place in the gynaecology clinic in front of clinical consulting rooms when patients moved between rooms. However, interconnected consulting rooms in the outpatient department meant that at times conversations could be overheard in the adjoining room. In the maternity assessment unit, curtains separated patients and confidential conversations could easily be overheard. On our unannounced visit we observed midwifery support assistants discussing patients within their earshot. Staff told us that if necessary, the office was used for sensitive conversations. However, most staff including maternity support workers, clerical staff and clinical staff took steps to maintain patient confidentiality.
- For patients who received bad news or were distressed arrangements were in place in the outpatient clinics to allow them privacy and time either alone or with a professional.

Understanding and involvement of patients and those close to them

- Partners and families were welcomed to be involved in the care and treatment of patients.
- Patients and those close to them were routinely involved in planning and making decisions about their care and treatment. However, some patients we spoke with were disappointed that they could no longer choose to have their baby at the AH.

- Patients were given choices in their care and treatment, even if their choice was not the recommended course of action. For example, a woman had chosen a home delivery with a baby in a breech position (bottom down) this was considered to be a high risk delivery which may need medical intervention in case of an emergency. Care had been taken to work with the patient to provide up to date and relevant information to ensure the patient was making an informed choice. Measures such as additional training were taken to accommodate this request. All staff displayed a patient centred approach.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition could have on their wellbeing and on those close to them. Specialist midwives were available trust wide to support patients with specific needs. For example, there was a bereavement midwife in post and plans were in place to expand this service. A safeguarding midwife also looked after patients with mental health and substance misuse problems. Specialist midwives were available for antenatal screening, infant feeding, teenage mothers, diabetes and risk and governance.
- Patients were routinely screened for anxiety and or depression. They were provided with additional support or referred to mental health services as required. In the community, patients were supported by midwives and if necessary referred to their GPs for further assessment and referral. Midwives would also liaise with health visitors to ensure continuity of care.
- Midwives we spoke with were passionate about providing accurate information to enable patients to be able to make their own choices regarding their care and options for labour and birth.
- We were told that there had been a service to allow patients to reflect on any distressing birth experiences; however, this had been discontinued recently.

Are maternity and gynaecology services responsive?

Good

We rated the service for responsive as good because:

- A wide variety of antenatal services were available at the hospital for local patients.
- Gynaecology services provided a range of routine and specialist procedures.
- Maternity services were being developed to enhance the experience of patents.
- Robust pathways to ensure patients were treated by the right person at the right time were in place for all maternity patients.
- The majority of gynaecology patients with "red flag" symptoms (those that need reviewing swiftly) were seen within two weeks.
- Patients were provided with clear information about who to contact if they were worried or in an emergency situation.
- Translation services including signing were available to patients through an interpreter service.

However:

- Some patients expressed concern about the loss of delivery services at the hospital and the longer journey to hospital that this had created.
- A much lower than the national average home birth rate was achieved, with no clear explanation for this.
- There was limited consideration of patients who may have had additional needs.
- Complaints were not always dealt with and closed within 25 days, in line with trust guidelines.

Service planning and delivery to meet the needs of local people

- Service leaders involved matrons and midwives in planning the future delivery of services at the hospital for example in the design and use of space in the new women's unit, based on a "hub" model of care.
- Plans were in place for all women's services to be relocated to the previous delivery and neonatal suites in December 2016.
- The maternity services liaison committee was a local group with multiple stakeholders including service users, Healthwatch, and charitable organisations. It had an interest in local maternity services. We saw meeting minutes from the meeting held in March 2016. Matters discussed were; antenatal education, home assessment of labour, breast feeding support and partners staying overnight in hospital. The minutes showed that local people were able to have their views listened to.

- Some members of the public and service users had expressed anger at the loss of the delivery suite at the hospital. Patients told us they were disappointed and feared not being able to arrive at the alternative hospitals in time in case of an emergency. However, in the year December 2015 to November 2016, there were no babies born before arrival of a midwife at home or at the Worcestershire Royal Hospital of patients that lived more than 20 miles away.
- Antenatal services were for all patients locally. Maternity assessment and gynaecology services were for patients with a low risk of complications. This was due to the current vacancies in both neonatal and obstetrics and gynaecology doctors for the whole of the trust. The vacancy rate medical cover for the service was recorded as a risk.
- Service leaders told us that they planned to concentrate on improving the gynaecology service in the coming year. An action plan had been implemented in which GP referral letters were triaged by a consultant, additional consultant clinics were offered, and outsourcing of gynaecology services was also being explored.
- Senior staff told us that they felt more positive about the services at the Alexandra Hospital (AH) now that there were clear plans in place for women's services.

Access and flow

- For gynaecology patients on ward 14 please see the surgery part of this report.
- From November 2015 to November 2016, 95% of gynaecology patients who had "red flag" symptoms (these are symptoms which could indicate cancer), were seen within 2 weeks of referral.
- Patients who experienced gynaecology symptoms out of hours were referred to the gynaecology assessment unit at the Worcestershire Royal Hospital (WRH) by their GP or emergency department.
- From November 2015 and October 2016 there had been 86 gynaecology operations cancelled. Of the 86 cancellations, 14 patients had not attended. In nine cases the patient had cancelled. Six of the operations were no longer required. 13 the patients were unfit for surgery. For 17 patients there was no bed available. Theatre time over ran causing 13 operations to be cancelled and14 were cancelled for 'other hospital reasons'.
- Patients who required urgent assessment were given details of who to contact for advice. Low risk assessment of a patient's pregnancy was available during the day from Monday to Friday. Outside of normal working hours, urgent pregnancy care and assessment was provided at the WRH. Patients with high risk factors were referred to the WRH at all times. Women less than 20 weeks pregnant were advised to contact their GP or visit the hospital emergency department if they had pain or blood loss. Women over 20 weeks of pregnancy were advised to contact WRH maternity triage for further advice. Patients with gynaecology problems were referred by a GP or emergency department to the gynaecology assessment unit at WRH.
- During routine antenatal care, patients arranged mutually convenient appointments. Gynaecology patients were sent appointments as they became available. Maternity patients had their next appointment booked whilst attending clinic.
- There were 25 gynaecology clinics cancelled from November 2015 to October 2016. This affected 105 patients. Of these, seven clinics and 73 patients were rescheduled. The main reason for cancellation of clinics was a lack of suitably qualified doctors to hold them.
- We were told that most clinics run on time and patients were seen as planned. However, the trust did not audit its antenatal waiting times, so we were unable to substantiate this.
- The maternity unit was closed at AH on 5 November 2015 and all inpatient obstetric activities were transferred to WRH.
- Patients also had the choice to give birth at other hospitals outside of the trust if they wished to. For all antenatal patients, a full consultant led service was available at the AH.
- Patients booked with their community midwife or GP at the beginning of their pregnancy. If assessed as requiring consultant led care they were immediately referred.
- There was a robust and routine antenatal pathway for each patient based on Royal College of Obstetricians and Gynaecologist and Royal College of Midwives guidelines.
- At each appointment, the majority of subsequent appointments were booked. If this could not be done, an appointment was booked at the next opportunity and the patient was alerted by text message or by letter.
- When a woman was in labour, she was advised to telephone the trust wide triage telephone number for a telephone assessment. Alternatively, she could have

gone directly to the triage centre at hospital where she was booked to deliver. If a home delivery was booked, she could telephone the community midwives 24 hours a day.

- The rate of homebirths for the trust was 1.5%. This is lower than the national average of 2.4%. One senior midwife told us that women "Seem to want a hospital delivery here." Other midwives told us that there was limited support from obstetricians and GPs for home births and that patients were concerned about the distance to WRH. However, there had been no formal research into this.
- Women who were booked before 10 weeks and six days of pregnancy totalled 87%; this was close to the target of 90%. Of the women who did not meet this target, a senior midwife told us the data had been analysed to show that 48% of these women referred themselves late, and approximately 30% had either recently moved into the area or were out of the country during the early part of their pregnancy. Community midwives told us that they received notifications from social workers or drug and alcohol teams about vulnerable women who had not yet booked for antenatal care. This allowed midwives to offer a booking appointment to them as soon as possible.

Meeting people's individual needs

- People with complex needs had access to a variety of specialist midwives. Staff told us that they knew how to access learning disability nurses for support and advice if required. At times patients would be accompanied by learning disability support workers. However, we were not assured that all staff had an understanding of minority groups' cultural, social and religious needs. For example, we were told on several occasions that if a patient had a learning disability or communication difficulties, they would be accompanied by a parent. In addition, not all staff knew what female genital mutilation or child sexual exploitation was.
- A multi-faith room was available in the hospital.
- Specialist midwives were available when required. For example, there were specialist diabetes, teenage, safeguarding and bereavement midwives. They were all visible, accessible and approachable at the AH when required. They were also available on email or by phone when not on site.
- Translation services were advertised throughout the hospital. We saw information on notice boards and in leaflets. Staff also told us that they knew that this service was available and how to use it. Information regarding domestic violence was available in three languages on display on the main outpatient notice board.
- Staff told us personalised plans had been made for people with a learning disability or additional needs. Such as having addition visits at home to support with antenatal education and birth planning.

Learning from complaints and concerns

- Information about how to raise a complaint or concern was displayed in the maternity assessment unit waiting room, antenatal waiting room and gynaecology outpatient department. Leaflets were also available. However, patients were not provided with information about how to make a complaint in the community.
- From August 2015 to August 2016, there were 19 complaints about maternity and gynaecology. The service took an average of 40 days to investigate and close the majority of complaints. This was not in line with their complaints policy, which stated that 90% of complaints should be closed within 25 days. In August 2016 there were five complaints still open, of these one was received in May and four in August 2016. The majority of complaints were in relation to clinical treatment (42%) and staff attitudes (26%).
- The service had introduced an openness letter. This letter was sent to patients for complaints or incidents where it was not thought that harm had occurred and therefore the duty of candour had not been established. This letter explained to patients the process for investigating their concern and asked them what aspects of their care they would like to be reviewed. This feedback was then used as the terms of reference for the investigation.
- Following a communication complaint, individual members of staff were seen to review their communication style and to make them aware of the impact that they had on a patient.
- The division has agreed to widely participate in Human Factors training, including Train the Trainers programme and roll this out across the division.
- Lessons learned from concerns and complaints were shared during team meetings and in the weekly electronic newsletter.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Gynaecology day case and inpatient services had a limited vision and strategy in place.
- Visibility of leaders was limited, due to the trust's multisite configuration.
- There was a lack of oversight from senior leaders with regards to some audits, mandatory training and staff knowledge with regards to managing a major incident.
- Some senior nurses had multiple roles, which impacted on their availability.
- There were some gaps in the senior leadership team's awareness of staff competencies.
- There was limited public engagement following the loss of the labour ward.
- Information specifically for maternity patients on the trust website, to help the public understand what maternity services were available where in the trust had not been updated for more than a year.

However:

- The maternity service's vision and strategy were clear, comprehensive and well documented.
- Leaders had a good insight into the challenges facing the service.
- Leaders were well respected and approachable. They kept patient safety and experience at the centre of service delivery and development.
- All staff we spoke with felt respected and valued.
- A culture of honesty and openness was reported throughout the service.

Leadership of service

- Senior leadership in the service had been inconsistent because of changes of people in different roles. Two of the five roles in the service were interim posts (temporary). The non-executive director for the service had recently retired. Plans were in place to recruit to this post.
- The acting Divisional Medical Director had been in post since June 2016; this was an interim post, due to end in March 2017. They were responsible for the women's and children's division within the trust. An obstetrician and gynaecology consultant had taken on the interim clinical director role for women's services (maternity and gynaecology). They had been in post two weeks when we visited; this was to provide leadership in the gynaecology service whilst the substantive clinical lead was on sick leave. This recent change of clinical lead had been managed well. The acting lead had a thorough understanding of the service and the problems within it. The priority was patient safety. Because of this new position, the doctor concerned had changed one session a week from clinical practice to management.
- The director of operations (a non-clinical director), the clinical lead for women's services, which incorporated both obstetrics and gynaecology, and the director of nursing and midwifery had had been in post between three months and three years.
- All of the divisional team had a good insight of the challenges that they had faced over the previous 18 months with regards to the reconfiguration of services. There had been rapid and safe transfer of delivery services to Worcestershire Royal Hospital (WRH).
- Divisional leads were passionate, informed and dedicated to continually improving the service to patients. They were clear about their roles in achieving the service vision. Staff told us that divisional leads were concerned about not only the "big picture" but also about patients' individual care at the hospital. Staff also told us the senior team would take time to see patients when necessary.
- Staff told us that all members of the senior leadership team were approachable and were very responsive.
- Matrons in gynaecology and community and outpatients services covered multiple sites in the trust and therefore, had limited time to be present in the hospital. However, they and staff told us that they were always available by email or telephone.
- One matron was responsible for two separate services, which limited time to monitor and manage their part of the women's division. Staff told us that this matron was rarely visible at the hospital.
- All leaders had a desire to concentrate on developing and improving the gynaecology service within the hospital. Limited plans were in place to develop

gynaecology at the hospital further. However, due to external factors including national plans for reconfiguration it was uncertain whether these plans would come to fruition.
- Local leaders within the maternity services had an understanding of challenges within the service and sought ways to improve.
- Leaders told us that they were proud of the teams they managed. Midwives told us they admired and appreciated their leaders. We observed positive interactions between managers and staff of all levels and saw that good working relationships had been formed.

Vision and strategy for this service

- Clear values had been defined by the trust. At service level, all staff we spoke with were aware of the trust "PRIDE" values. This stood for patients, respect, innovation, dependable and empowerment. They were clearly displayed on notice boards in outpatients and the maternity assessment unit. Staff we spoke with were familiar with the acronym and were able to describe most of the values.
- Following our inspection in July 2015, a plan had been developed for 2016/2017. There was a clear relationship between the trust's values and priorities. Patients' safety, outcomes and experience were at the centre of these. The patient care improvement plan (PCIP) included reference to the future of acute hospital services review and the sustainability and transformation plan (STP). This outlined the service's priorities in investing in staff by ensuring they had annual appraisals and appropriate training. Other priorities were to achieve the 18 week referral to treatment time for gynaecology and to achieve a 27% caesarean rate. Plans had been put into place to ensure that draft reports for serious incidents had been completed within four weeks and that 100% of initial case reviews had been completed within 72 hours. In addition, the plan stated that fewer than 60 incident reports should be open on the electronic reporting system. Some of these objectives had already been achieved, notably the caesarean section rate and the number of open electronic incident reports.
- The PCIP was reviewed regularly and a record was made of updates, new actions and target dates. Weekly priorities were identified and brought to the attention of all staff through email, team meetings and notice boards.
- The service had STP plans outlining the focus on sustainability and transformation up to 2020. Plans included the reorganisation of community midwifery around community hubs. The plan was designed to allow women to access care in their locality, increasing the normalisation of childbirth and reducing interventions. In addition, the gynaecology pathways had been revised to provide more investigations within the primary care setting. This fitted in with the STP plans around the 'hub' model of care. This meant that antenatal maternity and gynaecology outpatient services would all be placed together. Additionally specialist consultant clinics, midwifery clinics, scanning and phlebotomy services would all be in one place, alongside gynaecology and early pregnancy assessment units. The local vision of the service was clearly understood by all staff we spoke with. They were all optimistic about these plans to reconfigure and improve services.
- The gynaecology service had a vision to provide a dedicated gynaecology ward on another site. This new ward was linked into the trust wide future plans with the Future of Acute Hospital Services in Worcestershire. However, we were told this was not planned to be completed for two or three years. Nursing staff were unsure about the certainty of this plan being completed.

Governance, risk management and quality measurement

- A governance framework was in place for maternity and gynaecology services. Maternity clinical governance meetings were held monthly. We reviewed three sets of minutes from May, June and July 2016. Clinical issues, for example, neonatal checks and blood reports, updates from Public Health England regarding antenatal vaccinations and new patient safety alerts were discussed. In addition, there was evidence of discussions surrounding recent serious incidents with a focus on the duty of candour. Clinical performance indicators, for example, percentage rates of third and fourth degree tears were discussed, so that the service was aware of their performance in these areas.

Maternity and gynaecology

- Information from ward or department level was collected on a weekly basis. This informed the divisional governance meetings, which were held every four weeks. At the divisional governance meeting, data was finalised and corrective actions and processes were agreed for ongoing monitoring. Information was then escalated to the clinical governance group and in turn to the quality governance committee. Within nine weeks from the initial discussion at ward or departmental level this information was presented to the board.
- Clear reporting lines were in place from board to ward and ward to board. Staff we spoke with were clear about their roles and understood what they were accountable for. Leaders were, most of the time, aware of their roles and responsibilities. There were clear accountabilities in job plans.
- Staff felt confident in escalating concerns and had clear lines of accountability.
- We saw minutes from antenatal department meetings which covered a broad range of topics including policy updates and reminders, service and individual development. Information was shared to improve practice and service.
- Data was collected to measure quality of the services provided at trust level. However, we were not assured that local leaders had audited all relevant areas of practice. For example, there were no record keeping audits in place to monitor effectiveness and quality of clinical records, or research in place to understand why fewer than expected deliveries were taking place at home.
- There was a lack of oversight from senior leaders with regards to the levels of mandatory training, the Mental Capacity Act 2005 and its application, and staff knowledge with regards to managing a major incident.
- Senior leaders told us they were confident that all staff were trained to recognise female genital mutilation and child sexual exploitation. However, when we spoke with staff most were unable to tell us in detail about either. Training data also showed poor levels of compliance in these areas.
- Arrangements were in place with other neighbouring hospitals to support women who could not access services within the Worcestershire Acute Hospitals Trust for example if they lived nearer to another hospital. Meetings were held as required to develop service level agreements between trusts.
- The PCIP demonstrated that the division had a holistic understanding of performance which integrated the views of people with safety, quality, activity and financial information. The plan demonstrated that there was awareness of what measures were in place to help understand and improve services. For example, staff monitoring of referral to treatment times and waiting lists identified where extra clinics were needed, in an effort to reduce waiting lists.
- Leaders monitored responses to staff satisfaction surveys to understand and improve staff turnover rates.
- The dashboards we saw were up to date and included data from September 2016. This meant that they were produced in a timely way to monitor quality and performance. The type of data collected followed NHS guidelines. For example, women experiencing third and fourth degree tears, staff sickness rates and staff training rates for various competences were included on the dashboard. In addition, maternal outcomes such as caesarean section rate and breast feeding initiation rates were recorded.
- Following the move from the Alexandra Hospital to Worcestershire Royal Hospital (WRH) in November 2015, caesarean section rates had started to fall. Leaders told us this was because there was less reliance on locum doctors and a concentration of consultants on one site.
- There was a programme of clinical and internal audits, used to monitor quality. These included national audits such as postmenopausal bleeding and internal performance indicators such as percentage of women that were still smoking at the date of their delivery. However, the service did not audit compliance with completion of documentation or rates of gynaecology postoperative infections. This meant in some areas where the service did not have access to information regarding performance, risks in these areas may not have been identified.
- A risk management policy and associated register was used to identify and manage risk. All items on the register had review dates and almost all had evidence of progress.

Culture within the service

- All staff we spoke with felt respected and valued. They told us that they understood the trust's value of respect and that an honest and open culture was embedded throughout the service.

Maternity and gynaecology

- All staff we spoke with and observed had the needs, experience and care of patients as their highest priority.
- Staff told us that occupational health services were good and that they had used the service effectively. Managers encouraged the use of the occupational counselling service.
- Staff socialised together and told us that they felt that they achieved a work/life balance.
- From July 2015 to July 2016 there had been a 6% staff sickness rates, above the trust's target of 4%.

Public engagement

- Patients' views and experiences were gathered through the Friends and Family Test. The results from these were very positive.
- The maternity service liaison committee was a local group with representatives from service providers, patients and charitable organisations. The views of local service users were discussed in these meetings.
- There was limited public engagement following the loss of the labour ward in November 2015.
- The trust website had not been updated since November 2015. Staff told us that patients were not fully aware of what services remained in the hospital.
- Leaders were planning an open day to launch the new women's services. One leader told us that despite advice from the communication team, social media would not be used to inform service users of the plans for the unit.

Staff engagement

- 'Listening in action' groups had been introduced. These allowed staff to let the senior management team what they would like for their service.
- Staff had been taken around the new women's unit and invited to comment on or suggest ideas for the new unit.
- Staff were sent regular newsletters and updates by email.
- Departmental and staff meetings were held. The minutes of these demonstrated that information was given regarding developments in the trust and that staff had the opportunity to discuss the services in which they worked.

Innovation, improvement and sustainability

- In April 2016 the service was rated as 'outstanding' by the Nursing and Midwifery Council for its mentorship and training.
- No one we spoke with could tell us of a time when financial pressures had compromised care.

Services for children and young people

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

Information about the service

The only specialist children and young people's service at Alexandra Hospital in Redditch, was the children's clinic. This was formerly Kingfisher Ward. The children's clinic is an outpatients department where children and young people attend outpatient appointments with a doctor or another health professional. Clinics run from 9am to 5pm Monday to Thursday.

Children requiring ear, nose, throat (ENT), dermatology, eyes and ears, and orthopaedic outpatient's clinics are seen in the hospital's adult outpatients department.

Children's inpatient services have been temporarily transferred to Riverbank Ward at Worcestershire Royal Hospital (WRH) from 7 September 2016.It is estimated that this service change will be in place until the outcome of the 'Future of Acute Hospital Services in Worcestershire' public consultation is available, or until there is consistent 24 hour a day, seven day a week medical cover for two paediatric rotas to ensure safe services.

There were no children and young people's surgical services at Alexandra Hospital. Children and young people's surgery was transferred to WRH in September 2016. Children requiring surgery would attend or be transferred to WRH.

During the inspection we spoke with 14 members of staff including medical and nursing staff as well as support assistants and a play therapist. We also spoke with patients and their relatives or visitors. We made observations during the inspection and reviewed a range of documents during and following the inspection.

Children and young people's services provided by this trust are located on three hospital sites, the others being WRH and Kidderminster Hospital, these are reported on in a separate report. However, services on each hospital site are managed by one management team and are regarded and reported on by the trust as one service, with many of the staff working across sites. For this reason it is inevitable there is some duplication contained in the three reports.

Services for children and young people

Summary of findings

We rated this service as requires improvement because:

- Staff were not aware of any guidance to support them in identifying what incidents should be reported. This created a risk of under reporting of incidents.
- Incidents were not always graded. In addition learning from incidents was not identified. This meant there was a risk of the service and staff not learning from incidents.
- Record templates were not always clear and did not contain columns on documents that clearly identified where height and weight should be recorded.
- Staff were unaware of female genital mutilation (FGM) and child sexual abuse (CSE). There was a risk that staff would not recognise when a child was being abused or exploited.
- Level 3 safeguarding children's training was not always face to face and was not updated annually; this was not compliant with the guidance on safeguarding training.
- There were some policies relating to safeguarding children that were not available on the trust intranet, including a; 'no allegations policy'; and a; 'managing celebrity visits' policy. The safeguarding supervision policy also stated that it was in development on the intranet safeguarding pages.
- There was no clinical audit plan for the children's clinic. There was little evidence that continual improvement of the service and compliance with best practice was identified or actions taken to address shortfalls.
- The women and children's division had introduced a performance dashboard to monitor patient's outcomes. There was little evidence that performance in the children's clinic was discussed.
- There was no formal clinical supervision for nursing staff. Supervision was provided by an outpatient's manager via telephone. However, the manager also worked in WRH as an advanced nurse practitioner (ANP), and could only offer staff telephone support when there were quiet periods at WRH.
- Multidisciplinary working between all the trust's hospital sites was not effective at all times.
- The 'did not attend' (DNA) appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%.
- From September 2015 to August 2016 there had been three complaints about children's services at Alexandra Hospital. The hospital took an average of 31 days to investigate and close complaints, this was not in accordance with their complaints policy, which states complaints should be closed within 25 days.
- As a result of the service reconfiguration the children's service did not have a clear vision, and did not have a long-term strategy for children's services. Staff were unaware of the vision and values for the children's outpatients' service as these were not defined.
- The governance framework was not effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings.
- Monthly divisional governance meetings were not consistently adhering to their terms of reference. This included: not focusing on themes and trends from incidents; safeguarding training performance, and was not broken down to include compliance with level 3 safeguarding training.
- The divisional risk register, focused on the number of risks recorded, rather than how they were being managed. Although the hospital had recently closed to paediatric inpatients, there had been little discussion around how the transitional period was being managed.
- The outpatients manager had not been allocated any contracted hours for service leadership and they were fitting this in with their ANP role at WRH. This meant it was unlikely that staff would receive timely supervision and advice.
- Some staff did not feel fully consulted about the service reconfiguration.

However:

- The environment in the children's clinic was observed to be visibility clean and staff followed correct protocols.

Services for children and young people

- Overall, care records were generally written and managed well. However, record templates were not always clear and did not contain columns on documents to clearly identify where height and weight should be recorded.
- Staff had achieved the trust's mandatory training target of 90%.
- There was no paediatric resuscitation 'bleep' in use at Alexandra Hospital. There were clear protocols describing how children should be transferred to WRH if they needed to be treated by a specialist paediatric doctor.
- Medical and nursing staffing levels were planned and reviewed in advance based on an agreed number of staff per shift.
- The trust had a major incident plan in place. However, staff were not aware of a business continuity plan to deal with adverse weather.
- Staff who worked in the children's clinic took the time to interact with patients and their parents in a manner which was respectful and supportive.
- All the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after.
- Feedback from CQCs children and young people's survey 2014 was largely similar to other trusts including privacy, care and treatment and staff friendliness.
- Staff communicated with children, young people and their families in a way that they could understand their care and treatment
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of information available in the children's clinic.
- Staff understood the impact that a patients care, treatment and condition had on them and those close to them.
- Services in the children's clinic took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- The trust's 95% target for referral to treatment time (RTT) for non-admitted children and young people receiving an appointment within 18 weeks was regularly met.
- Managers told us service reconfiguration was made with the objective of making improvements for patients and staff. However, at the time of our visit it was too early in the reconfiguration process to measure whether this would result in sustainable improvements to children and young people's care.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Staff were not aware of any guidance to support them in identifying what incidents should be reported. This created a risk of under reporting of incidents.
- Incidents were not always graded. Learning from incidents was not always identified. This meant there was a risk of the service and staff not learning from incidents.
- Record templates were not always clear and did not contain columns on documents that clearly identified where height and weight should be recorded.
- Staff were unaware of female genital mutilation (FGM) and child sexual abuse (CSE). There was a risk that staff would not recognise when a child was being abused or exploited.
- Level 3 safeguarding children's training was not always face to face and was not updated annually; this was not compliant with the guidance on safeguarding training.

However:

- The environment was observed to be visibly clean and staff followed correct protocols.
- Overall, care records were written and managed adequately. However, record templates were not always clear and did not contain columns on documents to clearly identify where height and weight should be recorded.
- The trust's mandatory training target of 85% had been reached.
- There was no paediatric resuscitation 'bleep' in use at Alexandra Hospital. However, staff in the emergency department (ED) had received training in paediatric life support. There were clear protocols describing how children should be transferred to WRH if they needed to be treated by a specialist paediatric doctor.
- Medical and nursing staffing levels were planned and reviewed in advance based on an agreed number of staff per shift.
- The trust had a major incident plan in place. However, staff were not aware of a business continuity plan to deal with, for example, adverse weather.
- There was a multidisciplinary approach locally at the hospital to provide support for children with their long-term nutritional needs, including diabetes clinics and input from dietitians.
- Non-clinical staff told us they met daily with the band 5 staff nurse and could ask for advice throughout the day as they worked closely as a team.
- There was support for patients from allied health professional services, including physiotherapy and dietetics.

Incidents

- The trust used an electronic incident reporting tool to report incidents. The staff we spoke with were competent in the use of the electronic system and told us they always reported incidents where it was appropriate to do so. The trust had developed an incident reporting policy which was available to staff on the trust intranet. Review of the policy confirmed it outlined the reporting process and responsibilities, together with a risk scoring matrix for the categorisation of incidents. However, staff in the children's clinic told us they were not aware of any guidance to support them in identifying which incidents should be reported. This meant there was a risk that some incidents were not reported which did not fully reflect potential harm to children.
- There was one incident reported within the children and young people's services at Alexandra Hospital from 1 August to 21 November 2016. The incident in November 2016 involved a child who had arrived at the children's outpatients urgent review clinic late in the afternoon. The clinic staff were not aware that the child had been referred. However, the incident report did not record what actions had been taken in response, or identify learning. Even though the child did not suffer any harm, it had not been graded as no or low harm on the incident report in accordance with the trust's policy. The incident had been reviewed with the outpatients' manager and the family had been spoken with. In addition, this incident had been highlighted to some of the staff at WRH. But, there was no record of agreed actions in response to the incident on the electronic incident report.
- There had been no serious incidents (SI) which met the SI reporting criteria set by NHS England that related to the Alexandra Hospital children and young people's services from October 2015 to September 2016. There

was a policy in place for the investigation of SIs. The trust target would be for SIs to be investigated within 60 days. However, managers told us they were reviewing the investigation time period and there was a move towards introducing localised investigation targets.

- The outpatient's manager told us incidents were reviewed at monthly review meetings, which they attended. Lessons learnt from incidents were disseminated to staff via the meeting minutes.
- There had been no never events reported from October 2015 to September 2016. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff who worked in the children's clinic outpatients department told us that there were few incidents in outpatients at the Alexandra Hospital. However, staff were unaware of recent incidents reported by other departments in the trust but were aware that there was a trust wide monthly 'risk bulletin' that shared this information.
- Staff at the children's clinic told us the outpatients lead considered all incidents, which were reviewed further at divisional level. We did not request to see minutes from the monthly meetings.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Staff understood the duty of candour regulation and told us that they would share information with children and their parents or carers as soon as practicable following an incident. Managers told us the hospital would always speak to the family where there had been a safety incident, as well as sending the family a; "being open letter." Managers said the trust had two "open" duty of candour incidents that were undergoing investigation. However, neither of these incidents related to Alexandra Hospital.
- Paediatric mortality and morbidity meetings were held at the Worcestershire Royal Hospital. Medical staff told us there had been no reviews related to the children's clinic at Alexandra Hospital.
- The outpatient's manager told us they were sent patient safety alerts from the Department of Health's central alerting system (CAS) by the communications team. They would cascade any relevant alerts to all staff via email. Staff confirmed that they received patient safety alerts by email from the outpatients lead nurse.

Safety Thermometer

- Service reconfiguration which took place in September 2016, in the children and young people's services had led to the suspension of services on Ward 1 (Kingfisher), Alexandra Hospital, which was the children and young people's inpatient ward. This meant there were no inpatient services at the hospital. However, prior to the closure the hospital had reported data on patient harm each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included data from Ward 1. It covered hospital-acquired (new) pressure ulcers, including only the two more serious categories, grade three and four; patient falls with harm; urinary tract infections; and venous thromboembolisms (deep-vein thrombosis). From September 2015 to September 2016, Ward 1 had reported 100% harm-free care for the snapshot during this period.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained in the outpatient department. We saw areas we visited were visibly clean and the staff we spoke with told us they were satisfied with the level of cleanliness and had no concerns.
- We observed staff complying with infection control guidance. Personal protective equipment, hand washing facilities and hand gel was available throughout the clinical areas. Staff were bare below the elbows and wore personal protective equipment as required.
- We saw: "I am clean" stickers in use across all clinical areas stating the date and time of last cleaning. This showed that equipment was clean and ready for use.

- Equipment we reviewed was visibly clean and we saw that labels were used, dating when equipment had been cleaned.
- Clinical and domestic waste bins as well as sharps bins on the children's clinic were used and stored appropriately.
- All staff were required to compete infection control training, which had been completed by 80% of paediatric medical and nursing staff. However, these figures related to the whole of the women and children's division.
- We saw that toys in the children's clinic were cleaned as required and the hospital did not use soft toys in children's play areas.
- Monthly infection control and hand hygiene audits were undertaken by nursing and support staff on the children's clinic. These audits were displayed on the ward and recorded 100% compliance for October 2016.
- The trust submitted evidence of annual audits undertaken by the infection prevention and control (IPC) team in May 2016. In the IPC team's audit, the children's clinic was slightly under the trust target of 90%, achieving 82% compliance. However, the audit related to the children's clinic prior to the move out of Kingfisher Ward.
- We could not view a sample of cleaning schedules at the children's clinic. Staff told us work was in progress with the trust's IPC lead on cleaning schedules for children's clinic, but these were not fully completed at the time of our visit. This meant there was no guidance available to staff on the frequency of cleaning in the clinic.
- There had been no reported cases of MRSA or Clostridium difficile from September to November 2016 at the Alexandra Hospital children's service.
- In the CQC children's survey 2014 the trust scored 8.97 for the question 'How clean do you think the hospital room or ward was that your child was in?' This was about the same as other trusts.

Environment and equipment

- The children's clinic was housed in the former Kingfisher Ward. Staff told us most of the equipment from Kingfisher Ward and Ward 1 had been transferred to Riverbank Ward at WRH. Staff said the Kingfisher Ward had provided more space for the children's clinic and this had improved the environment for children and young people attending outpatient's appointments.
- The children's clinic consisted of four consulting rooms. A bay was being used for the storage of equipment. Staff told us that equipment, including monitors were awaiting removal, as it was left at the clinic following the service reconfiguration. We checked the service dates on some of the equipment and found these to be in date.
- There was a 'nursing den' on the ward, this was a cubicle where children's height and weight was measured and where staff conducted blood tests and skin prick tests for allergy clinics.
- The children's clinic had adequate equipment to meet the needs of children and young people. Equipment was maintained and portable appliances had been subject to relevant safety tests.
- Clinical waste was appropriately stored and disposed of.
- The resuscitation equipment in the children's clinic, contained varied sizes of kit to cater for the potential range in ages and sizes of the children. Daily checks were performed to ensure required equipment was available and that emergency medicines on the resuscitation trolley remained in date.
- Treatment rooms were appropriately secure and locked by use of a keypad.
- The children's clinic was adequately secure to ensure intruders did not enter the ward.
- There was a buzzer entry system for the children's clinic and we observed staff asking visitors who they were before allowing them entry to the clinic.
- The children's clinic had piped oxygen and suction, this had remained on the ward from the reconfiguration, although staff said they had never needed to use it.
- In the CQC children's survey 2014 the trust scored 9.16 for the question 'Did you feel safe on the hospital ward?' This was about the same as other trusts.
- The trust scored 9.51 for the question 'Did you feel that your child was safe on the hospital ward?' This was about the same as other trusts.
- The trust scored 8.87 for the question 'Did the ward where your child stayed have appropriate equipment or adaptions for your child?' This was about the same as other trusts.

Medicines

- There were suitable arrangements in place for management of medicines which included their safe ordering, prescribing, dispensing, recording, handling and storage.

- Staff told us they were still in the process of reviewing medicines as some had been left on the ward following the service reconfiguration, and were not needed at the Alexandra Hospital children's clinic. Staff said these would be sent to WRH.
- We saw that room and fridge temperatures were checked daily and that these had all been within the required range. We found that medicines were stored securely in the children's clinic.
- Medication records were completed for patients. A medicine administration record specific for children was used to record medication prescribed and administered and we saw these had been completed appropriately for patient files we reviewed. Each patient had their weight checked and prescriptions were written accordingly.
- Checks were made on medicines stock levels by the staff nurse and doctors. The doctors and staff nurse also double checked and completed checks on patient medication records. Key to the medicines room and cupboards were held by the band 5 nurse throughout the shift.
- There had been no medication incidents reported from September to November 2016.

Records

- Children and young people's individual care records were available on every shift at the children's clinic. Records were generally written and managed well. However, record templates were not always user friendly. For example, staff at the children's clinic recorded children's height and weight at every appointment. This was recorded in the patient history section of their records, but there was no specific area on the record for patients' height and weight to be recorded. Therefore, staff were recording this information in the patient history section that their written records referred to the height and weight of the child or young person. This could have confused someone reading the record from the trust's electronic record system. This was highlighted to staff in the clinics and they said they would address this with the outpatients' manager.
- We found children and young people's records were locked securely in trolleys located at the work stations. Records we reviewed were mainly legible and up to date and contained an appropriate level of information.
- Children and young people's records were scanned following every clinic onto the trust's electronic system. We viewed five children and young people's clinical records and found these were mostly clear and legible. However, we found one patient's record where the scanning process had blurred the doctor's note and it took us some time to decipher what the doctor had written. Staff told us it was rare that doctors' notes could not be read due to the scanning process and they would telephone or email the doctor if they could not read notes.
- There were 'flags' on the system to identify vulnerable patients. For example, children subject to child protection plans.
- Children and young people with child protection plans, their records could only be opened by staff that had authorised access. Therefore staff that did not need to know specific details of a child's protection could not access sensitive information.
- Staff told us the electronic patient record system had created work, as staff had to record on paper based notes. Staff said they then had to print a note, for each child or young person, to go with their notes for scanning. However, staff said that overall the system was effective, as staff across the trust had access to a child or young person's notes immediately.
- Staff told us there had not been any record audits since the service reconfiguration and they were not aware of any planned records audits.

Safeguarding

- There were systems in place to ensure safeguarding concerns were identified and reported. Nursing staff at the children's clinic told us safeguarding concerns would be recorded on the trust's electronic system.
- A new head of safeguarding was appointed in January 2016 and commenced in post May 2016. Staff at the children's clinic said they had not had any contact with the new safeguarding lead as they hadn't had any reason to contact them. However, staff at the children's clinic could name members of the safeguarding team and knew how to contact them if they needed support in identifying concerns and taking appropriate action. Staff at the children's clinic said they had not made any safeguarding referrals since the reconfiguration of services. Staff understood the safeguarding referral process and how to make a referral.

- There was an alert field in children and young people's notes to flag to staff if there were safeguarding concerns relating to a child or young person.
- Staff we spoke with had an understanding of the types of concerns that would prompt them to make a safeguarding referral including; neglect, physical, emotional, and sexual abuse. However, nursing and support staff said they were not aware of female genital mutilation (FGM) and said they did not think they had received any training on child sexual exploitation (CSE); although most of the staff told us they would seek advice from the new safeguarding lead if they had concerns. The trust had a programme of training that was being rolled out to staff. However, staff at the children's clinic were unaware of the programme and had not been informed on when or if they would be expected to attend.
- There were arrangements for safeguarding supervision and the staff we spoke with told us they could access this from the safeguarding team.
- There were four levels of safeguarding training, levels 1, 2, 3 and 4. The intercollegiate document,' Safeguarding children and young people: roles and competences for health care staff, 2014', states that, 'all clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/ child protection concerns must be trained to level 3'. Named professionals must be trained to level 4. Review of staff training data confirmed that 100% of registered nursing staff and support staff in the children's clinic had completed level 3 training. All eligible medical staff had completed level 3 training against a trust target of 90%. However, some staff said they had completed their level 3 training online. This is not compliant with the intercollegiate document which states that level 3 training should include an element of face to face training, and should be updated annually.
- Staff in the main outpatients department were required to do safeguarding adults and children at level two. However, data submitted by the trust showed that only 58% were compliant with level 2 safeguarding children training.

Mandatory training

- There was a structured induction and mandatory training programme for staff.
- We viewed the women and children's division 'workforce and training metrics' which provided us with information from July 2015 to June 2016. There were 12 mandatory training modules which each member of staff was required to complete in line with agreed frequency, this included; equality and diversity including bullying and harassment, medicines management, conflict resolution, health and safety, information governance, fire, moving and handling, safeguarding adults, safeguarding children, resuscitation, hand hygiene and infection control.
- The staff at the children's clinic showed us records confirming they had achieved the trust's mandatory training target of 85%%. Staff were allocated dedicated time to complete 'face to face' mandatory training, such as basic life support.Some of the mandatory training was completed online and it was expected that staff complete this whilst working on the ward during quieter periods. The staff we spoke with told us that this did not pose any difficulties and that they found training provided by the trust helpful.
- Overall, the women and children's division had a compliance rate of 64% for all mandatory training courses. Some courses had been poorly attended by specific staff groups whilst others had been well attended, for example, 0% of additional professional and technical staff had completed conflict resolution and equality and diversity; compliance with fire safety and infection control was 100% for this same group. Medical and nursing staff had a low level of compliance with medicines management for example, at 33% and 30% respectively. Higher attendance rates had been achieved for some other courses, for example 87% of medical staff had attended manual handling training and 85% of nurses had completed information governance. 84% and 87% of medical and nursing staff had completed basic life support (BLS). Staff in the children's clinic had completed both adults and children's BLS training.
- The percentage of staff trained paediatric intermediate life support (PILS) and/or European paediatric life support (EPLS) training had improved since the previous inspection. We confirmed that 91% of women and children's staff had completed their PILS training which

was similar to the figure in 2015, 68% of nursing staff had completed EPLS compared to 48% in 2015. Nursing staff at the children's clinic had up to date paediatric life support training.

Assessing and responding to patient risk

- Nursing staff at the children's clinic told us they did not complete risk assessments. Risks were assessed on an ongoing basis at each appointment for regular attenders to the department, or at individual clinics for children or young people attending one appointment. Staff told us the consultant in charge of the children's clinic would assess risks to patients on the day of their appointment and would escalate any concerns for further investigation or transfer the child or young person to WRH. Children attending the urgent review clinic would receive a full set of observations including urine testing, height and weight prior to seeing a doctor.
- There was no paediatric resuscitation 'bleep' in use at Alexandra Hospital. Staff said if there was an urgent issue with a child or young person in the hospital staff would have to telephone the Emergency Assessment Pathway (EAP) at WRH. The EAP would look to see if there was a consultant with paediatric resuscitation competence on-site. Staff at the children's clinic said, even though they were trained in basic paediatric life support they had declined to carry the bleep, due to a risk to the children's clinic if they answered a call in another part of the hospital. However, staff in the emergency department (ED) had received training in paediatric life support to mitigate the risk and carried a bleep. This meant ED staff could respond to the bleep.
- The children's clinic did not have support from a psychologist except for patients diagnosed with diabetes. Staff told us children with mental health needs usually only visited the children's clinic when their conditions were managed. Staff told us they would liaise closely with parent or carers of children that were prescribed anti-psychotic medicines and would offer a side room to young people with mental health needs if this was their preference due to their increased vulnerability. Ligature points had been identified and actions taken to minimise risk.
- There were clear protocols describing how children should be transferred to WRH if they needed to be treated by a specialist paediatric doctor.
- Nursing staff told us they had not received any training in recognising the signs and symptoms of sepsis (blood poisoning), although staff said there had been risk briefings circulated by the trust that carried information in regards to sepsis.
- Staff at the children's clinic told us the paediatric early warning score (PEWS) tool was used at WRH and had been used at the Alexandra Hospital for paediatric inpatients to monitor and manage deteriorating patients on the paediatric ward. However, this was not relevant to the outpatient's service as they did not complete PEWS on outpatients.
- The trust told us that the children's ambulance pathway had criteria to transfer children to Alexandra hospital ED based on the other pathways across from the West Midlands.

Nursing staffing

- Staffing levels were planned and reviewed in advance based on an agreed number of staff per shift. Staff had access to a band 8 outpatient's manager during clinic opening hours. However, this was via the telephone, as the outpatient's manager also worked clinically as an advanced nurse practitioner (ANP) at WRH.
- The women and children's division had a performance dashboard; this was used to monitor staffing levels, sickness levels, and vacancies in the service. The dashboard was a useful tool for managers in giving them an oversight of staffing across the division. However, it did not provide information on specific services, or site level information.
- Managers told us the service reconfiguration had considered the skill mix required for the children's clinic and how to utilise the staff skill set. Nursing staff at the children's clinic were registered nurses (child branch) and trained in advanced paediatric life support. Staff at the children's clinic told us that staffing arrangements worked well.
- There was one registered nurse working on each shift and one children's health care assistant (HCA) on each shift. The children's clinic nursing staffing numbers at Alexandra Hospital in November 2016 were 0.4 whole time equivalent (WTE) band 5 nurse. The nurse was supported at the clinic by 0.4 WTE children's health care assistant (HCA) and one WTE receptionist.
- The trust reported their staffing numbers at Alexandra Hospital in September 2016 as 18.91 establishment WTE

nursing staff, the actual number was 16.61. In total there was 2.30 staff less than was budgeted for. However, these figures related staffing numbers prior to paediatric inpatients being relocated to WRH.

- In September 2016, the trust reported a vacancy rate of 16% in children's services at Alexandra Hospital. This figure related to children and young people's services at Alexandra Hospital prior to the temporary closure of the children and young people's inpatient ward. There were no nursing vacancies in the children's clinic in November 2016.
- From September 2015 to August 2016, Alexandra Hospital reported a bank and agency usage rate of 1% in children's services. This figure related to children and young people's services at Alexandra Hospital prior to the temporary closure of the children and young people's inpatient ward.
- In September 2016 the trust reported a vacancy rate of 13% in children's services across all sites including: WRH, Alexandra Hospital and Kidderminster Hospital.
- In September 2016 the trust reported a turnover rate of 26% in children's service.
- From March 2015 to April 2016, the trust reported a sickness rate of 1% across all sites in children's services. Children's clinic staff told us if the band 5 nurse was absent due to sickness the hospital would not use agency staff. A nurse would be sent from WRH to cover the band 5 absence. From September 2015 to August 2016, the trust reported a bank and locum usage rate of 7% across all sites in children's services; Bank usage varied between 5% and 10% over the period.
- The emergency department employed two part time registered nurses (child branch) and had another full time (WTE) registered children's nurse due to take up employment in January 2017.

Medical staffing

- Managers told us one of the reasons for the reconfiguration was to alleviate pressure on the middle grade doctor's rota across the trust.
- Staffing levels and skill mix were planned at the children's clinic so that patients received safe care and treatment. A review of a sample of rotas confirmed that actual medical cover agreed to planned staffing arrangements. There was an onsite consultant from 9am to 5pm Monday to Friday.
- There were no paediatricians (children's doctors) in the hospital after 5pm. For this reason, it was intended that the ambulance service would not bring children with illnesses or injuries to the emergency department (ED). If a child was brought to the ED out of hours, then staff at the EAP would make a decision about the transfer of the child to WRH or whether a paediatrician would need to travel to the ED at the hospital.
- The children's clinic had contact telephone numbers and access to advice from specialist paediatric consultant at the EAP at all times.

In September 2015 the trust reported a consultant vacancy rate of 7% in children's services across all sites including: WRH, Alexandra Hospital and Kidderminster Hospital. The vacancy rate for other medical staff was 18% across all sites.

- From September 2015 to August 2016 the proportion of consultant and junior (foundation year 1-2) doctors reported to be working at the trust, were about the same as the England average for consultants and higher than the England average for junior doctors. A breakdown of the staffing skills mix was: 39% consultants, compared to the England average of 40%: 3% middle career doctors, compared to the England average of 7%: 39% registrars, compared to the England average of 46%: 18% junior doctors, compared to the England average of 7%.
- Bank and agency usage across all sites varied between 5% and 10% from September 2015 to August 2016 across the trust's sites. However, the children's clinic did not use agency staff. In the event that a nursing staff member was absent a nurse from WRH would be sent to cover the absence.

Major incident awareness and training

- The trust had a major incident plan in place and staff knew how to access this on the trust's intranet. However, staff in the children's clinic told us there was no business continuity plan they were aware of to deal with adverse weather or other events that might affect the continuity of services. Staff told us that they had an informal business continuity plan, whereby a staff member who lived locally would come in to the clinic and telephone families to cancel and rearrange their appointments. But this was an 'ad hoc' arrangement and had not been formalised.
- Staff at the children's clinic told us they had not completed a major incident rehearsal or received training in major incident awareness.

Services for children and young people

- The hospital's staff had access to the hospitals security guards. In the event of an incident involving a young person requiring physical restraint or safe holding, we were told that staff would request security to attend the children's clinic or the police would be called. However, security guards had not received training on children's restraint or safe holding. Staff told us it was highly unlikely that a child or young person would attend the children's clinic and require restraining. However, there was a risk that a situation may arise which would require a patient to be restrained and staff would not be appropriately trained.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

- There were some policies relating to safeguarding children that were not available on the trust intranet, including a 'no allegations policy'; and a 'managing celebrity visits' policy. The safeguarding supervision policy also stated that it was in development on the intranet safeguarding pages. This meant staff did not have access to the most up to date policies at all times.
- There was no clinical audit plan for the children's clinic. There was little evidence that continual improvement of the service and compliance with best practice was identified or actions taken to address shortfalls.
- The women and children's division had introduced a performance dashboard to monitor patient's outcomes. There was little evidence that performance in the children's clinic was discussed.
- There was no formal clinical supervision for nursing staff. Supervision was provided by an outpatient's manager via telephone. However, the manager also worked in WRH as an advanced nurse practitioner, and could only offer staff telephone support when there were quiet periods at WRH.
- Multidisciplinary working between all the trust's hospital sites was not effective at all times, and there had been an incident where a child was referred to the children's clinic by WRH. Staff at the children's clinic were not aware that the child was going to arrive at the clinic until the child arrived close to the clinic's closing time.

However:

- There was a multidisciplinary approach locally at the hospital to provide support for children with their long-term nutritional needs, including diabetes clinics and input from dietitians.
- The trend for appraisal rates from April 2015 to August 2016 demonstrated improvement, with and appraisal rate of 89% for medical and dental staff.
- Non-clinical staff told us they met daily with the band 5 staff nurse and could ask for advice throughout the day as they worked closely as a team.
- There was support for patients from allied health professional services, including physiotherapy and dietetics.
- Children, young people and parents and carers were supported by staff to make decisions.

Evidence-based care and treatment

- Patient's care was mostly planned and delivered in line with evidence based guidance, such as the National Institute for Health and Care Excellence (NICE) and the Royal College guidelines. For example, we viewed the transitional care pathway for young people with diabetes that were transitioning to adult services. The pathway was based upon the National Service Framework (NSF) for young people and the NSF for diabetes.
- Policies and guidelines were available on the trust intranet along with regional and national guidance. There were a range of trust wide policies as well as those specific to children and young people. We reviewed a sample of policies including, the treatment pathway for FGM and the safeguarding children's policy. The care pathways for FGM and safeguarding both referenced the current evidence base. However, we also found there were some policies that were not available on the intranet, including a 'no allegations policy'; and a 'managing celebrity visits' policy. The safeguarding supervision policy also stated that it was in development on the intranet safeguarding pages. This meant staff did not have access to the most up to date policy guidance at all times.
- We found that staff were confused about searching for the most up to date guidance on the trust's intranet. For example, we asked staff to search specific policies and guidance and they struggled to find them. Staff said, "The intranet is not the easiest to navigate to perform a

search." However, staff did manage to find the policies relating to FGM after three attempts. We found a search for a policy generated a number of results and staff didn't know if the results could be filtered to make accessing a specific policy easier.

Pain relief

- Staff at the children's clinic told us pain assessments were not made at the children's clinic. However, staff offered parents and carers advice following vaccinations to ensure pain was managed effectively.
- Distraction techniques were used to divert children from painful procedures such as vaccinations, and anaesthetic cream was used when taking blood from children.

Nutrition and hydration

- There was a multidisciplinary approach to provide support for children with their long-term nutritional needs, including diabetes clinics and input from dietitians.
- Staff told us that children's hydration was always assessed at urgent review clinics.
- Water and a selection of fruit squashes were available on the clinic and visitors could help themselves to these as required.
- Staff told us they did not get long delays at the children's clinic. However, in the event that a child was delayed staff told us, "We wouldn't leave a child without food. We would get them some food from the hospital canteen."
- The children, young people and parents we spoke with told us they were satisfied with the food and hydration provided.
- Snacks were available from machines in the hospital 24hours-a-day. These included fruit, sandwiches, crisps and cereals. This meant that patients could have food at any time outside of meal times.
- Staff working in the children's clinic promoted breastfeeding without judgement. They offered support to help mothers as much as possible, including offering a private bay.
- Children and young people were weighed at every appointment and weight assessed for their specific condition.
- Children and young people had access to speech and language therapists for swallowing assessments, advice and support via referral form the children's clinic. Nurses from the community services would visit and replace nasogastric tubes upon request.

Patient outcomes

- There was no local clinical audit plan for the children's clinic at Alexandra Hospital. Staff told us, "We aren't doing any audits at the moment. It hasn't been the priority as we have had more immediate issues to deal with due to the reconfiguration." This meant the children's clinic was not collecting information that would provide continual improvement of the service or monitor compliance with best practice.
- Outcomes from patient's care and treatment was collected and monitored in line with national audit requirements by the children's service. However, intended outcomes for some patients were worse than the national average and the trust had reconfigured children's services to make improvements. For example, the trust took part in the National Paediatric Diabetes Audit (NPDA) 2014/15 which showed that the percentage of patients with controlled diabetes was worse than other trusts.
- HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised HbA1c target, usually between 48 mmol/l and 58 mmol/l (7% and 8%)". In the 2014/15 diabetes audit, the trust performed worse than the England average. There were fewer patients at Alexandra Hospital (17%) having an HbA1c value of less than 58 mmol/l compared to the England average (22%). The hospital's mean HbA1c (73%) was higher than the England average (71%).

Competent staff

- Staff completed an annual appraisal as part of their personal development review. Staff at the children's clinic told us that they found the appraisal process helpful and had completed their appraisal within the preceding 12 months. From April 2015 to March 2016, 85% of staff within children's services and across all sites at the trust had received an appraisal compared to a trust target of 90%. In this period 88% of medical and dental and 76% of other medical staff received an

appraisal. From April to August 2016 88% of medical and 82% of other medical staff received an appraisal. However, it should be noted that the data provided by the trust did not differentiate between children's services and women's services, therefore, these percentages included data provided under women's and children's services

- The trend for appraisal rates from April 2015 to August 2016 demonstrated improvement, with and appraisal rate of 89% for medical and dental staff having an appraisal, compared with the figure from April 2015 to March 2016, when the rate had been 87%. There was also improvements in appraisal rates for non-medical staff groups with the rate having risen from the April 2015 to March 2016 rate of 76%, to the April to August 2016 rate of 82%. The two staff groups reached the trust target of 85% appraisal rates.
- Most staff had the right qualifications and experience to carry out their role, for example there were specialist nurses for some clinics, including diabetes, respiratory and epilepsy.
- The children's clinic band 5 lead nurse had completed a mentorship programme at a Worcestershire University. This was to facilitate the children's clinic supporting student nurses. Staff said they had a student nurse on placement and were intending to take other students. But the reconfiguration had meant that facilitating student placements was not a priority until the children's clinic was established.
- Registered nursing staff at the children's clinic told us clinical supervision was, "ad hoc." Staff said they could ask for clinical supervision, but there was no formal timetable. Nursing staff told us the outpatient's manager was available on the telephone if staff needed guidance and the medical staff at the children's clinic would also offer advice. The outpatient's manager told us they would return telephone calls during quiet periods in their work at the outpatients department at WRH.
- Non-clinical staff told us they met daily with the band 5 staff nurse and could ask for advice throughout the day as they worked closely as a team.
- Children were seen in the main outpatients ENT, ophthalmology and audiology clinics. Staff in the ophthalmology department told us there were no staff in the outpatients department that were trained specifically to care for children. Staff in the children's clinic told us they could not support children and young people in adult clinics as the children's clinic had one registered nurse and one HCA, and they were required to stay in the children's clinic.
- The children's clinic consultant had a job plan in place which outlined their duties, responsibilities and accountability.
- There was a process in place to ensure all medical and nursing professionals had their registration status monitored. We confirmed through a sample of some staff records that all staff listed as employed and registered had a valid registration.
- The Royal College of Nursing safer staffing guidance recommends that each ward or department has at least one qualified member of staff working each shift who has undertaken European Paediatric Life Support (EPLS) training. We reviewed the band 5 lead nurse's training record which confirmed this recommendation had been met for each for each shift at the children's clinic. The band 5 nurse also had up to date training in cannulation and taking blood samples.
- Nursing staff attended monthly outpatient's clinic meetings. These were where staff from across all the trust's children's outpatients' teams met. Staff told us the meeting was an opportunity for staff to share learning and new practice. Staff gave us an example of learning about new tourniquets from a recent meeting.
- Staff had access to the hospital's security guards. In the event of an incident involving a young person requiring physical restraint or safe holding, we were told that security would request to attend the children's clinic or the police would be called. However, security guards had not received training on children's restraint or safe holding. Staff told us it was highly unlikely that a child or young person would attend the children's clinic and require restraining. However, there was a risk that a situation may arise which would require a patient to be restrained and staff would not be appropriately trained.

Multidisciplinary working

- All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patients care and treatment. However, there had been some communication difficulties between services since the reconfiguration of the children's' services at the trust. For example, in the one recorded incident at Alexandra Hospital's reconfigured children's clinic in November 2016, an incident occurred involving

a child that arrived at the urgent review clinic. The clinic staff were not aware of the child having been referred. Staff contacted the PAU consultant who had also not known of the child's attendance. The clinic telephoned the child's GP who informed the clinic they had spoken to a member of staff at WRH and been advised by them that the child should attend the outpatients clinic at Alexandra Hospital. Staff told us the GP did not have the details of the member of staff at WRH he spoke with. However, staff at the Alexandra Hospital said staff at WRH should have looked at the availability of appointments at the urgent review clinic on the system or referred the child on the day of a 'Hot' clinic and emailed staff at the Alexandra Hospital to confirm arrangements. An investigation into the incident was ongoing at the time of our inspection.

- Staff at the children's clinic told us there were regular multidisciplinary team (MDT) meetings that were attended by managers. Staff told us they received minutes from the meetings, but did not attend. The outpatient's manager told us that children and young people's services worked collaboratively across sites and said other departments worked well with children and young people's services. However, staff at the clinic said they thought the PAU did not recognise the limits on the Alexandra Hospital children's clinic as there was only one band 5 nurse on-site.
- The staff we spoke with told us that there was good support for patients from allied health professional services, including physiotherapy and dietetics.
- Nurse specialists in respiratory medicine, diabetes and epilepsy were employed to provide expert support to children, young people and parents or carers in the outpatient clinics.
- We saw multidisciplinary team involvement in care was documented in children and young people's notes.
- Staff told us they liaised regularly with staff at the inpatient ward at WRH and the children's clinic at Kidderminster Hospital.
- The department did not have support from a psychologist except for patients diagnosed with diabetes. This meant that the children's clinic did not offer holistic care and review of patients with mental health needs.
- In the CQC children's survey 2014 the trust scored 9.18 for the question 'Did the members of staff caring for your child work well together?' This was better than other trusts.
- A nurse specialist that regularly led clinics at the children's clinic told us, "The staff here are exceptionally supportive, from the reception and health care assistant to the nurse. They are very accommodating."

Seven-day services

- The X-ray department was open seven days a week and was accessible when required.
- The children's clinic operated from 9am to 5pm Monday to Thursday.

Access to information

- Patients care and treatment was planned and shared with other services as necessary.
- Risk assessments were completed for all patients at the clinics they attended. We reviewed a sample of patient records in the children's clinics and found these to be complete.
- Patient records were requested in advance for outpatient appointments. We were not informed of any issues with access to records. Test results were obtained promptly from the relevant departments to ensure clinical decisions could be made based on supporting pathology or radiology results.
- Transition arrangements were in place for young people approaching adulthood to ensure they had access to appropriate support and the skills required to take control of the management of their continuing care.
- A copy of the child or young person's discharge summary was sent to their GP on discharge from the service.
- In the CQC children's survey 2014 the trust scored 9.17 for the question 'did a member of staff agree a plan for your child's care with you?' This was about the same as other trusts.
- Children's services used an electronic discharge system for children, which all staff could log in to and which supported the timely provision of information to local authorities and community services such as GPs and health visitors.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust reported as at September 2016 that Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training had been completed by 37%

of staff in children's services. MCA and DoLS training had been completed by 44% of medical and dental staff and 31% of nursing staff. This was below the trust target of 90%.

- Staff we spoke with had a good understanding of gaining consent from children and young people and the guidance in regard to a child's capacity to consent, including Gillick competency. These are guidelines which help to balance children and young people's rights and wishes law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. We did not ask to see any examples of Gillick competence having been used.
- Medical staff understood the MCA and the DoLS and explained how they would assess a young person's mental capacity and how a decision would be made in their best interest and recorded in the young person's notes. Nursing and support staff told us they would consult medical staff if they had concerns about a child or young person's capacity to make a decision. Nursing staff told us they could not understand the need for children's staff to complete MCA and DoLS training, as they could not appreciate the relevance to staff dealing with children.
- Children, young people and parents or carers were supported by staff to make decisions. Staff and patients we spoke with told us how their care and treatment was explained to them and they were told about different the care and treatment options available.
- Written consent could be obtained from children, young people or their parents or carers for certain medical and surgical procedures and we saw examples of these.
- The trust informed us a consent audit for children's services was not part of the forward plan for 2016/17, and no audit had been carried out in the previous 12 months. The trust added that it would be included in the forward plan for 2017/18.
- Hospital staff had access to hospital security guards. In the event of an incident involving a young person requiring physical restraint we were told that staff would request security to attend the children's clinic or the police would be called. However, security guards had not received training on children's restraint or safe holding. Staff told us it was highly unlikely that a child or young person would attend the children's clinic and require restraining. However, there was a risk that a situation may arise which would require a patient to be restrained and staff would not be appropriately trained.

Are services for children and young people caring?

Good

We rated caring as good because:

- Staff who worked on the children's clinic took the time to interact with patients and their parents in a manner which was respectful and supportive.
- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well looked after.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts including privacy and about care and treatment and staff friendliness.
- Staff communicated with children, young people and their families in a way that they could understand their care and treatment
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of information available on the children's clinic.
- Staff understood the impact that a patients care, treatment and condition had on them and those close to them.

However:

- The NHS Friends and Family Test had been suspended in children's clinics since the service reconfiguration. Patient feedback could not be used to monitor and improve services.

Compassionate care

- Staff who worked on the children's clinic took the time to interact with patients and their parents in a manner which was respectful and supportive.
- All of the patients and parents we spoke with told us that staff were kind and caring and that they felt well

looked after. Patients and parents told us that communication had been good. A young person told us they had attended the clinic for 15 years and said the staff "are like family".

- We observed staff supporting and treating patients in a kind and caring manner. For example, we saw a HCA and nurse discussing with a young person about how they had been feeling in between appointments. The staff demonstrated awareness and interest in the young person's life and situation.
- Patients did not have the opportunity to provide feedback via the NHS Friends and Family Test. The NHS 'Friends and Family' Test (FFT) is a method used to gauge patient's perceptions of the care they received and how likely patients would be to recommend the service to their friends and family. This is a widely used tool across all NHS trusts. However, the FFT had been suspended in children's clinics since the service reconfiguration. This meant the children's clinic was missing an opportunity to measure children, young people, parents and carers opinions on their care and treatment at the clinics following the reconfiguration.
- Feedback from the CQCs children and young people's survey 2014 was largely similar to other trusts including privacy and about care and treatment and staff friendliness; the survey found feedback was better than other trusts for staff attentiveness when a child or young person needed attention and staff introducing themselves.
- The trust performed about the same as the England average for 11 out of 14 questions relating to compassionate care in the CQC children's survey 2014. The trust performed better than other trusts for the questions, 'Were members of staff available when you or your child needed attention?' 'Did new members of staff treating your child introduce themselves?' and 'Do you feel that the people looking after you listened to you?'

Understanding and involvement of patients and those close to them

- We saw that staff communicated with patients in a way so that they understood their care and treatment and condition. For example, children's services had introduced a teenage care pathway to support young people and involve them in their care planning.
- Children, young people and their families said they could be involved in their own care and treatment if they wished.
- There was a range of information available on the children's clinic for parents or children and young people to take away with them or read in the waiting room, this included information on what children, young people, parents and carers could expect following a vaccination and the 'flu vaccine. There were also leaflets providing information on how to make a complaint and how to contact the patient advice and liaison service (PALS).
- The CQC children and young people's survey 2014 reported that the children's service had performed about the same as other trusts for communication.
- All of the patients and relatives we spoke with in the children's clinic told us that staff had communicated well with them and that they were satisfied with explanations provided about their care and treatment.
- The trust performed better than other trusts for two out of 19 questions relating to understanding and involvement of patients and those close to them in the CQC children's survey 2014. The trust performed better than other trusts for the questions: 'Before the operation or procedure did a member of staff explain to you what would be done during the operation or procedure?' and 'Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?' The trust performed the same as other trusts for the remaining 17 questions.

Emotional support

- Staff understood the impact that a patients care, treatment and condition had on them and those close to them. Emotional support was provided whilst caring for patients; however there was minimal formal support available, although there was a clinical psychologist available to provide counselling to patients with diabetes. There was no psychological support for patients with other conditions who may also benefit from specialist support.
- For other patients and families, who may be distressed, support was provided by the medical, nursing, and HCA staff team. Patients could also access counselling service by referral.
- The trust performed better than other trusts for three out of three questions relating to emotional support in the CQC children's survey 2014.

Services for children and young people

Are services for children and young people responsive?

Good

We rated responsive as good because:

- Services in the children's clinic took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- The trust's 95% target for referral to treatment time for non-admitted children and young people receiving an appointment within 18 weeks was regularly met.

However:

- The 'did not attend' appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%. However, staff were not aware of any initiatives to improve this.

Service planning and delivery to meet the needs of local people

- Information on the needs of the local population was used to inform how services were delivered. The trust informed us the annual business plan 2016/17 for neonatal and paediatric services was in development. The 2015/16 plan was based upon the centralisation of paediatric and neonatal inpatient services at WRH. The trust told us the goals of the plan had been achieved with the centralisation of inpatient services at WRH.
- Children's inpatient services had been temporarily transferred to Riverbank Ward at WRH from September 2016. Managers told us this was an emergency measure. Inpatient services at the hospital had been gradually reduced from April to September 2016. It was estimated that the service change would be in place until the outcome of the 'Future of Acute Hospital Services in Worcestershire' public consultation was available or until there was consistent 24 hour a day, seven days a week medical cover for two paediatric rotas to ensure safe services. Managers told us the service reconfiguration had been a "huge move" and had involved the "whole health economy." However, we did not see any noticeable signage across the hospital to inform people that the hospital was no longer accepting paediatric inpatients.
- Children's surgery had been transferred to WRH as part of the service reconfiguration. Children requiring surgery and attending the emergency department at the Alexandra Hospital would be transferred to WRH. However, staff told us young people aged 16 or 17 years would be given a choice with urology, and could choose to have their procedure with adult services at the Alexandra Hospital or children's services at WRH.
- The only specialist children and young people's service at Alexandra Hospital was the children's clinic, an outpatients department where children and young people attended outpatient appointments with a doctor or another health professional. Clinics ran Monday to Friday.
- Children requiring ear, nose, throat, dermatology, eyes and ears, and orthopaedic outpatient's clinics were seen by the adult outpatients department.
- Patients and stakeholders were involved in service development, with targets set by the commissioners considered. Managers said the public consultation would involve patients and stakeholders in service planning, and added that they hoped the outcome of the consultation was that the trust could maintain the reconfiguration model with WRH as a 'central hub' and the Alexandra Hospital and Kidderminster Hospital acting as satellite clinics.
- Managers told us that prior to the reconfiguration of services the trust had informed the public via the local press, as well as other stakeholders including the local Member of Parliament.
- Staff told us a new 12 week outpatients' clinics rota was being introduced across all sites at the trust. Staff said this would mean consultants would rotate across the trust sites and there would not be a regular consultant on any site.
- The outpatient's manager said they were putting together a business case to have a band 7 and two further band 6 nurses for the children's clinics. The outpatients lead told us, "I have costed it, but hasn't been submitted yet."
- The children's clinic offered two to three clinics a day. On the day we visited there was a diabetes clinic, BCG (tuberculosis vaccination) clinic, and a midwife led

'tongue tie' clinic. Staff told us from December 2016 with the introduction of the new 12 week rolling programme of clinics, children and young people in Redditch would have also have access to a paediatric outpatients cardiology clinic, which was new to the hospital as previously, paediatric cardiology clinics had only been offered at WRH

Meeting people's individual needs

- Services were planned which took into account the needs of different children and young people. Consideration had been given to children and young people's age and gender as well as any disabilities. For example, the children's clinic had a playroom waiting area for younger children and a waiting room equipped with DVD's, magazines, and a TV for older young people. However, there was no child friendly waiting area at the main OPD, which provided ear, nose and throat appointments for children and young people. Children and young people also did not have access to a child friendly bay in the fracture clinic.
- Staff told us children or young people with a learning disability would be offered a private bay upon request if they did not wish to wait in the main waiting room. Staff at the children's clinic told us they offered some days that were exclusively for children and young people with a learning disability and allowed more time for each appointment.
- Translation services were available either by using a telephone translation service, or face to face interpreter services could be arranged during office hours if required. We were told there was limited demand for translation services.
- Children and young people's ethnicity and religious needs were recorded on their patient records at the time of first registration with the children's clinic.
- The children's clinic had a side room that would be made available to women that were breast feeding.
- One of the consulting rooms in the children's clinic was used for clinical psychology for diabetic children and young people. The clinic had a bay that had been converted as part of the service reconfiguration into an older children and teenagers waiting area.
- There were suitable bathroom facilities for patients with a physical disability and adequate space on the all the clinic areas we visited to accommodate children, young people and their families or carers who used wheelchairs.
- Transition arrangements were in place for patients approaching adulthood to ensure children and young people had access to appropriate support and the skills required to take control of the management of their continuing care.
- Patients and their relatives and carers had access to a chapel and multi faith room on site.
- In the CQC children's survey 2014 the trust scored 9.80 for the question 'for most of their stay in hospital what type of ward did your child stay on?' This was about the same as other trusts, but related to all of the trust's hospital sites and Alexandra Hospital prior to the service reconfiguration.
- The trust performed the same as other trusts in the CQC children's survey 2014 for the question: 'How would you rate the facilities for parents or carers staying overnight?'
- There were no play therapists available at Alexandra Hospital. Play therapists facilitate communication between medical and nursing staff and patients and their parents to ensure the child's needs are catered for during care and treatment. This meant the child's wishes before and after care and treatment may not have been as comprehensive and may have placed additional pressures on nursing and medical staff. Play therapists also provided additional support in distraction for younger children whilst undergoing care and treatment. However, staff told us the children's HCA was very experienced and would provide support in distraction for a child where required.

Access and flow

- Across all the trust's hospital sites, from April 2015 to March 2016 the median length of stay for both elective and emergency patients aged one to 17 years was one day; this was the same as the England average. However, these figures relate to a period prior to the service reconfiguration.
- Across all the trust's hospital sites, from April 2015 to March 2016 the median length of stay for elective patients under the age of one was zero, for emergency patients it was one day, these were the same as the England average. However, again, these figures relate to a period prior to the service reconfiguration.
- Staff said with the closure of the inpatient ward at the Alexandra Hospital, the transfer of patients to WRH was

more complex, as all children requiring inpatient care would need to be transferred to the paediatric inpatients ward at WRH, due to their being no inpatient facilities at Alexandra Hospital.

- We viewed the children's services performance and efficiency metrics dashboard. We found the number of children or young people on the outpatient's waiting list had steadily increased from 327 in October 2015 to a peak of 855 in April 2016. The numbers of children and young people waiting was over 800 until September 2016 when the figure had reduced to 791. The trend was again downward in October 2016 with 723 children and young people waiting for appointments across all the trust's sites.
- The trust's 95% target for referral to treatment time (RTT) for non-admitted children and young people receiving an appointment within 18 weeks was regularly met across all sites, with the exception of October 2015 and February 2016, June and July 2016 when the percentage of children and young people seen within the 18 week target was 94%. The percentage of children and young people waiting for an appointment had stabilised and was regularly 97%.
- The 'did not attend' (DNA) appointment rate for new children and young people's services appointments was regularly above the trust's target of 7%, and was 10% or above in May, July, and August 2016. The DNA rate for follow up appointments was regularly above the trust's 7% target, reaching a peak of 16.5% in August 2016. This meant hospital resources were wasted and there was a financial cost implication for the trust. Staff at the children's clinic were unable to tell us what measures the trust had introduced to reduce the numbers of children and young people that did not attend for their appointments.
- Access to the children's clinic was via a single point of access. This was a call centre based at Kidderminster Hospital. All referrals from any source were triaged by the PAU consultant at Riverbank Ward at WRH. The PAU team would book a time for a child's appointment, and would send an email to the children's clinic team at Alexandra Hospital to inform them of the booking.
- There was a consultant available on the Emergency Assessment Pathway (EAP) at all times for staff to access advice. The EAP consultant also acted as the urgent on-call consultant.
- All children and young people arriving at the children's clinic would book in with the clinic receptionist and then have their height and weight measured and recorded. Children and young people would then wait in the waiting room until called for their appointment.
- The children's clinic provided open access urgent review clinics for children and young people with long term conditions who required a speedy review of their care and treatment. There were urgent review clinics every afternoon, with three or four appointments being reserved for these clinics. Patients requiring urgent review at Alexandra Hospital were seen by the on-site consultant. Staff told us there was "flexibility" in the urgent review clinics schedule and staff would prioritise patients arriving for clinics on the basis of clinical need.
- The children's clinic administrator arranged appointments on the electronic appointments system. Clinics were co-ordinated by the department of medical records at WRH, and some clinic times had been changed as a result of the service reconfiguration. Managers told us, that there have been no complaints about clinics being reconfigured.
- Children and young people were sent an appointment time for clinics. Staff told us if parents or carers wished to change an appointment they could telephone the children's clinic and rearrange it. However, staff also told us many appointments at the children's clinic had been rearranged by the booking office at Kidderminster Hospital, and as a result of the service reconfiguration, some appointments had been rescheduled and delayed by months. Staff said they were spending a lot of time answering telephone calls to parents and carers who were concerned, explaining why their appointment time had changed. We saw one of the hospital's cancellation letters dated 23 November 2016. The appointment had been moved from 29 December 2016 to 10 February 2017. The letter did not explain the reason for the change in the appointment time and date. Staff said the letters had made some parents anxious, and as a result staff had spent a lot of time alleviating parental anxiety over changed appointment times and delays to care and treatment.
- None of the parents and carers we spoke with told us they had long waits in the waiting rooms at the children's clinic. We did not see any children or young

people waiting for over 20 minutes for their appointment. The outpatient's manager told us the children's clinic staff were; "excellent at keeping to appointment times."

- Parents and carers we spoke with told us it was very rare, that a clinic would be cancelled. The policy for cancellation was the hospital would provide six weeks' notice. Staff we spoke with were aware of the policy. Staff told us that where a clinic had to be cancelled at short notice, for example because of staff sickness, patients would be telephoned as soon as the children's clinic were aware, informed of the clinic cancellation, and given a new appointment in the same telephone call.
- Children, young people and their families were positive about services at the children's clinic and told us waiting times in the clinic were short. One parent said: "We come every three months. From the moment we get here and go to reception, to leaving usually takes between 30 and 45 minutes. It doesn't take long at all."
- The children's clinic had urgent review clinics for children that needed a speedy review of their care and treatment. Urgent review clinics were open access for long-term patients. There were urgent reviews every afternoon, with three or four appointments being reserved for these clinics. Children and young people would be reviewed by a consultant or registrar.
- The hospital had also introduced 'hot clinics' on Monday, Tuesday and Wednesday between 2pm and 4pm. Hot clinics were consultant led clinics aimed at providing an urgent senior consultant opinion. The clinics gave other health professionals the opportunity to discuss a child or young person in their care, such as GPs, with a specialist consultant, or provided rapid access to a consultant. However, staff told us children and young people could frequently get into a regular clinic faster than they could a 'hot' clinic.
- The women and children's division had introduced a performance dashboard to monitor patient's outcomes. We viewed the dashboard and found it was largely aimed at monitoring children and young people that were admitted as inpatients to WRH. However, the performance and efficiency metrics dashboard monitored the number of children and young people's waiting for outpatients' appointments, the referral to treatment times, and the numbers of children and young people that did not attend their appointment. Even though there was evidence in governance meeting minutes that the performance dashboard was reviewed, there was little evidence in the minutes that performance in the children's clinic was discussed.

Learning from complaints and concerns

- From September 2015 to August 2016 there had been 10 complaints about children's services. The trust took an average of 29 days to investigate and close complaints. This is not in line with their complaints policy, which states 90% of complaints should be closed within 25 days. However, managers told us the children and young people's service had been compliant with the trust's 25 day complaints investigation target since June 2016.
- From September 2015 to August 2016 there were three complaints about children's services at Alexandra Hospital. The hospital took an average of 31 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be closed within 25 days. The three complaints related to: in relation to clinical treatment; and two complaints with regards to staff attitude and behaviour.
- There was a process in place for responding to complaints and information was available to make patients aware of how to make a complaint.
- Leaflets and posters informing patients how to make a complaint or contact PALS were available in the children's clinic.
- Staff told that most complaints were resolved and responded to immediately. Managers told us they identified trends from complaints, and complaints were mostly due to communication issues from nursing and medical staff. Staff and managers told us written complaints were rarely received.
- Although complaints were received infrequently we were told by staff that they would be discussed with the lead for outpatients. Managers told us complaints handling in children and young people's services had improved. This was due to joint weekly and monthly reviews of complaints with staff. Managers had also completed multidisciplinary training in complaints handling. Staff told us learning from complaints was disseminated by the outpatients manager via email or during the outpatients managers visits to the service.

Services for children and young people

Are services for children and young people well-led?

Requires improvement

We rated well-led as inadequate because:

- As a result of the service reconfiguration the children's service there was no credible statement of vision and guiding values. As a result of the emergency service reconfiguration the children's service did not have a clear vision, and did not have a long-term strategy for children's services. Staff were unaware of the vision and values for the children's outpatients' service as these were not defined.
- The governance arrangements and their purpose were unclear. The governance framework was not effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings.
- The governance arrangements and their purpose were unclear. Monthly divisional governance meetings were not consistently adhering to their terms of reference (TOR). This included: not focusing on themes and trends from incidents; safeguarding training performance, being reported as mandatory training, and not broken down to include compliance with level three safeguarding training. Discussions in regards to the divisional risk register focused on the number of risks recorded rather than how they were being managed. Although the hospital had recently closed to paediatric inpatients, there had been little discussion around how the transitional period was being managed.
- Leaders did not have the necessary capacity to lead effectively. The outpatients manager had not been allocated any contracted hours for service leadership and they were fitting this in with their advanced nurse practitioner role at WRH. This meant it was unlikely that staff would receive timely supervision and advice.
- Some staff told us they did not feel fully consulted about the service reconfiguration.

However:

- There was good teamwork in the children's clinic and medical staff always took time to listen to concerns of nurses or support staff.

Leadership of service

- In September 2016 the CYP service was reconfigured. Alexandra Hospital children's services were part of the Women and Children's Division. There was a 'ward to board' flowchart that demonstrated clearly the divisional structure and lines of accountability. However, children and young people's outpatients were not identified on the flowchart. The division was led by a team which included the divisional medical director, the director of nursing and midwifery, and the director of operations.
- The children's service had a documented accountability structure. The senior staff nurse and specialist nurses reported to the outpatient's manager. The outpatient's manager reported to the divisional director of nursing and midwifery. This divisional lead reported to the divisional team. Medical staff reported to the interim clinical director, who also reported to the divisional team.
- Senior managers told us the chief executive was approachable and always responded to emails. The managers said they had been consulted and involved in the service reconfiguration by the project manager who ensured they stayed informed. However, staff on the children's clinic told us they had not seen or been visited by any directors or divisional managers since the reconfiguration.
- The clinical leaders for children and young people's service at Alexandra Hospital were visible. Nursing staff told us they could approach the lead consultant at the outpatients department for advice at any time.
- The outpatient's manager told us divisional leaders were visible and approachable; ward staff understood the challenges at a local level. However, it was not apparent that divisional leaders fully understood the challenges children and young people's services presented both in the children's clinic.
- The staff we spoke with told us that they had good working relationships with the band 8 outpatient clinic manager, who was supportive and approachable. They told us they managed 19 staff as well as working in their role as an advanced nurse practitioner (ANP) at WRH. The outpatients manager told us they had not been allocated any contracted hours for service leadership and they were fitting this in with their ANP role. The outpatient's manager was supported at WRH by a band 6 senior staff nurse that worked across all sites. The

manager said a band 6 at WRH gave them a management day, "where they can," by covering their duties at WRH to allow them to visit the outpatient's clinic at Alexandra Hospital. However, due to their other commitments the manager could not visit the children's clinic at Alexandra Hospital on a regular basis. This meant it was likely that staff would not receive timely supervision and advice.

- The children's clinic was a nurse led clinic. The local leadership at the clinic was a band 5 staff nurse. Both the nursing lead for outpatients and the band 5 staff nurse told us the outpatient's manager had recommended that the band 5 staff nurse was promoted to a band 6 senior staff nurse, but this had not been confirmed. Staff at the children's clinic told us the clinic could "feel isolated sometimes" since the reconfiguration and the closure of Ward 1.

Vision and strategy for this service

- As a result of the reconfiguration the children's service did not have a clear vision. Managers told us there was not a fixed date for the public consultation on service reconfiguration, but the consultation process would take three months. Managers said the consultation would probably take place early in 2017. Managers told us the trust had a vision for children's services were based on the reconfiguration central hub model; but the trust could not produce a long term strategy for the service until the outcome of the public consultation was available.
- The trust told us that the children's ambulance pathway had criteria to transfer children to Alexandra hospital ED based on the other pathways across from the West Midlands. This pathway had been agreed with all health partners during the planning process.
- Staff were unaware of the vision and values for the children's outpatients service as these were not defined. We found that staff were aware of the trust's 'Patients, Respect, Improve, Dependable, and Empower' (PRIDE) values, and told us staff annual appraisals were structured around the trust's values.
- Staff told us there had been an outpatient improvement programme in 2016. Staff said they had attended a meeting during the summer of 2016, and this involved staff in looking at signposting and dementia awareness, but was mostly geared to adult outpatients' clinics. However, staff told us they had not heard anything further about the programme since the meeting. Staff said they thought it was due to the staff member whose initiative it was leaving the trust.

Governance, risk management and quality measurement

- Governance included a four weekly divisional report based upon weekly situation reports.
- Ward managers reported to the divisional meetings, which fed into the clinical governance group and quality governance committee. In turn, these groups reported into the trust board. Paediatric reporting was identified, but this only listed WRH Riverbank Ward
- The governance framework was not fully effective because there was no evidence that information flowed between the directorate and divisional governance or quality meetings. Meeting minutes lacked detail and agenda items were not always included in accordance with the committees' terms. Significant risks had not all been recorded on the risk register. We identified and reported on similar concerns in the September 2015 inspection.
- There was a women and children's division monthly governance (WCGM) meeting, as well as a monthly children's directorate quality improvement committee (QIC). Both committees were independent of each other and there was no formal approach for information to flow between the two committees.
- The WCGM was tasked to ensure all aspects of governance were defined and monitored for paediatrics, neonatal care and obstetrics and gynaecology, in accordance with its terms of reference. Similar responsibilities were defined for the QIC at a directorate level.
- During the September 2015 inspection we identified that the WCGM had not consistently discussed all standing agenda items in accordance with its terms and this had not improved for example, there was no discussion around training and competencies of staff.
- We also noted that there had been little improvement recording information in the meeting minutes. For example, discussions around incidents still focused on the numbers and the length of time outstanding rather

than themes and trends. Also, safeguarding training performance, was reported as mandatory training, and not broken down to include compliance with level 3 safeguarding training.

- Discussions in regards to the divisional risk register focused on the number of risks recorded rather than how they were being managed. For example, the September 2016 minutes recorded. At the time of inspection there were 4 moderate risks with no actions recorded. The register recorded that overdue actions would be reviewed by the end of September 2016' There was no mention of which directorate the risks related to or what they were and whether they were being managed effectively.
- Review of the QIM minutes for September and October 2016 both included standing agenda items in accordance with its TOR. There was evidence of discussion around some items presented but not all. There was a process in place to carry actions forward to the next meeting.
- During the September 2015 inspection we noted that there was a lack of discussion around incidents, in particular themes and trends or categorisation of incidents. Similarly we had also noted a lack of discussion around the risk register with focus on closing the identified risk rather than the content of ongoing risks being managed and discussed and that there was no discussion around the dashboard. We saw no improvement with regards to discussion around risks or incidents. There had been some improvement in relation to the dashboard. Minutes listed areas where underperformance had occurred but there was no further detail, in particular around how this could be improved or possible reasons for the underperformance.
- We also noted that although the Alexandra Hospital had recently closed to paediatric inpatients, there had been little discussion around how the transitional period was being managed.
- There were nine risks recorded on the paediatric risk register. Each risk had been scored according to its likelihood and impact, with mitigating controls documented if they were in place. Some risks had been described in detail, with good controls to ensure the risk was managed. We saw that improvements had been made on since the previous inspection in September 2015 because many of the long standing risks had since been reviewed and closed or reviewed and revised.
- During our inspection we identified additional risks which had not been added to the risk register. For example, the ambulance service continuing to take children to the ED and the logistics and risk to children and young people in transferring them to WRH.
- The clinical audit plan for 2016/17 was approved at the May 2016 WCGM. And there was evidence in the September minutes that medical staff were being reminded that if they wished to undertake additional audits that these were added to the audit plan, which we had identified as an issue in the previous meeting. There had been no completed audits taken to the September or October 2016 meetings and there was no meeting held in August 2016.

Culture within the service

- The care provided in the children's clinic was patient focused.
- Staff told us there were good working relationships amongst their peers as well as other disciplines and that Alexandra Hospital was a pleasant place to work. Staff at all levels told us how there was good teamwork in the children's clinic and medical staff always took time to listen to concerns of nurses or support staff. However, staff also told us there had been sadness within the staff group due to the closure of Ward 1. Some staff were not aware of whether the ward would re-open, even though most staff we spoke with said the change made sense in addressing the trust's staffing issues.
- Some staff told us they did not feel fully consulted about the reconfiguration. Managers told us this was due to a very short timescale before urgent reconfiguration. The outpatients lead said they always disseminated all information in regards to the service reconfiguration to staff to ensure staff had the same information as they had. The outpatients lead told us they had attended a 'listening into action' event at the hospital that had been geared to staff working in outpatients departments.
- Managers told us they were aware that a few staff had changed working patterns as a result of the service reconfiguration, and this had created some tensions with a few staff.
- Staff told us that they were encouraged to report incidents and were aware of the importance of sharing information with patients and families when an incident

occurred which involved them. One staff member told us: "We tend to hear about things that need to be done or haven't been done very quickly. We tend not to receive feedback on positive achievements as quickly."

Public engagement

- Staff told us feedback from the public since the service reconfiguration had been mostly positive; but, staff were aware of some members of the public's feeling anxiety and "trepidation" about the service reconfiguration.
- Managers told us since the service reconfiguration there had been, "a couple of informal complaints from parents with children with complex needs with regards to increased travelling." Managers said in response they had written to the parents of children with complex needs and invited them to attend WRH children's ward to allay parents, children and young people's anxieties.
- Patients were given the opportunity to provide feedback as part of the Care Quality Commission's children and young people's survey 2014.
- The children's clinics were not providing children, young people or their families with the opportunity to provide feedback via the NHS Friends and Family' Test (FFT) data collection. Staff said the FFT was temporarily suspended whilst services reconfigured.

Staff engagement

- Staff told us there had not been consultation with staff in regards to the reconfiguration of service.
- Staff at the children's clinic told us they felt well supported and listened to by the outpatient's manager. However, staff said they did not get much information from other services or shared learning.
- An annual staff survey took place each year to gauge staff perception on a range of matters.
- We were told that staff were able to raise issues as part as part of their annual appraisal. Staff told us the outpatient's manager would always resolve any issues between the medical and nursing staff.
- Staff received a monthly trust newsletter as well as divisional 'risk bulletins' which informed staff of issue that had been discussed at the QIM meetings.
- The trust had annual staff achievement awards where members of staff were nominated by their peers for an award. The receptionist at the Alexandra Hospital children's clinic had won the 2016 non-clinical employee of the year 2016; the band 5 nurse had also been nominated for an award in the category of nurse of the year and the HCA had been nominated for health care assistant of the year, both members of staff had received certificates of commendation from the trust in 2016.

Innovation, improvement and sustainability

- Managers told us service reconfiguration was made with the objective of making improvements for patients and staff. However, at the time of our visit it was too early in the reconfiguration process to measure whether this would result in sustainable improvements to children and young people's care. A manager told us the service was, "enjoying having enough staff."

End of life care

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

Information about the service

Alexandra Hospital is part of Worcestershire Acute Hospitals (WAH) NHS Trust. Patients at the end of life are nursed on general hospital wards and there is a dedicated end of life care side room (Stephen Bailey Suite) attached to ward 12. From April 2015 to March 2016 there had been 129,580 in-patient admissions and 1,840 inpatient deaths across all hospital sites within the trust, of which 641 were at Alexandra Hospital. From April 2015 to March 2016 there had been 2,259 referrals to the specialist palliative care team, of which 49% were for patients with cancer and 46% for those with non-cancer.

Worcestershire Royal Hospital was also visited as part of this inspection process and end of life care in each hospital is reported upon separately. End of life care (EoLC) services on both hospital sites are run by one management team. As such they are regarded within and reported upon by the trust as one service, with some of the staff working at both sites. For this reason it is inevitable there is some duplication contained within the reports.

The specialist palliative care (SPC) team consisted of 1.5 (whole time equivalent (WTE) consultant posts, 10 clinical nurse specialists (6.93 WTE) and 4 CNS and 2 EoLC facilitators. There were 1.5 WTE consultants in palliative medicine posts; this included the lead consultant who was based at the Alexandra hospital. There were 10 post holders to 6.93 WTE SPC clinical nurse specialists across the trust as a whole. Four CNSs were based at the Alexandra, of which one was a combined palliative care and lung CNS and another was a combined palliative care and upper gastrointestinal CNS. In addition there were two EoLC facilitators employed by the trust, one of which was based at Alexandra.

During this inspection we visited a number of inpatient wards and clinical areas including care of the elderly, general surgery, respiratory, emergency department, urology, cardiology and general medicine. In addition we visited the chapel, multi-faith room, the bereavement office, and the hospital mortuary. We observed care and viewed 13 care records. We spoke with two patients and one relative. We also spoke with a range of staff including the SPC consultant and lead nurse, SPC CNSs, end of life care facilitators, bereavement officers, the chaplain, a mortuary manager and technician, a porter, ward based medical and nursing staff and a discharge liaison nurse. In total we spoke with 31 staff members. We looked at policies and procedures and reviewed performance information about the trust.

End of life care

Summary of findings

We rated the end of life care service as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. Incidents relating to end of life care were reviewed by the lead nurse for specialist palliative care.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- There was clear evidence of the trust using national guidance to influence the care of patients at the end of life. A comprehensive programme of end of life care training was available for the full range of staff within the trust.
- There was good evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital including allied healthcare professionals as well as medical and nursing members. The specialist palliative care team provided a seven day face to face assessment service across the trust.
- People were supported, treated with dignity and respect and told us they felt involved in their care. We observed staff communicating with patients and relatives in a manner than demonstrated compassion, dignity and respect.
- Patients and relatives told us that the staff were caring, kind and respected their wishes. People we spoke with were complimentary about the staff and told us they felt appropriately supported.
- The specialist palliative care team responded quickly to referrals and typically would see patients within a few hours if the need was urgent. The majority (92%) of patients were seen within 24 hours and there was a good balance between cancer and non-cancer referrals.
- The specialist palliative care team worked proactively with the emergency department to identify patients who may benefit from palliative care input.
- The trust had begun to record and audit preferred place of care at the end of life and there were clear systems in place to make improvements in this area.
- The specialist palliative care team had audited complaints that had an end of life care component, identified trends and had taken action to address improvements.
- There was a clear vision for the service and a draft strategy was in place, highlighting the key areas the trust were focusing on in relation to end of life care.
- There was consistent promotion of the delivery of high quality person centred care and strong leadership for end of life care. Staff were consistently passionate about end of life care, positive about their roles and consistent in their belief that the quality of end of life care was good.
- Innovations included close working between the specialist palliative care team and emergency department staff to identify patients at the end of life and provide specialist support. The trust was one of ten that had been chosen to participate in a quality improvement partnership with The National Council for Palliative Care (NCPC) and Macmillan cancer support.

End of life care

Are end of life care services safe?

Good

We rated safe as good because:

- Staff understood their responsibilities to raise concerns and to record safety incidents. Incidents relating to end of life care were reviewed by the lead nurse for specialist palliative care.
- Appropriate anticipatory prescribing of medicines was used at the end of life.
- There was good identification of patients at risk of deterioration and identification of patients in the last days of life.
- Equipment was generally available for the care of patients at the end of life.
- The trust had taken action to improve the facilities in the mortuary since a previous inspection. This included replacing fridges, flooring and improving the hot water facilities.
- Issues relating to obtaining syringe drivers had been addressed by changing the system for obtaining them after this had been identified as an area of risk on the service risk register.

However:

- We were not able to establish specialist palliative care staff's compliance with mandatory training (including safeguarding adults training) as this evidence was requested but not provided by the trust.

Incidents

- Incidents were reported using an online reporting tool. Staff we spoke with had a good understanding of the process for reporting incidents and we viewed examples of where incidents involving end of life care had been reported.
- From October 2015 to September 2016 the trust reported no incidents which were classified as never events for end of life care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In accordance with the Serious Incident Framework 2015, the trust did not report any serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from October 2015 to September 2016.
- Staff were aware of their responsibilities to report incidents and all incidents that included an element of end of life care were reviewed by the trust lead for palliative and end of life care.
- An audit of significant events in end of life care identified that 40% of incidents were related to issues of patient flow throughout the trust. As a result, the specialist palliative care team had taken action to work proactively on a daily basis with emergency department staff to improve patient flow for those at the end of life. For example, work was focused on patients from nursing or care homes who were identified as not requiring an acute hospital bed. Nursing staff from the specialist palliative care team would liaise with the care and nursing homes where it was appropriate for the patient to return.
- Staff we spoke with had an awareness and understanding of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person

Environment and equipment

- There was a mortuary at Alexandra Hospital. We reviewed mortuary protocols and spoke with mortuary and portering staff about the transfer of deceased patients. The mortuary was manned by a team of staff based at Worcestershire Royal Hospital, with one staff member rotating to Alexandra on a daily basis. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The mortuary fridges were temperature monitored and alarmed. We saw that if the alarm was triggered this would alert reception staff who would contact the mortuary staff.
- We observed the use of syringe drivers (a battery powered pump that delivers continuous medicines through a tube placed under the skin) on the wards and saw that regular administration safety checks were being recorded. Ward staff told us that syringe drivers were generally available when they needed them.

However, we noted that access to syringe drivers in a timely way had been identified on the trust risk register although the issues were generally related to their availability at Worcestershire Royal hospital. Changes to the way syringe drivers were accessed had been made and staff we spoke with told us obtaining syringe drivers generally worked well. However, we saw one case where a patient had to wait for more than six hours for their syringe driver to be commenced. We saw in their records that staff had followed the trust protocols to obtain the driver and that in the meantime the patient had been given appropriate medication via an alternative route and was assessed as being comfortable during this time. Staff told us accessing syringe drivers was not generally an issue of concern.

Medicines

- Medicines were prescribed using clinical guidelines on the trust's intranet. The guidance included different treatment options for a range of symptoms that could be experienced at the end of life.
- Medicines for use at the end of life, including those for use in a syringe driver, were readily available on the wards. Nursing staff said that end of life care medicines were accessible, including outside of normal working hours if required through an on call pharmacist. However, staff told us that there were generally adequate stocks of end of life care medicines available on the wards.
- We viewed the medication and medical records of thirteen patients at the end of life and saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice and had attended training relating to anticipatory prescribing. They also told us that the specialist palliative care team were available to provide advice and support around appropriate prescribing, particularly in complex cases.
- There were systems in place within the mortuary for the safe storage, monitoring and disposal of medicines. Medicines were stored in a locked medicines cabinet and returned to pharmacy for destruction. Records of this were maintained.

Records

- The trust had developed an Optimising Care at the End of Life Plan. This had been implemented following an initial pilot in 2014. Staff told us the plan had been in use for 18 months and was embedded into practice in many areas. We observed the use of these and saw that information was recorded and shared appropriately and that the plans were completed comprehensively.
- Care plans reflected national guidance and records included risk assessments, such as those for the risk of falls, pressure area damage and nutritional screening.
- The trust used a combination of paper and electronic patient record systems. Records we viewed were stored securely and written comprehensively.
- We reviewed 13 DNACPR (do not attempt cardiopulmonary resuscitation) forms and saw that these were generally completed accurately and comprehensively. All were dated, stored in the front of the patient's medical notes and included clearly recorded decisions and clinical information. Discussions with patients and relatives were recorded on the form and in some cases in further detail in the medical notes. For example, 12 out of 13 included records of discussion with the patient or with their families where appropriate.
- There was one incident on ward 14 where it was indicated on a discharge communication from another hospital that the patient had a DNACPR in place. However, there was no DNACPR form in the patient's notes. This was addressed by staff at the time of the inspection.
- Records within the mortuary were comprehensive and included processes for appropriate checking of identification.

Safeguarding

- Staff we spoke with demonstrated an understanding of safeguarding procedures within the trust.
- We saw that safeguarding issues were considered as part of multidisciplinary discussions, in particular when discussing preferred place of care and issues relating to patients being discharged home to their preferred place of death.
- In the last 12 months 99% of trust-wide staff had attended safeguarding adults training. Evidence was requested to support that specialist palliative care staff had attended safeguarding adults training, however this was not provided by the trust.

Mandatory training

End of life care

- Mandatory training data for specialist palliative care staff was requested by CQC during our inspection. However, this had not been provided by the trust.
- Nursing and Midwifery staff had a 2016 training completion rate meeting or exceeding the trust target of 90% for fire awareness, infection control, information governance and resuscitation training. Medicine management, conflict resolution and equality and diversity had a completion rate below 50%.
- The trust used a combination of face to face and electronic learning packages for staff in relation to end of life care. End of life care was considered to be essential rather than mandatory training for clinical staff.
- Porters had face to face mortuary training that included the transfer of the deceased including promoting dignity and respect.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of malnutrition and dehydration and the risk of pressure damage.
- An early warning scoring system was in use throughout the trust to alert staff to deteriorations in a patient's condition. Patient's recognised as being at the end of life had their care plan transferred to the Optimising Care at the End of Life framework when they were expected to die within a few days.
- The AMBER Care Bundle was in use throughout the trust, a tool used to support the identification of patients at risk of dying within the next one to two months. AMBER provided a framework for assessment of the patient's medical plan including their resuscitation status and decisions about treatment escalation. This enabled staff to manage end of life care risks more proactively, for example in relation to keeping patients comfortable and ensuring that opportunities for meeting their wishes were taken.
- Patients identified as being at the end of life were reviewed every few hours by nursing staff on the wards and as a minimum daily by medical staff. Ward staff told us they had access to the specialist palliative care team who responded quickly when needed.

Nursing staffing

- The specialist palliative care team across the trust included 10 (6.93 whole time equivalents) specialist palliative care clinical nurse specialists (CNSs) and two end of life care facilitators. There were four specialist palliative care nurses and one end of life care facilitator based at Alexandra.
- The specialist Palliative Care team provide face to face assessments of patients from 8.30am to 4.30pm, seven days per week. Monday to Friday there was a team based at the Alexandra Hospital and one based at Worcestershire Royal Hospital. On Saturdays and Sundays there was one CNS on duty who covered both hospital sites including and was available by air page.
- Specialist palliative care nurses worked closely with ward based nurses and there were end of life care link nurses/champions on each ward. End of life care link nurses had received additional training and support from the specialist nurses to carry out their role and were available as a resource to other nursing staff on the wards.
- Staff told us they prioritised care for patients at the end of life as much as possible by ensuring that staff were available to meet the needs of both the patient and their relatives.

Medical staffing

- The trust had two consultants in palliative medicine across all hospital sites. The lead consultant (0.9 whole time equivalent) was based at Alexandra. The trust also had speciality trainee doctors working with the specialist palliative care team from time to time.
- There was 24 hour on call palliative care consultant cover and out of hours advice was available from local hospices.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team.
- Medical staff we spoke with told us the specialist palliative care team were available for advice as needed and responded quickly to urgent referrals. All referrals were responded to within 24 hours.

Major incident awareness and training

- The trust had a major incident plan that included a system for chaplaincy support and arrangements for the use of the mortuary.
- Staff working with the palliative care team had an understanding of the major incident plan.

End of life care

Are end of life care services effective?

Good

We rated effective as good because:

- There was clear evidence of the trust using national guidance to influence the care of patients at the end of life including the AMBER care bundle and an evidence based optimising care at the end of life document.
- There was good evidence of multidisciplinary working and involvement of the specialist palliative care team throughout the hospital including allied healthcare professionals as well as medical and nursing members.
- The specialist palliative care team provided a seven day face to face assessment service across the trust.
- The trust had participated in the National Care of the Dying Audit (NCDAH) and made use of audits in other areas to identify and address areas for ongoing improvement.
- End of life care training was available for the full range of staff within the trust and the specialist palliative care team and end of life care facilitators made the most of both formal and informal learning opportunities to ensure all essential staff were appropriately trained.
- There was evidence of mental capacity assessments and consideration of Deprivation of Liberty Safeguards for patients who lacked capacity to make decisions. Discussions around DNACPR (do not attempt cardiopulmonary resuscitation) decisions were recorded and there was evidence of best interest discussions involving family members.

However:

- We were not able to establish whether specialist palliative care staff had received annual appraisals. This evidence was requested but not provided by the trust.

Evidence-based care and treatment

- The trust had introduced an 'optimising care at the end of life' plan in 2014. The plan been developed to include national guidance sources such as the Leadership Alliance for the Care of Dying People and the National Institute for Health and Care Excellence (NICE).
- The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The specialist palliative care team monitored national guidance and ensured end of life care tools in use within the trust were reflective of current recognised practice, such as NICE Care of the Dying Adults in the Last Days of Life (NG31) 2015.
- A specialist palliative care operational policy included reference to national guidance. Minutes from a 'High Impact Action Group – End of Life' meeting dated 13 June 2016, included evidence of discussion of national guidance and its relevance to the care of patients at the end of life.
- The trust used the AMBER care bundle, a national tool used to support the identification of patients at risk of dying within the next one to two months. This approach was used when clinicians were uncertain whether a patient may recover and provided a framework to consider care at the end of life and the involvement of the patient and family members in this while continuing to actively provide treatment.

Pain relief

- Members of the specialist palliative care team had attended courses and attained qualifications in symptom control and pain management.
- Doctors we spoke with were aware of the guidance around prescribing for key symptoms at the end of life. They knew they could access the guide on the intranet and also seek support from the specialist palliative care team.
- Patients and relatives we spoke with told us that staff were quick to respond when patients experienced pain and other symptoms. Nursing staff were proactive in assessing levels of pain and other symptoms on a regular basis. Nurses used a 0-10 sliding scale to assess pain. We did not see other types of pain assessment tools in use; however staff told us they also took account of body language and facial expression when assessing pain.
- Care plans included pain assessment prompts and clear records of pain assessments.
- Anticipatory medicines were prescribed appropriately for patients at the end of life.

- The specialist palliative care team had been successful in a bid to participate in the Building on the Best quality improvement partnership with The National Council for Palliative Care (NCPC) and Macmillan Cancer Support for acute hospitals. The focus of this bid was to improve pain and symptom management for patients with palliative and end of life care needs and the project was due to start in early 2017.

Nutrition and hydration

- Staff were clear that patients at the end of life should eat and drink as they wished and that staff would support them to do that. Staff demonstrated an awareness of guidance in supporting nutrition and hydration in end of life care.
- Care plans for patients at the end of life included an assessment of nutritional needs and aspects of nutrition and hydration specifically relating to end of life care. Regular mouth care was incorporated, as well as involvement of the family and the need to be led by the patient in terms of what they could and could not eat and drink.
- CNSs and end of life care facilitators worked with ward staff to increase awareness around end of life care nutrition and hydration issues.
- The specialist palliative care team were represented at an artificial feeding multidisciplinary meeting where the use of artificial forms of feeding was discussed for each patient being considered for it. The decision making process included meeting with the patient and family to involve them in discussions.
- Patients and relatives we spoke with told us they had been involved in discussions about food and drink and ways to meet patient's needs and maintain comfort.

Patient outcomes

- The trust participated in the End of Life Care Audit: Dying in Hospital 2016 and there was evidence of improvements in meeting the standards when compared with the 2014 results. There was evidence of improved performance in relation to organisational indicators where all had been achieved. The trust performed better than the England average for three of the five clinical indicators. The trust had developed an action plan to address the areas where improvements were needed that included improving communication skills training for staff, such as the recently implemented Sage and Thyme communication training offered by the specialist palliative care team. This training supported staff to better respond to people who are distressed. The team were also exploring the use of advanced communication skills training and whether this needed to be expanded to cover different staff groups.
- As part of the audit process the trust identified there had been an 8% increase in the use of the AMBER care bundle and a 14% increase in the use of the end of life care pathway over a 12 month period. There had been an 8% increase in discussions about preferred place of care at the end of life and a 21% increase in documented advance care planning. This demonstrated an improvement in the adoption of the end of life care guidance available to staff in the trust.
- End of life care champions on the wards participated in audit of the use of the AMBER care bundle and had received training relating to this.

Competent staff

- The palliative care nursing team were skilled in end of life care issues and had completed training in areas such as symptom management, advanced communication skills and independent prescribing. The team received regular clinical supervision.
- There were end of life care champions on every ward, with some clinical areas having two or three champions. The champions attended meetings and training specific to their role and could access enhanced end of life care training and support from the specialist palliative care team including accessing shadowing opportunities. One nurse we spoke with had attended a five day training course at a local hospice that included attending action learning sets where improvements to end of life care were discussed specific to the clinical areas staff were working in. We were told that the concept for the end of life care suite had come from another nurse on a similar placement.
- The team provided a range of formal training to general staff caring for patients at the end of life. This included mandatory and essential training such as on induction or preceptorship courses. End of life care facilitators also ran palliative and end of life care workshops for different groups of staff, care after death training and healthcare assistant certificate courses.
- In recognition of the difficulties presented with staff leaving clinical areas to attend training, the end of life care facilitators also provided ward based training for staff. We viewed certificates given to ward staff and

porters on the integrated care after death pathway training where this was carried out opportunistically on the ward areas. In addition, the specialist palliative care team had identified that nursing staff would benefit from additional syringe driver training and had conducted a series of 'drop in' sessions in the hospital foyer for those finding it difficult to attend formal training.

- Junior doctors we spoke with told us they had attended end of life care training within the trust including communication training and anticipatory prescribing at the end of life.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life when needed, all staff told us the specialist team were accessible and supportive.
- Porters received training on induction and on an ongoing basis from mortuary staff around the transfer of the deceased to the mortuary. This included aspects of dignity and respect and well as communication with the bereaved.
- Evidence was requested to support that specialist palliative care staff had received annual appraisals, however this was not provided by the trust.

Multidisciplinary working

- The specialist palliative care multidisciplinary team (MDT) was led by a lead nurse and lead clinician. It consisted of consultants in specialist medicine, palliative care clinical nurse specialists (CNSs), end of life care facilitators, social support services, allied healthcare professionals, spiritual support, bereavement support, pharmacy support, pain specialists and other clinical nurse specialists.
- Weekly MDT meetings were held where trust specialist palliative care staff would attend to discuss their most complex patients. These meetings were video linked across hospital sites. We observed a meeting taking place and saw that issues relating to risk, preferred place of care, symptom management and patient choice were all discussed.
- There was a clear process for the transfer of care from hospital to community services, including for care plans and medication. Effective communication between hospital specialist staff, community specialist staff and hospice staff was established through the existing multidisciplinary relationships.
- There were monthly specialist palliative care face to face business meetings and additional operational meetings that were undertaken.
- There was access to specialist allied health professionals such as occupational therapy, physiotherapy and speech and language therapy.
- Specialist palliative care staff would attend regular ward based meetings as part of their routine visits to review patients on the wards. This enabled them to work closely with medical and nursing staff on the wards to support patients at the end of life.
- The specialist palliative care team worked closely with cancer and non-cancer specialist teams and palliative care consultants would attend regular MDTs to provide input.

Seven-day services

- Palliative care clinical nurse specialists provided a seven day face to face service between 8.30am and 4.30pm, Monday to Sunday. This consisted of two specialist teams at Alexandra hospital and Worcestershire Royal hospital from Monday to Friday. There was an on-call CNS available to provide face to face assessments on Saturdays and Sundays.
- Allied healthcare professionals provided an urgent service over the weekend for those patients who needed it.
- Mortuary staff were on-call out of hours.
- The chaplaincy service provided multi-faith and no faith pastoral and spiritual support 24 hours a day, seven days a week via and on call service.
- Consultants in palliative medicine were on-call via a locality rota 24 hours day, seven days a week.

Access to information

- There were end of life resource folders kept on wards and in clinical areas, providing staff with information on symptom management, end of life care and how to access specialist services both in and outside of normal working hours.
- Ward based end of life care link nurses attended regular meetings with the specialist staff and participated in maintaining information in the clinical areas to ensure it was up to date for both patients and staff.
- The electronic patient record system enabled sharing of information across services, including with patients' GPs.

End of life care

- The specialist nurse and end of life care facilitators attended the wards on a daily basis to review patients and provide support to ward staff. This included sharing up to date evidence based information in planning and delivering care to patients, particularly around symptom management.
- We saw that information was clearly recorded in patient's care plans. The specialist palliative care team entries into patient records were clearly identifiable so as to be easy for ward staff to access recommendations and specialist advice.
- The trust was planning on introducing the EPaCCS (electronic palliative care co-ordination system) by the beginning of 2017. This enables recording and sharing of people's care preferences and details about their care at the end of life.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a clear understanding of consent, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. We observed an example of a patient who lacked capacity receive a referral for an independent mental capacity advocate.
- Five of the 13 DNACPR (do not attempt cardiopulmonary resuscitation) records we viewed were for patients who did not have mental capacity. In three cases we saw clear evidence of a record of a mental capacity assessment but not in the other two. In all cases there was clear evidence of involvement of the family in best interest decision making.
- DNACPR decisions were made appropriately and in line with national guidance. The trust was aware of developments in guidance relating to this and regularly audited DNACPR records. We viewed an audit from March 2016 that demonstrated forms were appropriately completed in more than 90% of records.

Are end of life care services caring?

Good

We rated caring as good because:

- Patients and relatives were supported, treated with dignity and respect, and told us they felt involved in their care. Where survey results showed room for improvements in terms of communication, the specialist palliative care team took action to address this.
- We observed staff communicating with patients and relatives in a manner than demonstrated compassion, dignity and respect.
- Patients and relatives told us that the staff were caring, kind and respected their wishes. Patients and relatives we spoke with were complimentary about the staff and told us they felt appropriately supported.
- There were examples of where staff went out of their way to support patients and their families at the end of life, including arranging ward based weddings.
- Survey data showed that relatives of those who had received end of life care at the trust were satisfied with the support they received from staff.

Compassionate care

- Staff were seen to be caring and compassionate. We observed communication between staff and patients and their relatives and saw that staff were caring and respectful.
- Patients and relatives we spoke with shared their experiences of end of life care at Alexandra. We were told that staff were courteous and helpful and took time to speak with patients and relatives. People were satisfied with the care provided.
- We spoke with one patient and one relative during our inspection. Patients and relatives were positive about their experience of care, stating that staff were quick to respond to patient needs. We heard that staff were kind and caring and that communication with patients and relatives was clear, open and empathetic.
- The trust offered a VOICES (National Survey of Bereaved People) questionnaire to bereaved relatives and carers of deceased patients over the age of 18, for whom a death certificate was issued during the period 1 April to 30 June 2016. The sample excluded those patients who died in the emergency department, children under the age of 18 and those who experienced a sudden death. The results of the survey showed that 96% of respondents were satisfied with communication and emotional support offered to them. 98% felt that dignity and respect were maintained and 93% felt that the level of privacy was appropriate. However, the most recent survey report (January to March, 2016) showed there had been a decline in relative's experience in some

areas. For example, in the number of respondents feeling they had been given the opportunity to talk about their loved one's care or any concerns that they may have had. The specialist palliative care team had identified this slight decline and as a result had taken action to address some of the issues in essential staff training.

- Specialist palliative care nurses had been trained in advanced communication skills and communication skills training was available for all staff.
- Where possible patients at the end of life were cared for in a side room. Staff told us that this was sometimes difficult as side rooms were also used to manage infection control but that there was clear prioritisation and the views of the patient and relatives were considered. There was an end of life care suite available on ward 12 where patients from any ward area could be referred for end of life care.
- We were given examples of where staff went out of their way to support patients and their families at the end of life. This included arranging a ward based wedding for the daughter of a patient at the end of life and arranging for another patient to renew their wedding vows.

Understanding and involvement of patients and those close to them

- Patients we spoke with and their relatives told us they felt involved in their care. They told us that staff communicated with them sensitively and that they were given the time they needed to make decisions about their care.
- Relatives we spoke with told us they felt involved in their loved ones care. Results from the VOICES bereavement survey showed that 91% of relatives stated that they felt involved in decisions about care. This was an improvement of 9% from the 2014 survey. 88% of respondents stated they felt that personal wishes were respected, which meant that earlier discussions regarding care were held.
- The trust had increased the use of advance care plans in the past 12 months. We saw this demonstrated in regular audits.

Emotional support

- Clinical staff received training in communication skills including training for supporting people in distress. The trust had a chaplaincy and clinical psychology service available.
- The chaplaincy service provided spiritual support for patients and their families. A team of volunteers worked with the on-site chaplain to provide this. This support included face to face contact with patients and relatives such as out of hours support when a patient has died or is in the last hours of life.
- The trust's bereavement service found that 98% of respondents felt they had received appropriate emotional support from staff.
- We spoke with one patients and one relative being supported at the end of life and all told us they had received appropriate emotional support from staff.
- There were volunteers available within the emergency department to provide support to bereaved relatives. This included sitting with them and offering emotional support.

Are end of life care services responsive?

Good

We rated responsive as good because:

- The specialist palliative care service worked collaboratively with other services and organisations to ensure that services were planned and delivered to meet the needs of local people.
- The specialist palliative care team responded quickly to referrals and typically would see patients within a few hours if the need was urgent. 92% of patients were seen within 24 hours.
- There was a good balance between cancer and non-cancer referrals to the specialist palliative care team, with patients with cancer making up 49% of referrals and those with non-cancer 46% and the remaining 5% unclassified.
- The specialist palliative care team worked proactively with the emergency department to identify patients who may benefit from palliative care input.
- The trust had begun to record and audit preferred place of care at the end of life and there were clear systems in place to make improvements in this area.
- Discharge coordinators were available to support the process of rapid discharge at the end of life.

End of life care

- The specialist palliative care team had audited complaints that had an end of life care component, had identified trends and had taken action to address improvements.

Service planning and delivery to meet the needs of local people

- A Worcestershire end of life care network met regularly every three months and included representation from the trust and a range of county wide services. In addition consultants in palliative medicines across the county met regularly to discuss county wide developments to meet the needs of local people.
- Services were planned to meet the needs of the local demographic and a primary aim of the end of life networks was to raise awareness of end of life issues and ensure that patients received care in line with their wishes and preferences.
- There was an emphasis within both the specialist team and on general wards to support patients to die in their preferred location. The trust had not previously collated data relating to the percentage of patients who died in their preferred location. However they were beginning to do so and had initial figures relating to this. A February 2016 audit showed that 74% of patients had no preference recorded in their records. Of the 26 patients where their preference was recorded, 62% had achieved their preferred place of care at the end of life.
- The February 2016 audit of in-hospital deaths showed a small increase (6%) from the previous year in the percentage of patients who had died where a conversation about preferred place of death had been recorded.
- The specialist palliative care team had developed a tool to identify the preferred place of death of patients on the team's active caseload. They had also added preferred place of care discussions to all of their training and educational activities to raise awareness among ward based staff. Ongoing annual audits of preferred place of death were planned.
- There was one designated bed for people receiving palliative care on ward 12. Side rooms were available, although we were told that these were limited and use of these for patients at the end of life was secondary to their use in the management of infection control.

Meeting people's individual needs

- Staff carried out holistic assessments of patients' needs at the end of life. This included their emotional and spiritual needs and their preferred place of care.
- Patients who were in the last days and hours of life were identified and support from the specialist palliative care team was accessible. The trust scored similarly to the national average in relation to the identification of patients at the end of life as part of the 2016 National Care of the Dying audit.
- Discharge liaison nurses were available to support the process of getting people home, including for those patients at the end of life. Staff told us that where care packages were accessible in the community they could get patient's home in a matter of hours if necessary.
- An advance care planning 'future care' booklet was available to patients and their families. An audit of the records of patients at the end of life showed there had been a 21% increase in the recording of advance care plans for patients at the end of life.
- Translation services were available 24 hours a day. There were specialist nurses within the trust for both learning disabilities and dementia.
- There was a multi-faith chapel and prayer room available with information about different faiths and religions. The mortuary service had a policy to deal with deaths of those from different faiths and cultures and staff gave us examples of when this had happened.
- Mortuary viewing facilities were appropriate and there was a system in place where relatives would be escorted to the mortuary by bereavement staff. Relatives were also able to view outside of normal operating hours where the senior staff on duty would arrange for them to be supported to do this.
- Information was available in the form of a bereavement leaflet that included contact numbers for relatives of a variety of support agencies they could contact should they need to.

Access and flow

- Referrals to the specialist palliative care team came through from ward staff and a good deal were picked up through routine ward visits. Ward staff told us the team always responded promptly and that urgent referrals were seen within a short space of time on the same day. Trust figures show that 92% of referrals are seen within 24 hours.
- In total in 2015/16 there had been a total of 2,259 referrals to the specialist palliative care teams across

both Worcestershire Royal and Alexandra hospitals. Of those, 49% were for patients with a cancer diagnosis and 46% were for patients with a non-cancer diagnosis and 5% were unclassified.

- The specialist palliative care team worked closely with emergency department staff to explore patient flow through the department. This work had commenced following comments from relatives regarding waiting times and the capacity of emergency department staff when a patient at the end of life accesses the services. This included specialist palliative care nurses proactively engaging with emergency department staff on a daily basis to raise awareness of the support they could offer and to help identify patients who may benefit from their input. This work sat within an overall aim to improve access and flow for patients through the emergency department and support patients at the end of life being cared for in their preferred place.
- In addition, staff we spoke with in the emergency department told us they would often access the specialist palliative care team to provide support for patients at the end of life who came from nursing homes. This included times when the nursing staff in the home needed more support to care for the person in their usual place of residence, rather than them needing a hospital admission.
- The trust had audited preferred place of care at the end of life in 2016 as part of an ongoing audit process. They had identified that 74% of patients had no preference documented in their records. Of those that did, 62% had achieved their preferred place of care at the end of life. As a result of this audit the specialist palliative care team had added preferred place of care to their patient record system so that monitoring of this could lead to improvements over time.

Learning from complaints and concerns

- Information was available for patients on how to complain or feedback about the service experienced. People were signposted to the Patient Advice and Liaison Service (PALS) where concerns were unable to be resolved at ward level.
- A complaints audit carried out in March 2016 explored nine complaints from Alexandra that had an end of life care component. More than 50% of these had an element of poor communication or attitude that contributed to the complaint. As a result the specialist palliative care team had added a focus of communication skills to their training, including advanced communication skills for non-specialist staff and sessions on how to demonstrate a caring attitude when under pressure.
- The lead nurse of the specialist palliative care team told us they would be involved in investigations and supporting learning from complaints if these centred on patients at the end of life.
- Minutes of monthly palliative care team meetings demonstrated that complaints relating to end of life care were discussed with a view to learning lessons and making improvements.
- Feedback from bereaved relatives included concerns raised about the length of time it took to process death certificates. Action was being taken to resolve this and we viewed minutes of a privacy, dignity and bereavement group meeting where this had been discussed and formed part of an action plan to improve services.

Are end of life care services well-led?

Good

We rated well-led as good because:

- There was a clear vision for the service and a draft strategy was in place, highlighting the key areas the trust were focusing on in relation to end of life care.
- There was consistent promotion of the delivery of high quality person centred care and several audits had been undertaken to evaluate the service. There were clear and timely action plans in place to address improvements identified.
- There was strong leadership from the specialist palliative care team and from ward based nursing staff and trust wide leadership from the chief nurse and non-executive leadership at board level.
- Staff were consistently passionate about end of life care, positive about their roles and consistent in their belief that the quality of end of life care was good.
- A range of meetings took place across the trust and the locality with representation from the specialist palliative care team where the planning and development of end of life care services was discussed. There were also clear reporting structures across the directorate and the trust as a whole.

End of life care

- A number of innovations were apparent with a focus on improving end of life care across the trust.

Leadership of service

- There was clear leadership in end of life care across the trust. The senior consultant in palliative medicine was the clinical lead and together with the nursing lead for palliative care worked to develop the service to meet the needs of patients.
- Members of the specialist palliative care team, including the end of life care facilitator were enthusiastic and motivated to share practice and develop ward and clinical based services across the trust to better meet the needs of patients at the end of life.
- There was good local leadership at ward based level with end of life care being seen with an appropriate level of priority. End of life care ward champions were available on every ward, generally with more than one for each area to ensure a good level of additional skill and support available.
- There was a clear commitment to quality end of life care across wards within the hospital and we saw ward managers and staff alike focused on improving and developing end of life care in general ward settings.

Vision and strategy for this service

- The trust were working with other end of life care services within the locality to develop an end of life care strategy. There was a clear vision for end of life care that included people receiving individualised and coordinated care. In addition, there were defined objectives relating to specialist and non-specialist services, county wide and trust wide activities.
- Members of the specialist palliative care team participated in county wide network activities, ensuring the trust was involved in strategic discussions about end of life care.
- Minutes of meetings demonstrated that strategic and developmental activities relating to end of life care were high on the agenda, including in the trust wide 'high impact action group' meetings for end of life care. Information is disseminated to staff through the end of life care champions and end of life care facilitators working on the wards.
- The chief nurse was the executive lead for end of life care across the trust. In addition there was a non-executive director lead for end of life care. There was a clear reporting structure for end of life care within the trust and evidence of end of life care discussions at board level.

Governance, risk management and quality measurement

- Specialist palliative care reports within the specialised clinical services division of the trust with governance systems in place to ensure effective reporting, learning and improvements to end of life care across the trust.
- In the previous inspection it was identified that the trust did not have a palliative/end of life care risk register. This had since been developed with issues such as the supply and flow of syringe drivers identified as a potential area of risk. The main area of risk had been identified as being at Worcestershire Royal hospital due to a fragmented system, however monitoring of the systems across all sites was in place to ensure that issues were identified and addressed across the trust as a whole.
- Regular meetings were held where issues of governance were discussed including monthly team meetings and weekly multidisciplinary meetings.
- Audit was used to monitor the quality of service and inform improvements to practice. Examples we viewed included do not attempt cardiopulmonary resuscitation (DNACPR) audits, significant event and complaint audits, AMBER care bundle audits and the trust participation in the National Care of the Dying Audit (NCDAH).
- Staff were involved in sharing lessons and improving practice across the service, including specialist staff and ward based end of life care champions.

Culture within the service

- Staff were consistently positive about delivering quality care for patients at the end of life and told us they felt supported to deliver good end of life care.
- Staff were proud of their work around end of life care. The specialist palliative care, bereavement, chaplaincy and mortuary staff demonstrated an enthusiasm and passion for continuously improving services to meet the needs of patients and families.

Public and staff engagement

- Bereavement surveys were sent out to relatives of patients who had received end of life care within the

trust. There was clear evidence that the results of these surveys influenced the development of the service with action taken to address issues of concern. For example, in relation to the flow of end of life care patients through the emergency department.
- The trust participated in activities to raise awareness and hold discussions with the public on death and dying during 'dying matters' week each year.
- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to. For example, staff were able to feedback to management via 'listening in action sessions' issues that impacted on patient care. Examples of action taken included the introduction of refreshments and tea and coffee making facilities in a dedicated relative's area within the hospital.
- Specialist palliative care staff and end of life care champions attended regular team meetings where they had the opportunity to input into the development of the service.

Innovation, improvement and sustainability

- There were a number of innovations relating to care for patients at the end of life. This included the work of the specialist palliative care team in working proactively with the emergency department to raise awareness and promptly address issues relating to symptom management or end of life care for patients in the emergency department.
- There was a strong audit culture within the specialist palliative care team where areas for improvement were identified and clear action taken to address these. For example, in relation to the use of the VOICES bereavement questionnaire for bereaved relatives and regular audits of the AMBER care bundle and optimising end of life care records.
- The specialist palliative care team Building on the Best quality improvement partnership project with The National Council for Palliative Care (NCPC) and Macmillan cancer support for acute hospitals demonstrated a commitment to continued improvement to end of life care services. The trust was one of 10 that had been selected to participate in the project. The team had in place a clear plan to involve generalist staff in the project and to create care improvements for patients at the end of life who were being cared for at ward level. The team had undertaken scoping exercises to flesh out the project and had focus groups planned for early 2017 to involve key staff in further defining and implementing the project. The plan was to pilot the initiative in one ward at Alexandra hospital and one ward at Worcestershire Royal hospital.
- The lead consultant in palliative medicine was involved in discussions as part of end of life care related mortality reviews. This enabled them to have an input into improving end of life care as part of this process.

Outpatients and diagnostic imaging

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

Information about the service

Worcestershire Acute Hospitals NHS Trust provides outpatient and diagnostic imaging services to a population of more than 550,000 people in Worcestershire, as well as people from surrounding counties and further afield, including Herefordshire, Dudley, South Staffordshire, Shropshire, Warwickshire and Birmingham. Outpatient and diagnostic imaging services are provided at three hospital sites; Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Hospital and Treatment Centre.

Outpatients includes all areas where people undergo physiological measurements, diagnostic testing, receive diagnostic test results, and are given advice or receive care and treatment without being admitted as an inpatient or day case patient.

The outpatient and diagnostic imaging service is led by the specialised clinical services division. This division also includes; theatres, anaesthetics, critical care, endoscopy and bowel screening, ophthalmology, rheumatology, pre-operative assessment and day case, sterile services, pathology, pharmacy, haematology, oncology and palliative care, radiology and breast screening services. The current structure includes a divisional operational manager, divisional director of nursing and divisional medical director. This team is supported by a deputy divisional operational manager, deputy divisional director of nursing and deputy divisional medical director, plus a directorate manager and matron.

The Alexandra Hospital serves a population of approximately 200,000 people in Redditch and surrounding areas. Outpatient service provisions include; ophthalmology, trauma and orthopaedics, cardiology, ear, nose and throat (ENT), general surgery, urology, dermatology, general medicine, vascular surgery and rheumatology. The diagnostic services cover; computed tomography (CT), magnetic resonance imaging (MRI), plain film radiography, nuclear medicine, fluoroscopy and breast imaging. The diagnostic laboratories include pathology, biochemistry and microbiology.

During April 2015 to March 2016 the trust saw approximately 744,808 outpatient appointments across the three hospital sites; 192,289 of which were carried out at the Alexandra Hospital. The diagnostic imaging department undertakes approximately 32,000 examinations each month, trust wide.

Outpatient clinics are available from 8.30am to 5.30pm, Monday to Friday. The outpatient department has five clinic areas, with 20 consulting rooms and four minor treatment rooms; all of which are located on the ground floor of the Alexandra Hospital.

The diagnostic imaging department has four x-ray rooms, two CT scanners, one MRI scanner and three diagnostic ultrasound rooms.

The outpatient and diagnostic service had previously been inspected in July 2015 and was rated requires improvement for safe, responsive and well-led and good for caring. The service was rated requires improvement overall and was required to complete a number of actions to ensure compliance with the Health and Social Care Act 2008. We inspect but do not rate the effectiveness of the service, as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Outpatients and diagnostic imaging

We carried out an announced inspection at Alexandra Hospital from 23 to 24 November 2016. We visited outpatient clinics and diagnostic services held at Alexandra Hospital, including radiology, ophthalmology, urology, ENT, trauma and orthopaedics, oncology and haematology.

We spoke with 58 members of staff, including consultants, radiographers, radiologists, nurses, healthcare assistants, reception staff and medical secretaries. We spoke with 17 patients and relatives. We observed interactions between staff and patients and considered the environment. We also reviewed the trust's performance data. Some of the performance data is only available trust wide and relates to all hospital sites covered by the trust. Performance data regarding the Alexandra Hospital only has been used where available.

Summary of findings

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

We found that:

- There were long waiting lists for the majority of specialities and the trust had not met all cancer targets for referral to treatment times. The trust was failing to meet a range of benchmarked standards with regards to the time with which patients could expect to access care.
- Mandatory and safeguarding training levels did not always meet the trust's target and not all staff had received an annual personal development review.
- Incidents were not always categorised appropriately, in terms of the level of harm caused. Incidents were not always reviewed in a timely manner and we were not assured that learning from incidents was cascaded to all staff.
- Complaints were not always responded to in a timely manner.
- There was a lack of radiation protection team infrastructure.
- Aging and unsafe equipment across the trust was inadequately risk rated and there was a lack of capital rolling replacement programmes. There had been two patient safety incidents in the trust, involving patients who had been physically injured by unsafe x-ray equipment.
- We were not assured the service had a realistic strategy for achieving the priorities and delivering good quality care.
- The governance arrangements and the management of risk were not sufficiently robust and further improvements were needed.

However, we also found:

- Patient records were stored securely and effective systems were in place to ensure clinicians had access to appropriate and up-to-date patient information.

Outpatients and diagnostic imaging

- Patients were treated with kindness, dignity and respect and spoke positively about the care they had received.
- Care and treatment was delivered in line with national guidance.
- Some departments had developed services, such as one-stop clinics, in order to better meet the needs of patients and improve service provision.
- There was effective multidisciplinary working across outpatient and diagnostic imaging services.
- Local leadership was strong, supportive and approachable. However, staff did not feel directorate and divisional leads were visible.
- Staff were proud to work at the hospital and were passionate about the care they provided.

Are outpatient and diagnostic imaging services safe?

Inadequate

Overall, we rated the outpatient and diagnostic imaging service as inadequate for being safe because:

- Incidents were not always categorised correctly and investigations carried out lacked detail. We were not assured that learning from incidents was cascaded to all staff.
- Not all staff had completed mandatory and safeguarding training and there was a risk that staff did not have up-to-date knowledge in order to protect patients, visitors and staff from potential harm.
- Medicines that required cold storage were not always stored and monitored in line with trust policy. We were not assured that all staff were aware of actions to be taken when refrigerator temperatures exceeded the recommended range.
- We were not assured there was an effective system in place to monitor and manage the risk to all patients on the waiting list.
- Safety was not a sufficient priority with regards to the replacement of aging and potentially unsafe x-ray equipment across the trust.
- Standard operating procedures within radiology were not adequately reviewed and were not subject to robust document control. Examination protocols, including medical exposure parameters, were insufficiently revised.
- There was inadequate review of risks to patients from aging medical devices in radiology. Risk assessments were in place but were not subject to regular review and items on the risk register were not sufficiently prioritised.

However:

- All areas we inspected, including clinical and waiting areas, were visibly clean and tidy.
- Equipment (other than that required for imaging, for example, x-rays) the outpatient department was well maintained and had been safety tested to ensure it was fit for purpose. However, emergency equipment was not always checked on a daily basis.

Outpatients and diagnostic imaging

- Outpatient staffing levels and skill mix were planned and reviewed regularly so that patients received safe care and treatment.
- The department had effective systems in place to ensure appropriate and up-to-date information was made available for clinicians to review patients who attended outpatient appointments.

Incidents: Outpatients

- We were not assured that patients were always protected from harm. Incidents were not always reviewed in a timely manner, investigations that had been carried out lacked detail, incidents were not always categorised to reflect the level of harm caused and there was limited evidence that learning from incidents was cascaded to all staff.
- There had been no never events reported in outpatients from October 2015 to September 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event (Revised Never Events Policy and Framework, NHS England March 2015).
- There were no serious incidents reported to the Strategic Executive Information System (STEIS) from October 2015 to September 2016.
- From our previous inspection in July 2015, we found that the number of incidents reported within the outpatient department was exceptionally low. There was a view that staff would not routinely report common issues, such as clinic overruns, especially if they felt they would remain unresolved. During this inspection we found that the number of incidents reported had remained low within the outpatient department. This was partly due to how incidents were reported through the trust wide electronic reporting system. All incidents were categorised by directorate and speciality. This meant that when clinics overran, for example, this would be reported as an incident relevant to that specific medical speciality and not the outpatient department. Therefore, we were not assured that learning from all incidents was shared across the outpatient department, as staff were not necessarily aware of and/or involved in all incidents related to the department.
- From September 2015 to August 2016 there were 100 incidents reported through the National Reporting System and Learning System (NRLS) for the outpatient and diagnostic imaging service; 13 incidents were related to outpatients, 85 were related to radiology and two were related to endoscopy. Incidents were graded in severity from no or minor harm, or moderate to severe harm; 71 of the 100 incidents were graded as no harm and 29 were graded as minor harm. No incidents were graded as having caused moderate or severe harm. Eight of the 13 incidents related to outpatients were graded as no harm (62%) and the remaining five were graded as minor harm (38%). The incidents reported included documentation errors, rejected blood samples and mislabelled diagnostic requests. There were no particular themes identified.
- We were not assured that all incidents were categorised appropriately, in terms of the level of harm caused. Nor were we assured that detailed investigations of all incidents were carried out. One of the incidents we reviewed related to a patient who slipped through a standing hoist sling and fell to the floor whilst attending the outpatients department. We were told that the patient suffered a fractured femur as a result of the fall (a crack or break in the thigh bone). This incident was categorised as having caused “minor harm”, despite the fact that staff knew the patient had suffered a fracture at the time the incident was reported via the electronic reporting system. According to the trust incident reporting policy, this incident should have been categorised as a moderate harm. We reviewed the divisional initial case review of this incident and saw that some details had not been completed. For example, the date and time of review had not been detailed, nor had the harm level, what communication had occurred with the patient/family and whether further investigation was required. The initial case review stated that a manual handling advisor had visited the outpatient department and discussed the incident with staff. Feedback from the visit was awaited (at the time the initial case review was carried out), but no issues were raised by the manual handling advisor with staff. The initial case review concluded that there were no lessons to be learned from the incident and the

grade of care was "good practice – a standard of care you would accept for yourself". Therefore, we were not assured that all incidents were categorised and investigated appropriately.

- Staff we spoke with were aware of the trust wide electronic reporting system and how to use it to report an incident. We were told the trust shared learning from serious incidents with staff via a dedicated 'learning from serious incidents' page on the intranet. Staff also told us that learning from incidents was shared at team meetings. We reviewed three sets of team meeting minutes and saw some evidence that incidents were discussed. For example, minutes of the meeting held in July 2016 discussed the incident regarding the patient who slipped through a standing hoist sling and fell to the floor. Staff were advised that as a result of this incident, it was felt that improvement in the documentation of mobility assessments was needed. Staff were told that a mobility assessment was to be completed for all patients who required handling of any description. There was no evidence that this learning had been identified on the initial case review completed. We did see evidence that some specialities, such as ophthalmology and rheumatology, discussed incidents at team meetings. Senior nursing staff were able to give us examples of lessons learned as a result of incidents, but other members of the nursing team we spoke with were not. One member of staff told us they felt they should get more feedback. Therefore, we were not assured that learning from incidents was effectively shared with all members of the outpatient department.
- According to the quality governance performance dashboard for outpatients from January to July 2016, the outpatient service trust wide reported a total of 22 incidents. The majority of incidents were reported in June and July 2016; six (27%) and seven (32%) incidents respectively. The dashboard also reported that a total of 21 incidents remained open longer than 20 working days. In June 2016, a total of seven incidents remained open (33%) longer than 20 working days. Therefore, we were not assured that all incidents were reviewed in a timely manner, despite so few incidents being reported within the service.
- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- According to the trust incident reporting policy, all incidents that resulted in significant harm (including moderate harm) required the duty of candour to be applied. However, because the incident described above had not been categorised appropriately, there was no evidence to show that the duty of candour process was followed.
- Staff we spoke with were aware of the duty of candour regulation (to be open and honest) ensuring patients received a timely apology when there had been a defined notifiable safety incident.

Incidents: Diagnostic imaging

- There had been no never events reported for this service from October 2015 to September 2016.
- There had been four reportable incidents from across the trust to the Care Quality Commission (CQC) as required under the Ionising Radiation Regulations 2000 (IRMER), in the last 12 months. These incidents had been low risk medical exposures, which had not resulted in serious harm to patients and all were subject to investigation through local governance arrangements.
- The imaging department reported 90 incidents from August 2015 to June 2016 across all imaging modalities. These incidents covered a range of near misses and minor harm to patients. Four incidents related to image archiving issues, whereby images were not available for reporting, four were related to a delay in the reporting of images and a further three incidents were related to incorrect reporting by a locum consultant. Six incidents were due to patients who required two week wait appointments but received routine appointments in error. Two theatre lists were delayed due to breakdown of the magnetic resonance imaging (MRI) scanner; equipment was subject to regular service and maintenance but had not been replaced at the time of inspection. A further two theatre lists were delayed due to the unavailability of the radiographer. Two incidents related to lists being delayed or cancelled due to breakdown of the MRI scanner.
- One serious incident was reported when a part of the chest x-ray unit fell off the wall and grazed a patient's hip. We were informed at the time of inspection that

another patient had been injured by the same piece of equipment, which resulted in a broken foot but this was not seen on the incident log for the hospital. The equipment had been fixed, however there were ongoing concerns regarding its mechanical function. Staff we spoke with were unable to confirm whether this incident had been reported to the health and safety executive (HSE) under the 'reporting of injuries, diseases and dangerous occurrences regulations' (RIDDOR, 2013). Accidents which result in a person (e.g. a patient) suffering a specified injury whilst at a hospital, in this instance a fractured foot, and which would require hospital treatment should be reported under RIDDOR (HSE, Reporting injuries, diseases and dangerous occurrences in health and social care. Guidance for employers, 2013 Revision 3). Therefore, we were not assured that all incidents were reported in line with national guidance.

- We saw posters for staff on the topic of duty of candour. Staff understood what this meant and their role in being open and honest when things went wrong.

Incidents: Radiation Protection

- The department had a full set of Ionising Radiation (Medical Exposure) Regulations IR(ME)R procedures and standard operating procedures, as required under the regulations.
- The Ionising Radiation Regulations 1999 (IRR99) aim to protect staff working with ionising radiation. This legislation requires radiology services to produce 'local rules', which is a set of rules describing what systems and processes are in place in individual services to protect staff. The radiology service had developed their 'local rules' and these were up to date and displayed in all relevant areas of the department. We also observed that the ophthalmology department had produced 'local rules' for the use of laser equipment, which were designed to minimise the risk of harmful exposure to laser radiation to staff, patients and members of the public.
- Radiation protection services were supplied by an external radiological protection service and were used by the trust from April 2016. The company were responsible for the provision of a radiation protection advisor, a medical physics expert, a radiation waste advisor and a magnetic safety advisor. Prior to April 2016 this service provision was through another third party provider. At the start of the contract there was a kick-start meeting to discuss the new ways of working. However, there was no action plan formulated around areas the trust were particularly concerned about or required focused support for.
- We saw minutes of the radiation protection committee meeting that was held annually. This was the only formal meeting scheduled with the medical physics expert and radiation protection advisor, as part of the service level agreement with the external radiological protection service. The next annual meeting was due to be held in December 2016.
- The last radiation protection audit was carried out in July 2016. The medical physics service had indicated that there were insufficient radiation protection supervisors for the trust and that there needed to be up to date training and associated training records held. The service provider had offered to provide this training but at the time of inspection this had not been actioned.
- Staff felt that under the new medical physics contract they were not as well supported but acknowledged that the contract was in its infancy.
- Physics reports, which were concerned with the service and performance of the equipment, were sent to the team leaders at each site but staff told us they were not as readable and comprehensive as the reports generated by the previous provider.
- Radiation dose audits, although carried out periodically, were not thought to be regular and robust and this was predominantly due to staffing levels. The department wanted more guidance and assistance from the medical physics provider, but in the absence of a radiation protection governance structure it was felt this was difficult to coordinate. A dose audit is where radiation doses from medical exposures are statistically analysed to ensure that equipment is working correctly, operators are using the equipment safely and effectively and to help gain an overall picture of doses to the local population.
- Diagnostic reference levels (DRL), as required under IR(ME)R, were on display in some x-ray rooms but there was no evidence of recent review. Furthermore, there were no paediatric values and no DRLs were on display in computed tomography (CT). DRLs are typical doses for examinations commonly performed in radiology departments. They are set at a level so that roughly 75% of examinations will be lower than the relevant DRL.

They are not designed to be directly compared to individual doses, although they can be used as a signpost to indicate to staff when equipment is not operating correctly.

Cleanliness, infection control and hygiene: Outpatients

- Standards of cleanliness and hygiene were generally well maintained. Reliable systems were in place to prevent and protect people from a healthcare associated infection.
- The areas we inspected, including clinical and waiting areas, were visibly clean and tidy.
- We saw the service level agreement for the provision of housekeeping services, which included daily, weekly and monthly cleaning schedules. Housekeeping staff cleaned the consultation and treatment rooms daily, when the outpatient department was closed.
- Nursing staff were responsible for cleaning the examination couch, overhead light, desk, chairs, computer and phone in each consultation and treatment room on a daily basis. We saw completed cleaning schedules in place for November 2016, which confirmed areas had been cleaned.
- Monthly cleaning audits were carried out by the housekeeping team. We reviewed the results of audits carried out from December 2015 to November 2016 in the outpatient, audiology and ear, nose and throat (ENT) departments and saw compliance was high, with an average score of 97%.
- Trust data for July 2016 showed completed infection control and hand hygiene training met the trust target of 90% compliance, 92% of staff had completed infection control training and 100% of staff had completed hand hygiene training. Therefore, we were assured that staff had completed appropriate training and had up-to-date knowledge of infection control and prevention measures in order to protect patients, visitors and staff from potential harm.
- The infection prevention team carried out an annual audit of services based on the infection prevention quality standards. The audits were carried out from August to October 2016 and included compliance with; hand hygiene, personal protective equipment (PPE), staff knowledge and waste management. The outpatient and ophthalmology department scored a compliance of 74% and 71% respectively. The physiotherapy department were 100% compliant. We saw evidence that an action plan was developed in response to the audit findings and actions identified had been completed.
- The outpatient department participated in the Saving Lives audit, designed to ensure effective prevention and control of healthcare associated infections. This is in accordance with national recommendations (Department of Health, Saving Lives: reducing infection, delivering clean and safe care, 2007). From April 2016 to January 2017, compliance in the outpatient, ophthalmology and audiology department was 100%.
- The outpatient department conducted weekly hand hygiene audits in line with the trust's infection prevention control programme. The audit included whether staff were 'arms bare below the elbow' and if they washed their hands before and after each patient contact. From May 2016 to October 2016, compliance in the outpatient department was 100%.Toilets were clean and well equipped with hand washing gels and paper towels. Posters advising patients and visitors of good handwashing technique were displayed.
- Hand sanitising gel dispensers were available in corridors, waiting areas and clinical rooms. We saw posters in waiting areas and other communal areas advising patients and visitors to use hand gel dispensers. The main entrance/exit to the outpatient department had signage on the floor reminding visitors to "STOP Clean Your Hands".
- Staff complied with infection prevention and control policies. Clinical staff adhered to the provider's 'arms bare below the elbow' policy to enable good hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons. We saw staff clean their hands between direct patient contact.
- Patients with known tuberculosis would be seen at home by the community respiratory team, where possible. There were no designated rooms for seeing patients with communicable diseases, such as influenza or tuberculosis. Staff told is that if it was necessary to isolate a patient, an appropriate consultation or treatment room would be designated for their use. The patient would not be seated in the waiting area, in order

to reduce the spread of any known communicable diseases to other patients and visitors. The room would then be deep cleaned prior to any other patient use. This was in line with infection control procedures.

- The outpatient department had one infection control and hand hygiene link nurse who attended infection prevention and control link nurse study days and cascaded information to members of the team. An infection control folder was available for staff to use as a resource, which contained up-to-date infection control and prevention guidance. We reviewed this during our inspection. Staff also had access to infection control policies via the trust intranet.
- The trust participated in patient-led assessments of the care environment (PLACE). Each year members of the public undertake unannounced visits to assess how the environment supports; cleanliness, general building maintenance, patient's privacy, dignity and wellbeing, food, dementia and disability. The outpatient department's PLACE audit for 2016 showed they scored better than the England average for cleanliness. The outpatient department scored an average of 99%, whilst the England average was 98%.
- In December 2016, 33% of staff within the outpatient department had been vaccinated against influenza. Public Health England recommends that all frontline staff are vaccinated annually in order to reduce the risk of catching and/or spreading influenza.

Cleanliness, infection control and hygiene: Diagnostic imaging

- We observed all staff working 'arms bare below the elbow' and there was good use of hand gel between patients.
- A cleanliness audit undertaken in May 2016 reported that areas around the intravenous urogram and magnetic resonance imaging (MRI) room were dusty, but at the time of the inspection they were clean. Some areas within radiology were dirty. Compliance against the 100% trust target for cleanliness was 85% in May and 88% in August 2016.
- During the inspection we found the department was clean but there were multiple areas that appeared worn and torn, including waiting chairs.
- Cleaning schedules were seen in all rooms and were up to date.
- Hand hygiene audits were undertaken weekly. We saw that compliance was between 90% and 100% for most weeks, with the exception of one week in October 2016 when compliance was 79%.
- There were concerns that ultrasound intracavity probes were not being cleaned sufficiently. Intracavity probes are used to obtain ultrasound images inside the body. After speaking with the ultrasound lead we were informed that there had been conflicting advice from the infection control team as to which type of disinfectant should be utilised for cleaning. One type of disinfectant was currently being used and the department was waiting for a definitive response. Staff investigated a sterilisation cabinet as an alternative, which is a cheaper overall option and would not reduce capacity due to waiting time for the probes to be cleaned. However, there was no capital budget to purchase the initial equipment required.

Environment and equipment: Outpatients

- Generally, the design, maintenance and use of facilities, premises and equipment in the outpatient department met patients' needs.
- Adult and paediatric emergency equipment, such as defibrillator (device that gives a high energy electric shock to the heart through the chest wall to someone who is in cardiac arrest), oxygen and suction, were available in the outpatient department for use at short notice. The equipment was checked on the day's the outpatient department was open to ensure it was in working order. We reviewed completed checklists from 17 October to 23 November 2016 and found four occasions (15%) when the emergency equipment had not been checked. On the 7 November 2016 it was documented that the equipment had not been checked because of "staff shortage". We raised this with senior staff at the time of inspection, who told us that they maintained oversight of the emergency equipment checklists. However, if they were not on duty no other member of staff was allocated to ensure the checklist was completed. Therefore, we were not assured there was a reliable system in place to ensure emergency equipment was checked daily, in line with trust policy. The oxygen cylinders and emergency medicines were all in-date.
- The maintenance of equipment was completed via a service level agreement with the manufacturer or the trust's estates department. A schedule of work was in

place and equipment was assessed annually as safe for use. We saw evidence of maintenance checks for equipment in the outpatient department. We reviewed 22 pieces of equipment and all had been safety tested.
- Equipment used in the physiotherapy gymnasium, such as treadmill and exercise bikes, had been safety tested.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. All sharps boxes were clean, were not overfilled and had temporary closures in place to minimise the risk of needle stick injuries.
- We saw completed cleaning schedules in place for November 2016, which confirmed equipment had been cleaned daily. The equipment we saw in the outpatient department was visibly clean and "I am clean stickers' were used to indicate when equipment had been cleaned and was ready for use. We saw staff clean equipment between direct patient contacts.
- Clear signage and safety warnings were in place outside the clinic room where ophthalmic lasers were used. This room was observed to be locked when not in use.
- The outpatient department's PLACE audit for 2016 showed they scored slightly worse than the England average for condition, appearance and building maintenance. The outpatient department scored an average of 91%, whilst the England average was 93%.
- The trust facilities department carried out regular audits of the environment based on the national PLACE audit, current legislation and best practice. The outpatient department scored a compliance of 89% in January 2016, 89% in May 2016 and 95% in August 2016. We saw evidence that actions were taken to address areas of non-compliance. For example, the audit carried out in January 2016 reported that the equipment was not clearly identified as clean and ready to use. The audit carried out in May 2016 reported that "all equipment was spotless, clearly labelled and ready to use".

Environment and equipment: Diagnostic imaging

- An inventory of equipment was seen however, there was no formal capital rolling replacement programme for some of the aging equipment across the trust. Two x-ray rooms at the hospital had been on the risk register since November 2014. There had been multiple failures of the equipment resulting in downtime in the department and on two occasions the equipment had injured patients. At the time of the inspection there were no plans in place to replace this equipment and senior managers informed us that the next option would be to lease equipment with the cost absorbed by the radiology department. This was on the trust risk register.
- There were numerous maintenance issues with the aging equipment and this had a negative impact on service delivery. The units were in high demand with a large throughput of examinations, approximately 200 to 300 patients per day. There was multiple downtime and although the maintenance contract was responsive this was still of great concern to the department. In rooms one and two, faults with the automatic exposure control system had been noted, which had the potential to affect the radiation exposure received by the patient.
- We saw evidence of quality assurance (QA) reports from the radiological protection service and handover documents for equipment testing and commissioning across all imaging modalities.
- Personal protective equipment (PPE), to protect staff from radiation, was available and stored clean and subject to regular safety checks.
- Quality assurance (QA) testing undertaken by radiographers was carried out at the hospital but it was identified by the medical physics service that this was not being undertaken frequently enough and that there were a lack of trained members of staff to undertake the activity. Currently the department had all band five and six staff able to undertake the QA. We reviewed a number of electronic records and so this concern was thought not to be specifically directed at this hospital site. We noted a three month gap in the quality assurance testing of room one around the time of a fault identified by the physics service QA testing.
- The MRI scanner had been placed on the risk register due to its age. A replacement scanner was due to begin installation in December 2016, with final testing in February 2017.
- Resuscitation trolley checks were seen and were up to date.
- At the time of the inspection, a sharps bin situated in the fluoroscopy room had a guidewire protruding from it. Staff rectified this immediately following our request. All other sharps bins and clinical waste bins were appropriate stored, filled and labelled correctly.

Medicines: Outpatients

- Medicines were stored securely. However, we were not assured that medicines which required cold storage were always stored and monitored in line with trust policy.
- The outpatient department had appropriate lockable storage facilities for medicines. Medicines that needed to be kept below a certain temperature were stored in locked refrigerators. No controlled drugs (medicines subject to additional security measures) were stored in the outpatient department. The keys for medicines cupboards and refrigerators were stored in a safe and only registered nursing staff could access the safe key. This prevented unauthorised personnel from accessing medicines. There were separate medicine cupboards and refrigerators in the clinic areas used by ophthalmology, ENT and the outpatient department.
- Trust policy stated that a record of refrigerator temperatures must be maintained and pharmacy alerted if the temperature was outside the required range, to ensure medicines stored were safe for patient use. We reviewed the refrigerator temperatures from 1 October to 23 November 2016 and found that temperatures were not always recorded on a daily basis. There was a total of 12 occasions when refrigerator temperatures had not been documented; two omissions were noted in ophthalmology, nine in ENT and one in outpatients. The minimum and maximum temperatures were within the required range for refrigerators in ophthalmology and ENT. However, there were 15 occasions when the refrigerator temperature in outpatients exceeded the maximum range. Furthermore, from 3 to 7 October and 1 to 9 November 2016 it was documented daily that the refrigerator had exceeded the maximum recommended temperature. There was no evidence that any action had been taken. We were told this was because the temperature had not been reset, in line with trust policy. There was only one occasion when it was documented that staff had taken any action to address exceeded refrigerator temperatures; this was when the maximum temperature reached 17°C on 24 October 2016. Therefore, we were not assured that all staff were aware of the procedure to follow when refrigerator temperatures exceeded the recommended range. This meant there was a risk that patients received degraded medicines. Following our inspection, we saw evidence that an action plan had been developed to address this issue. New documentation had been introduced by the trust, which included clear guidance on actions to be taken when refrigerator temperatures exceeded the acceptable range.
- The trust had recently revised its guidance on action that should be taken when ambient room temperatures exceeded the recommended range. We saw a copy of the draft guidance during our inspection, which stated that medicines stored between 25°C and 30°C was acceptable; the pharmacy department should be informed if the temperature exceeded 30°C for seven consecutive days. The ambient room temperature was recorded daily in the outpatient department. We reviewed the ambient temperatures from 19 September to 23 November 2016 and found there were no occasions when the temperature exceeded 30°C. Ambient room temperatures were not recorded in the ophthalmology and ENT clinic areas. Senior staff told us that the clinic room where ophthalmology medicines were stored was air conditioned, which maintained the room temperature within the safe storage range. However, because the ambient room temperatures were not recorded we were unable to corroborate this. We observed the ambient room temperature was within the safe storage range during our inspection.
- Outpatient staff had some medicines available within the clinic areas and could access specific medicines from pharmacy, if necessary.
- The outpatient department did not use FP10 prescriptions. FP10 prescriptions are the common form on which a prescription is written. They are used for outpatients and can be taken to any pharmacy for the medicines to be dispensed. Prescription pads for dispensing of medicines from the on-site pharmacy were stored securely. We saw that systems were in place to monitor prescriptions issued.
- Patient group directives (PGDs) were used in ENT and ophthalmology to cover the supply and/or administration of eye drops and eye ointments. A PGD is a document signed by a doctor and agreed by a pharmacist, to give direction to a nurse to supply and/or administer specific medicines to a pre-defined group of patients using their own assessment of patient needs, without necessarily referring back to a doctor for an individual prescription. We saw that PGDs had been authorised and signed appropriately.
- Medicine incidents were reported via the electronic incident reporting system. From September 2015 to

August 2016 a total of 18 medicine incidents were reported for outpatient departments trust wide (this equates to 7% of total incidents reported for the service). All incidents were graded as having caused no or low harm. Common themes included wrong dose and/or delay in administration, documentation errors and complications of intravenous medicine administration, such as extravasation. Extravasation is the process by which fluid and/or medicines given through a vein accidentally leak into the surrounding tissue. One of the incidents related to an ophthalmology patient who had received the wrong dose of botulinum toxin. We requested evidence that actions had been taken and lessons learnt from this incident were shared with staff. We were told that this incident was discussed at the ophthalmology department audit meeting. However, the meeting was not robustly minuted at the time and so there was no evidence to demonstrate that action had been taken and lessons regarding this incident had been shared.

Medicines: Diagnostic imaging

- Patient group directives (PGDs) were seen in place and in date for all medicines given in the diagnostic imaging department. This meant that appropriately trained radiographers were able to administer contrast and other intravenous medications to patients without the need for radiologists to prescribe this medication.
- The medicines used in the diagnostic imaging department were well managed. The drugs were all stored safely and were regularly checked for use by dates. We witnessed a drug check at the time of the inspection. Medication was kept in locked cupboards, with the exception of the contrast media, which was stored appropriately and which was only accessible by key members of staff. Temperatures were regularly recorded for both the fridge and the storage cupboard. We saw that temperatures recorded were within the required range. This meant we were assured that medicines stored were safe for patient use. Staff were aware of the procedure to follow when temperatures exceeded the recommended range.
- The imaging department had a good process in place for prescribing medication used for CT colonograms. Patients would attend the department to pick up the medication, where radiographers were available to discuss how to take the medication and discuss the test itself. This process was well recorded on the radiology information system and in manual logs to track the medication.
- An anaphylaxis kit was kept in CT in case of any allergic reactions to the contrast media given to patients during the scans.

Records: Outpatients

- Records were accurate, complete, legible, and up to date and stored securely.
- The outpatient department used a combination of paper and electronic patient records. Paper records were maintained for each clinic attendance and then scanned into the patient's electronic record by an external provider. The external provider captured the date and time the scanned patient records were available. We were told that all non-urgent paper records were scanned to the patient's electronic record within 48 hours and all urgent paper records were scanned within one hour of receipt. Staff told us it was uncommon for patient records to be unavailable for clinics. The trust reported they mitigated unavailable patient records by accessing the electronic clinical letter system and results system. If further information was needed, the patient's GP was contacted for further clinical information. If the patient had an urgent post admission appointment, staff and the external provider used the "priority scan" service to ensure patient records were available in clinic. Information received from the trust prior to inspection stated that the external provider followed a missing notes process if patient records were not found immediately. We requested a copy of this but were told the trust did not have a formal process in place for missing patient records. We were told that the trust planned to have a formal process in place by the end of March 2017.
- Performance against the service level agreement was regularly monitored and reviewed by the trust on a monthly basis. From April 2016, the service level agreement with the external provider for the availability of patient records was 98%; this had been increased from a previous target of 95%. From February to September 2016, trust wide data for all outpatient attendances, elective admissions and emergency admissions showed that 99.7% of patient records were available for patient attendances; this exceeded the trust target of 98%.

Outpatients and diagnostic imaging

- From September 2015 to August 2016, the outpatient department reported two incidents when paper notes had been scanned into the wrong patient records.
- From October 2015 to September 2016, there were 37 incidents reported through NRLS for all outpatient departments trust wide. Based on a total trust wide outpatient attendance of approximately 815,000 over a 12 month period, this equated to a documentation incident rate of only 0.005%. The majority of these incidents (43%) related to patient records that had either not been scanned or had been scanned to another patient's electronic record in error. Only one incident reported concerned a patient who had been cancelled by the consultant on the day of their appointment because clinical information was unavailable.

Records: Diagnostic imaging

- The imaging department used a radiology information system (RIS) and picture archiving and communication system (PACS). This meant patients radiological images and records were stored securely and access was password protected.
- We saw evidence of pregnancy checks and MRI safety checklists; these were stored against the patient's records.

Safeguarding: Outpatients

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff we spoke with understood their responsibilities and were aware of safeguarding policies and procedures. However, not all staff had completed safeguarding children level two training.
- Staff were required to complete safeguarding adults and children training on trust induction, following commencement of employment, and refresher training every three years. Refresher safeguarding training was completed via e-learning modules, with some ad hoc sessions provided for safeguarding children training. The safeguarding children e-learning module was developed in collaboration with experts from six safeguarding children boards and had been updated to include female genital mutilation, radicalisation, forced marriage, child trafficking and child sexual exploitation.
- Training data for July 2016 showed that 100% of outpatient staff and 97% of medical and dental staff within the specialised clinical services division (which included outpatients, ophthalmology, rheumatology and radiology) were compliant with safeguarding adults training. This exceeded the trust target of 90%. However, the compliance rate for safeguarding children level two training was 58% for outpatient staff and 33% for medical and dental staff within the specialised clinical services division. Therefore, we were not assured that all outpatient, medical and dental staff had up to date knowledge in order to protect children from potential harm. We saw no evidence that any action had been taken to address non-compliance with safeguarding children training. We reported that the trust must ensure all staff are compliant with the trust target for safeguarding children training as a priority, in our previous report.
- The hospital had a separate outpatient department for children and young people (see Children and Young People section of the report for findings). Senior staff told us that children were seen by staff in audiology, ENT and ophthalmology but not by staff in the outpatient department. Training data provided after our inspection for January 2017 showed that 86% of ophthalmology outpatient nursing staff were compliant with safeguarding children and adults training. ENT outpatient staff at the Alexandra Hospital were 83% compliant with safeguarding children training and 100% compliant with safeguarding adults training. We saw there were safeguarding policies in place and clear pathways to follow if staff had concerns. Pathways included child sexual exploitation, domestic violence and female genital mutilation. Staff could access safeguarding adults and children information via the trust intranet.
- Staff we spoke with were aware of safeguarding procedures and knew how to escalate concerns. Staff could give us examples of when they had made safeguarding referrals. We saw evidence that safeguarding referrals were made when indicated.
- Information and relevant contact numbers for safeguarding were seen in public areas in the outpatient department.

Safeguarding: Diagnostic imaging

- Training data for July 2016 showed that 92% of radiology staff had completed safeguarding children training level two and 100% had completed safeguarding adult training. This exceeded the trust target of 90%.

- Radiology medical staff also met the trust target for safeguarding training. The compliance rate for safeguarding children level two and safeguarding adults training was 90% and 93% respectively.
- We saw 'paused and checked' posters displayed in all imaging areas visited. The Society and College of Radiographers produced this resource to reduce the number of radiation incidents occurring within radiology departments. 'Paused and checked' is a prompt to ensure safety checks are carried out on each patient before and after an exposure to radiation is undertaken. The checks included whether the exam is justified, pregnancy status, examination history for recent studies and duplication, correct anatomical area and laterality for exam and that radiation safety measures for staff and/or carers have been taken. Staff knew about the posters and where to locate them, however, there use was not embedded in everyday work. Radiographers did not routinely check the electronic imaging record for all patients and relied on verbally questioning the patient as to previous scans. This meant staff were not following best practice.

Mandatory training: Outpatients

- Staff compliance with trust mandatory training was varied across the outpatient and diagnostic imaging service. The trust target of 90% compliance had not been met for all topics covered. We reported that the trust must ensure all staff are compliant with mandatory training in our previous report.
- Mandatory training covered a range of topics, which included health and safety, manual handling, fire safety, information governance and resuscitation. All staff within the outpatient and diagnostic imaging service we spoke with were aware of the need to attend mandatory training.
- Training was completed via e-learning modules and/or face-to-face sessions.
- The July 2016 training figures showed training compliance in some areas met the trust's target:
  - 92% of outpatient department (OPD) staff had attended fire safety training
  - 100% OPD staff had attended manual handling training
  - 92% OPD staff had attended resuscitation training
  - 91% of medical and dental staff within the specialised clinical services division (SCSD) had attended fire safety training
  - 94% of medical and dental staff within SCSD had attended manual handling training
  - 91% of medical and dental staff within SCSD had attended resuscitation training
- However, compliance in some areas of mandatory training was below the trust's 90% target:
  - 58% of OPD staff had attended information governance training
  - 75% of OPD staff had attended health and safety training
  - 42% of medical and dental staff within SCSD had attended conflict resolution training
  - 27% of medical and dental staff within SCSD had attended equality and diversity training
  - 31% of medical and dental staff within SCSD had attended medicines management training
  - 89% of medical and dental staff within SCSD had attended health and safety training
  - 81% of medical and dental staff within SCSD had attended information governance training
- Staff could access their training record via the trust's electronic staff record, which provided alerts to staff when their mandatory training updates were due. We observed this during our inspection.
- Senior staff had access to training compliance within the outpatient department and arranged the mandatory face-to-face training sessions for staff. Senior staff were notified of non-attendance via email.
- We saw evidence that mandatory training compliance was reviewed at divisional quality governance meetings. However, the minutes we reviewed stated that there were "issues with training data" in April 2016. Whilst the minutes for July 2016 stated that "health and safety and personal development review (PDR) training figures need to be improved". There was no detail to show what the "issues" were and what action had been taken to address the "issues" and improve health and safety and PDR compliance. The minutes for June 2016 did not include any reference to mandatory training compliance. We also reviewed three sets of minutes for outpatient team meetings. We saw evidence that staff were reminded to complete mandatory training at the July 2016 and January 2017 meeting, but not at the October 2016 meeting. Therefore, we were not assured that consistent action was taken to address non-compliance with mandatory training.

Mandatory training: Diagnostic imaging

Outpatients and diagnostic imaging

- The July 2016 training figures showed training compliance in some areas met the trust's target:
  - 96% of radiology staff had attended manual handling training
  - 100% of radiology staff had attended hand hygiene training
  - 91% of radiology staff had attended infection control training
  - 93% of radiology medical staff had attended manual handling training
  - 90% of radiology medical staff had attended health and safety training
  - 93% of radiology medical staff had attended hand hygiene training
- However, compliance in some areas of mandatory training was below the trust's 90% target:
  - 82% of radiology staff had attended information governance training
  - 87% of radiology staff had attended fire safety training
  - 88% of radiology staff had attended resuscitation training
  - 82% of radiology staff had attended health and safety training
  - 63% of radiology medical staff had attended information governance training
  - 83% of radiology medical staff had attended fire safety training
  - 83% of radiology medical staff had attended resuscitation training
  - 83% of radiology medical staff had attended infection control training

Assessing and responding to patient risk: Outpatients

- The trust had a harm review process in place for patients on 62 day cancer pathways, with no reported harms to date. The Clinical Commissioning Group (CCG) told us this information was presented to the executive trust board. The CCG planned to review this process through a themed discussion at the clinical quality review meeting. This review had not taken place at the time of our inspection. According to information provided by the trust during inspection, a total of 5,100 patients exceeded the 18 week referral to treatment time (RTT). 3,151 patients waited 18 to 25 weeks and 1,949 patients waited 26 to 51 weeks. During inspection we were told that harm reviews had not been carried out on patients who exceeded the 18 week RTT. However, according to information provided following the inspection, medical specialities were validating all patients who exceeded the 18 week RTT and reviewed all patients who had waited over 40 weeks on a weekly basis. This included trauma and orthopaedics, gastroenterology, respiratory, neurology, ophthalmology and rheumatology. According to the RTT improvement plan for dermatology, for example, patients who waited over 18 weeks for their outpatient appointment were contacted via telephone / post to ensure their condition remained stable. We were told that root cause analysis (RCA) and harm reviews were carried out on patients that waited longer than 52 weeks to be seen. However, the only evidence provided by the trust to corroborate this was RCAs which had been undertaken in July 2015. Therefore, due to the conflicting information we were told and the lack of recent evidence received we were not assured there was an effective system in place to monitor and manage the risk to all patients on the waiting list in a timely manner.
- Staff were aware of what actions they would take if a patient became unwell in the outpatient department. This included a call for urgent medical assistance, which meant that staff holding the emergency bleeps would be alerted to attend the department. Staff gave us examples of when they had appropriately escalated patients who had deteriorated within the department.
- There were emergency call alarms situated in the consulting and treatment rooms in the outpatient department. Staff would use the emergency call alarms to summon urgent assistance as needed, such as when a patient had deteriorated within the department. Emergency call alarms were also situated in the toilets, so that patients could summon urgent assistance as needed.
- During our inspection we observed that clinical waiting areas were constantly staffed. This meant staff had oversight of patients who were waiting to be seen and could respond promptly when needed.

Assessing and responding to patient risk: Diagnostic imaging

- The pre-inspection data informed us that the world health organisation (WHO) Five Steps to Safer Surgery checklist was not currently used for interventional radiology procedures. At the time of the inspection we saw evidence of the WHO documentation but did not gain sight of any audit around the process.

Outpatients and diagnostic imaging

- We saw evacuation plans in place for patients who may collapse in MRI. These plans differ from that across the hospital due to the high level of magnetic field, which prevent normal crash teams and equipment from entering into the scanning rooms.
- The MRI safety screening checklist was seen to be completed for all patients. These were sent to patients with their appointments and completed documentation was stored on RIS. If there was any uncertainty regarding a patient's compatibility with the magnet this was referred to a consultant radiologist or to the referrer.
- There was no departmental action tracker for issues surrounding actions required or undertaken after physics reports or routine and emergency servicing and maintenance.
- We were informed that a newly installed CT scanner which offered lower patient doses was not utilised for paediatric scanning due to the fact that some radiologists felt the image quality produced was inadequate. Staff had a lack of understanding around the requirements of optimising the scanner in order to address the dose versus image quality issue. This demonstrated the lack of overall radiation protection governance across the trust and the lack of advice sought and input from the medical physics service. No initial optimisation audits had been undertaken as a result of the scanner installation. No audits have been undertaken around the image quality concerns.
- The radiology department had guidelines to ensure that female patients and staff of childbearing age were asked if they were, or might be pregnant. This was in line with IR(ME)R regulations.

Nursing staffing: Outpatients

- There is no recognised baseline acuity tool used nationally for nurse staffing in outpatient departments. A staffing review was carried out in August 2016, to determine the number of registered nurses and health care assistants required to staff the outpatient department safely, based on the number and type of clinics held per day. The calculated establishment also included one whole time equivalent (WTE) senior sister who was supernumerary to staffing requirements and an additional 23% provision for relief, to cover acuity, sickness and annual leave. Outpatient staff at the Alexandra Hospital also covered clinics held at a local community hospital, which was included in the calculated establishment.
- The calculated establishment was 10.63 WTE registered nurses and 14.57 WTE healthcare assistants. As of August 2016, 10.15 WTE nursing staff and 12.6 WTE healthcare assistants were in post; this equated to a 4.5% and 13.5% vacancy rate for nursing staff and healthcare assistants respectively. Specialties such as ophthalmology, ENT and audiology supplied their own staff to support clinics.
- Senior staff told us they had recently advertised for additional staffing and interviews were scheduled for December 2016.
- Senior staff reviewed staffing requirements in advance of clinic sessions held per week. Where additional staffing was required to cover extra clinics, sickness or annual leave, this was covered by bank staff (staff employed on zero hour contracts who worked when needed) or permanent staff who had agreed to work different shifts than originally planned and/or volunteered to work over and above their contracted hours. No agency staff were used within the department.
- Senior staff told us staff were flexible and willing to swop shifts and/or work additional hours to support the service.
- The service had sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment on the days of our inspection.
- Staff confirmed there was sufficient nursing staff to deliver care safely within outpatients. We reviewed the staffing rotas from 10 October to 23 November 2016 and observed that planned staffing requirements were met for all shifts. We saw evidence that action was taken to mitigate risks when indicated, such as staff working additional hours and the redeployment of staff.
- From April 2015 to March 2016, the trust reported a turnover rate of 7% for nursing staff working in outpatients. Senior staff told us the main reason staff left the department was due to retirement. We currently do not have national data to compare these figures with. Therefore, we are unable to determine whether staff turnover rates were worse or better than the England average.
- The sickness rate for nursing staff for the same period was 17%. According to data for all NHS staff, the national average sickness rate for acute hospitals is 3.7%. Therefore, the sickness rate was higher than the England average.

- New staff were inducted locally using a checklist and would be allocated to work with a 'buddy' to support them. Senior staff had produced a 'guide to outpatients', which included an overview of the department, useful contacts, induction checklist and competency pack, which all new staff were required to complete. Induction training included mandatory training, a period of shadowing and a workbook which had to be signed off to confirm competency levels. A blank copy of the induction and competency pack was observed during inspection. The senior sister was on a period of sickness absence during our inspection and we were unable to corroborate whether these were completed because they were stored securely in a locked filing cabinet, which only the senior sister had access to.

Radiology staffing

- The risk register cited a continuous issue with recruitment across all staff groups, however there had been a recruitment drive and students working at the trust had been offered substantive posts once qualified. Until professional accreditation had been awarded these staff were employed at band three and four in order to increase staffing levels.
- 30 WTE radiographers worked in the hospital and at the time of our inspection there were two band five vacancies out to advert.
- CT radiographers told us they rotated through CT and planar imaging; this provided a greater number of CT trained staff to draw upon, for example, to support CT on-call arrangements.

Medical staffing: Outpatients

- In the outpatient department medical staffing was arranged by the individual specialities, such as rheumatology, cardiology, gastroenterology and dermatology. Due to the nature of how services were arranged, medical staff were required to work across the range of sites within the trust, in order to facilitate outpatient clinics.
- We were told that there was a shortage of medical vacancies across all specialities, including rheumatology, urology, geriatric medicine and trauma and orthopaedics. From April 2015 to March 2016, the trust reported an average vacancy rate of 32% for consultants and 34% for all other grades of medical staff. According to the board report for November 2016, there were 153.3 whole time equivalent (WTE) medical vacancies as of 24 October 2016. This meant there could be a delay in patients being seen for new or follow-up appointments. The trust had identified a recruitment and retention strategy in the patient care improvement plan. However, recruitment continued to be a challenge for the trust. As of November 2016, the trust had successfully recruited to 23 WTE posts, which included 10 WTE consultants, eight WTE career grade doctors and five WTE locum appointments for doctors in training. Commencement of employment dates ranged from November 2016 to July 2017.
- The individual specialities arranged medical cover for their clinics. This was managed within the clinical directorates, who agreed the structure of clinics and patient numbers.
- Consultants were supported by junior colleagues in clinics where this was appropriate.

Medical staffing: Diagnostic imaging

- At the time of the inspection, the trust had six vacancies across the three hospital sites. The department was looking to recruit worldwide and were awaiting sign off of a package to help with recruitment issues. This included home working where reporting stations were set up at their resident.

Major incident awareness and training: Outpatients

- The trust had a major incident policy, which staff could access via the trust intranet.
- The trust had pathways and policies in place for the management of clinical emergencies, such as cardiac arrest and anaphylaxis (a severe, life-threatening allergic reaction).
- Staff we spoke with understood their roles and responsibilities with regards to major incidents.
- Staff were aware of fire safety precautions and emergency evacuation procedures.

Major incident awareness and training: Diagnostic imaging

- We saw a major incident folder in the x-ray viewing area detailing procedures in place for such emergencies. All staff we spoke to were able to locate this information.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

We inspected, but did not rate the service for effectiveness as we are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients & diagnostic imaging services.

We found that:

- Radiology clinical audits were ad hoc and did not meet the requirements of ionising radiation (medical exposure) regulations IR(ME)R.
- From April 2015 to March 2016, the follow-up to new appointment rate at the trust was lower than the England average.
- The consent audit for outpatient and diagnostic imaging was not part of the trust's forward plan for 2016/17 and therefore no audit had been carried out in the last 12 months.

However, we also found:

- Specialities within outpatient and diagnostic services delivered care and treatment in line with national guidelines.
- Staff had appropriate skills to manage patients care and treatment with systems in place to develop staff, monitor competence and support new staff. However, not all staff had received an annual performance development review.
- Staff were encouraged and supported to develop new skills to improve service provision.
- The physiotherapy department had a formal supervision process in place to support and develop staff.
- Outpatient and diagnostic imaging teams worked with other specialities across the trust and external providers to plan and deliver care and treatment.
- Teams reported effective multidisciplinary team working and we saw evidence of joint working to improve service provision.
- Staff had the information they needed to deliver effective care and treatment to patients.
- Nursing, diagnostic imaging and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients.

Evidence-based care and treatment: Outpatients

- We saw evidence that specialities within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE), national guidelines, best practice and legislation, where appropriate. For example, the cardiology department followed NICE guidance for the management of atrial fibrillation (a common abnormal heart rhythm characterised by an irregular and rapid pulse) (NICE 2014, atrial fibrillation: the management of atrial fibrillation).
- We saw evidence that specialities had pathways in place for the management and treatment of specific medical conditions that followed NICE and national guidance. For example, the dermatology department had up to date clinical pathways in place that followed NICE guidance for the management and treatment of specific skin conditions, such as severe plaque psoriasis.
- The ophthalmology department had up to date policies and clinical pathways that followed NICE and the Royal College of Ophthalmologists guidance for the management of age-related macular degeneration (a common eye condition and leading cause of central vision loss amongst people over the age of 50 years), cataract surgery and glaucoma, for example.
- We saw evidence that the physiotherapy department had developed treatment pathways and guidelines which covered referrals, consent, musculoskeletal conditions, orthopaedics, neurology, rehabilitation, women's health and respiratory conditions and interventions. These had been developed in accordance with best practice and current-evidence based guidance. Treatment pathways and guidelines were reviewed and ratified at the physiotherapy governance forum, or the appropriate specialty governance forum such as trauma and orthopaedics.
- Trust policies were assessed to ensure guidance did not discriminate on the basis of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation and/or age.
- The ophthalmology department had access to six metre vision lanes, in line with national guidance (The Royal College of Ophthalmologists, Ophthalmic Services Guidance: Opthalmic Outpatient Department, 2012). Two vision lanes, used to assess patient's vision, had been set up in a corridor in the clinic area used by ophthalmology. This had been risk assessed and the

corridor was identified as the only space the vision lanes could be installed at the correct distance. We saw that privacy curtains had been fitted to ensure patients privacy was protected when undergoing sight assessments.
- The chronic obstructive pulmonary disease (COPD) service was designed in line with NICE and British Thoracic Society guidelines.

Evidence-based care and treatment: Diagnostic imaging

- The consent audit for outpatients and diagnostic imaging was not part of the forward plan for 2016/17 therefore no audit had been carried out in the last 12 months. We were told it would be included in the forward plan for 2017/18.
- A number of local clinical audits were carried out and had been registered with the trust clinical audit team. The audits included:
  - The use of breast magnetic resonance imaging (MRI) in detecting contralateral lobular breast cancer
  - Rectal MRI: Indications, protocols and accuracy
  - Retrospective audit of the departmental use of plain abdominal radiographs in the clinical setting of abdominal pathology
  - Turn over time for paediatric chest X-ray reporting and prostate cancer: Utilisation of MRI in diagnostic pathway (NICE 2014)
- Patients with a family history of breast cancer who fell outside of the age limits for breast imaging underwent MRI scans at Kidderminster Hospital.
- The medical physics service were consulted for the purpose of establishing research procedures and dose constraints.
- The radiation protection supervisor had set up a cross county audit of non-medical referrer x-ray requests to check the validity and appropriateness of the referral.
- At the time of our inspection there was no audit schedule within the diagnostic imaging department. All audits undertaken were discussed at staff meetings. Audits were undertaken infrequently and the senior managers felt there were not enough audits undertaken, especially those required under the Ionising Radiation (Medical Exposure) Regulations IR(ME)R.
- The radiation protection supervisor had been attempting to collaborate and standardise audits across all sites and areas of radiation protection; it was felt that this was locally led and not a trust wide coordinated process.
- When the trust employed an out of hours radiologist service for computed tomography (CT) scans, referral rates increased and staff were concerned that requests that were inappropriate and against local protocol were being accepted. The previous clinical director had addressed this and there had been an improvement.

Nutrition and hydration: Outpatients

- Patients who attended outpatient appointments were not generally in the department for long periods of time, therefore beverages and food were not routinely provided. Staff told us they would offer hot drinks and/or food to patients and relatives who had been waiting in the department for a long time and to patients that had a long wait until transport arrived to take them home. We observed this during our inspection.
- Glucose gel and tablets were available in the outpatient department for patients with diabetes when required. They were stored in a hypoglycaemic box on the emergency trolley. Glucose preparations are recommended when a patient has a 'hypo' and needs to increase their blood glucose levels rapidly (a 'hypo' is commonly used to describe hypoglycaemia, which is where the blood glucose level of a patient with diabetes falls below the normal range).

Pain relief: Outpatients

- Pain relief could be prescribed within the outpatient department and subsequently dispensed by the pharmacy department as required.
- Outpatient clinics had access to simple analgesia (such as paracetamol) and local anaesthetic preparations when required. Senior nursing staff told us that any pain relief needed by patients who attended outpatient clinics was prescribed by a doctor before it was administered and recorded in the patient's notes.
- Patients that we spoke to during our inspection had not required pain relief during their time within the outpatient department.
- The Alexandra Hospital held specialist back pain clinics, which were led by physiotherapists who could refer patients for diagnostic imaging and/or pathology as needed. The physiotherapy department also ran a

chronic pain group, called the "functional restoration programme". The programme ran for six weeks, with four patients per group, and provided pain education and graded exercise within the gymnasium on site.

- Patients could also be referred to specialist pain clinics held at the Worcestershire Royal Hospital, Kidderminster Treatment Centre or clinics held at local community hospital sites. The pain management service was led by four anaesthetic consultants with experience in advanced pain medicine. This is in line with the Royal College of Anaesthetists recommendations. The pain management service included specialist pain nurses, orthopaedic physiotherapy practitioners and clinical psychology staff.

Patient outcomes: Outpatients

- The outpatient service did not participate in local or national benchmarking clinical audits, these were undertaken by individual medical specialities. Each speciality participated in national benchmarking clinical audits, where appropriate, such as bowel cancer screening, diabetes management and chronic pulmonary obstructive disease (COPD). This was in line with NICE recommendations.
- From April 2015 to March 2016, the follow-up to new appointment rate at the trust (which included the three acute hospital sites and two community hospital sites) was lower than the England average.

Patient outcomes: Diagnostic imaging

- The trust did not participate in the imaging services accreditation scheme. We were told that the trust wished to pursue this accreditation and were looking to work with a buddy trust in order to achieve this.

Competent staff: Outpatients

- Staff had the right qualifications, skills, knowledge and experience to do their job when they commenced employment. All staff underwent a period of corporate and role specific induction. The outpatient department had an induction and competency pack for all new substantive staff. This was observed during our inspection. All new starters underwent a four week induction process.
- Staff were required to update their knowledge periodically in accordance with the trust's mandatory training matrix. Staff we spoke to confirmed they had received updates on mandatory training. However, the mandatory training data for July 2016 showed varied compliance in outpatients. Therefore, we were not assured that all staff had updated their knowledge on specific topics, such as information governance and health and safety, in accordance with trust policy.
- The trust personal development review (PDR) policy stated that all staff were required to have an annual appraisal. Trust data for July 2016 showed that 75% of outpatient staff were compliant with appraisals. Therefore, we were not assured that all staff had completed an annual appraisal.
- The PDR was designed to develop staff in terms of knowledge, skills, attitude, values and behaviours and ensure staff met the requirements of their job description and demonstrated the six 'C's' when carrying out their role. (The six 'C's' refer to a set of fundamental values for all staff working in health care, that underpin the principles of high quality care for all; care, compassion, courage, communication, commitment and competence). We received mixed feedback when we asked staff whether they found the appraisal process useful. Some staff told us they found the PDR useful because it gave them the opportunity to identify learning needs, training and/or development opportunities. However, some staff told us the PDR was not useful; they felt it was a paper exercise and they were not engaged in the process by senior staff and/or managers. Therefore, we were not assured that all staff were encouraged and given the opportunity to develop their knowledge and skills.
- Revalidation was introduced by the Nursing and Midwifery Council in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration. The trust supported staff with the revalidation process. Regular revalidation drop-in sessions and clinics had been held. The trust's libraries had also produced a 'little library book of nursing revalidation' to assist nursing and midwifery staff with finding and using evidence to support revalidation. Three nursing staff within the outpatient service had successfully revalidated.
- The physiotherapy department had a formal supervision process in place to support and develop staff. Physiotherapists were allocated a supervisor, who

they met with on a regular basis. The department also held monthly education sessions and journal club meetings to ensure staff remained up to date with current evidence-based guidance and practice.
- Some members of the physiotherapy team had attained the qualification of extended scope practitioners. This meant they had completed appropriate master's degrees and were members of the Society of Orthopaedic Medicine.
- Specialist clinic areas provided additional training for staff to ensure competence in the speciality. Bespoke competencies were in place, as well as specific clinical skills required for specific specialities. For example, the nurse specialist in ear, nose and throat (ENT) had additional competencies, such as micro suction ear cleaning. Staff in the ophthalmology department had completed various bespoke competencies, such as visual acuity testing, glaucoma scanning, eye bathing and LogMAR testing (a chart comprised of rows of letters used to assess visual acuity). We saw evidence of these during our inspection. We also saw evidence that ophthalmology staff had annual training on the use of laser equipment to maintain competence.
- The outpatient department had "link nurses" for topics, such as infection prevention and control, mental health, learning disability and dementia. Link nurses attended additional training and link nurse meetings, and shared their learning with the rest of the team.
- There were opportunities for staff to undertake additional training courses in order to develop their skills and knowledge. Clinical nurse specialists were degree level trained, as a minimum, and had attained additional competencies appropriate to their role.

Competent staff: Diagnostic imaging

- In July 2016, 96% of staff had undergone a PDR.
- We saw training records for staff across all modalities. These included equipment training for the x-ray rooms, CT and MRI.
- Continuing professional development (CPD) was actively encouraged and some staff were undertaking CT colonography courses. The department had a CPD lead radiographer and they helped to coordinate lunchtime CPD sessions, when staffing levels allowed.
- Non-medical x-ray referrers were trained by senior radiographic staff and radiologists and monitored over a six to eight week period for competencies prior to being able to request medical exposures.
- Clinicians underwent e-learning for IR(ME)R and radiation protection.
- The MRI superintendent was a reporting radiographer and was assigned one to two reporting sessions per week; the scope of their practice was for knees and lumbar spines.
- Two sonographers were trained to undertake musculoskeletal imaging with another member of staff currently undergoing training.
- The department employed reporting radiographers which allowed for additional reporting capacity. The sessions for reporting had increased since the July focused inspection and this had assisted in bringing reporting times down to a manageable level.

Multidisciplinary working: Outpatients

- Outpatient and diagnostic teams worked with speciality teams across the trust to plan and deliver care and treatment. The outpatient department provided the clinical environment and nursing staff, which enabled specialities to assess, plan and deliver patient's care and treatment.
- We observed good collaborative working and communication amongst staff in the department. Staff told us they worked well as a team.
- Dermatology and ophthalmology had developed joint one-stop clinics for patients with suspected skin cancer on or close to the eye. Patients underwent Moh's micrographic surgery, where suspicious skin legions were removed. The skin cells were then examined whilst the patient waited so that further skin cells could be removed if needed. Moh's micrographic surgery is considered the single most effective technique for the removal of common skin cancers.
- Regular multidisciplinary team meetings were held at the trust. These included oncology, ophthalmology, cardiology and gastroenterology.
- Physiotherapists and occupational therapists worked collaboratively with specialties, such as neurology, cardiology, rheumatology, respiratory, women's health and trauma and orthopaedics, to provide outpatient services for patients. For example, the service offered cardiac rehabilitation group sessions to patients who had suffered a cardiac event. This included exercise classes, patient education, relaxation and stress relief advice.
- The trust provided a chronic obstructive pulmonary disease (COPD) service, which included specialist

nurses, specialist physiotherapists, specialist pharmacist, cognitive behavioural psychotherapist and British Lung Foundation fitness instructors. The team worked closely with respiratory consultant physicians and other health care professionals to improve the quality of life for people living with COPD.

- Occupational therapists worked collaboratively with the rheumatology department to provide outpatient services for patients with hand injuries and symptoms of long term conditions, such as rheumatoid arthritis and fibromyalgia (a chronic condition that causes widespread pain in the muscles and bones, tenderness and fatigue).
- The pain management service worked collaboratively with orthopaedic physiotherapy practitioners and clinical psychology staff.
- The outpatient service used specialist nurses in clinics to support care provision. During our inspection we observed specialist nurses in oncology, haematology, ENT, anti-coagulation and cardiology.
- The ophthalmology department had nurse specialists who were trained to administer ranibizumab treatment to patients with wet age-related macular degeneration (a common eye condition and leading cause of central vision loss amongst people over the age of 50 years).
- Information about ongoing care and treatment was available to GPs, teams and services in a timely way via the electronic patient record system. When patients were discharged from a service the relevant GP, teams and/or services were informed.

Multidisciplinary working: Diagnostic imaging

- There was some cross site working within the MRI department.

Seven-day services: Outpatients

- Outpatient services were not available seven days a week. Outpatient clinics were available from 8.30am to 5.30pm, Monday to Friday. Senior staff told us that some occasional evening and Saturday clinics were held in order to meet patient demand.
- Physiotherapy outpatient services were available from 8am to 4.30pm, Monday to Friday.
- Pharmacy dispensary services were available from 9am to 5.30pm, Monday to Thursday, 9am to 5pm on Fridays and 10am to 12.30pm on Saturdays.

Seven-day services: Diagnostic imaging

- The MRI department was open Monday to Friday 8am until 8pm, but only if staffing allowed. There was a flexible staff rota and senior managers in MRI stated that to run a robust seven day service an additional five radiographers would be required.
- Three out of four Saturdays the MRI scanner was open from 8am until 8pm.
- To expand, the MRI service would also require additional radiologists for the purpose of reporting, this was predominately due to the increased demands on the service and the highly specialised scan techniques that were undertaken which required specialist radiologists.
- The department were looking towards extending the working day for CT radiographers and they were building a business case for 8am to 8pm working.
- There were plans in place for full implementation of a 24 hours a day, seven days a week service working at both acute sites.
- The CT department was open 9am until 5pm but offered 24 hours a day, seven days a week scanning for emergencies.
- The ultrasound department was open 9m to 5pm Monday to Friday and offered a sonographer led service on a Saturday from 9am until 5pm; Sundays were covered by the on call radiologist.
- The general x-ray department was open Monday to Friday from 9am until 6pm with walk in access for GP patients.

Access to information: Outpatients

- Staff had the information they needed to deliver effective care and treatment to people who used services.
- From February to September 2016, the availability of patient records exceeded the trust target of 98%. Trust wide data for all outpatient attendances, elective admissions and emergency admissions showed that 99.72% of patient records were available for patient attendances.
- GPs generally received information on patient's care and treatment in a timely manner. GP letters were typed directly into the electronic clinical letter system used by the trust. The electronic system generated GP letters and uploaded a copy to the patient's record overnight, when the system was updated. The turnaround time for GP letters varied amongst specialities. For example, staff told us that GP letters were turned around within one to

two weeks for gastroenterology and one to two days for diabetes and endocrinology. All staff we spoke with told us that urgent letters were turned around within 24 hours.
- There were computer terminals in clinic rooms, which enabled staff access to patient information such as case notes, care plans, risk assessments, blood results and x-rays via the electronic systems used by the trust.
- Staff had access to the trust intranet to obtain information relating to trust policies, procedures, pathways, NICE guidance and e-learning. Senior staff demonstrated how to access policies and procedures on the trust intranet during our inspection.

Access to information: Diagnostic imaging

- The trust had a radiology information system (RIS) and picture archiving and communication system (PACS) for the storage of radiology images and patient information and reports; these could be accessed across all hospital sites. Both systems were password protected and could only be accessed by authorised members of staff. The hospital used the national image exchange portal for image transfer.
- The risk register for radiology cited concerns around PACS archiving and stability of the storage solution. Additional storage had been purchased, however the archive was not reliable and the trust were awaiting transfer to the new data centre. This would provide a permanent solution but the date of this transfer had been delayed. At the time of the inspection the PACS manager stated that the image retrieval issues should be rectified by February 2017 as this was the projected date for migration of all legacy data onto the new servers.
- The RIS server was also at 'end of life' and full, which meant it needed constant management. Radiology were waiting on a move to the trust dataset to allow the directorate to replace the RIS server. The project was in the early stages of constructing a plan to move into the virtual server set-up. At the time of the inspection it was stated that this project should now be completed by the end of the year.
- In September 2016 a new image router was installed by the out of hours private reporting company, as there had been issues with image transfer. This took a long time to complete and the trust were frustrated by the slow data transfer of patient information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards: Outpatients

- The trust had up to date policies regarding consent, the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff could access these policies via the trust intranet.
- All clinical staff, which included consultants, junior doctors, nurses and health care assistants, were required to complete MCA and DoLS training three yearly. Training data provided after our inspection for January 2017 showed that 71% of outpatient nursing staff had completed MCA and DoLS training, which was below the trust target of 90% compliance. Therefore, we were not assured that all outpatient nursing staff had up-to-date knowledge of the MCA and DoLS. ENT and ophthalmology staff were 100% compliant with MCA and DoLS training.
- Staff we spoke with were able to describe the relevant consent and decision making requirements relating to MCA and DoLS and understood their responsibilities to ensure patients were protected. Staff could access MCA advocates for support and advice as needed.
- The trust had four nationally recognised consent forms in use. These included a consent form for patients who were able to consent, one for children or young persons and another for procedures where consciousness was not impaired.
- The trust used electronic consent forms with the exception of consent form four, which was for patients who were not able to consent to investigations or treatment, this was a hard copy form because two consultants were required to complete it.
- Medical and nursing staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. We observed nursing staff obtain verbal consent from patients before they carried out baseline observations, such as blood pressure measurement.
- Written consent to treatment was initiated by medical staff or suitably qualified healthcare professionals during outpatient consultations, this included discussion on the benefits and potential risks of the proposed treatment.
- Patients told us that staff were good at explaining planned procedures or treatment before they were asked to consent to them.

Outpatients and diagnostic imaging

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards: Diagnostic imaging

- Diagnostic imaging staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. We observed consent was obtained before CT colongraphy examinations were carried out. Verbal consent was used for intimate examinations in ultrasound.

Are outpatient and diagnostic imaging services caring?

Good

Overall, we rated the outpatient and diagnostic imaging service as good for being caring because:

- Patients were treated with compassion, kindness, dignity and respect during their interactions with staff.
- Staff were observed to interact with patients in a friendly, respectful and considerate manner.
- Patients felt involved in their care and were happy that they had received sufficient information to make informed decisions about their care.
- The NHS Friends and Family Test results for October 2016 were better than the England average.
- Staff provided information to patients in a way they could understand.

However:

- Patient confidentiality was not maintained at all times because patients could be overheard when they gave their personal details to reception staff.
- The 2016 outpatients department patient-led assessment of the care environment (PLACE) results for privacy, dignity and wellbeing were worse than the England average.

compassionate care: Outpatients

- We saw patients were treated with compassion, kindness, dignity and respect.
- We observed reception staff greet patients in a courteous and friendly manner and direct them to the appropriate waiting area.
- We saw staff knock on doors before entering consultation and treatment rooms. There were privacy curtains in consultation and treatment rooms to protect patient's privacy and dignity during examinations and/or treatment. However, the outpatient department's patient-led assessment of the care environment (PLACE) audit for 2016 showed they scored worse than the England average for how the environment supports the delivery of care with regards to privacy, dignity and wellbeing. The department scored an average of 73%, whilst the England average was 84%. We requested details of actions taken in response to findings from the PLACE audit but we were only provided with actions taken in regards to how the environment supported patients living with dementia. Therefore, we were unable to determine whether the trust had taken any action to improve the environment with regards to patient's privacy, dignity and wellbeing.
- We observed good examples of caring, considerate staff throughout all areas of outpatient services.
- We saw staff taking the time to interact with patients in a friendly, respectful and considerate manner. We saw a healthcare assistant sitting with and reassuring an elderly patient whilst they waited for their clinic appointment.
- Patients and their relatives told us that staff were very kind and caring.
- The outpatient service took part in the Friends and Family Test (FFT). The FFT was launched by the NHS in 2013 for acute trusts. It is a feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used. We reviewed the FFT data reported to NHS England by outpatient services trust wide for October 2016. 95% of patients would recommend the service to friends or family and this was higher than the England average (93%). However, 3% of patients said they would not recommend the service which was in line with the England average. The FFT response rate was 5% which was lower than the England average (7%).
- Patients who arrived at the main reception area stood in a queue before they were called forward to the reception desk. We saw a poster that requested patients did not approach the desk until they were called forward; this was to reduce the risk of confidential information being overheard when patients were asked to confirm their personal details. However, we

overheard patients give their personal details (such as address and contact telephone number) to reception staff. Therefore, we were not assured that patient confidentiality was maintained at all times.
- Patients were provided with the option of being accompanied by a friend or relative during consultations. Staff told us that chaperones were also available if required. The trust had an up-to-date policy on the use of chaperones which stated that, wherever possible, the chaperone should be of the same sex as the patient.
- One patient commented that; "the staff were so reassuring, helpful and friendly".

Compassionate care: Diagnostic imaging

- It was cited in quality governance meetings that inpatients were being left unaccompanied in radiology waiting areas. At the time of the inspection, we did not observe this and when we spoke with staff they felt that this had been addressed and patients were no longer left alone in the department.

Understanding and involvement of patients and those close to them: Outpatients

- Staff communicated with patients so that they understood their care, treatment and condition.
- Patient's we spoke with felt well informed about their care and treatment. Patients told us; "staff were brilliant, explained everything", "felt fully informed" and "explained treatment explicitly".
- Each patient we spoke with was clear about why they were attending the outpatient department and who they were going to see. We observed reception staff check that patients knew which clinic they were attending and which clinician they were going to see.
- We observed staff introduce themselves to patients and their relatives when they were called in for their appointment.
- One patient told us their consultant encouraged them to phone if they had any problems and needed any advice.
- Patients understood when they would need to attend the hospital for investigations or when to expect a follow up outpatient appointment.
- One patient told us they had received copies of letters sent to their GP.
- We observed the public noticeboard in outpatients contained information about domestic violence and safeguarding from abuse. The information was displayed in several languages, which included Bengali and Polish.

Emotional support: Outpatients

- Staff could access the patient advisory liaison service if a patient required advocacy support.
- Staff gave patients information leaflets relevant to their condition and/or treatment and told them where they could access additional advice, such as local support groups and national charitable organisations.
- There was access to local support groups to offer both practical advice and emotional support to patient and carers, such as Macmillan cancer support, sight concern and deaf direct. Examples included monthly "chat and share" groups for people with hearing loss and tinnitus and the Worcestershire glaucoma support group. We saw information on local support groups displayed publically throughout the outpatient department.
- The physiotherapy department ran a functional restoration programme for patients with chronic pain. The programme was designed to help anyone with chronic pain manage their condition more positively, in order to improve their quality of life. The programme consisted of six weekly sessions and included pain education and graded exercise.
- The department had access to clinical nurse specialists who were able to provide support and advice to patients and staff as needed.
- The hospital had a chaplaincy service, which provided spiritual care and religious support for patients, carers and relatives as needed.
- One patient commented that "everyone of the medical team was very helpful and it was explained what was going to take place, which helped to keep me calm".

Are outpatient and diagnostic imaging services responsive?

Inadequate

Overall, we rated the outpatient and diagnostic imaging service as inadequate for being responsive because:

Outpatients and diagnostic imaging

- Patients were unable to access the majority of services in a timely way for assessments, diagnoses and/or treatment. There were long waiting lists for the majority of specialties including trauma and orthopaedics, gastroenterology, dermatology, thoracic medicine, neurology and geriatric medicine. In October 2016 5,100 patients exceeded the 18 week referral to treatment (RTT) target; 3,151 patients waited between 18 and 25 weeks and 1,949 patients waited between 26 and 51 weeks to be seen.
- The trust did not consistently meet all cancer targets for RTT.
- 9% of clinics were cancelled between May and October 2016. The trust could not provide any explanation for this.
- Did not attend rates were above the England average. Processes to minimise this were inconsistently applied throughout the outpatients department.
- The service did not have a robust demand and capacity assessment in place.
- There was limited seating arrangements for patients with mobility difficulties and/or bariatric patients.
- Complaints were not always responded to in a timely manner.

However:

- Some specialities had introduced one-stop clinics, which reduced the number of appointments patients had to attend.
- Signage suitable for patients with dementia had been introduced in the outpatient department since our previous inspection in July 2015.
- Effective arrangements were in place to support patients with complex needs.
- Translation services were available for patients.

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

- Some specialities had developed services to meet the needs of the local population by introducing one-stop clinics to reduce the number of appointments patients would be required to attend. Examples of this included the one-stop breast clinic, for patients referred with suspected breast cancer. The clinics were consultant led and supported by clinical nurse specialists. Assessments and diagnostic tests could be performed at the same appointment and meant that patients would only need to attend the hospital once to obtain a diagnosis and discuss treatment options, where appropriate. Further examples included one-stop joint dermatology and ophthalmology clinics, for patients with suspected skin cancer and one-stop vascular clinics.
- We saw evidence that commissioners were involved in the planning of services. For example, one of the Clinical Commissioning Groups (CCG) had commissioned a community based consultant ophthalmology led service. The service had been established to reduce the number of unnecessary and inappropriate referrals to the local hospital and improve patient choice and convenience, by providing services within the local community, closer to home. This meant patients had faster access to diagnostics and treatment and reduced the waiting times for ophthalmology outpatients appointments across the whole health economy. Services included the treatment of low risk glaucoma, blepharitis and conjunctivitis.
- In response to an increased demand for ophthalmic services, the trust had employed and trained nurse specialist practitioners to treat patients with wet age-related macular degeneration, diabetic macular oedema and retinal vein occlusion. This meant the ophthalmology department had capacity to treat more patients and thereby reduce the waiting times for patients who required this treatment.
- A range of rapid access clinics were available, which meant patients could be referred for urgent care. Examples included rapid access chest pain clinics and suspected wet age-related macular degeneration.
- Specialist clinics for patients with HIV and Hepatitis were available.
- Facilities and premises were appropriate for the services that were planned and delivered. The outpatient department provided 20 consulting rooms and four minor treatment rooms. There was adequate seating and equipment available in all areas of the outpatient department. However, we saw there was limited seating for people with reduced mobility, such as chairs with a higher seat and arms. The majority of chairs available were in fixed rows with no arms.
- There were adequate toilets within the department. Disabled toilets and baby changing facilities were also provided.
- We saw patients were given follow-up appointments at a time and date that suited them.
- Information was provided to patients in accessible formats, such as written information, before they

attended the outpatient department. This included contact details, hospital map and directions, consultant name and information about any tests, samples or fasting, where appropriate. Patients attending ophthalmology clinics were informed of various sight tests that might be required and that they could be in the clinic for some time. This meant patients were prepared for lengthy appointments.

- There was clear signage to outpatient areas and receptions were manned during clinic times to assist patients with directions. The hospital also had volunteers to help direct people to where they needed to go.
- The audiology and ear, nose and throat (ENT) clinic area had a waiting area for children, which contained books and posters. There were no other children friendly waiting areas within the outpatients department. The hospital did have a separate outpatient department for children, which was located on the first floor. This was inspected under services for children and young people.
- Water was available for patients and visitors in the outpatient department. Hot drinks could also be purchased from a vending machine within the department.
- A café and shop was situated by the main entrance of the hospital, which patients and their relatives or friends could visit to purchase hot and cold snacks and meals if they wished.
- Patients attending the hospital had access to visitors' car parking. However, patients told us that car parking was expensive. Staff told us they would issue patients with a car parking concession if they were in the department for more than two hours.
- The hospital was accessible by public transport. Information on all local bus services was available on the trust website.

Access and flow: Outpatients

- We were not assured that patients had access to care and treatment in a timely way.
- National guidance recommends that patients referred for a health condition, should expect to start non-urgent consultant-led treatment, or be seen by a specialist for suspected cancer, within maximum waiting times. Waiting time starts from the point the hospital or service receives a referral letter. The maximum waiting time for non-urgent consultant-led treatments on a non-admitted pathway was 18 weeks. The maximum waiting time for suspected cancer was two weeks. Referral to treatment (RTT) performance was monitored trust wide. Therefore, the data we received was for the trust (i.e. Worcestershire Royal Hospital, Alexandra Hospital and Kidderminster Treatment Centre) and was not hospital site specific. Performance against the 18 week RTT standard had been declining since February 2016 and had plateaued around 88% from the beginning of the financial year. Performance in July 2016 was 88%, which was an underperformance against both the 92% national standard and the trust's sustainability and transformation fund (STF) trajectory of 91%. Areas not meeting RTTs included the following:
  - Thoracic medicine 72%
  - Dermatology 78%
  - Trauma and orthopaedics 80%
  - Neurology 86%.
- The June and July 2016 performance for RTT incomplete pathways was 88%.
- Information provided by the trust showed that in October 2016, 5,100 patients exceeded the 18 week RTT. 3,151 patients waited between18 and 25 weeks and 1,949 patients waited between 26 and 51 weeks. The specialities that did not meet the trust target in October 2016 were:
  - Trauma and orthopaedics: 470 patients waiting 18 to 25 weeks and 393 patients waiting 26 to 51 weeks.
  - Ophthalmology: 378 patients waiting 18 to 25 weeks and 182 patients waiting 26 to 51 weeks.
  - Gastroenterology: 123 patients waiting 18 to 25 weeks and 75 patients waiting 26 to 51 weeks.
  - Dermatology: 184 patients waiting 18 to 25 weeks and 101 patients waiting 26 to 51 weeks
  - Thoracic medicine: 169 patients waiting 18 to 25 weeks and 169 patients waiting 26 to 51 weeks.
  - Neurology: 150 patients waiting 18 to 25 weeks and 25 patients waiting 26 to 51 weeks.
  - Geriatric medicine: 22 patients waiting 18 to 25 weeks and 14 patients waiting 26 to 51 weeks.
- From September 2015 and August 2016 the trust's RTT for non-admitted performance was worse than the England overall performance. The figures for August 2016 showed 87% of this group of patients were treated within 18 weeks.
- The ophthalmology specialty were above the England average of 94% at 98% for non-admitted RTT

(percentage within 18 weeks). 'Other' specialty was also above the England average of 93%, at 94% for non-admitted RTT (percentage within 18 weeks). Rheumatology met the England average of 93%.

- General medicine, ENT, cardiology, gynaecology, trauma and orthopaedics, general surgery, urology, neurology, geriatric medicine, oral surgery, gastroenterology, dermatology and neurosurgery specialties were below the England average for non-admitted RTT (percentage seen within the 18 week target):
  - General medicine trust score 92%; England average 95%
  - ENT trust score 88%; England average 92%
  - Cardiology trust score 85%; England average 91%
  - Gynaecology trust score 84%; England average 96%
  - Trauma and orthopaedics trust score 82%; England average 90%
  - General surgery trust score 78%; England average 92%
  - Urology trust score 76%; England average 90%
  - Neurology trust score 74%; England average 89%
  - Geriatric medicine trust score 73%; England average 97%
  - Oral surgery trust score 69%; England average 88%
  - Gastroenterology trust score 68%; England average 86%
  - Dermatology trust score 64%; England average 93%
  - Neurosurgery trust score 64%; England average 83%
- The trust's RTT for incomplete pathways was worse than the England overall performance and worse than the operational standard of 92% for eight months of the year. From November 2015 to February 2016, the performance was the same as the England average and standard. The latest figures for August 2016 showed 89% of this group of patients were treated within 18 weeks.
- The cardiothoracic surgery, neurosurgery, other, general medicine, ophthalmology, cardiology, urology, ENT and general surgery specialties were above the England average for incomplete pathways RTT (percentage seen within the 18 week target).
  - Cardiothoracic surgery trust score 100%; England average 89%
  - Neurosurgery trust score 100%; England average 84%
  - Other trust score 97%; England average 93%
  - General medicine trust score 97%; England average 95%
  - Ophthalmology trust score 96%; England average 93%
  - Cardiology trust score 94%; England average 93%
  - Urology trust score 94%; England average 91%
  - ENT trust score 92%; England average 90%
  - General surgery trust score 89%; England average 88%
- The Neurology, geriatric medicine, gynaecology, trauma and orthopaedics, oral surgery, thoracic medicine, plastic surgery and dermatology specialties were below the England average for incomplete pathways RTT (percentage seen within the 18 week target).
  - Rheumatology trust score: 95% England average: 96%
  - Gastroenterology trust score: 91% England average: 91%
  - Neurology trust score: 87% England average: 92%
  - Geriatric medicine trust score: 88% England average: 98%
  - Gynaecology trust score: 85% England average: 93%
  - Trauma and orthopaedics trust score: 85% England average: 87%
  - Oral surgery trust score: 81% England average: 90%
  - Thoracic medicine trust score: 77% England average: 93%
  - Plastic surgery trust score: 75% England average: 87%
  - Dermatology trust score: 72% England average: 94%
- The trust performed worse than the national standard for patients with suspected cancer being seen by a specialist within two weeks of an urgent GP referral. The trust performance for June and July 2016 was 69% and 76% respectively, against the national standard of 93%. The medical specialities with the highest number of patient breaches in July 2016 were colorectal (178), skin (63), upper gastrointestinal (25) and urology (23).
- The trust performed worse than the operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The trust performance for June and July 2016 was 68% and 66% respectively, against the national standard of 85%. The medical specialities with the highest number of patient breaches in July 2016 were urology (18), lower gastrointestinal (11) and skin (5). As at August 2016, the backlog of patients waiting over 62 days to commence treatment was 148.

Outpatients and diagnostic imaging

- The trust had not achieved the cancer two week wait for symptomatic breast patients. The trust performance for June and July 2016 was 56% and 74% respectively, which was significantly below the 93% national target.
- From July 2015 to June 2016, the trust performed consistently better than the 96% operational standard for patients waiting less than 31 days from diagnosis of cancer to receiving their first treatment.
- Staff we spoke with were unaware of any patient harm reviews undertaken to mitigate risks to patients who had breached the RTT/cancer waits. According to information provided by the trust following the inspection, we were told that a harm review process was in place for patients on the 62 day cancer pathways whose wait exceeded this target. We were told that no patient harms had been reported to date. We also saw evidence that medical specialities were reviewing patients who had waited over 40 weeks for their first outpatient appointment on a weekly basis.
- We spoke with the chief operating officer who told us that each speciality had a recovery action plan to address patient waiting lists. The trust planned to meet RTT targets by the end of March 2017. Staff we spoke with told us that some specialities, such as cardiology, urology and ophthalmology, put on additional clinics to meet urgent patient demand and reduce backlogs. However, we were also told that some specialities, such as general surgery and thoracic, did not put on additional clinics. We requested evidence from the trust of additional clinics held as part of waiting list initiatives. The information we were provided with showed an additional 195 appointments occurred at the Alexandra Hospital for the period May to October 2016. The majority of these were in general surgery, cardiology, thoracic medicine and ophthalmology, with an additional 53, 27, 21 and 20 appointments respectively. Therefore, whilst the trust had taken some action to address patient waiting times, we were not assured that patients had access to care and treatment in a timely way.
- The trust reported 2% of clinics were cancelled within 6 weeks from May and August 2016. 3% of clinics were cancelled over 6 weeks in 2016, 4% in June, 5% in July and August. The main reasons for cancellations as reported by the trust were; annual leave of consultant, on-call commitments, study leave of consultant, professional leave of consultant and meetings. Consultants we spoke to told us that they would try to cover any medical staff shortages, for example due to sickness, by seeing additional patients on their clinic lists.
- Data provided by the trust showed a total of 707 clinics were cancelled at the Alexandra Hospital from May to October 2016. Of these 226 (32%) were cancelled six weeks or less from the appointment date. Based on the number of clinics held the week commencing 21 November 2016, this equates to approximately 9% of total clinics cancelled. According to the patient improvement programme, the trust was aware of the moderate to high level of clinic cancellations with less than six weeks' notice across specialities. In the short term, the current cancellation database had been updated to ensure divisional directors were aware of all cancellations. The long term plan was to have an electronic request form that required approval for the cancellation of any clinic. The aim was that this process would interface with the clinic scheduling tool so when a clinic was cancelled it would automatically update within the tool, so where possible the room could be utilised by another speciality; resulting in a reduction in wasted capacity. At the time of inspection, the electronic tool was being piloted. Therefore, we were unable to determine the impact this would have on capacity and service provision. Furthermore, we requested the reasons why the 707 clinics had been cancelled but the trust were unable to provide this information. This meant we were not assured the cancellation database was updated and that divisional directors were aware of all cancellations.
- There is no national target for patients to be seen by a clinician within a specific time. In August 2016, the trust reported 43% of patients waited over 30 minutes to see a clinician. Some patients we spoke with told us they were not seen at their specified appointment time but were kept informed when the clinic was running late. During our inspection we observed a clinic was running 30 minutes behind schedule. We saw staff apologise profusely to patients for the delay. Patients told us they generally did not complain about waiting to be seen, as the service they received during their appointment was good.
- At the previous inspection in July 2015, it was unclear whether any demand and capacity assessments had been conducted. This was despite clinic capacity and usage being listed as an objective within the

department. At the time of the current inspection, the service did not have a robust demand and capacity assessment in place. The service had started a manual demand and capacity audit in October 2016. Data was being collected until 1 December 2016 and it was planned to report the findings to the divisional leads in January 2017. Therefore, we were unable to determine the impact the demand and capacity assessments would have on service provision and reducing patient waiting lists.

- Referrals and appointments were managed centrally by the booking centre. Patients who required an urgent two week appointment were booked via a separate pathway. Referrals were triaged upon receipt to ensure that urgent patients were prioritised. If patients could not be booked within the required time frame, the relevant consultant would be contacted and asked if it was clinically acceptable for the patient to wait to be seen. If it was not, the patient would be regraded so that an appointment could be arranged within the required time frame.
- From April 2015 to March 2016, the 'did not attend' (DNA) rate for the trust was generally lower than the England average. The exception was from August 2015 to December 2015, when the DNA rate was higher than the England average. According to data for July 2016, the directorates with the highest DNA rates included speciality medicine, head and neck, dermatology and urology and ophthalmology and rheumatology. In an effort to reduce the DNA rate we were told that some specialities used the SMS text appointment reminder service for patients. However, this service had not been implemented by all specialities at the time of our inspection. As part of the outpatient improvement programme, the trust planned to implement the SMS text appointment reminder service across all specialities, with the hope that it would reduce the total outpatient DNA rate by 10%. According to data provided, as of August 2016 progress against this work stream was 25% complete. The trust planned to have completed this by December 2016. Therefore, whilst the trust had taken action to reduce the DNA rate we were unable to determine the impact this initiative had on service provision at the time of our inspection.
- We were told that the hospital did not routinely contact patients if they failed to attend their appointment. If a patient did not attend their appointment this would be recorded on the electronic system as a 'DNA' and the patient would be informed by letter that they had been discharged. If the patient contacted the hospital within two weeks of the original appointment date, a second appointment would be arranged. However, if the patient did not contact the hospital we were told they would be removed from the patient waiting list and would need to be re-referred by their GP. The exception to this was oncology patients and children. For example, if an oncology patient did not attend an appointment the consultant or specialist nurse would telephone them and re-arrange their appointment.

Access and flow: Diagnostic imaging

- Demand in ultrasound was in excess of capacity and had been cited on the risk register as a moderate risk. There were vacancies in the department and an increased rate of sickness, all of which compounded the lack of capacity. Two radiographers were recruited for training posts in September but this was a long term plan due to the two year training programme. Ad hoc staff and agencies had been utilised in an attempt to reduce the pressures.
- Waiting times for patients once they arrived on location for outpatient diagnostic imaging and radiology were not monitored at the time of inspection. However, the specialised clinical services division (SCSD) management team were currently exploring options for systems that captured and displayed outpatient data.
- Plain film appendicular skeleton images for patients attending the minor injuries unit were reported almost immediately as there was a hot reporting radiographer during the core working hours. The hot reporting session was carried out at all of the three sites within the trust, with images available on the picture archiving and communications system (PACS) on all sites as soon as the patient examination had been completed.
- The department utilised a short notice cancellation system whereby patients who were able to accept short notice appointments were contacted if an appointment became available due to a cancellation or DNA.
- The auto reporting policy for patients that had undergone a medical exposure but did not require a formal radiological report had been approved within radiology and was available on the intranet. This ensured that radiographers were aware which

examinations required no formal report and ensured that regular audit was carried out on these images which should have had a clinical evaluation by the referring clinician associated with them.

- Due to a distracting and noisy computed tomography (CT) control room the senior manager introduced a help desk for CT and subsequently for ultrasound. This new practice eliminated phone calls and interruptions by staff whilst radiographers were scanning patients. This desk was located in the admin office where trained CT practitioners took calls, coordinated lists and undertook vetting of CT scan requests.
- Radiology had three dedicated porters who were well coordinated and liaised with each modality according to the clinical needs of the patient and the workflow within the department.
- There was direct access for GPs to refer for locally agreed magnetic resonance imaging (MRI) scans. The MRI senior manager saw these requests with radiologist back up as required to ensure that the most appropriate scan was carried out. The GP referrals list was currently in need of review.
- Staff stated that the hospital would benefit from the installation of a new MRI scanner and this in turn would allow repatriation of scans that had been reassigned to the Worcester Royal Hospital because of image quality issues. This also would assist with the two week wait targets.
- If a new scanner was installed patients would need to be imaged at other sites within the trust. There would be a lot of work required around redistributing staff and extending the lists. Staff felt that there was not enough forward planning for capital replacement and that the process was rushed.
- The radiology IT manager stated that there were issues with the new IT structure in the trust and that since it was taken over by a private provider there were access and flow issues relating to logging IT faults.
- In CT, the waiting list was divided into in and outpatients on the radiology information system (RIS). The department acted as an overspill for Worcestershire who did not manage their list in this way and therefore made filtering the requirements for patients more difficult.
- The current waiting time for plain film reporting was 0.6 days for any urgent request and 1.89 days for routine imaging. These reporting times have improved since July following on from a section 31 notice served on the trust.

Meeting people's individual needs: Outpatients

- The outpatient clinics we visited were accessible to patients living with physical disabilities and wheelchair users. However, the seating arrangements within the outpatient department were not always fit for purpose. Many of the chairs within the department were low to the ground and did not have arms or supports. This meant that some patients with mobility difficulties found it difficult to sit and/or stand from the chairs. Some additional chairs with higher seats and arms had been brought into the department, but this was generally limited to one chair per clinic area. If more than one patient with mobility difficulties were waiting they may have had to sit on a chair that was not suitable for their needs.
- There was equipment available that was suitable for use by large patients, such as examination couches. However, we did not observe any chairs suitable for larger patients and/or visitors in outpatient waiting areas.
- The outpatient department's patient-led assessment of the care environment (PLACE) audit for 2016 showed they scored worse than the England average for how the environment supported the delivery of care for patients with dementia and disability. The department scored an average of 60% for dementia and 61% for disability, whilst the England average was 75% and 79% respectively. We requested evidence of actions taken in response to findings from the PLACE audit and were provided with actions taken in regards to how the environment supported patients with dementia. We observed that signage suitable for patients living with dementia had been introduced in the outpatient department. However, we were unable to determine whether the trust had taken any action to improve the environment with regards to patient's living with disability.
- Staff we spoke with had good awareness of patients with complex needs and those patients who may have required additional support. Staff told us that patients living with dementia or a learning disability would be prioritised and seen as soon as possible to reduce anxiety during their visit to outpatients. The outpatient department had a relatives room which could be used by patients and their relatives if they became anxious or agitated whilst waiting to be seen.

Outpatients and diagnostic imaging

- The outpatient department had a dementia, mental health and learning disability champion, who were available to provide support and guidance to staff. Additional support was also available from the trust's learning disability liaison team. Staff told us that a member of the learning disability team would attend a patient's appointment, if needed. Interpreter services were available. An interpreter could be booked to attend appointments when required; a dedicated telephone translation service was also available. We saw information about translation services displayed throughout the outpatient department.
- A hearing loop was available within the outpatient department for patients with hearing difficulties. Sign language interpreters could also be provided.
- We saw a wide range of information leaflets for patients in all areas of outpatients. Some leaflets had been produced by the trust and some were from national organisations, such as the British Lung Foundation, British Heart Foundation and Arthritis Research UK. The leaflets we saw were all in English. Staff told us they could access information leaflets in other languages as needed.
- Staff in the ophthalmology department could provide information for patients with impaired vision in braille. Consent forms could also be produced in braille.
- We reviewed clinic schedules and saw new patients were given a longer appointment time then patients attending follow-up appointments. Appointment times varied, depending on the speciality. This meant new patients had more time to ask questions and for follow-up tests to be arranged.

Meeting people's individual needs: Diagnostic imaging

- Posters with patient information relating to CT scans and contrast media were available. There was also information about how to get results, information about safeguarding, how to make a complaint and contact the patient advisory liaison service (PALS).
- We observed aftercare leaflets were given to patients following CT colongraphy examinations.
- Translation services were available.

Learning from complaints and concerns: Outpatients

- The trust reported 44 complaints regarding all outpatient and diagnostic imaging areas at Alexandra Hospital between December 2015 and November 2016. The trauma and orthopaedic directorate received the most complaints (30%), followed by head, neck, dermatology and urology (18%) and gynaecology (14%). The most common themes for complaints included clinical treatment (39%), appointment waiting times (including delays or cancellations) (27%) and values and behaviour of staff (20%). We saw evidence that action was taken as a result of complaints received in order to improve the quality of care. For example, complaints regarding values and behaviours of staff were addressed with the members of staff concerned. Clinical specialities had recovery action plans in place to address patient waiting times and this work was ongoing at the time of inspection.
- Staff told us that, where possible, complaints were resolved locally and at the time of the complaint. If staff were unable to deal with a patient's concerns satisfactorily they would be directed to the patient advisory liaison service (PALS).
- All formal complaints received by the trust were sent to the divisional leads within the service and were allocated to a senior member of staff to investigate and action. The trust aimed to provide written acknowledgment within 72 hours of receipt of a complaint and provide a full written response within 25 working days when the outcome of the investigation was known. However, the percentage of complaints responded to within 25 days was 68%, for the period from December 2015 to November 2016. The response rate had got worse since our July 2015 inspection, when we reported that 100% of complaints were responded to within 25 days. Therefore, we were not assured that all complaints were dealt with in a timely manner and in accordance with trust policy.
- Senior staff told us that learning from complaints was shared at regular team meetings, via emails and at daily staff huddles. We reviewed three sets of team meeting minutes, which confirmed that complaints were shared with staff. Staff we spoke to also confirmed they were aware of complaints and had received feedback via team meetings.
- Information was available on the trust website and also throughout the outpatient department, which provided details of how patients could raise complaints about any aspect of care they had received.

Learning from complaints and concerns: Diagnostic imaging

Outpatients and diagnostic imaging

- The majority of complaints to the trust were regarding long waits for appointments and obtaining radiology results.
- The trust reported five complaints regarding diagnostic imaging departments at Alexandra Hospital between December 2015 and November 2016. Four of the complaints were regarding values and behaviour of staff and one related to breast screening facilities. We saw evidence that action was taken as a result of complaints received. For example, one member of staff attended a customer service course following a complaint regarding their attitude.
- Staff we spoke to confirmed they were aware of complaints and had received feedback via team meetings.

Are outpatient and diagnostic imaging services well-led?

Inadequate

Overall, we rated the outpatient and diagnostic imaging service as inadequate for being well led because:

- We could not be assured the service had a robust, realistic strategy for achieving the priorities and delivering good quality care.
- The service was in the early stages of reviewing the departments demand and capacity as part of the effectiveness and productivity work stream in their improvement plan. This information was not available for review at the time of inspection.
- The governance framework was ineffective and meeting minutes lacked detail around the content of information presented and whether actions were taken to address issues raised.
- Some staff felt that at divisional level no one really understood radiology and were reactive to issues in the department as opposed to being proactive. Staff felt local leadership was good but divisional and trust leadership was poor.
- Radiation protection governance and infrastructure was poor and we were not assured that all requirements under the statutory radiation regulations were being met. There was not a coordinated and trust wide overview of radiation protection issues and actions were not always taken to address concerns raised.
- We were not assured that replacement of ageing and unsafe radiological equipment was being adequately prioritised with divisional management altering the risk rating and at times removing the risk altogether, with no knowledge by the radiology department.
- The radiology strategy document lacked detail to enable planning of required action plans and did not contain timeframes as to when actions should be completed.

However:

- Staff reported that local leadership was good and managers were approachable and supportive. However, staff did not feel directorate and divisional leads were visible within the service.
- Since the visit in July 2016 from CQC, the consultant radiographer told us the department had improved its focus and drive to improve reporting turnaround times, particularly for plain film reporting.
- Staff were proud to work at the hospital and were passionate about the care they provided.
- Following a service improvement request from CQC, (Section 31 notice) in July 2016, the reporting radiographer service increased the number of cold reporting sessions and was in the process of increasing the number of chest and abdomen plain film reporting sessions. This had improved the sustainability of the plain film reporting and helped to reduce the risk of further reporting backlogs as experienced earlier in the year.

Leadership of service: Outpatients

- The trust had changed the divisional structure since our previous inspection in July 2015. Since November 2015 the outpatient department was one of eight directorates within the specialised clinical services division. This was the largest division in the trust and also included the directorates of ophthalmology, rheumatology, pre-operative assessment and day case, pathology, pharmacy and radiology and breast screening services. The specialised clinical services division was led by a divisional medical director, divisional director of operations and divisional director of nursing. These roles were all supported by deputies. The division also had a business advisor and support manager. The outpatient and endoscopy and bowel cancer screening directorate was led by a clinical director, directorate manager and matron. The matron was responsible for

overseeing the provision of outpatient services trust wide. The day-to-day management of the outpatient department at the Alexandra Hospital was provided by a senior and junior sister.

- Staff reported that local leadership within the department was strong. Managers were visible, supportive and approachable. The matron was on site once to twice per week and could be contacted via mobile for support and advice when needed. However, some staff we spoke with did not feel the directorate and divisional leads were visible within the department.
- Staff told us that local leadership was good and felt they could approach managers with concerns. Managers told us they had an 'open door' policy and they encouraged staff to share any issues, concerns or ideas they may have. Staff we spoke to confirmed this. We observed good, positive and friendly interactions between staff and local managers.
- Staff felt that line managers communicated well with them and kept them informed about the day to day running of the clinical areas and any issues or concerns that had been raised. We observed that the matron and senior staff were visible in the department during our inspection.
- Senior staff we spoke to said that the outpatients department was represented at board level. The chief operating officer (COO) was the executive lead for the outpatients improvement programme and told us that patient waiting lists was one of the top three priorities for the trust. However, the COO had only been in post since mid-November 2016. This meant we were unable to determine how effective the executive leadership was and whether they understood the challenges within the service and had identified actions needed to address them.

Leadership of the service: Diagnostic imaging

- At the beginning of 2016 there had been restructuring of the directorate that radiology belonged to. A number of management posts within radiology were new, and roles and responsibilities changed. A new clinical director was announced during the week of the inspection. Multiple members of staff of various grades and specialities were extremely positive about the change. The new clinical director had tackled numerous tasks even prior to their appointment; staff had confidence in their abilities.
- The clinical governance lead for radiology stated that there had been some issues with the management structure within the directorate. This had been rectified and staff were now in post. This would help to assist with reviewing incidents.
- Some staff said that at divisional level no one really understood radiology and were reactive to issues in the department as opposed to being proactive. They said that local leadership was good but divisional and trust leadership was poor.
- Since the revision of the management structure, we were told that senior members of staff were more accessible and that they were approachable and visible both when they were needed and on a general day to day basis radiographers spoke highly of the local management.
- Numerous staff told us that they felt that historically the hospitals within the trust were "site-ist" with different local working practices and no cross county vision. The new clinical director aimed to be proactive towards working collaboratively and standardising processes and procedures.
- Staff in magnetic resonance imaging (MRI) generally rotated between sites within the trust. Radiographers in MRI were concerned regarding a culture of 'Chinese whispers'. There was poor communication between sites with no central message, poor email communication and a lack of standardising protocols between sites. There appeared to be a lack of confidence in managers and staff in this area had low morale. We were told that the MRI senior manager did not rotate enough to all sites.
- The site lead at Redditch also managed the site lead at Kidderminster which although was an additional workload worked well for the two departments.
- Radiographers spoke highly of the site superintendent and department and the lead radiographer was very proud of the team who had worked very hard during a period of stress and change.
- The superintendent was cited as being a "brilliant manager" who despite only being in post for one year had made very positive changes in the department and had improved staff morale. The superintendent was said to be dedicated and had time for everyone, everyone was treated fairly and as individuals.
- The superintendent had been nominated as manager of the year.

- Each x-ray modality had a lead radiologist who the cross site senior manager felt should head dose optimisation as required under the ionising radiation (medical exposure) regulations IR(ME)R.
- The team lead in planar x-ray attended a morning theatre huddle and a weekly projection meeting.
- The department had a highly motivated and skilled patient archiving and communication system (PACS) and radiology information system (RIS) manager who led a team of three highly skilled staff. The team actively managed to cover all of the trust sites and offered support and troubleshooting on a weekly basis.
- Since 2014 there had been no out of hours radiologist to cover computed tomography (CT), this was due to the trust allowing 24 hour open access for CT scans which the radiologist felt was an unachievable move. The trust employed an out sourced radiologist company to provide CT cover for requests and reporting from 8.30pm until 9am.
- The site senior manager stated that the chief executive officer (CEO) had an open door policy and had taken concerns to them, they felt listened too and acknowledged but did not feel that much could be changed.

Vision and strategy for this service: Outpatients

- The trust vision was focused on providing safe, effective, personalised and integrated care for local people by a skilled and compassionate workforce. The department had developed a mission for the service, based upon the trust vision, which was to deliver the highest standard of care to all patients by actively promoting a supportive, caring and clean environment. This was publically displayed within the department. The trust values were based on the acronym "pride", which stood for patients, respect, improve and innovate, dependable and empower. Staff we spoke with were aware of the vision and values and were able to describe them.
- We could not be assured the outpatient service had a robust, realistic strategy for achieving the priorities and delivering good quality care because the service did not have a ratified strategy in place at the time of our inspection. We were told by the directorate management team that a three year outpatients modernisation strategy had been devised and had been submitted to the executive board for approval. The strategy was focused on improving referral to treatment times, reducing waiting times, improving the outpatient environment, improving efficiency and productivity, developing clinic room scheduling and utilisation and devising standards and operating procedures across all hospital sites. However, because the strategy had not been ratified at the time of our inspection we were unable to determine whether the trust would be able to deliver it and what impact it would have on service provision. We were told that the division planned to present the strategy early in 2017, although no deadline for this had been identified at the time of our inspection. We requested a copy of the unratified strategy but were not provided with this. The trust did provide a position statement on the outpatient improvement programme, which set out a broad three-phase strategy for outpatients over the next three years; dated November 2016. However, this did not include details of when they expected to meet the different phases of the strategy and also lacked detail on how objectives would be met. For example, the position statement stated that a detailed plan to deliver phase two of the strategy was being developed. Furthermore, because the strategy had not yet been presented, staff we spoke with were not able to describe their role in achieving it.
- The directorate management team told us the aim of the specialised clinical services division was to facilitate safe patient care, delivered by a united, skilled and appreciated workforce. The directorate management team described the outpatient department as the "hoteliers" for the trust. The intention for the outpatient service was to help the trust to deliver the correct services on the correct site in the county, ensuring adequate clinical support and the provision of standardised pathways and equipment. Staff we spoke with had some awareness of these aims.
- A project manager had been employed in May 2016 to look at driving improvements in the outpatient department. The trust had recognised that the outpatient department was fragmented and there was a need to standardise processes across all outpatient clinics. An outpatients improvement programme had been developed, which encompassed the strategy for outpatients and detailed specific objectives the department were required to meet in order to improve patient experience and reduce clinic delays and wasted clinic slots, by increasing efficiency and productivity. At the time of our inspection, the service was in the

process of gathering information in order to inform and improve service provision. A number of work streams had been identified within the outpatient improvement programme and included:

- Environment:
  - Information: The service aimed to standardise information available for patients in the waiting room. Produce a standardised communications folder for each outpatient site.
  - Cleanliness: Develop generic / consistent cleaning schedules for clinical areas in outpatients.
  - Patient care: Notify patients of clinic delays in real time.
  - Safeguarding: To provide adequate signage that was suitable for dementia specific patients. Provide hearing loops with all outpatient areas across each of the hospital sites.
  - These actions had been marked as completed and evidence of action within the department.
- Standards and operating procedures:
  - Devise standards and operating procedures for all outpatient staff and clinics. The first draft completed in September 2016 and had been circulated for comment.
- Clinic room scheduling and utilisation:
  - Develop/update current tool for clinic room and outpatient staff utilisation. We saw these actions had been marked as completed and evidence of action within the department.
  - Devise standards for all outpatient departments and measures to ensure these are being maintained. This was still in progress at the time of inspection.
- Efficiency and productivity:
  - Performance: A full understanding of current performance by specialty for outpatients. Identify any efficiencies that can be made as a result of late/ overrunning clinic. This was still in progress at the time of inspection.
  - Measures: Utilise metrics for reporting and monitoring of progress/impact / success of project - patient care improvement programme reports. To have consistent reporting mechanisms in place from information team. We saw these actions had been marked as completed and evidence of action within the department
  - SMS Text Reminder: SMS text reminder to be switched on for all clinics minus agreed specialities. This was still in progress at the time of inspection.
  - Breast Unit: Breast Unit supplies delivered to the correct location. This action had been marked as completed and evidence of action within the department.
- Information and communications technology:
  - Televisions: All televisions within outpatients working
  - WIFI: Advertise Wi-Fi provided information in all outpatient areas. Provide free Wi-Fi to all patients within the outpatients area
  - Patient survey: Provide patient surveys within outpatients - (outpatients improvement programme relating questionnaires)
  - SMS Text Reminder: SMS text reminder system to be configured so patients are automatically opted in with opportunity to opt out. These actions had been marked as completed and evidence of action within the department.

- During our previous inspection in July 2015, we found it had been unclear from discussions with the nursing lead for the outpatient department whether any demand and capacity assessments had been conducted. This was despite clinic capacity and usage being listed as an objective on the department's strategic document. During this inspection we saw that the service was in the early stages of reviewing the departments demand and capacity as part of the efficiency and productivity work stream. The service had started a manual snap shot demand and capacity audit. Outpatient staff were recording information on when a clinic started late or overran and the reasons for this, the number of patients booked for appointments and the time the medical staff arrived for clinics. Data was being collected from 10 October until 1 December 2016. The project manager planned to report the findings to the divisional leads in January 2017.
- Progress against delivering the outpatient improvement programme was regularly monitored and reviewed. The project manager reported progress on a weekly basis to the divisional operations manager and the executive director for strategy and planning. A monthly review was presented to the trust executive improvement board. Whilst some progress had been made the trust did not expect to complete this programme until March 2017.

Therefore, at the time of inspection we were unable to determine whether the trust would be able to deliver the outpatient improvement programme and what impact it would have on service provision.

Vision and strategy for this service: Diagnostic imaging

- There was an existing strategic document under review. There were elements of the planned developments that would be supported through the current actions being taken. For example, a capacity and demand model countywide, reviewing staffing and equipment availability, this was likely to provide further detail to support a decision on CT out of hours working. Currently this was to provide cover after 11pm at Worcestershire Royal Hospital and 8pm at Alexandra Hospital by on-call radiographers. The capacity review would also provide details of the skill mix and allow for an informed decision on required skills countywide to maximise services and efficiencies. Each of the identified service developments would be assigned and managed under the newly implemented work streams; this would support implementation and governance and provide overview and management, led by clinical leads.
- Each of the identified service developments would be assigned and managed under the newly implemented work streams; this would support implementation and governance and provide overview and management, led by clinical leads.

Governance, risk management and quality measurement: Outpatients

- The outpatient directorate management team attended monthly divisional and directorate quality governance meetings. The minutes confirmed that incidents, complaints, risks and departmental performance dashboards were discussed. However, the minutes lacked detail and there was no evidence that actions were taken to address governance issues raised. For example, incidents discussed were focused on the numbers and length of time incidents were outstanding, rather than themes and trends. Similarly, discussions which took place about the divisional risk register focused on the number of risks recorded, rather than how they were being managed.
- The outpatient department maintained a quality governance performance dashboard. The dashboard included data on mandatory training and personal development review compliance, incidents, complaints, audits and National Institute for Health and Care Excellence (NICE) guidance compliance. The dashboard was maintained by the specialised clinical services divisional quality governance team and was reviewed at divisional and directorate governance meetings. We were told that the trust was in the process of developing a new safety and quality information database, but this had not been implemented at the time of our inspection. We reviewed three sets of outpatient team meeting minutes and there was no evidence to show that results of the quality governance performance dashboard were shared with staff.
- The outpatient service did not participate in clinical audits and compliance to NICE guidance. We were told that clinical audits were undertaken by individual medical specialities.
- The outpatients improvement programme detailed performance measures for the outpatient department. These included the audit of start and finish times for outpatient clinics, the monthly outpatient clinic performance report, the number of incidents reported due to overbooking of clinics and the number of complaints reported due to long waits in clinic. We saw evidence that staff were auditing which clinic rooms were used and by whom, the time the clinic room was ready for use, the time the first patient entered the clinic, the time the last patient left the clinic, the time the clinic finished and the longest waiting time. This information was recorded daily for every clinic session. We were told that the results of the audit would be used to improve the efficiency and productivity of outpatients by reducing the number of clinics that started and finished late. As the audit was still ongoing at the time of our inspection we were unable to determine how this information would be used to improve service provision.
- We saw evidence that regular reviews were held to monitor and improve progress against the quality improvements initiated by the trust for the outpatient department. Progress was monitored monthly by the improvement programme board, which in turn reported monthly to the executive improvement board.
- All incidents which were reported as resulting in moderate harm, severe harm or death generated an automated email to the patient safety team and divisional staff, who then allocated the serious incident to an appropriate clinician or senior member of staff to investigate. No never events or serious incidents had

been reported by the outpatient department from October 2015 to September 2016. From a review of incidents reported and data provided, we were not assured there were robust governance processes in place to ensure all incidents were reviewed in line with trust policy and national guidance. For example, one incident we reviewed was categorised as having caused 'minor harm', when the patient had fallen through a standing hoist resulting in a fractured femur. According to trust policy and national guidance this incident should have been categorised as having caused moderate harm to the patient. We reviewed the investigation of this incident and found some details had not been completed. We also requested copies of the three most recent serious incident root cause analyses reports but were only provided with the action plans developed in response to these incidents. Therefore, we were unable to determine whether incidents were robustly investigated. Furthermore, we were not assured that all incidents were investigated in a timely manner.

- The risk register did not represent all the risks identified by the leads for the service. The majority of risks related to diagnostic equipment. We asked the leads what was the biggest risk to the department; staffing was identified but this was not on the risk register. The majority of staff we spoke with were not aware of the main risks within the department. There was no evidence that risks were discussed at outpatient team meetings.
- We saw evidence that patient waiting lists were reviewed on a weekly basis. This meeting was led by the head of elective performance and patient access. Each medical speciality had developed an action plan in order to improve referral to treatment time (RTT) performance and sustainability. The chief operating officer told us the trust did not expect to meet RTT targets until the end of March 2017. Whilst some progress had been made against specific objectives detailed within the action plans, we saw that some actions had been rated as amber and red, which meant they were behind the target date for completion. Therefore, we were unable to determine whether the trust would be able to meet its planned trajectory targets and what impact this would have on patient waiting lists.

Governance, risk management and quality measurement: Diagnostic imaging

- A new radiology governance lead had been in place since February 2016. They had felt frustrated and unsupported at the beginning, with a lack of clear objectives set. We heard that there was also a lack of action plan that would have given this role a clear focus. The role was developed to manage incidents, work towards the imaging services accreditation scheme (ISAS), to standardise policies across the trust and to undertake actions and liaise with Care Quality Commission (CQC).
- We heard how the governance lead was feeling more positive and had started to see progress after feeling the trust had not moved forwards in the previous ten years of working there as a radiographer. They felt positive about the new management and governance structure and believed that this would mean their role would benefit from better support and guidance.
- Prior to the inspection, we were told that the imaging department did not utilise the world health organisation (WHO) interventional checklists. Following discussion, the governance lead told us that this was now fully implemented and was in the process of having its compliancy audited. There had also been a review of National Safety Standards for Invasive Procedures (NatSSiPs) which was ongoing.
- We saw evidence of minutes from the directorate quality governance meetings which covered governance across the directorate. At the time of the inspection there was a newly developed radiology clinical governance team who now met monthly and discussed local governance inside of radiology. At the radiology governance meetings the risk register, complaints and incidents were discussed.
- The risk register included a range of risks across the trust such as aging equipment, staffing levels and the reporting backlog. Prior to the new governance structure the risk register was reviewed by the cross site senior manager. However, under the new structure these were now reviewed within the team. Previously it was felt that concerns within radiology were not being listened to and that some staff at directorate level had a lack of understanding of the needs of the radiology department hence the new structure.
- Incident management was not well managed prior to the new governance team being implemented.

Incidents were not reviewed in a timely manner as per trust policy. Since July 2016, training had been provided to the site leads to better review the incidents. Senior managers did not prioritise this prior to the governance lead joining.

- The trust held an annual radiation protection committee (RPC) meeting, which was chaired by the clinical director. It was unclear how the RPC fed into the trust wide governance structure. Last year's meeting had highlighted the lack of radiation protection supervisors within the trust. This had still not been rectified at the time of the inspection. The RPC minutes in 2015 highlighted multiple areas where departmental actions were required. At the time of inspection many of these actions were still outstanding such as images quality deterioration on aging equipment, variations on performance of rooms across the trust and accuracy of exposure settings.
- The cross site superintendent held six weekly team lead meetings where radiation protection was a standing agenda item and any concerns were fed to the directorate and divisional meetings.
- Staff stated that issues and risks were always fed up to the division leads but that there was little in the way of feedback from this level. Items were placed on the risk register and removed without explanation. Monthly team lead meetings were held where all site superintendents met with the cross site lead to discuss items discussed at directorate level in order to disseminate information to local sites.
- There was no capital replacement programme for the diagnostic imaging department across the trust. There were several pieces of equipment that were on the risk register as being 'end of life' or failing repeatedly. The trust had said that the equipment that needed replacement must be done under a lease. At the time of the inspection there were no plans in place to replace this through capital procurement and that the only way of replacing the equipment would be to lease it with the cost absorbed by the radiology department. It was felt that there was a lack of forward planning to replace very costly equipment for which failures had trust wide impact for patient throughput and access.
- Several members of staff we spoke with highlighted their concerns about patient safety due to aging equipment, parts being obsolete and the equipment not being mechanically sound.
- At the time of the inspection a senior manager discussed their concerns around the failing x-ray equipment at the hospital. A bid was placed for replacement of the units last financial year but was not approved. The equipment remained on the risk register which was monitored by the cross site senior manager and initially was rated as a high risk; this was downgraded to medium at divisional level with no consultation with radiology and no explanation. This caused concern within radiology that their concerns were not being listened to and that some staff at directorate level had a lack of understanding of the needs of the radiology department. It was described that the trust's capital programme had a planning horizon of one year, in considering lease of equipment the additional revenue cost was expected to be absorbed at department/divisional level.
- The cross site senior manager was looking into ways to generate income in order to fund capital replacement items, one of which was to restructure the cost coding for ultrasound examinations in order for work carried out to be more effectively cross charged for.
- The cross site senior manager was constantly concerned about service delivery at the hospital due to room closures because of aging and faulty equipment.
- CQC carried out an unannounced inspection at Worcestershire Royal Hospital on 27 July 2016. The purpose was to look at specific aspects of the care provided by radiology services at Worcestershire Acute Hospitals NHS Trust. Concerns were initially raised by a member of the public, and the trust was given the opportunity to respond to these, however when satisfactory assurances were not received, the local inspection team decided to conduct an unannounced inspection. In particular, consideration was given to the time that it took to report on routine and urgent plain film x-ray examinations, and the governance processes in place to ensure that any backlog in reporting was managed, escalated and resolved. We also looked at staffing within the department. The radiology department could not provide us with evidence of board oversight or knowledge of the backlog. This meant we were not assured that there were suitable governance and escalation processes in place to protect patients from actual or potential harm. Lessons were not being learnt from incidents and safety goals had not been set.
- The length of time for the reporting of diagnostic imaging tests had been on the trust risk register since

2003 and we saw no evidence of a review of the situation and clear actions to reduce the backlog. During our inspection, we found that from 1 January to 26 July 2016, 10,442 plain film x-ray examinations remained unreported. Following our inspection, the trust submitted data demonstrating that the total number of unreported images from 2013 to 2015 was 25,622. There were no procedures in place to trigger the escalation of risk caused by lengthy delays in reporting. A full report was published in November 2016.

- A Section 31 notice was served on the trust with actions for the trust. This included a reduction in the backlog of imaging that required reporting, report weekly reporting turnaround times and put an action and escalation plan into place to ensure that this situation did not arise again. The trust was also required to lay out an audit schedule around the reporting of medical exposures. At the time of the inspection, the reporting figures were zero backlog for the years 2014, 2015 and 2016 with an agreed risk assessment not to report anything more historic. The current report waiting times for plain film imaging were half a day for urgent and less than 48 hours for routine. This demonstrated that the department had utilised external and internal additional reporting capacity and have resourced the action plan at trust level to ensure the requirements of the notice have been met.
- The trust were reactive to the initial issue and demonstrated that there was no proactive approach to the reporting backlog. Subsequent to the Section 31 there was a longer term strategy. There has been an increase in cold reporting sessions for radiographers, employment of additional staff enabling a more robust and sustainable workforce, and the appointment of a new radiographer to undertake chest and abdominal x-ray reporting which is where the majority of the reporting delays lay.

Culture within the service: Outpatients

- Staff were proud to work at the hospital. They were passionate about the care they provided for their patients and felt they did a good job.
- Nursing staff within the outpatients department told us they felt respected and valued. They talked of strong local leadership who supported them on a day-to-day basis
- Multidisciplinary teams worked together and were focused on improving patient care and service provision.
- Staff we spoke with reported an open and honest culture within the outpatient department. Local managers were supportive and approachable and staff felt confident to escalate concerns and report incidents.
- Staff did not express concerns about bullying or harassment to Care Quality Commission (CQC) team during our inspection.

Culture within the service: Diagnostic imaging

- Since the visit in July 2016 from CQC, the consultant radiographer told us that the department had improved its focus and drive to improve reporting turnaround times particularly for plain film reporting. Previously it was felt there were restrictions on improving the reporting radiographer services due to the culture of both the radiologists and reporting radiographers. Staff said they felt the actions placed upon them were “the best thing that could have happened to us”.

Public engagement: Outpatients

- There was some evidence that people who used the services were engaged by the department to help shape and improve them. For example, the outpatient improvement programme was using feedback gathered from patients to improve the outpatient department. From August to November 2016. Patients were asked to rate the outpatient environment, facilities, staff and their overall impression of the department and care they received. The majority of feedback from patients was positive. For example, 96% of patients rated their overall care as excellent, 4% rated it as adequate and less than 1% rated it as poor. The trust had made improvements to the outpatient department following patient feedback received. This included standardised noticeboards and cleaning schedules, dementia friendly signage, and ‘standards of behaviour’ for all staff to adhere to. Since our previous inspection, the service had commissioned an external outpatient survey. Data was collected in May 2015 and the results were published in December 2015. We saw evidence that the service had developed an action plan in response to results of the survey. For example, actions taken in response to patients who felt they were not kept informed of clinic delays included regular updates of whiteboards with clinic running times and

announcements to patients in the waiting room. Reception staff were also asked to inform patients of any delays when they booked in. We observed that patients were kept informed of clinic delays during our inspection.
- NHS Friends and Family Test questionnaires were available for patients in clinic waiting areas and we saw information displayed, which encouraged patients to leave comments about the service. The response rate for the trust was 5%, which was lower than the England average (7%).
- Patients and relatives we spoke with were positive about the service and care they received in outpatients.

Staff engagement: Outpatients

- The outpatient department held minuted team meetings, which all staff were invited to attend. Staff that were unable to attend were emailed minutes of the meetings. Staff we spoke with said they felt informed of plans for outpatient services and were encouraged to share ideas of how to improve service provision.
- Staff were involved in the improvement plans for outpatients. The service held 'listening into action' sessions in June and July 2016 with 40 staff from outpatients. Senior managers told us they were overwhelmed by the number of staff who attended the sessions. Staff identified areas for improvement, such as the environment and communication, which helped form the improvement plan. Staff we spoke with told us they felt actively engaged and their views were reflected in the planning and delivery of services. Listening into action (LiA) is a way of working designed to empower staff at all levels in identifying and driving though the changes and improvements they want to see most. The trust told us the aim was to change the way the trust worked, allowing everyone working at the trust to remove the barriers that get in the way of delivering quality for patients. LiA supported an aim of the trusts; to listen to what frustrates staff at work, what they would like to see improve and change and how leaders can support, enable and 'unblock the way' for staff to make that change happen. All staff were encouraged to get involved.

Staff engagement: Diagnostic imaging

- Staff were working with aging equipment and they were concerned about their patient's safety. The aging equipment did little in the way to motivate staff to want to stay and it impacted on staff recruitment. Radiology technology is rapidly advancing and staff want to work in departments where equipment is modern and also safe for them and patients.
- Some staff were being looked after by occupational health due to the mechanical issues with the aging equipment.
- The MRI superintendent felt very proud of their staff, they were flexible and able to compromise on their working day to accommodate all patients. There were no breaches and this was testament to the staff attitude.
- The MRI superintendent felt happy working at the hospital and felt they had been well supported to undertake their reporting qualification.
- There were action plans in place to ensure staff that were offered jobs were contacted as soon as possible. Students were also being offered jobs when they completed exams and placements.
- Recruitment was deemed to be improving.
- We met with a radiographer team lead who informed us that the site lead superintendent had been an inspirational person in her professional life. They had begun work as a radiography assistant, was supported to go on and complete radiographic training and was recently appointed as a diagnostic lecturer at a local university.
- One radiologist we spoke to raised concerns that the inspection process was of limited use because; "management did not listen and nothing gets done". They felt there were long standing issues with equipment faults, staffing and demand on the service but that nothing changed. Staff were suffering due to the demands placed on them and they raised concerns around front line staff receiving abusive phones calls from frustrated patients. They felt that staff were doing their best but that they were not appreciated.

Innovation, improvement and sustainability: Outpatients

- The outpatient department had agreed objectives and action plans in place in order to develop and improve service provision, these were detailed in the patient care improvement programme. Plans were related to improving the efficiency and effectiveness of the department and patient experience. We saw evidence that the trust had made some progress towards achieving its plans. For example, environmental improvements had been made to the outpatient

environment, which included the installation of dementia friendly signage throughout the department. The outpatient improvement programme was ongoing at the time of our inspection. Therefore, we were unable to determine whether the trust would be able to deliver its proposed improvement plan.

- We saw evidence that some medical specialities were proactive in training staff to meet the demands of the service. For example, the ophthalmology department had invested in training staff in additional skills and competencies, in order to increase capacity and improve service provision for patients.

Innovation, improvement and sustainability: Diagnostic imaging

- Following the Section 31 notice the reporting radiographer service had increased the amount of cold reporting sessions and was in the process of increasing the number of chest and abdomen plain film reporting sessions to eight sessions a week through a new training post. This would improve the sustainability of the plain film reporting and help to reduce the risk of a repeat of the reporting backlog experienced earlier in the year.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Ensure patients privacy, dignity and confidentiality is maintained at all times, particularly during handover.
- Ensure patients are always assessed and treated in line with the Mental Capacity Act 2005.
- Ensure that patient documentation, including risk assessments, are completed accurately and routinely to assess the health and safety of patients. This must include pain assessments, venous thromboembolism assessments and fluid balance charts.
- Ensure that patient weights are recorded on their drug charts.
- Ensure that there is clear oversight of all deteriorating patients and that the National Early Warning Score chart is completed accurately.
- Ensure there is an embedded risk assessment process to determine the criteria for patient moves to non-medical wards.
- Establish a female genital mutilation training programme for all staff working in children and young people's services.
- Ensure staff are aware of the Mental Capacity Act 2005.
- Ensure operating team brief is attended by all required members of staff, as per national guidance.
- A robust system must be in place to ensure that all electrical equipment has safety checks as recommended by the manufacturer.
- Ensure that all equipment is checked as per policy, particularly in midwifery services.
- Ensure that patients are cared for in a safe environment that has the appropriate equipment to facilitate care to a deteriorating patient.
- Ensure that medicines are stored within the recommended temperature ranges to ensure their efficacy and safety.
- Review arrangements for the storage of intravenous fluids for emergency use to ensure patient safety.
- Ensure that medicines are always administered to patients as prescribed.
- Ensure that there is a system in place in the emergency department to record medicines (including intravenous morphine) administered to patients by ambulance crews.
- Ensure infection prevention and control procedures are always carried out as per trust policy and national guidelines.
- Ensure theatres and anaesthetic rooms are compliant with national guidance, Health Technical Memorandum 03-01: Specialised Ventilation for Healthcare Premises.
- Improve performance against the 18 week referral to treatment time, with the aim of meeting the trust target.
- Improve performance against the national standard for cancer waiting times. This includes patients with suspected cancer being seen within two weeks and a two-week wait for symptomatic breast patients.
- Ensure patient harm reviews are carried out on patients who breach the referral to treatment times and cancer waits in order to mitigate any risks.
- Ensure that incidents are accurately reported and investigated.
- Ensure all mortality and morbidity meetings are recorded and lessons are learnt.
- Ensure there are systems and processes established in surgical service to address identified risks, such as cancelled operations, bed capacity and access to emergency theatres.
- Ensure divisional management teams are aware of patient harm reviews.
- Ensure divisional management teams have oversight of the patient waiting lists and of initiatives and actions taken to address referral to treatment times and cancer waits.
- Develop a clear strategy for surgical services which includes a review of arrangements for county wide management of emergency surgery.
- Ensure children's and young people's service carry out clinical audits to identify effectiveness and areas for improvement.
- Ensure staff are aware of the strategy for diagnostic and imaging services.
- Ensure patient notes are stored securely and safely.
- Ensure staff complete the required level of safeguarding training, including safeguarding children.
- Ensure staff compliance with mandatory training meets the trust target of 90%.

Outstanding practice and areas for improvement

- Ensure all staff receive an annual appraisal and that there is appropriate supervision for staff.
- Ensure that there are sufficient registered children's nurses in post so that the emergency department always has at least one registered children's nurse on duty per shift in line with national guidelines for safer staffing for children in emergency departments.
- Ensure only appropriately trained staff members are left in charge of a ward to care for patients.
- Ensure all patients are clinically assessed by a competent member of staff within fifteen minutes of arrival in the emergency department.

Action the hospital SHOULD take to improve

- Ensure there are consistent mortality review group meetings in order to review the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) across the service.
- Ensure that clinical audits in the emergency department are reviewed to enable the findings to improve practice. Accurate performance data should be collected and discussed at relevant governance meetings.
- Ensure robust risk management processes are in place with defined action plans and regular reviews.
- Ensure governance meetings reflect their terms of reference.
- Ensure all staff use appropriate personal protective equipment and decontaminate their hands appropriately at all times, especially before and after every patient contact and when moving between clinical areas.
- Review the arrangements for the storage of intravenous fluids for emergency use.
- Ensure trust policies are up to date and reflect current national guidance.
- Develop documents that clearly identify where specific information should be recorded.
- Ensure record keeping systems are coordinated to enable staff access to all relevant patient information.
- Ensure there is an effective escalation process when the hospital is approaching full capacity.
- Ensure there are sufficient consultant emergency medicine doctors to keep patients safe.
- Ensure all new bank and agency staff receive thorough inductions and ward orientations before starting work.
- Document and record all meetings where performance in the children's clinic is discussed.
- The provision of children's services should be clarified with external providers to ensure the safe care of children in the emergency department.
- Ensure all women are asked about domestic violence during their pregnancy in line with national guidance.
- Share results from national audits and action plans with all levels of staff to improve patient outcomes.
- The trust should improve its local audit schedule and consider more regular audits in documentation, the environment, equipment, surgical site infections and hand hygiene audits. Audit results should be followed up with improvement action plans where indicated.
- Ensure staff have knowledge of the key objectives within their service.
- Ensure all cancelled clinics and outpatient appointments are rescheduled in a timely manner.
- Review the high levels of unplanned medical admissions onto the surgical wards and implement steps to reduce the number of cancelled operations.
- Ensure all treatment areas where children and young people are provided with care and treatment, including adult services, are appropriate and child friendly environments.
- Ensure appropriate waiting areas are available for children and young people when sharing adult services.
- Take action to address the 'did not attend' appointment rate for new children and young people's services appointments.
- Ensure patients are discharged from the critical care unit within four hours of the decision to discharge, in order to improve the access and flow of patients within critical care.
- Investigate complaints within the timescales stated in the trust's complaints policy.
- Review the choices offered to patients about where they are discharged to for continuing care.
- Ensure information from the children's clinic flows to the board via effective governance processes.
- Engage and consult with all staff when considering any service reconfiguration and involve staff in the strategic plans to develop the surgical services across the three hospital sites.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect 1. Service users must be treated with dignity and respect. 2. Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular— A. ensuring the privacy of the service user; **How the regulation was not being met:** **The hospital did not ensure that patient privacy, dignity and confidentiality were maintained at all times.** **All surgical wards had white electronic boards with names of patients and some aspects of their care displayed which could be seen by all visitors.** **Nurse handovers on the stroke unit were held at the end of the bed and included information about the patients' health/condition/cognition and social circumstances. This could be heard by other patients and visitors.** **Patients were routinely cared for within the emergency department corridor. Trolleys in corridor have no space between them and no screens are used to maintain privacy. Confidential conversations relating to patients clinical care could be heard by all patients, non-clinical staff and visitors. No privacy for assessments or handovers.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent 1. Care and treatment of service users must only be provided with the consent of the relevant person.

This section is primarily information for the provider

Requirement notices

2. Paragraph (1) is subject to paragraphs (3) and (4).
3. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*.
4. But if Part 4 or 4A of the 1983 Act** applies to a service user, the registered person must act in accordance with the provisions of that Act.
5. Nothing in this regulation affects the operation of section 5 of the 2005 Act*, as read with section 6 of that Act (acts in connection with care or treatment).

* Mental Capacity Act 2005

** Mental Health Act 1983

How the regulation was not being met:

Patients were not always assessed and treated in line with the Mental Capacity Act 2005 (MCA) to gain consent. We found two patients were consented for surgery on incorrect consent forms (one with a Deprivation of Liberties Safeguard (DoLS) in place). This meant there was a risk the patient did not understand what they were agreeing to.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 Safe care and treatment** 1. Care and treatment must be provided in a safe way for service users. 2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— A. assessing the risks to the health and safety of service users of receiving the care or treatment; B. doing all that is reasonably practicable to mitigate any such risks;

Requirement notices

C. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
D. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
E. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;
F. the proper and safe management of medicines;
G. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;
H. where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

How the regulation was not being met:

Patient documentation, including risk assessments, were not always completed accurately or routinely to assess the health and safety of patients. These included pain assessments, venous thromboembolism assessments and fluid balance charts.

Patient weights were not recorded on their drug charts.

There was no clear oversight of the deterioration of patients. The National Early Warning Score (NEWS) chart was not completed in full.

Medical outliers were sent to any ward where a bed was available without the move being risk assessed.

Training on female genital mutilation had not been established or completed by all staff who worked within children and young people's services.

Some staff in the maternity and gynaecology service had poor knowledge of the Mental Capacity Act 2005. Therefore, no assurance that vulnerable patients could be adequately protected by staff.

This section is primarily information for the provider

Requirement notices

Not all operating surgeons were present at team brief as per guidance.

There was not a robust system in place to ensure that all electrical equipment had been safety checked yearly.

There were inadequate supplies of emergency equipment, such as suction units and call bells for ambulance patients waiting in the corridor.

Medications were not always stored within the recommended temperature ranges to ensure their efficacy or safety.

Intravenous fluids for emergency use were stored in emergency trolleys which were not tamper evident.

Medicines were not always administered to patients as prescribed.

There was no system in place in the emergency department to record medicines (including intravenous morphine) administered to patients by ambulance crews.

Infection prevention and control procedures were not always carried out as per trust policy and national guidelines.

Not all staff adhered to the infection control policies with regards to hand hygiene and the use of personal protective equipment.

Some theatres and anaesthetic rooms were not compliant with national guidance, Health Technical Memorandum 03-01: Specialised Ventilation for Healthcare Premises.

The hospital was not achieving the trusts target for referral to treatment time (RTT) for surgical services. RTT for surgery was worse than the England average.

The hospital was not achieving the cancer 62 day wait national target of 85% (66% in July 2016).

The hospital was not achieving the cancer two week wait national target 93% (July 2016 74.5% with 28 breaches, year to date performance 45%).

There is a risk that patients may have suffered harm due to the long waits, i.e. preventable potential deterioration to their condition. Staff we spoke with, including

This section is primarily information for the provider

Requirement notices

executives were unable to provide assurance that harm reviews for patients on the waiting list were being carried out. We asked the trust for assurance that harm that there was a process in place to assess this risk, however, the trust have not provided us with a response. The RTT is likely to deteriorate further due to cancellation of elective work until 16 January 2017.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 Good governance** 1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. 2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— A. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); B. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; C. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; D. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e). How the regulation was not being met:

This section is primarily information for the provider

Requirement notices

Staff in children's outpatient department were not aware of a risk matrix which provided guidance on what to report as an incident. This meant there was a risk of under reporting of incidents.

There was no embedded process to determine the criteria for patient moves.

There was inconsistent oversight of mortality and morbidity meetings.

The hospital had not ensured systems and processes were established and operated effectively in the surgical service. The hospital did not have robust action plans in place to address identified risks, such as cancelled operations, bed capacity and access to emergency theatres.

The divisional management team did not appear to have oversight of, or were aware of any initiatives undertaken to reduce referral to treatment times/ cancer waits and mitigate risk to patients on waiting lists.

There was no clear strategy for a county wide surgical service, especially for the management of emergency surgery.

The business plan lacked detail and failed to consider the vision or the service as well as the risks it faced. Clear objectives and not been set and were not supported by milestones and actions.

The service was not carrying out any clinical audits of children's clinic services. This meant there was a risk of the effectiveness and improvements to services not being recognised and acted upon.

The divisional management team were unable to describe the strategy for outpatients and diagnostic imaging and told us that a strategy was not expected until next year.

Medical records were not always stored securely.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Requirement notices

Regulation 18 Staffing

1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.
2. Persons employed by the service provider in the provision of a regulated activity must—
   A. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,
   B. be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

How the regulation was not being met:

Not all staff had the correct level of safeguarding training to enable them to carry out the duties they are employed to perform.

The level of safeguarding children's training that staff in certain roles received was not compliant with intercollegiate document 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff (March 2014) particularly in the emergency department, midwifery department and theatres.

The provider had not ensured staff received mandatory training and appraisals to provide safe and effective care. Compliance with mandatory training and appraisals did not meet the trust target.

There were not sufficient numbers of suitably qualified, skilled and experienced nurses to care for the patients attending the emergency department. There were not sufficient registered children's nurses to ensure there was one on duty on each shift.

There was not always formal clinical supervision in place for nurses.

The discharge lounge was staffed by one health care assistant per shift. When the health care assistant needed a meal or comfort break they were unable to get a prompt response to ensure cover was available.