Care Quality Commission

Sherwood Forest Hospitals NHS Foundation Trust

Newark Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Inadequate
Minor injuries unit	Inadequate
Medical care	Inadequate
Surgery	Requires improvement
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

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

There are four registered locations King's Mill Hospital in Sutton-in-Ashfield, Newark Hospital and Mansfield Community Hospital.

Newark Hospital provides a range of treatments, including consultant-led outpatient services, planned inpatient care, day-case surgery, endoscopy, diagnostic and therapy services, and a 24 hour Minor Injuries Unit & Urgent Care Centre. There were 47 beds across two medical wards. The day case surgery ward had facilities for up to 30 patients.

In February 2013, the trust was identified as being one of the 14 healthcare providers in England which had higher than expected mortality rates. This led to the trust being reviewed by Professor Sir Bruce Keogh, NHS Medical Director for England and the trust was subsequently placed into "Special Measures" by Monitor, the independent regulator of NHS foundation trusts. CQC undertook a first comprehensive inspection of the trust in Spring 2014. Although some improvements had been made CQC recommended a further period in special measures and gave an overall rating of 'Requires Improvement.'

We carried out an announced inspection visit from 16 to 19 June 2015 and three unannounced visits on 7, 9 and 30 June 2015. We held focus groups with a range of staff in the hospital and we also spoke with staff individually.

Overall, this trust was rated as Inadequate. We made judgements about 13 services across the trust based on the five key questions that we ask.

At Newark hospital we rated the minor injuries unit, medical and outpatient and diagnostic imaging service as "Inadequate" and the surgical service as "Requires Improvement."

Our key findings were as follows:

- Overall the hospital was clean, hygienic and well maintained but policies were not always followed on one of the wards.
- Improvements were needed to the safety of the minor injuries unit. Training on the care and treatment of children was needed. There were environmental risks for people who were at risk of self-harm.
- Medical staffing on the Minor Injuries Unit relied on locum medical staff. Nursing staffing levels were as planned within the surgical and outpatient service and staff felt they had the right number to meet patient's needs. Beds had been reduced on one of the medical wards so that safe staffing levels could be maintained. Nurse staffing levels were as planned and there was an escalation process in place if levels fell short.
- Patient's privacy was not always respected in the minor injuries unit. Doors/curtains were not always closed. Despite this we observed positive interactions between patients and staff.
- Patients attending the surgical service received individualised care. Care and treatment was evidence based and pain was well managed. The surgical service saw patients within national targets for treating people within 18 weeks of referral.

Summary of findings

- In January 2015 the trust identified a significant number of patients, around 19,500 in total, where the outcome of their outpatient appointment was not recorded in the electronic system correctly, or they were overdue for review appointments. The trust's initial response to the backlog of patients did not identify which patients needed review most urgently. There were delays in responding to the issue and in completing the work as planned.
- We were concerned about the trusts performance in relation to the management of people with sepsis. There have been longstanding concerns about the management of patients with sepsis. This is a severe infection which spreads in the bloodstream. In 2010 and 2012 we raised mortality outlier alerts with the trust, when information showed there were a higher number of deaths than expected for patients with sepsis. The trust had identified a third mortality outlier for patients with sepsis in the period April 2014 to January 2015. Our analysis of the data from April 2014 to February 2015 found 88 deaths of patients with a diagnosis of "unspecified septicaemia" compared with an expected number of 58. The death rate for patients with this diagnosis was 32%, almost twice as much as the England rate of 17%.
- There were no specific audits that assessed the outcome of patients at Newark Hospital. It was not clear how the trust monitored the effectiveness of the service they were providing.
- There was a strategy for Newark Hospital but staff were frustrated by lack of pace to deliver this vision and felt there was poor leadership. We found little evidence of the progress made with implementing the vision and strategy. Morale amongst staff, particularly those in more junior levels was poor at Newark Hospital. Newark Hospital provided the trust with a range of opportunities to deliver new models of care but we saw little evidence that these opportunities were being taken forward.

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

Importantly, the trust must:

- Ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
- Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance.
- Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.
- Ensure all equipment, including emergency lifesaving equipment, is sufficient and safe for use in the minor injuries unit.
- Ensure safe care for patients with mental health conditions at the minor injuries unit and especially those who may self-harm or have suicidal intent.
- Ensure staff have the appropriate qualifications, competence, skills and experience to care for and treat children safely in the minor injuries unit.
- Ensure the inter-facility transfer protocol with East Midlands Ambulance Service is updated and is effective in providing safe and timely care for patients at the minor injuries unit.
- Ensure the ligature risk posed by the use of non-collapsible curtain rails in the minor injuries unit is addressed.
- Ensure there are effectively operated systems to assess, monitor and improve the quality and safety of the services provided in the minor injuries unit.
- Ensure systems and processes are effective in identifying where quality and safety are being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to outpatient appointment issues
- Ensure robust and effective governance links and oversight are established and maintained between outpatient services at Newark and Kings Mill Hospitals.
- Ensure the quality of the service provided by the specialist palliative care team is effectively monitored and reviewed to ensure the service is meeting the needs of patients throughout the trust.

Summary of findings

- Ensure risks for end of life care services are specifically identified, and effectively monitored and reviewed with appropriate action taken.
- Ensure that pacemaker devices removed from deceased patients are safely and promptly disposed of.

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?
Minor injuries unit	Inadequate	Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Care provided to children and to patients with mental health conditions was not safe. Patients were not always assessed and treated according to evidence based guidance and standards. The leadership, management and governance of the minor injuries unit did not ensure the delivery of high-quality person-centred care. However staff worked well as a team and individually demonstrated significant commitment to providing high quality care for patients. Quality, performance and risks were not understood by the local leadership team. Patients were mostly positive about how they were cared for and supported. Staff responded to patients' anxiety or distress with compassion and offered emotional support. However, at times patient's privacy was not respected. Most patients could access care and treatment in a timely way. The unit consistently performed better than the England four hour standard.
Medical care	Inadequate	The leadership and governance of the service did not ensure the delivery of high quality person centred care. Safety was not a sufficient priority. Patients being treated for sepsis, a severe infection which spreads in the bloodstream, were not always assessed and treated in line with good practice. Knowledge regarding sepsis treatment was varied amongst staff. Some patients were having care provided using isolation precautions to prevent the spread of infectious diseases, without suitable arrangements in place. Systems were in place to report, investigate and learn from incidents locally, but we did not see evidence of learning being shared across the division with other trust sites. There were no specific audits that assessed the outcome of patients at Newark Hospital. It was not clear how the trust monitored the effectiveness of

Summary of findings

the service they were providing. There were policies in place for staff to follow in relation to nursing care such as pressure ulcer and medicines management. Patients were not routinely assessed for delirium. The environment was clean with infection prevention and control audits taking place. We saw examples of good delivery of care and the patients we spoke with told us without exception that they were pleased with the care which they were receiving. Patients understood the treatment being given to them and made choices about their care. New activities have been introduced for people living with dementia with plans to expand these to include craft activities. Patients and their relatives had responded positively to the introduction. Staff felt supported by their managers. There was a culture of good team work, but staff felt more distant from senior management and executive level leadership.

Surgery **Requires improvement**

Outcomes for patients using the service were not monitored regularly or robustly. There was limited evidence of local audits taking place.
There was a lack of clear vision or strategy for Newark Hospital and limited communication from senior management to the staff working within Newark Hospital. Monitoring of quality and safety of the service was not always robust or effective. Staff did not always feel actively engaged or empowered.
There was an effective patient safety incident reporting system and evidence of sharing and learning so as to improve care. There were sufficient staff to deliver safe care and treatment. Staff followed the trust policy to manage medicines safely, and all medicines were stored appropriately and recorded accurately. Good infection control practices were in place.
Care and treatment were evidence based and pain management was effective. A multi-disciplinary team approach was evident with good multi-disciplinary working in all the wards and well attended multidisciplinary team meetings.
Patients were positive about the individual care and treatment they received both on the ward and within theatre. There were processes in place to support patients living with physical or learning disabilities when coming to hospital for procedures.

Summary of findings

Once referred for surgery at Newark Hospital, patients were able to attend within a reasonable timescale. The surgical services met the national target for treating people within 18 weeks of referral. Patients were satisfied with their care and appreciated a local service. Staff supported patients with individual needs and provided patients with useful information before their surgery.

Outpatients and diagnostic imaging

Inadequate

Systems for processing and learning from incidents were not used consistently or effectively. Learning from incidents was not always shared across the trust.

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

The time patients waited from referral to treatment was consistently worse than the England average and below the expected national standard. When attending clinics, some patients experienced long delays for their appointments. Patients' records were not always available when needed for clinics. A lack of storage facilities meant that records were sometimes stored inappropriately. Volunteers sometimes had inappropriate access to patients' personal and confidential information.

The vision and strategy for the outpatients and diagnostic imaging service was not clear or well developed. Governance structures were in place but did not always operate effectively to interact and share information across the trust.

Patients were appropriately supported and involved in their care. Nursing and medical staffing levels and skill mix were adequate to keep patients safe. There were shortfalls in clerical and administrative staffing.

Systems and processes were generally reliable in keeping people safe, including safe management of medicines and infection prevention and control.

Summary of findings

Staff felt locally well supported by colleagues and managers, though not by more senior managers. They felt the Diagnostics and Rehabilitation division, specifically at Newark Hospital, did not have a high profile within the trust.

Newark Hospital

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Newark Hospital

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

Newark hospital provides a range of treatments, including consultant-led outpatient services, planned inpatient care, day-case surgery, endoscopy, diagnostic and therapy services, and a 24 hour Minor Injuries Unit & Urgent Care Centre.

There were 47 beds across two medical wards. One of the wards, the Fernwood Unit, opened in February 2013 and was a specialist rehabilitation ward for elderly patients who require a short period of recuperation before they are ready to return home after receiving hospital treatment. Surgical services at Newark included pre-operative assessment, day surgery, two operating theatres, recovery and a surgical Ward. The day case surgery ward had facilities for up to 30 patients.

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

We inspected the trust in April 2014 and rated Newark Hospital as 'Requires Improvement.'

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

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

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group, Monitor, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the royal colleges and the local Healthwatch.

We carried out an announced inspection visit from 16 to 19 June 2015 and two unannounced visits on 7 and 30 June 2015. We held focus groups with a range of staff in the hospital, including nurses, administrative and clerical staff, allied health professionals, domestic staff and porters. We also spoke with staff individually.

We talked with patients and staff from support services, ward areas, and outpatient services. We observed how people were being cared for, talked with patients, carers, visitors and relatives, and reviewed patient records of personal care and treatment.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Inadequate	Not rated	Good	Good	Inadequate	Inadequate
Medical care	Requires improvement	Inadequate	Good	Good	Inadequate	Inadequate
Surgery	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Inadequate	Not rated	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Requires improvement	Good	Requires improvement	Inadequate	Inadequate

Notes

Minor injuries unit

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

Information about the service

Newark Minor Injuries Unit and Urgent Care Centre was open 24 hours, seven days a week. Patients were offered assessment and treatment for minor injuries and illnesses. Last year the unit saw 21,000 patients of which 25% were children. During our inspection we spoke with two patients, one relative and18 staff, and we reviewed 11 patient records.

Summary of findings

Urgent and emergency services at Newark Hospital were inadequate.

Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Care provided to children and to patients with mental health conditions was not safe. Effective emergency preparedness plans were in place. Patients were not always assessed and treated according to evidence based guidance and standards.

Patients were mostly positive about how they were cared for and supported. Staff offered care that was kind, respectful and considerate. They responded to patients' anxiety or distress with compassion and offered emotional support. However, at times patient's privacy was not respected.

Most patients could access care and treatment in a timely way. The unit consistently performed better than the England four hour standard.

The leadership, management and governance of the minor injuries unit did not ensure the delivery of high-quality person-centred care; however staff worked well as a team and individually demonstrated significant commitment to providing high quality care for patients. Quality, performance and risks were not understood by the local leadership team.

Minor injuries unit

Are minor injuries unit services safe?

Inadequate

The safety of the service was inadequate.

Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Some equipment was missing, out of date or unsafe and medicines were not always stored safely. Trust wide learning from safety incidents was not systematically shared with the unit.

Care provided to children and patients with mental health conditions was not safe. Staff had not received the required training and facilities were not safe for these patients. Medical staffing relied on a high percentage of locum doctors; however nurse staffing levels were acceptable.

Approaches to infection control were good. Most staff had been trained in and understood their safeguarding responsibilities for children but medical staff had not received safeguarding training for adults. Effective emergency preparedness plans were in place.

Incidents

- The unit had reported two serious incidents requiring investigation (SIRI's) to the Strategic Executive Information System (STEIS) during 2014. We looked at the serious investigation reports from these incidents and saw that there had been full investigations. On both occasions the incidents related to the care of children.
- Staff were aware of the trust's electronic reporting system and how to use it. They received feedback from incidents they reported via email. Information and learning from incidents was displayed on staff notice boards in an area accessible to patients. However, staff were not aware of wider learning from incidents across the hospital or trust or indeed from the incidents that had occurred in the Accident and Emergency unit at Kings Mill Hospital.
- The unit nursing lead participated in Newark divisional clinical governance meetings where deaths were discussed. The unit did not participate in emergency department speciality mortality and morbidity meetings.
- The leaders of the service were not aware of the requirements of the Duty of Candour regulation, introduced in November 2014 for all NHS trusts. It is a legal requirement for providers of health care to act in an open and transparent way with people using services. The regulation sets out specific requirements providers must follow when things go wrong with care and treatment.

Cleanliness, infection control and hygiene

- The unit was clean and tidy, although space was limited. The room containing the computer server, referred to as the 'network room' was cluttered with IT equipment, crutches and also contained some patient lost property. This was not an appropriate storage area for patient property.
- Adequate hand washing facilities and alcohol gel were available throughout the department. Staff followed hand hygiene procedures, 'bare below the elbow' guidance and wore personal protective equipment such as gloves where appropriate, so as to help prevent the spread of infection.
- Infection control audits were carried out and reported on at clinical governance meetings. Actions for improvement were identified.
- Mandatory training for staff included sessions on infection control and hand hygiene.

Environment and equipment

- Essential lifesaving equipment was missing from one of the three resuscitation bays during our announced visit. We brought this to the attention of staff. However, when we checked two hours later it was still missing and we had to ask staff to replace it. This meant that in the event of a cardiac arrest essential equipment would not have been available. It is unacceptable for life saving equipment to not be available. During our conversations with staff it was apparent this equipment could have potentially been missing from the trolley for several days.
- On two occasions we also found out of date equipment in resuscitation trolleys even though the check lists for these trolleys were signed and dated as correct. When we spoke with staff about the system for checking equipment they said it was done during the night shift where possible and if not the day staff were informed. This meant that there was not a robust system in place for checking availability and suitability of life saving equipment.

Minor injuries unit

- We found obsolete equipment at the bottom of the drugs cupboard. We brought this to the attention of the pharmacist who advised us that the equipment would have been used to administer a paediatric medicine which was no longer used. They removed the equipment immediately.
- In 2007 the Department of Health issued an alert to NHS trusts requiring action to reduce potential suicide risks relating to patients using curtain rails from which to hang themselves. Curtain rails within the unit were not collapsible, and therefore posed a risk. The trust had carried out a risk assessment in February 2014 which stated that all curtain rails were non-collapsible, but did not identify actions to reduce this risk. It also stated that the unit did not regularly see or treat patients at risk of deliberate self-harm or suicide. However, staff told us that they treated patients at risk of self-harm and some were regular attendees. Data provided by the trust showed that there had been 66 patients in this category between January and June 2015 which represented less than one percent of total attendances. These patients were at risk.
- The unit did not have any ligature cutting equipment should this be needed in an emergency.
- There was a safe and effective system for the repair and maintenance of equipment.

Medicines

- Medicines were administered and recorded safely and appropriately but not always stored safely. Fluids used for intravenous drips were stored in the corridor. This meant they were not stored securely and could be tampered with. When we returned for an unannounced visit these fluids had been moved to a store room but the door was propped open and even when closed remained unlocked.
- During our announced visit it was custom and practice to leave medications which were no longer required by patients unsecured in a treatment room for return to pharmacy. This meant these medications were not safely stored according to the trust's medicines management policy. On our unannounced visit this practice had been changed to ensure safe storage.
- Nurses in the area used a patient group direction (PGD) for the prescription of simple pain relief and antibiotics. They were also able to administer respiratory medicines, eye drops. PGDs provide a legal framework that allows some registered health professionals to supply and or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor. PGDs were all correctly completed, authorised and in date.
- A pharmacist visited the unit Monday to Friday from 9am to 5pm to dispense medicine. At other times the nurses were able to administer medicine under the PDGs. The pharmacy dispensing folder used in the unit dated January 2012 and for review January 2014 was out of date. This meant that staff could not be sure they were issuing medication safely. When we brought this to the attention of the pharmacist they advised that an updated version had been provided to the department. The updated folder was found in another office and moved to the correct location during our visit.

Records

- Patient records were kept electronically and in paper format. These were stored securely in locked cabinets. We looked at 11 records of care and most were completed in accordance with the trust's policy.
- Staff used a computer at the side of the reception desk to access patient information. The computer containing all their personal information faced out to the corridor. On three occasions during our inspection staff left their access cards in this computer and moved away. This meant that computer records were visible to members of the public and patient details were not kept confidential.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children.
- Ninety four per cent of nursing and medical staff had received paediatric level three safeguarding training. Safeguarding issues had been considered in the children's records we reviewed. A member of the trust's safeguarding team attended the unit for drop in sessions monthly so that staff could discuss concerns, processes or procedures.
- There was an incident during 2014 where a safeguarding referral had not been made for a child and the investigation showed that the medical staff member concerned did not understand their responsibilities for the safeguarding of children. Following the incident the investigation report recommended, "Newark staff should attend the specific emergency department

safeguarding day facilitated by the Kings Mill hospital team. This could be delivered at Newark." When we asked the trust how many staff had completed this training they told us none of the Newark staff had attended. This meant that learning from incidents had not been followed up and safeguarding responsibilities may not be understood by all staff.
- All nursing and medical staff had received training in the safeguarding of adults.

Mandatory training

- Seventy seven percent of nursing staff had received mandatory training in essential subjects such as infection control, medicines management, patient handling, health and safety and information governance. This was worse than the trust target of 90%.
- Seventy seven percent of nursing staff had received mandatory training in essential subjects such as infection control, medicines management, patient handling, health and safety and information governance. This was worse than the trust target of 90%.
- Mandatory training completion rates for medical staff ranged between 75% and 100% against a target completion rate of 90%.

Assessing and responding to patient risk

- Patients were first seen by the receptionist who took their details and then prioritised in time order unless their condition required immediate review by a nurse. Administration staff were able to recognise this because the computer registration system prompted them to do so.
- Staff in the unit used a recognised early warning score to identify when a patient's condition was serious or deteriorating. For children, they used a paediatric warning score (POPS).
- Staff told us there were regularly delays in transferring sick patients to acute hospitals because of lack of ambulances. This was identified as a risk on the Newark divisional risk register. The trust had an agreement in place with the regional ambulance service (Inter-facility transfer protocol) which was overdue for renewal in 2013/14. This was an agreement to transfer sick patients within one hour of a request. However, data we saw for the week commencing 22 June 2015 showed that seven out of approximately 57 patients (12%) had waited longer than one hour for transport. This meant that patients may not be receiving safe, timely treatment.
- There was an agreed protocol for the rapid transfer of acutely unwell patients, essential training had been completed, and sufficient PGD's were in place to support the treatment of common injuries and ailments.
- However, health practitioners did not demonstrate competence in the assessment and management of children or vulnerable groups This did not meet the Royal College of Emergency Medicine (RCEM) standards. However, health practitioners did not demonstrate competence in the assessment and management of children or vulnerable groups. This did not meet the Royal College of Emergency Medicine (RCEM) standards.
- None of the nursing staff were trained in the care and treatment of children. Serious investigation reports prepared by the trust stated "There are no dual registered nurses (holding both adult and paediatric registration) employed within MIU" The Platt report (1959) stated that children in hospital must be cared for by staff trained in caring for children. The Royal College of Nursing guidance recommends that emergency departments, urgent care centres and minor injuries units maximise existing resources and at the same time invest carefully into the existing nursing workforce to enhance their paediatric skills. The guidance recommends a number of competencies staff should be trained in. The RCEM guidance for Unscheduled Care Facilities (July 2009) sets out a minimum requirement that health practitioners must demonstrate competence in assessment and management of children and young people. Nursing staff in the minor injuries unit had not received any additional competency based training to care for children. The trust told us that these competencies had been developed and were due to be presented at the children's speciality governance meeting in July 2015 before being implemented.
- Some staff told us they felt there was no support for paediatric cases as there was no on site paediatrician and they would transfer these patients to Kings Mill Hospital as soon as possible. Other staff told us they could call the paediatric team or the consultant on call there for advice. We asked to see the trust protocol for dealing with sick children in the minor injuries unit and the trust confirmed that there was no protocol in place.
- Most nursing staff had completed appropriate life support training for adults and children. Two out of 15

had not completed advanced life support for adults (ALS) and one nurse's qualification had expired without re-certification. One nurse had not completed children's life support training.
- All doctors had completed ALS training but the trust were unable to confirm whether one of the four doctors had completed children's life support training.
- Effective systems and processes were not in place to support patients with mental health conditions. Although staff had access to a self-harm risk assessment form, patients at risk of self-harm or with suicidal intent were cared for in an inappropriate area containing equipment and fixtures which were a risk to their safety. Staff had not received training in mental health awareness and had not been required to demonstrate competence in assessment and management of vulnerable groups, including mental health as required by the RCEM.

Nursing staffing

- The unit employed one department leader and one deputy, four emergency nurse practitioners (ENPs) and eight staff nurses (whole time equivalent).
- Planned staffing levels were mostly achieved in the unit. Average sickness absence of 6.3% for July 2014 to June 2015 and staff vacancies of 20% meant that levels were supplemented by agency nurses at a rate of 3.2%.
- Some staff told us that nurses from other departments worked in the unit to cover gaps in staffing. They were concerned that these nurses had not been trained to work in the minor injuries unit. During our unannounced visit a nurse from Sconce ward was working in the department. During our announced visit a Band 5 nurse from Minster ward was working as receptionist on the unit. She told us this had happened two or three times over the past month.
- A nursing handover meeting took place between shifts and information was recorded on a handover sheet which staff signed to confirm their awareness of issues. There was also a communication book including copies of any updated documents which staff were required to read and sign.

Medical staffing

- The unit was funded for 5.6 whole time equivalent doctors and 3.6 were employed at the time of our inspection.
- Between March 2014 and March 2015, 62% of doctors working in the unit were locum doctors. These are doctors who are not permanently employed by the trust. Nursing staff told us this created additional pressure for them especially at night and weekends as doctors were not familiar with the unit or trust protocols.
- There was a doctor present in the unit 24 hours, seven days a week. At weekends and overnight the doctor also covered the medical wards in the hospital. Doctors told us they worked long shifts and regularly had to manage very sick patients, which was not usual for minor injuries units.
- There was no consultant support to the unit. Although this would not normally be a requirement for a minor injuries unit, and minor injuries units are also not usually led by specialist doctors there were a number of factors indicating this support would be essential in this case. The geographical isolation of the unit along with the lack of specialities within Newark Hospital to provide support meant that medical staff could have lacked senior advice and guidance when treating patients with serious conditions such as heart attacks, stroke and serious infections like sepsis.
- Doctors participated in a one to one medical handover between shifts.

Major incident awareness and training

- The unit had suitable major incident plans in place and information was available to all staff on the trust intranet.
- There was one entrance to the unit. Offices and most staff areas were kept locked and there were closed circuit television cameras. There was only one on site member of security staff supported by a porter. They could be reached on a dedicated telephone number. Staff told us in the case of an emergency they would call the police.

Are minor injuries unit services effective?
(for example, treatment is effective)

Not sufficient evidence to rate

We did not rate the effectiveness of this service because we were not confident that we are collecting sufficient evidence to make the judgement.

Minor injuries unit

The unit failed to meet many of the minimum requirements set out by the Royal College for Emergency Medicine for units which see the less seriously ill or injured patients. Clinical outcomes for patients were not monitored or compared with similar services. Staff were not always able to access appropriate training.

Staff used appropriate clinical guidance to assess and treat patients. Patients' pain was appropriately managed. Staff had the information they needed to deliver effective care and patients were involved in and supported to make decisions about their care.

Evidence-based care and treatment

- The Royal College for Emergency Medicine set out minimum requirements for units which see the less seriously ill or injured patients. The unit failed to meet many of these requirements including staff competency in assessing and managing children and vulnerable adults, staff training in safeguarding children and adults, suitable resuscitation equipment, identified clinical leads for medicine and nursing, close links with the nearest A&E department, protected teaching and clinical supervision for all practitioners and staff opportunities to work in acute hospitals or GP setting to ensure continued clinical competence.
- Clinical guidelines were available in line with National Institute for Health and Care Excellence (NICE) guidance. These were available to staff within the unit, on the trust intranet and used in patient records.
- Staff followed standardised pathways for the care and treatment of patients.

Pain relief

- Patients were offered prompt pain relief and this was repeated at regular intervals; however it was not always recorded in patients' records.

Facilities

- The environment in the unit was challenging because space was limited. There was no separate waiting area for children and young people although one corner of the waiting room was equipped with toys. The Royal College of Paediatrics and Child Health recommend separate children's waiting areas or a reasonable compromise, which this did not provide.
- Information about the department and staff was displayed on a whiteboard behind reception which was in an area that patients would be unable to see once seated in the waiting area.
- The waiting area had patient toilets and a drinking water fountain. There was a television available for patients in the waiting area. However, as it was positioned high on a wall it was difficult to see from certain chairs.

Nutrition and hydration

- Although there were no formal comfort rounds where patients were offered drinks, staff told us they documented this in patient records. We looked at eleven records and none contained evidence that patients had been offered drinks whilst in the unit.
- A water fountain was available for visitors and patients who were mobile.

Patient outcomes

- We saw two patients being treated in the unit who, according to trust protocols should have been transferred to another hospital for effective treatment.
- Between January and March 2015 the number of unplanned re-attendances to the unit was just under seven percent. This was slightly better than the England average but two percent worse than the England standard.

Competent staff

- Although 5,250 children attended the minor injuries unit in 2014, comprising 25% of patients, health care practitioners did not demonstrate competence in the assessment and management of children.
- For the 12 months to May 2015 82% of nurses, 45% of administrative and clerical staff and 100% of medical staff had received appraisals.
- Medical staff told us they did not have training opportunities as they were unable to attend teaching sessions which were delivered at Kings Mill Hospital.
- Nursing staff told us they were sometimes able to attend teaching sessions which were delivered at Kings Mill Hospital emergency department and a list of training opportunities was on display in the staff area
- An agency nurse told us they were given time to read emails and familiarise themselves with protocols and procedures as part of their induction to the unit.

Minor injuries unit

- Doctors told us there were no issues with the process of revalidation.

Multidisciplinary working

- Staff were able to refer patients to a co-located GP out of hours service from 6pm in the evening until midnight seven days a week. Staff had contact telephone numbers for the local crisis team for patients experiencing mental health issues. However, the trust mental health risk assessment form required most patients to be transferred to Kings Mill hospital where they would have access to psychiatric assessment from the mental health services.
- There was an admissions protocol agreed between the trust and the statutory ambulance service for patients who were suitable to be brought to the unit and those who should be taken directly to a major A&E department.

Access to information

- Staff were able to access all the information they needed to deliver effective care and treatment to patients. The unit held a mixture of electronic and paper records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff asked for consent from patients before their treatment and patient consent was recorded in the records we looked at.
- We saw and heard staff discussing care and treatment options with patients and their relatives to enable them to make informed choices.
- Nursing staff understood their responsibilities under the Mental Capacity Act 2005 and we saw documented evidence of a two stage capacity assessment. This is a way of assessing whether a patient is able to make a specific decision for themselves at a moment in time. But medical staff had not received training in the Mental Capacity Act 2005.

Are minor injuries unit services caring?

Good

The care provided to patients using the service was good.

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

Compassionate care

- We observed positive interactions between staff, patients and their relatives. Staff consistently demonstrated caring attitudes towards patients. Patients' privacy and dignity were not always respected. The resuscitation rooms had curtains installed behind the doors. Although curtains were pulled across, doors remained open and signs showed rooms as 'free' when they were actually engaged. Staff did not routinely use the signs to indicate when patients were occupying the rooms. Doors were left open when discussions were taking place so that people in the waiting area and corridor could overhear.
- Staff did not always knock on closed doors before entering occupied treatment rooms. One patient was treated in the corridor during our visit as the treatment room was in use. Although a mobile screen was used this did not ensure total privacy for the patient who was visible from one end of the corridor. The patient was not asked if they were happy with being treated in a corridor area.
- Feedback from patients on the NHS choices website was positive and included comments about how kind staff were and how patients were put at ease.

Understanding and involvement of patients and those close to them

- Staff explained care and treatment options to patients and patients told us they knew about the plans for their care.
- We saw staff recognised when patients needed extra support and where they provided it. A nurse spent a long time explaining to a patient living with dementia what the plans were for their treatment as they needed to be transferred to another hospital. The relative told us this had helped to relieve the patient's anxiety.
- One mother gave feedback to the patient advice and liaison service that a visit to Newark whilst on holiday was the best hospital experience she had had with her autistic child. Staff were willing to listen to her about how to talk to her child and reduce their anxiety.

Minor injuries unit

Emotional support

- We saw staff talking with patients and their relatives and responding to questions in an appropriate way. All staff gave responses and reassurance to patients and relatives who were anxious or concerned.

Are minor injuries unit services responsive to people's needs?
(for example, to feedback?)

Good

The responsiveness of the service was good.

Most patients could access care and treatment in a timely way. The unit consistently performed better than the England four hour standard. Concerns and complaints were listened to but not always used to improve the quality of care. Patients had access to interpreting services and post treatment information was available. There was a risk that the needs of some patient groups, including those in vulnerable circumstances such as children and patients with mental health conditions were not always met. There was confusion about the limitations of the unit.

Service planning and delivery to meet the needs of local people

- Some diagnostic tests had to be sent to the acute hospital by taxi. This could take two hours and impacted on the time patients waited for diagnosis and treatment.
- Information was available on the trust's website about the services provided at the unit. However, there was still some confusion amongst patients about the limitations of the unit and how to use it appropriately. The dual title of minor injuries unit and urgent care centre implied both insignificant and significant injuries and conditions could be treated there and presented a confused identity to local people. We saw two patients being treated in the unit who, according to trust protocols should have been transferred to another hospital for effective treatment.

Meeting people's individual needs

- The unit had access to translation and interpreting services as well as a phrase book and pictorial communication book.
- Post treatment information leaflets were readily available for patients. However only one leaflet had been translated into another language and none were available in other formats such as large print or braille
- There was a room available for relatives to use containing comfortable chairs and magazines.
- Staff were aware of the trust's learning disability liaison service.
- There was no separate waiting area for children in the unit. Toys and books were located in one corner of the adult waiting area but there was no provision in the waiting area for adolescents.
- Staff had contact details for the Newark based crisis team for patients with mental health conditions; however patients requiring psychiatric assessment would be transferred to Kings Mill Hospital. There was a mental health link nurse in the unit but they did not have a defined role description and had not received any specific training to fulfil the role. We were not assured the staff were sufficiently knowledgeable about the care of patients with mental health needs.
- The unit kept a selection of route planners. These were available to patients and families who had been transferred to another hospital for their care.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival. Between January and March 2015 the unit's performance was better than the target at 98%.
- Staff told us they would sometimes admit patients to an inpatient ward at Newark hospital whilst waiting for a bed at Kings Mill Hospital. This meant there could be a delay in them receiving specialist treatment. There was no data to demonstrate how often this happened so the trust was unable to monitor this.
- X-ray and computerised tomography (CT) scans were available 24 hours a day.
- X-ray staff were available in the hospital Monday to Sunday 9am to 5pm. Out of hours cover was via an on call service with a 30 minute response time.
- Between April 2014 and May 2015 there were two occasions when an ambulance waited more than one hour to transfer the care of patients to nursing staff. These are known as 'black breaches'. Just under 1.5% of

patients arrived at the unit by ambulance equivalent to approximately 302 per year. Of these less than one percent waited more than one hour for a transfer of care.

Learning from complaints and concerns

- Systems and processes were in place to advise patients and relatives how to make a complaint. Information was displayed within the unit and leaflets were available to patients. Staff understood their role in supporting patients to make formal complaints. Staff received feedback about complaints via email.
- Staff told us they did not receive information or learning from complaints in the wider trust.

Are minor injuries unit services well-led?

Inadequate

The leadership of this service was inadequate.

The leadership, management and governance of the minor injuries unit did not ensure the delivery of high-quality person-centred care. There was no credible statement of vision and guiding values. Staff were unclear about the strategy for the unit and there was a lack of clinical governance at unit level. Quality, performance and risks were not understood by the local leadership team and there was little evidence of learning for improvement and innovation. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage them was not taken.

Although staff did not feel engaged with the trust, they worked well as a team and individually demonstrated significant commitment to providing high quality care for patients.

Vision and strategy for this service

- Nursing staff were unclear about the vision and strategy for this service and they told us it was constantly changing.
- Medical staff were also unable to explain clearly the vision or future direction of the service.
- The divisional structure at the trust placed the minor injuries unit in the Newark Hospital division, rather than the emergency care and medicine division. This was due to change in July 2015. However, at our inspection of April 2014 we had told the trust that they must improve operational links with the emergency department at Kings Mill hospital.
- The identity of the unit was not clear and the transition from a full emergency department to a minor injuries and urgent care centre had not been fully achieved. The unit had facilities such as resuscitation areas, point of care testing equipment and 24 hour x-ray, which are not normally features of a minor injuries unit. Minor injuries units are usually led by GPs or nurse practitioners. At Newark, staff treated patients with heart attacks, stroke and severe infections such as sepsis. These conditions are not minor injuries.

Governance, risk management and quality measurement

- There was a lack of clinical governance at unit level. The lead doctor told us they attended monthly clinical governance meetings which were held at Kings Mill Hospital. We reviewed the minutes of these meetings from June 2014 to May 2015. We saw there was no representation from Newark minor injuries unit and there was only one reference to Newark.
- At our last inspection in April 2014 we found that there was no evidence of shared learning or practice between the minor injuries unit at Newark and the emergency department at Kings Mill Hospital. This continued to be the case at this inspection. The divisional clinical director told us the unit would be joining the Emergency Care & Medicine division from 1 July 2015, and from that time their lead doctor would be attending the Emergency Care Clinical Governance meeting.
- The divisional clinical director told us at the time of our inspection that the Newark clinical governance forum met monthly and the minor injuries unit presented clinical information at these meetings. We reviewed the minutes of these meetings for March, April and May 2015 and saw the minor injuries unit was represented by a senior nurse at two out of three meetings. Medical staff had not attended any of the meetings which meant there were no doctors from the unit present at any of the meetings and no unit representation at all in April 2015.
- There was ineffective monitoring of learning from incidents. For example, following an incident in 2014

involving staff not fully understanding their role in children's safeguarding, the recommendations from the investigation report were not put in place and there was no system to check if they had happened or not.
- The agreement with the regional ambulance service to transfer patients who require acute care to another provider was overdue for renewal in 2013/14. In addition, the ambulance service had on occasions been unable to transfer these patients within the agreed time frame. The associated risk was on the Newark divisional risk register. When last reviewed on 2 June 2015, the service director noted that current controls were not effective in bringing about a resolution

Leadership of service

- The clinical lead for the unit was an associate specialist doctor. There was no consultant support. The geographical isolation of the unit along with the lack of specialities in Newark Hospital meant that medical staff lacked senior advice and guidance when treating patients with serious conditions.
- Nursing and clinical leads did not demonstrate an understanding of the challenges to good quality care in the unit and could not identify actions needed to address them.
- The trust told us that a consultant from the emergency department at Kings Mill Hospital was the unit lead for the care of children. Staff in the unit were not aware of this and we saw no evidence that this consultant worked in the unit, visited the unit or took part in any clinical governance or other meetings relating to the care of children within the unit.
- The unit failed to meet many of the Royal College for Emergency Medicine's minimum requirements for Unscheduled Care Facilities which see the less seriously ill or injured patients.
- None of the nursing staff were trained in the care and treatment of children. The unit did not meet the recommendations of the Royal College of Nursing or the minimum requirements of the Royal College of Emergency Medicine. Training and assessment in essential competencies for caring for children were still under development.

Culture within the service

- There was a strong culture of supportive teamwork amongst the nursing staff. An agency nurse told us they felt part of the team in the unit and their work was valued.
- Individual staff were highly committed and worked very hard to ensure patients received high quality care.

Public and staff engagement

- There were monthly staff forums and team briefings, by video link, held in the boardroom at Newark Hospital. Some staff told us they were able to attend but others said it was difficult because of workload in the unit.
- Staff had been invited to participate in the 2014 NHS staff survey. The trust's score of 3.66 was worse than the average score for staff engagement.
- Staff told us they did not feel as integrated with the trust's emergency department at Kings Mill Hospital as they would like.
- Patient feedback forms were available on reception for patients to complete.
- We asked the trust to provide us with the results of any patient surveys they had carried out. They did not provide this information.

Innovation, improvement and sustainability

- Staff told us there were plans to develop a single front door service where patients could be directed to the appropriate service: minor injuries or GP services.

Medical care (including older people's care)

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

Information about the service

Newark hospital had two medical wards, Sconce and Fernwood, and an endoscopy unit which provided medical care. Sconce Ward routinely provided care for the elderly with some admissions from the hospital's minor injury unit until patients could be transferred to King's Mill Hospital. Fernwood Ward was a GP led rehabilitation unit where patients would stay for up to 21 days before being discharged.

There were 2298 admissions to medical care services at Newark Hospital between July 2013 and July 2014. Of these admissions, 77% were day cases, 13% elective cases and 10% emergency cases. Most admissions were in the gastroenterology and podiatry specialties at 33% and 24% respectively.

The inspection of the trust took place between 16 and 19 June 2015 with unannounced inspections taking place both before and after the main inspection on 7, 8 and 30 June 2015. During our visits to Newark Hospital's medical services we visited Sconce and Fernwood Wards and the endoscopy unit. We spoke with 13 patients and relatives, 26 members of staff and reviewed records and associated the care plans of 12 patients. In addition we used the short observational framework for inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us.

Summary of findings

Medical care was inadequate overall.

The leadership and governance of the service did not ensure the delivery of high quality person centred care. Safety was not a sufficient priority. Patients being treated for sepsis, a severe infection which spreads in the bloodstream, were not always assessed and treated in line with good practice. Knowledge regarding sepsis treatment was varied amongst staff. Some patients were having care provided using isolation precautions to prevent the spread of infectious diseases, without suitable arrangements in place. Systems were in place to report, investigate and learn from incidents locally, but we did not see evidence of learning being shared across the division with other trust sites.

There were no specific audits that assessed the outcome of patients at Newark Hospital. It was not clear how the trust monitored the effectiveness of the service they were providing. There were policies in place for staff to follow in relation to nursing care such as pressure ulcer and medicines management. Patients were not routinely assessed for delirium.

The environment was clean with infection prevention and control audits taking place. We saw examples of good delivery of care and the patients we spoke with told us without exception that they were pleased with the care which they were receiving. Patients understood the treatment being given to them and made choices about their care. New activities have been introduced

Medical care (including older people's care)

for people living with dementia with plans to expand these to include craft activities. Patients and their relatives had responded positively to the introduction. Staff felt supported by their managers. There was a culture of good team work, but staff felt more distant from senior management and executive level leadership.

Are medical care services safe?

Requires improvement

The safety of the medical service required improvement.

There was an increased risk of harm to patients using the service. Staff were not all aware of procedures to manage sepsis, a serious form of blood poisoning, despite there being long standing concerns about sepsis management at the trust. Staff were aware of how to report patient safety incidents and told us learning from incidents was shared with them, but we found this did not happen in all cases. Nursing vacancies meant that the number of beds on Sconce ward had been reduced.

Patients with infections who required isolation were not always nursed safely. The wards were clean and hygienic, and equipment was generally maintained appropriately. Patient records were kept securely and staff received mandatory training each year to support them in their roles.

Incidents

- Between March 2014 and February 2015, 47 serious incidents were reported relating to medical care across the trust. The two categories of incident with the highest numbers were slips, trips and falls and development of grade three pressure ulcers, with 16 and nine serious incidents each respectively.
- Staff were aware of how to report incidents via the trust's electronic incident reporting system. Incidents were investigated with learning shared through staff meetings, newsletters and a lessons learned noticeboard on each ward. We saw evidence of learning from incidents relating to falls on Sconce Ward and missed screening tests on Fernwood Ward which included corrective actions that had been identified and actioned.
- In addition to the lessons learned notice board, ward staff told us that learning from incidents was also shared and discussed at monthly ward meetings, ward assurance meetings and in newsletters. We saw monthly ward meeting minutes showed discussion of complaints and incidents.

- Incidents were discussed at the clinical governance meeting for the hospital and learning points were identified.
- There were no separate mortality and morbidity meetings to share learning from deaths and complicated cases. Shared learning from deaths took place through the hospitals general Clinical Governance meeting which had a range of items on the agenda.
- The Duty of Candour Regulation was introduced in November 2014 for all NHS Trusts. It is a legal requirement for providers of health care to act in an open and transparent way with people using services. The regulation sets out specific requirements providers must follow when things go wrong with care and treatment. Staff told us that they would be happy to escalate any concerns they had regarding the duty of candour and they felt supported to do so.

Safety thermometer

- The NHS Safety Thermometer is a point of care survey tool developed by the NHS to give a 'temperature check' on harm that can be used alongside other measures to make improvements towards harm free patient care. Measures include percentage of patients experiencing harm free care, pressure ulcers, falls causing harm, catheter and acquired urinary tract infections and venous thromboembolism rates.
- Data provided by the trust showed that on average between May 2014 and May 2015, 97% and 93% of patient stays on Fernwood and Sconce Wards respectively were harm free.
- Both medical wards displayed information about the ward's performance on notice boards. Safety data included figures from the previous month's incidence of falls, pressure ulcers and medication incidents. Also included were figures for the ward's annual incident rate figures for comparison.

Cleanliness, infection control and hygiene

- Staff worked in accordance with the trust's infection prevention and control policy and all were bare below the elbow. Staff wore appropriate personal protective equipment (PPE) such as gloves and aprons, and used sanitising gel frequently. Precautions such as use of appropriate PPE, hand washing and hand sanitisation help to lower the risk of the spread of infectious diseases.
- The trust's infection prevention and control team carried out various audits, including hand hygiene, linen storage, commode cleanliness, and isolation precautions. These showed that staff on Sconce and Fernwood Wards had fully met the requirements infection prevention and control practices between 2014 and 2015, other than in isolation precautions. Outcomes from the audits were fed back to the nurse in charge at the time of the audit, and subsequent audits showed improved practice.
- Four patients on Sconce Ward were receiving care using isolation precautions at the time of the inspection. All four patients were located in single occupancy side rooms, but all four doors to the rooms were left open. A review of the patients' clinical notes showed that in one case, advice had been sought from the infection prevention and control team regarding keeping the patient's room door open and a risk based approach had been taken. However, in the other three cases there was no evidence in the clinical notes that advice around the suitability of keeping the room doors open had been sought.
- During a subsequent unannounced visit we saw two patients on Sconce Ward receiving care using isolation precautions with the doors to the single occupancy rooms open. Staff indicated that leaving the doors open had been risk assessed but were not able to provide any documentary evidence of risk assessments. Leaving doors open when patients are receiving care using isolation precautions may pose a risk that an infection could spread to other patients on the ward.
- Between August 2014 and May 2105 there had been no incidence of clostridium difficile infections on Sconce and Fernwood Wards. There was no incidence of MRSA (Methicillin-resistant Staphylococcus aureus) between August 2014 and May 2105 on Sconce and Fernwood Wards. MRSA is a bacterium responsible for several difficult-to-treat infections.
- Patients on Sconce and Fernwood Wards were routinely screened for MRSA with further screening taking place after 21 days. Data provided by the trust showed

between August 2014 and May 2015 there were two occasions on Sconce Ward and one occasion on Fernwood Ward where the 21 day MRSA screening had not been undertaken. Failure to screen patients adequately for MRSA infection could potentially result in infection not being identified early, the patient not being isolated from other non-infected patients and MRSA infection spreading to other patients on the wards.

- Data from a Newark Hospital wide cleaning audit in July 2014 showed that Sconce and Fernwood Wards achieved 100% compliance for both cleaning undertaken by the estates department and nursing staff.

Environment and equipment

- Sharps boxes are containers for disposing of used medical needles and other sharp medical instruments. Audits highlighted varying levels of correct management regarding the disposal of sharps, but had improved overall in the year to March 2015.
- Resuscitation equipment was available on both Sconce and Fernwood Wards. Resuscitation equipment included suction equipment, a defibrillator, general consumables for example face masks and airway tubes and a sealed box containing emergency medicines and other equipment. The sealed box was secured by a tamper proof tag. Labels indicated that the box and its contents were suitable for use up until a particular date. The records showed that checks on these boxes were undertaken by a central trust team rather than staff on individual ward. Records showed the ward staff performed daily checks on the suction equipment, defibrillator and general consumable items. Scheduled checks on the resuscitation boxes and daily checks on other resuscitation equipment helped to ensure that appropriate resuscitation was available to ward staff should they have been needed.

Medicines

- On Fernwood Ward, patients brought a 28 day supply of their medication and were given support to take their own medicines as usual.
- There were two medicine stores on Sconce Ward. One of these areas was smaller and in addition to the store room, two medication trolleys were located near to the nursing station on one half of Sconce Ward. The second medicine store was larger and the medication trolleys were located within the locked medicine store room. Having two medicine storage trolley storage areas over the large ward meant that both sides of the ward had adequate local access to medications. One of the four trolleys was not kept suitably clean. Dust and debris were visible on the inside of the trolley.
- All four medicine storage trolleys contained pill cutters, which were used to cut tablets in order to adjust the dose of medication given to patients. Three of the pill cutters had not been cleaned following use and had accumulated a powdery residue from medications. This meant that patients were at risk of receiving contaminated medication.
- Medicines requiring cool storage were stored appropriately. Records relating to storage fridge temperatures showed that the fridge temperature was being regularly monitored and recorded by staff and that the fridge was operating at the expected temperature. However, the temperature of the rooms used to store medicines that needed to be stored at room temperature were not being monitored and recorded. This meant that we could not be assured that medicines were always stored in a way which maintained their quality.
- Controlled drugs (CDs) are medicines that are required to be stored and recorded separately. Checks of controlled drugs during the inspection showed that all were in date and their use had been appropriately recorded in the controlled drug register. Checks on controlled drugs were undertaken by two nurses on a daily basis.
- On Sconce Ward we found that portable oxygen cylinders were not being stored in a secure manner. We raised this with the ward manager who addressed this concern.
- On Sconce Ward, nurses did not always sign and date bottles of liquid medicines when they opened them. We only found one that had been signed and dated on opening. Liquid medication should be used within a specified number of days once opened. These medicines were not being appropriately managed, and patients were at risk of receiving medicines that was no longer safe to use.

- We looked at the prescription and medicine administration records for three of 24 patients on Sconce Ward. We saw that arrangements were in place for recording the administration of medicines. These records were fully completed. The records showed people were getting their medicines when they needed them, and any reasons for not giving people their medicines were recorded. However, we found a prescribing error which we brought to the attention of the ward manager and this was amended.
- Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that all records were up to date. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that medication was available for patients when they were needed.
- On Sconce Ward we observed a medication round and saw correct procedures being followed with regards to the supply and administration of medicines to a patient.

Records

- Patient records were stored securely in locked records trolleys or filing cabinets.
- Patients' clinical notes were stored at the hospital closest to the patient's post code. Three to four trips were made daily by hospital transport which meant that notes were usually available for patients on the wards.

Safeguarding

- Safeguarding training was provided for all new staff during their induction. Refresher training on safeguarding adults was delivered during annual mandatory training update sessions.
- Between August 2014 and May 2015 training rates for safeguarding adults and safeguarding children level two and three on both wards was better than the trust's target of 80%.
- Staff on Fernwood Ward told us that they completed a body chart for all newly admitted patients to record any skin damage. If there were any concerns they would be reported using the trust's incident reporting system and a safeguarding alert would be raised. Safeguarding concerns would also be discussed with staff during the multidisciplinary handover meeting.
- Safeguarding champions had been identified on both Sconce and Fernwood Wards. These champions provided a point of contact for ward staff to approach if they had any safeguarding related concerns.
- Staff told us that the trust's safeguarding team were approachable and easily accessible.

Mandatory training

- All newly appointed staff received a one day induction to the trust.
- All staff received a one day mandatory training update session once every year. This included training on dementia awareness, safeguarding adults, infection prevention and control and fire safety.
- Senior staff on Sconce Ward told us that all ward staff were up to date with mandatory training. A member of staff that we spoke with on Fernwood Ward confirmed that their mandatory training was up to date.
- Mandatory training data for staff at Newark Hospital showed 83% of staff were compliant with mandatory training.

Assessing and responding to patient risk

- It is important for staff to carry out patient observations regularly, so that any changes to a patient's condition can be identified quickly and appropriate treatment started. The trust audited this and an example from one of these audits showed that the percentage of observations that were taken late during a week in June 2015 on Sconce Ward ranged between 2% and 17%. On Fernwood Ward the percentage of observations taken late over the same period ranged between 0% and 8.5%. Late observations at 17% and 8.5% mean that nearly one in five and one in ten observations respectively would be taken late.
- Early warning score is a tool used for monitoring poorly patients, based on routine observations such as temperature and urine output. Monitoring early warning scores helps to identify patients who are becoming more unwell so that necessary treatments can be given. On Sconce Ward we saw one patient referred to the medical staff as a result of their early warning score. In this case, the sepsis care bundle was started. Sepsis is a potentially life-threatening condition triggered by an infection which spreads in the bloodstream. Trust data showed that in 2014/15 two patients on Sconce ward

had symptoms which should have triggered the sepsis management pathway within an hour; neither patient received all aspects of this care pathway, although they each received some of it.

- Data provided by the trust showed between August 2014 and May 2015, 99% of patients on Sconce and Fernwood Wards had a falls risk assessment completed. Falls can be common with elderly patients on wards so ensuring that a patient's risk of falling while on the ward is carried out is important.
- Following investigations of patient falls, changes to blood pressure monitoring had been put in place to help identify patients at risk of falls. We checked the latest monitoring data and found that this was being done as recommended.
- A random sample of three sets of patient's clinical notes reviewed on Sconce Ward showed that all three sets of notes contained completed skin assessments, fluid balance charts and bed rail assessments. Staff on Sconce Ward told us that they had good access to pressure relieving equipment if it was required to reduce the risk of patients developing pressure ulcers.
- If patients became unwell on Fernwood Ward, staff accessed support from a general practitioner or a patient could attend Newark Hospital's minor injuries unit. If a patient became very unwell then staff called 999 for support.

Nursing staffing

- Staff on Sconce Ward told us that it was difficult to recruit nursing staff and they had seven vacancies for qualified nurses. We were told that agency staff were used on most night shifts.
- Due to the vacancies and staff shortages, the number of beds on Sconce Ward had been reduced a few weeks before the inspection from 35 to 26 beds and then one day prior to the inspection further reduced to 24 beds. Staff told us they felt that the reduction to 24 beds would remain in place until staffing levels improved. With 24 beds on Sconce Ward the ratio of nurses to patients was one to eight which is in line with National Institute of Health and Care Excellence (NICE) safer staffing levels guidance.
- We did not find any evidence the trust was monitoring the impact on the rest of the trust or on the patients requiring care at this hospital of the closure of these beds.
- There were three nurse vacancies on Fernwood Ward and the staff shortage was being managed from within the Fernwood Ward nursing team. Some staff told us that they felt frustrated as they routinely worked extra hours.
- Trust data showed that staffing levels had been determined for both Sconce and Fernwood Wards and were reviewed on a six monthly basis. Trust staffing plans showed that a skill mix of 50% registered nurses to 50% healthcare assistants was planned for Sconce Ward. A skill mix of 33% to 67%, registered nurses to healthcare assistants was planned for Fernwood Ward. At the time of the inspection, staffing levels and skill mix on both Fernwood and Sconce Ward were as planned.

Medical staffing

- Each day started with a board round to review patients. The board round was attended by medical staff, nursing staff, occupational therapists, physiotherapists, discharge coordinator and pharmacy.
- Fernwood Ward operated as a GP led rehabilitation unit and did not have dedicated medical staffing provided by the trust. Medical provision was provided by GPs who supported the unit. The GP's were not employed by the trust.
- Sconce ward had three specialty grade doctors who covered the ward through a rota. During the day time hours of 9am-5pm one specialty grade doctor worked on the ward. In addition, a specialty grade doctor was on call for the ward between the hours of 7.30am-7pm. This doctor also worked on the MIU and the day unit areas to give advice and or review medical admissions.
- Weekend cover for Sconce Ward was provided by one of the speciality grade doctor and the Newark based consultant on a rota.
- Overnight medical cover for Sconce Ward was provided by medical staff working in the hospital's minor injuries unit. Staff reported that medical support was usually available quickly and that medical staff attended the ward when requested.

Medical care (including older people's care)

- Consultants cover for Sconce ward was provided by two consultant medical staff. They both attended the ward for ward rounds twice a week. In between these times, the staff grade doctors could contact them for advice and support. Any patient whose condition was deteriorating would be transferred to Kings Mill Hospital.
- Medical staff told us they felt supported in their roles.

Major incident awareness and training

- There was a major incident and business continuity plan which assessed the impact of various types of major incident on staffing, space available and supplies examples of which included information technology, water, electricity and medical supplies. Examples of the types of major incidents that had been assessed included criminal acts, terrorism, accidental fire, utility failure and serious hospital acquired infection.
- All staff received fire safety training as part of their mandatory training.

Are medical care services effective?

Inadequate

The effectiveness of the service was inadequate.

There were no specific audits that assessed the outcome of patients at Newark Hospital. It was not clear how the trust monitored the effectiveness of the service they were providing. There were policies in place for staff to follow in relation to nursing care such as pressure ulcer and medicines management. Patients were not routinely assessed for delirium.

Staff were appropriately managing patients' pain and were working in a cross disciplinary manner when providing care to patients. Patients' nutrition and hydration were being monitored by staff. The trust had a policy and procedures to monitor the professional registration status of staff to help ensure that only suitably registered staff were employed. Patients benefitted from seven day access to physiotherapy and occupational therapy service on Sconce and Fernwood wards. Upon discharge from both Sconce and Fernwood wards, information regarding patients was provided to the patient's GP to help facilitate continuity of care.

Evidence-based care and treatment

- Prior to and during the inspection we asked the trust to provide us with copies of audit activity for Newark Hospital. We were not provided with this information. Staff on Sconce Ward told us that they undertook a number of local audits, including infection prevention and control, safety thermometer, medicines, saving lives and documentation audits. We did not see the results of these audits.
- Staff on Fernwood Ward also told us that they participated in local audits, examples of which included audits of falls, safety thermometer, missed medication doses and cleanliness. We noted the results of audits were discussed at the hospitals clinical governance meetings.
- Fernwood Ward used functional independence measures and functional assessment measures (FIM + FAM) to assess patient outcomes. The FIM+FAM assessment is a tool used to asses levels of disability in patients. Staff on Fernwood Ward used these tools to assess patients on admission and again at discharge.
- Patients were not routinely assessed for delirium. There were guidelines in place for the care and treatment of patients living with dementia, but we did not find these were being followed because we found gaps in care planning.
- There were policies in place on the wards for the management of pressure areas, infection prevention and control and medicines management.

Pain relief

- None of the patients we spoke with reported that there had been any issues with the management of any pain that they were experiencing.
- We saw evidence that pain assessments had been carried out and appropriate pain relieving medication had been administered.

Nutrition and hydration

- The trust used hydration charts, fluid balance charts and nutrition charts to monitor the nutrition and hydration of patients.
- Three sets of randomly selected patient notes all contained appropriately completed fluid balance charts used to monitor patients hydration levels.

- During an unannounced visit following the main inspection, four further sets of patient notes that were reviewed contained appropriately completed fluid balance charts indicating that the hydration levels of patients were being appropriately monitored.
- During the unannounced visit a set of notes from a patient being fed through a percutaneous endoscopic gastrostomy (PEG) tube had the appropriate PEG feeding documentation and records completed. A PEG tube is a tube that is passed into a patient's stomach through the abdominal wall, most commonly when patients are unable to eat.
- A Malnutrition Universal Screening Tool (MUST) is designed to identify adults who are underweight and at risk of malnutrition. An example of a correctly completed MUST chart was reviewed in a patient's clinical notes on Sconce Ward. The chart had been reviewed at the required weekly intervals.
- We saw staff assisting patients to eat and drink during meal times. Outside of meal times we saw that patients had access to drinks that were within their reach.

Patient outcomes

- The Hospital was monitoring patient outcomes in relation to sepsis care and treatment, but we found no other evidence of the service that the clinical outcomes of patients at Newark Hospital were being monitored.
- Measures such as the length of stay of patients and the risk of readmission to hospital were only available as trust-wide data. There was no specific monitoring of these measures at Newark Hospital.
- The standardised relative risk of readmission rates at Newark Hospital was generally lower or in line with the England average for both elective and non-elective admissions between June 2013 and May 2014.
- In April 2015 the trust applied for accreditation of the endoscopy service to the Joint Advisory Group on GI Endoscopy (JAG) but the service was not successful in gaining accreditation. An action plan had been produced by the trust and a review of the plan indicated progress was being made against it. The trust planned to re-apply for accreditation in August 2015.

Competent staff

- The trust had a policy in place regarding professional registration. The policy applied to all health professionals required to register with a national regulating body in order to practise. The policy stated that no person required to hold a professional registration may be employed by the trust as a registered practitioner until they provided evidence of registration and in the case of doctors, a licence to practice that had been verified by the Trust. This applied equally to temporary appointments and those holding honorary contracts. The policy helped to assure the trust that either temporary or permanent staff being employed were appropriately registered with their professional body.
- The trust had a system to ensure that each employee's registration status was monitored and remained valid. Monthly reports were produced using the trust's human resource systems to identify any member of staff whose professional registration's validity was approaching its renewal date. These reports were forwarded to the individual's line manager who would check the registration status of the employee and update the human resource system once evidence was reviewed that the individual's registration had been renewed. This system provided a means by which the trust assured itself that staff maintained their professional registration.
- Some staff on Sconce Ward told us that they had not received any training relating to sepsis. They were not aware of the sepsis pathway and would escalate concerns about patients with possible sepsis to a member of medical staff. If a patient is suspected of having sepsis then it is important to start treatment quickly. Some staff were unaware of the contents of the sepsis box used to deliver sepsis treatment. The sepsis boxes contained equipment and medicines and were placed on the wards to allow quick access to the necessary treatments if a patient was suspected of having sepsis.
- Data provided by the trust on the numbers of staff that had undertaken sepsis training was not clear. Although the data told us that nine members of staff working at Newark Hospital had received it, it was not clear how many other staff needed to undertake the training.
- Staff were offered an appraisal annually. Data provided by the trust showed that in the period between August 2014 and May 2015 on Fernwood Ward, staff appraisals were taking place and completion rates were usually above the trust's target of 90%.

- Sconce Ward's appraisal data showed that the 90% trust appraisal rate target had not been achieved in the period between August 2014 and May 2015. Although appraisal rates had improved between January and May 2015, the average appraisal rate over this period was only 81.6%.
- Staff told us that dementia training was delivered annually as part of the mandatory training updates, but this module only lasted for an hour. Staff on Sconce Ward told us that they had requested further dementia training so that they could get a greater understanding of dementia. It was not clear if this was going to be delivered.
- We were told that all of the endoscopists, medical and nursing, were subject to periodic thorough assessments in sedation practice. The four nurse practitioner endoscopists had undergone sedation training, basic life support and in one case advanced life support training, and were accredited nurse prescribers.

Multidisciplinary working

- All staff that we spoke with on both Fernwood and Sconce Wards reported there was good team working and were good interactions between staff of all disciplines.
- Staff on Fernwood Ward told us that daily multidisciplinary team (MDT) meetings took place. MDT meetings included medical and nursing staff, physiotherapy, occupational therapy, social workers and pharmacy.
- Sconce Ward held MDT meetings on Tuesdays which included medical and nursing staff, physiotherapy, occupational therapy, social services and the discharge coordinators.
- On Sconce Ward and in addition to the Tuesday MDT meeting, each day started with a board round which also included medical and nursing staff, physiotherapy, occupational therapy and the discharge coordinators.

Seven-day services

- Both Sconce and Fernwood Wards provided a seven day physiotherapy and occupational therapy service.
- Weekend medical cover on Sconce Ward was provided by staff grade medics and a consultant medic working on a one in four rota.
- Out of hours medical cover on Sconce Ward was provided by contacting the minor injury unit. Staff reported that medical support was usually available quickly and that medical staff attended the ward when requested.
- The escalation of deteriorating patient's process on Fernwood Ward included the Newark hospital minor injuries unit, GP or the emergency 999 service.
- The endoscopy unit provided occasional Saturday morning clinics to ensure that waiting time targets were achieved.

Access to information

- Staff on Sconce Ward reported that there were frequent delays in assessing patients' future social care needs in the community. These delays could take up to two weeks to resolve. Delays in performing patient assessments could result in medically fit patients having their discharges delayed and therefore having to stay on Sconce Ward. We were told that these delays could affect approximately one in six patients.
- Staff on Sconce Ward confirmed the handover procedure was followed by an accountability handover. An accountability handover is when a member of nursing staff with responsibility for a specific patient provides another member of nursing staff with details of the patient and their care needs, usually at the patient's bedside during shift changes or when responsibility for care is transferred from one nurse to another.
- Discharge letters were sent to patient's GPs electronically from Sconce Ward which meant GPs were able to access patient information relating to their hospital care and treatment.
- Discharge summaries were sent out with the patients from Fernwood Ward and recipients included social workers, district nurses, GP and community services. The discharge summaries were comprehensive and gave details of aims and goals for the patient once discharged. This allowed people responsible for a patient's on-going care once discharged, to be fully aware of details of treatment and aims for the patient.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Mental capacity assessments were undertaken before nurses gave a particular aspect of a patients care for example, undertaking a falls risk assessment. However, staff did not have a clear understanding of when a mental capacity assessment should be performed.
- There were no patients with deprivation of liberty safeguards (DoLS) in place on the wards at the time of our inspection but staff did understand the process that was in place. DoLS are a legal safeguard for people who cannot make decisions about their care and treatment.

Are medical care services caring?

Good

The care afforded to patients was good.

Patients told us without exception that they were pleased with the care which they were receiving. We observed good interactions between staff and patients with patients being reassured and spoken to with kindness. Staff actively listened to patients and reassured them. Patients felt involved in their care and were offered emotional support when needed. Local patient surveys showed a high proportion of patients would recommend the hospital to others.

Compassionate care

- Patients we spoke with on Sconce and Fernwood Wards told us without exception that they were pleased with the care they received.
- We observed some good interactions between staff and patients, with patients being reassured and spoken to with kindness. Staff actively listened to patients and engaged in two way conversations with them. Staff were reassuring and were seen to be trying to keep patients positive through their interactions with them.
- One patient was transferred to Sconce Ward from the minor injuries unit while awaiting ambulance transport to King's Mill Hospital for further treatment. The patient was pleased about the transfer to Sconce Ward. The patient's carer described the care given to the patient as excellent.
- Another patient on Sconce Ward had been transferred to Newark from King's Mill hospital. They told us that they had been given the choice to transfer to Newark hospital as it had been too far for visitors to travel to King's Mill hospital. The patient told us that there was always someone there to help, including at nights. If the patient used the call bell it was responded to promptly. The patient had seen the consultant that day and had been visited by the pharmacist three times that day. The patient reported that everyone was friendly and that they felt at ease. The patient's relative also told us that they were happy with the care and their relative was treated with dignity. They also told us about the more relaxed visiting times at Newark compared to King's Mill and that they felt visiting was better at Newark.
- Two patients on Fernwood Ward were also pleased with their care. One described their experience as 'brilliant'. The second described their experience as 'absolutely outstanding' and the staff on the ward as 'miracle workers'.
- Friends and family test data was available for Sconce Ward. Friends and family tests are surveys completed by patients and indicate how likely a patient would be to recommend the hospital to their family and friends as a place to receive treatment. Data for January 2014 appeared to be missing however between December 2013 and November 2014, Sconce Ward performed well with all responses over that period being above 85% of people indicating that they would recommend the ward. The average response rate of people indicating they would recommend the ward over that period was 95%.
- Patient led assessments of the care environment (PLACE) are assessments undertaken by teams of NHS and independent healthcare providers and members of the public. These assessments focus on the environment in which care is provided in addition to assessing non-clinical services such as cleanliness, food, hydration, and the extent to which the provision of care with privacy and dignity is supported. The PLACE data for the trust showed that with regards to cleanliness, food and facilities the trust performed better than the England average in 2013 and 2014. Despite a small decrease in performance in 2014 from 2013 with regards to privacy, dignity and wellbeing the trust performed at a similar level to the England average.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- Patients on Sconce Ward told us that they had seen medical and pharmacy staff frequently during their stay. Patients on both Sconce and Fernwood Ward demonstrated an awareness of their care and what was being delivered. Three patients we spoke with on Sconce Ward told us they felt involved in their care and they were aware of their treatment plans.
- One patient on Sconce Ward had been offered the choice on whether to move hospitals from King's Mill to Newark in order to be closer to home and relatives. This demonstrated that where appropriate, patients were asked about their preferences with regards to their care.
- A relative of a patient reported that they received relevant information. They told us that both they and the patient were aware of the medication that was being given and the tests that would be carried out.

Emotional support

- One patient had been taken home by the mental health team as this team would be providing their care at home. This was an example of a patient being supported by the appropriate team to be discharged from hospital.

Are medical care services responsive?

Good

The responsiveness of the service was good.

People's needs were met through the way services were organised and delivered. Following referral to hospital, patients were able to attend for treatment within a reasonable timescale. Staff provided person centred care and had recently set up an initiative to support patients living with dementia. They had access to interpreting services for patients whose first language was not English. Patients usually experienced a smooth discharge from hospital following treatment, although about one in every 14 patients were discharged after 10pm.

Service planning and delivery to meet the needs of local people

- The hospital's endoscopy unit offered occasional Saturday morning sessions if there were any patients who would otherwise wait longer for their treatment after being referred than nationally set targets.
- Patients would be referred to Fernwood Ward from other trust wards for them to have supported rehabilitation following for example a surgical procedure, stroke or infection. Patients also were referred to Fernwood Ward from their own homes or care homes.
- There was a large pay and display car park at the hospital. None of the patients or relatives that we spoke with reported any difficulty in parking when visiting. 'Special saver' car parking tickets were also available for regular visitors or patients which helped reduce the cost of parking.
- The trust operated a free mini-bus service between Newark hospital and King's Mill hospital seven days a week which people who wanted to travel to King's Mill hospital for visiting time could book. The bus arrived at King's Mill hospital in time for the two hour afternoon visiting times and then returned to Newark hospital later in the afternoon.

Access and flow

- On Fernwood Ward, patients were funded by the clinical commissioning group for 21 days care on the ward. We were told that the average patient stay was 16.5 days.
- Staff on Sconce Ward told us the ward had effective discharge procedures with 80% of patients returning home, 12% being discharged into care homes and 8% moving to the Fernwood Ward. Effective discharge aids patient flow through the hospital.
- Data provided by the trust showed that the trust's overall bed occupancy rate was always higher than the England average between April 2013 and September 2014, at 91% to 96%. Bed occupancy rates of above 85% can affect the quality of care being delivered to patients and the orderly running of the hospital. It was not clear what the bed occupancy rate for Newark Hospital was.
- Discharge coordinators attended the Sconce Ward's multidisciplinary meetings. This assisted the coordinators to maintain an oversight of the patients on the ward which were ready for discharge.

Medical care (including older people's care)

- The trust monitored the reasons for delayed transfer of care for patients. Between April 2013 and November 2014 trust data showed that there were three reasons for delayed transfer of care which were greater than the England average specifically; awaiting community equipment and adaptations, awaiting a care package in the patient's own home and completion of assessment of the patient. Delays to medically fit patient discharges can have a negative effect on the availability of beds for other patients. It was not clear if this data reflected the picture at Newark Hospital specifically or if this was a trust wide picture.
- Between December 2014 and May 2015 15 patients at Newark Hospital were moved to different wards at night, between 10pm and 6am. This was lower than the average number of patient moves on other wards across the trust for which we had data with the average number of moves being 95 per ward. Moving patients at night can be disorientating and disruptive to other patients, and there is a risk of losing continuity of care.

Meeting people's individual needs

- Staff told us that they had access to interpreting services if required. Data from the trust showed that both face to face and telephone interpreting services were accessed by staff to communicate with patients. Polish, Latvian, Russian and British sign language services were the most frequently accessed. Other languages were also accessed both on a face to face and telephone basis.
- Healthcare assistants did not receive specific training on chaperoning patients. We were told most of the elements of chaperoning were included in the healthcare assistant induction training including matters relating to communication, privacy and dignity and the concept of chaperones.
- We saw examples of patients living with dementia that had 'All about me' booklets contained within their medical notes. The 'All about me' booklet is a tool that allows information from the person living with dementia and their family to be shared with those providing care. Information includes the person's preferences and relevant details of their family history. The aim of the booklet is to help improve person centred care.
- A patient requiring specific medication to treat Parkinson's disease at certain times had the administration of their medication timed to help ensure that medication was not given late which may have affected the patient's condition.
- Staff on Sconce Ward had recently introduced a dementia café which was scheduled to become a monthly activity for those patients living with dementia. During the café patients could have coffee and other drinks while playing games, which provided mental stimulation. Staff planned to introduce craft activities to future café events. We were told that the café has been well received by patients and their families.
- The endoscopy unit at Newark hospital provided separate services for male and female patients either by using different parts of the unit or by inviting them to clinics being held at different times.
- The hospital had not reported any mixed sex breaches to NHS England and we did not identify any concerns in relation to this during our inspection.

Learning from complaints and concerns

- The trust's website provided links to the complaints department page which contained information about making a complaint and links to relevant documents such as the complaints policy, complaints information leaflet, complaints forms and the patient advice and liaison service (PALS).
- Leaflets advising patients and visitors on how to make a complaint were seen throughout Newark hospital during our visit,
- Staff on Fernwood Ward told us that they had not received any complaints in the last two years. This was supported by trust data which showed that between August 2014 and May 2015 there had been no complaints regarding Fernwood Ward.
- Trust data showed that between August 2014 and May 2015 there had been one complaint regarding Sconce Ward. Staff told us that there were no unresolved or outstanding complaints relating to Sconce Ward.

Are medical care services well-led?

Inadequate

The leadership of the service was inadequate.

Medical care (including older people's care)

The leadership and governance of the service did not ensure the delivery of high quality person centred care. Although a vision document regarding Newark Hospital had been produced some staff told us that they felt separate to other hospitals in the trust. Staff at Newark Hospital had not been made aware of serious incidents occurring at King's Mill Hospital indicating there was no overall strategy for sharing information about and learning from incidents across the trust.

Staff survey data indicated that the numbers of staff who reported good communication between them and senior managers was lower than the England average. Staff also told us that senior hospital management were not always visible at Newark hospital. Recruitment at Newark hospital was an issue and shortages in staff had forced management to be reactive and reduce the numbers of beds on Sconce Ward. This limited the numbers of patients who could have benefited from receiving their care at their local hospital rather than another hospital within the trust.

Vision and strategy for this service

- The trust had a vision document for Newark Hospital, 'A Vision and Strategic Direction for Newark Hospital – October 2013'. The vision's summary stated that 'Newark Hospital will be a centre of excellence for a broad range of diagnostic, rehabilitation and treatment services – including urgent and planned care.'
- The strategy was not meaningful for the staff and we did not find any evidence of how this strategy was being implemented and how the service had moved forward.
- We spoke with staff nurses at the hospital. They had knowledge of the strategy but told us it was always changing and they had little faith in the leadership of the organisation to take this forward. Staff were very frustrated by this and many had subsequently lost all faith in the trusts leaders.
- There were no risks on the Newark Hospital risk register relating to the delivery of the vision and strategy.
- Information regarding the trust's shared set of values and behaviours was on posters located around the Newark Hospital site.
- There had been a campaign in 2014 called "Choose Newark Hospital." This was designed to encourage local people to use their local hospital.

Governance, risk management and quality measurement

- Systems to assess, monitor and improve the quality and safety of the service were not operated effectively. At a local level we were told about audits that were taking place on both Sconce and Fernwood Wards including audits of infection prevention and control, safety thermometer, medicines, saving lives, documentation audits, falls and cleanliness. We asked the trust to provide audits for us to review but these were not provided. This meant we were unable to assess the quality of the audits or see if changes to practice had been implemented
- The governance arrangements for the hospital had very recently changed. They had moved to a divisional structure and the wards were part of the division of emergency care and medicine. It was too early to assess how this new structure was working in practice. Not all staff, particularly those in lower bands, were clear about the changes and what this meant in practice.
- Up until June 2015 Newark Hospital was a division in its own right. There were monthly Newark Hospital divisional clinical governance meetings. We reviewed the minutes of three of these meetings. We found evidence that discussion took place about incidents, performance data such as patient harm data, infection prevention and control and HR data such as sickness.
- Records showed attendance at the governance meetings was patchy. Although the hospital manager and Matron were present for every meeting, key staff such as consultant medical staff, ward and department leaders were not present for many of the meetings.
- Systems to assess, monitor and mitigate risks relating to the health, safety and welfare of patients were not operated effectively. Newark Hospital had a divisional risk report which included risks, risk ratings and measures that were in place to minimise the risks. None of the risks had timescales for when the mitigating actions would be implemented. Not all risks had a named lead. The register identified some of the issues that we were told about during the inspection such as staff shortages and patient falls on Sconce ward. The

June 2015 risk register did not include the risk relating to the treatment of patients with sepsis that was identified at the clinical governance meeting in May 2015.

- The risk register was in the process of transferring to the new governance structure and would be incorporated into the emergency care and medicine division. It was too early to comment on the effectiveness of this new system. The senior leaders told us shadow arrangements were in place in the interim to ensure governance issues that were specific for Newark Hospital were not lost in the transitional period.
- Monthly safety thermometer data for Sconce and Fernwood Ward was included in reviews of safety incidents across medicine. This helped staff identify any trends and themes that needed addressing.
- We asked staff about a recent serious patient safety incident at King's Mill Hospital but none of the staff we spoke with were aware of the incident. This indicated a potential failure to share learning from incidents between the two trust locations. A member of ward staff told us, "I wouldn't have a clue about the last serious untoward incident." Although processes existed to share learning from incidents, this indicated that not all staff were being made aware of incidents and learning from them which posed a risk that similar incidents could occur.

Leadership of service

- Without exception, staff spoke highly of the Newark Hospital leaders and they felt did their best for the staff, the patients and for the interests of Newark Hospital itself. There had recently been a restructure and a new structure had just come into place at the time of our inspection. The new structure was designed to rotate senior leaders between the hospital sites. Staff were concerned about this change and were worried they would lose their dedicated hospital manager.
- Staff reported feeling supported by their immediate line managers. On Sconce Ward some staff told us that senior hospital management were not visible however senior staff or a matron would attend the ward if there were issues.
- Senior staff had been forced to be reactive to situations such as staff shortages on Sconce Ward. Evidence that bed numbers had been decreased due to staffing levels was seen during the inspection however some staff reported that there had been times recently, before the reduction in beds, when staff felt that they were being stretched when providing care to more patients.
- Staff felt that Newark Hospital was forgotten by the executive team. They expressed concern that the trust were not doing enough to maximise the hospitals potential. This made staff anxious and uncertain about their future. Some staff commented they frequently worried the hospital would close down. Staff had lots of ideas of how the hospital could deliver services that were much more productive and wanted to be empowered to do this. They felt the senior leaders in the organisation were not listening to them.

Culture within the service

- Staff told us there was a great family atmosphere at Newark Hospital and people worked well together as a team. They told us they were proud to work at Newark and they delivered good care. Many of the nurses had worked at the hospital many years.
- Staff were committed to the hospital and were very aware of the need to ensure it was providing services that were of good quality and were good value for money. We spoke with a number of nurses who were full of ideas for how the hospital could be developed but they did not feel empowered to make changes.

Public engagement

- The trust had a patient information advisory forum which aimed to raise and maintain the standard of written information for patients, their carers and all service users. The group was made up of members of the public and chaired by the trust's communication manager.
- There was an active Newark residents' campaign group whose aim was to ensure that services continued to be delivered from Newark hospital for local residents.

Staff engagement

- Staff excellence awards were held annually to celebrate the achievements of staff.
- A free staff counselling support service was available which provided a fixed number of sessions to provide confidential advice and support to staff.

Medical care (including older people's care)

- Staff engagement sessions were held in May and were planned for June. The acting chief executive attended to give a briefing for staff.
- Staff had been invited to participate in the 2014 NHS staff survey. The trust's score of 3.66 was worse than the average score for staff engagement.

Innovation, improvement and sustainability

- A dementia café on Sconce Ward was a newly implemented monthly activity for patients living with dementia. Staff planned to introduce craft activities to future café events.
- Staff on Fernwood Ward had identified some improvements that they wished to make to improve patient experience which included improving the current referral form making the ward more homely and less clinical.

Surgery

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

Information about the service

Sherwood Forest Hospitals NHS Foundation Trust provided surgical services at Newark Hospital as part of the planned care and surgery division. Newark Hospital provided day case surgery across two day case theatres. Specialties included; general surgery, urology, orthopaedics, ophthalmology, podiatry and pain management. Each theatre operated Monday to Friday with two sessions daily. Surgical activity at Newark Hospital had reduced since 2014 and facilities were not used to full capacity.

Surgical services at Newark included pre-operative assessment, day surgery, two operating theatres, recovery and a surgical ward. The ward had facilities for up to 30 patients and comprised of 14 beds, 12 trolleys and four recliner chairs. These were allocated according to type of procedure and patient dependency. Between July 2013 and June 2014, there were 2,000 episodes of surgical care. Of these, 93% were day case procedures and 7% were planned overnight admissions for social reasons. The day care unit was open from 7am to 10pm with two beds designated for overnight admissions.

During our inspection we spoke with eight patients, two relatives, 11 staff from a range of related surgical roles and two members of the volunteer service.

Summary of findings

This service required improvement overall.

Outcomes for patients using the service were not monitored regularly or robustly. There was limited evidence of local audits taking place.

There was a lack of clear vision or strategy for Newark Hospital and limited communication from senior management to the staff working within Newark Hospital. Monitoring of quality and safety of the service was not always robust or effective. Staff did not always feel actively engaged or empowered.

There was an effective patient safety incident reporting system and evidence of sharing and learning so as to improve care. There were sufficient staff to deliver safe care and treatment. Staff followed the trust policy to manage medicines safely, and all medicines were stored appropriately and recorded accurately. Good infection control practices were in place.

Care and treatment were evidence based and pain management was effective. A multi-disciplinary team approach was evident with good multi-disciplinary working in all the wards and well attended multidisciplinary team meetings.

Patients were positive about the individual care and treatment they received both on the ward and within theatre. There were processes in place to support patients living with physical or learning disabilities when coming to hospital for procedures.

Surgery

Once referred for surgery at Newark Hospital, patients were able to attend within a reasonable timescale. The surgical services met the national target for treating people within 18 weeks of referral. Patients were satisfied with their care and appreciated a local service. Staff supported patients with individual needs and provided patients with useful information before their surgery.

Are surgery services safe?

Good

The safety of the service was good.

Patients were protected from avoidable harm and abuse. Staff were able to identify and report incidents appropriately. There was evidence of sharing and learning with identified actions implemented and audited. There were sufficient staff to deliver safe care and treatment. Staff carried out assessments to reduce risks to patients, such as falls, pressure ulcers and blood clots.

All the patient records we reviewed contained the right information and care plans. Staff followed the trust policy to manage medicines safely, and all medicines were stored appropriately and recorded accurately. Good infection control practices were in place.

Incidents

- Between January and May 2015 three patient safety incidents had been raised at Newark hospital. All three incidents related to either needle stick or scalpel blade injuries. An example of learning following from those incidents was a visual display to raise awareness of needle stick risks and, additional training in safe sharps management was offered at ward and department level.
- Staff demonstrated knowledge of the electronic incident reporting system used by the trust. However, staff told us that there was no formal training on the electronic system and that learning was through colleague demonstration.
- Sharing and learning from incidents took place through regular daily briefings and was visible on communication boards located in all departments. Staff discussed and highlighted outcomes and actions from incidents or complaints at the communication board and at ward handovers. We saw a summary of an incident on the communication board.
- Mortality and morbidity meetings occurred monthly providing an opportunity to discuss and review deaths and complications. These were linked to clinical governance meetings. Minutes demonstrated that these

meetings were well attended and we saw that individual deaths had been discussed and learning outcomes were appropriate. Minutes of meeting were readily available for staff to read.

- Staff were aware of the requirements of the Duty of Candour regulation. This states that providers should be open and transparent with people who use services; it sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Whilst Newark hospital did not use this tool they did monitor performance against the possible harms identified in the tool. For example, required staffing levels and actual staffing levels were clearly displayed and, information including infection rates, incidents of patient falls and pressure ulcers were visible on the ward. This enabled staff and visitors to see how effective the ward was in relation to patient safety. There had been two reported patient falls with no harm and no pressure ulcers in the month preceding our inspection.

Cleanliness, infection control and hygiene

- The operating theatre and surgical ward at Newark Hospital appeared clean and all corridors were free from obstruction.
- Hand gel was available in prominent positions throughout the hospital and we observed staff and visitors applying the gel on entering and leaving clinical areas. All staff were 'bare below elbows' in line with good infection control guidelines.
- Theatre staff changed into appropriate clothing at the beginning of each shift and wore over gowns when leaving the area.
- There had been no incidence of reported methicillin-resistant Staphylococcus aureus (MRSA), clostridium difficile (C. diff) or surgical site infection in the last twelve months.
- The on-site sterilisation unit at Kings Mill Hospital sterilised surgical Instruments and delivered and collected instruments from Newark Hospital daily.
- After use dirty instrument trays were placed directly into a trolley for return to the sterilisation unit on the Kings Mill Hospital site. The collection trolleys did not fit through the door to the dirty utility area at the rear of each operating theatre. Therefore trolleys with used equipment were taken through the department to the delivery / collection area at the theatre main entrance. We were told that this had been risk assessed and, as the trolleys were closed units, this process was accepted. During our inspection we did not see any contamination of clean clinical areas.

Environment and equipment

- The surgical day case ward was on the same ground floor level as the theatres, making access between the two areas easy. Corridors were uncluttered with no obstructions.
- Store rooms were tidy and equipment was clearly labelled with no storage at floor level. Management of equipment is one of the elements of standard infection control precautions; NHS guidance recommends equipment should never be stored on the floor.
- Emergency resuscitation equipment had been checked in accordance with trust policy and signed as being fit for use. All items were in date and in good order. They were stored in a visible easily accessible area.
- Emergency equipment was readily available for those patients with suspected sepsis. Sepsis is a potentially life-threatening complication of an infection.
- Monitoring and anaesthetic equipment, including a difficult intubation trolley, were all well laid out and met the British Association of Day Surgery Standards.
- The medical electronic department, based at Kings Mill Hospital was responsible for the servicing, calibration and maintenance of equipment at Newark Hospital. Technicians visited weekly or were contacted by telephone for urgent repairs. Portable appliance testing (PAT) stickers were in place demonstrating when equipment was next due to be serviced.
- There was a shortage of theatre trolleys suitable for day case surgery. Three were on order including one with specialist ophthalmic adaptations. During our visit a standard operating table had been adapted for ophthalmic use which was safe but not ideal for patient comfort.

Surgery

Medicines

- Medicines were stored appropriately in the surgical ward and operating theatres.
- Medicines, including those requiring cool storage, were stored in locked cupboards in accordance with legal and policy requirements and books recording the use of controlled drugs were consistently signed by two registered professional for each use. The stock levels matched the record book in accordance with legal requirements. Fridge temperatures were recorded daily and were within an acceptable temperature range.
- Discharge medicines were prescribed safely and effectively and we observed nursing staff administering medicines in line with national guidance.

Records

- All staff we spoke with had completed information governance training and were aware of the need to maintain patient confidentiality at all times.
- Patient records were stored safely in filing cabinets in the ward area by the reception area. The filing cabinets were unlocked but not labelled as 'patient notes'. The reception area was staffed during the day by a ward clerk. The risk of inappropriate access to patient notes was therefore considered to be low.
- We reviewed three sets of medical and nursing notes on the surgical day case ward. Notes were accurate, complete, legible and, up to date.
- Staff had clearly documented discharge planning which included discharge criteria and a prescription sheet.

Safeguarding

- Nursing staff showed a good awareness of adult safeguarding and told us they would report any safeguarding concerns to a senior member of staff on duty.
- Nursing staff offered additional support to vulnerable adults. For those patients with multiple or complex needs including patients with learning disabilities, their carers or relatives were allowed to accompany them wherever possible.
- A learning disability nurse (LDN), based at Kings Mill Hospital, and could be contacted by the department. Staff told us that the LDN often knew of impending admissions and would provide advice in advance.

Mandatory training

- All staff working within the surgical ward and theatres at Newark Hospital were either up to date or had dates to attend a mandatory training day. Subjects covered on the day included information governance, basic life support, mental capacity act, safeguarding, mentorship, manual handling and infection control. Mandatory training data for staff at Newark Hospital showed 83% of staff were compliant with mandatory training. This was less than the trusts target of 90%.
- We were told of a comprehensive trust / departmental induction which took place over six full days. This was described by one member of staff as, "The best induction I have ever had".

Assessing and responding to patient risk

- We looked at two sets of post-operative observations. Physiological observations were recorded using an electronic tablet that calculated the early warning score (EWS). EWS is a tool for early detection of the deteriorating patient, based on a numerical scoring system according to physiological observations. The score indicates what action may be required ranging from additional observations to urgent medical review. The two sets reviewed showed the scores were acted on appropriately.
- We saw that staff completed risk assessments on admission. These included anaesthetic risk and fasting times, venous thrombolytic embolism (VTE), Methicillin-resistant Staphylococcus aureus (MRSA) screening, Waterlow score (pressure ulcer risk), fall risk, bed rail assessment and Mental Capacity Act (MCA).
- Monitoring of patients in theatre followed the Association of Anaesthetists of Great Britain and Ireland AAGBI and Royal College of Anaesthetist (RCoA) guidelines.
- Five steps to safer surgery is a National Patient Safety Agency (NPSA) supported initiative to prevent patient harm during surgery. We observed staff following the five steps including briefing, sign in, time out, sign out and debriefing.

Surgery

- We observed the use of the 'World Health Organisation' (WHO) check list for two patients having cataract surgery. The process was rushed but documentation was accurate and complete. Staff in theatre told us that they were confident to take the lead in initiating the WHO checklist.
- Nurse team leaders audited performance against the safer surgery checklist. The theatre management group discussed the results and shared them with the surgical division. The results demonstrated that performance had improved over the last five years with compliance at sign in, time out and sign out being consistent at 98% and the briefing / debriefing showing an improvement from 31% compliance in September 2014 to 90% compliance in April 2015.

Nursing staffing

- There were sufficient staff of an appropriate skill mix to enable effective care to be delivered. In theatre a band six team leader was in charge of the day to day management of the department and supported the nursing team. A band seven (matron) had overall responsibility for theatres at Newark Hospital and Kings Mill Hospitals. This person spent time on each site, approximately one day per week at Newark Hospital.
- The surgical ward was staffed according to activity. The nurse rota was planned each Friday based on the operating list for the following week. Staffing levels were planned one week ahead and were reliant on staff good will, for example, staff told us their shifts could be changed on a Friday for the following week. Staff told us that this worked for them. However without longer term rota planning there was a risk to the service should there be unexpected sickness or absence.
- There was a ratio of one nurse to eight patients in line with national staffing recommendations.
- Surgical services rarely used agency and bank staff. However there was a temporary staff induction check list for competency and orientation if required.

Surgical staffing

- Medical staffing was provided from the planned care and surgery division.
- Between October 2013 and March 2015 there had been no use of locum medical staff.
- Operations at Newark Hospital were carried out as day case only, although a small number of patients were admitted overnight for social reasons. Overnight medical cover was provided by the minor injury unit doctor based on the medical ward at Newark Hospital. Patients requiring unexpected overnight stays for clinical reasons were transferred to Kings Mill Hospital.

Are surgery services effective?

Requires improvement

The effectiveness of the service required improvement.

Outcomes for patients using the service were not monitored regularly or robustly. There was limited evidence of local audits taking place.

Care and treatment were evidence based and we saw best practice in relation to nutrition and hydration. Pain management was effective with support and advice available from a trust wide pain management team based at Kings Mill Hospital. A multi-disciplinary team approach was evident across all of the surgical division, with good multi-disciplinary working in all the wards and well attended multidisciplinary team meetings.

Evidence-based care and treatment

- Patients had their needs assessed and their care planned and delivered in line with evidence-based guidance, standards and best practice including National Institute for Health and Care Excellence (NICE) guidance. For example, nursing staff followed guidance relating to falls, pressure ulcers, nutrition support, venous thromboembolism (blood clots), and recognising and responding to acute illness. In theatres, NICE guidance was followed in relation to preventing surgical site infections.
- We saw evidence that patients' nutrition and hydration met the NICE and National Patient Safety Agency guidelines.
- Staff across the surgical division had access to policies and procedures using the trust internet.

Pain relief

Surgery

- We observed staff asking patients about pain or discomfort following surgery and providing them with pain relief if required.
- Nurses were trained to prescribe medications on discharge using patient group directives (PGD). PGDs allowed registered nurses to supply commonly used prescription-only medicines to patients, without individual prescriptions.
- Pain assessment was based on a verbal rating score of 0-3. Nursing staff also used a behavioural pain assessment scale (BPAS) which helped them assess pain in patients with poor communication and those patients living with dementia.
- There was a trust wide pain management team, based at Kings Mill Hospital, who were contactable for advice 8am to 6pm Monday to Friday.

Nutrition and hydration

- Frozen meals were transported from Kings Mill Hospital to the wards at Newark Hospital, where they were re-heated in a microwave.
- Hostess staff worked on the ward to serve food to patients. They were all up to date in training in food hygiene, including food preparation and re-heating. We saw their training certificates displayed in the ward kitchen.
- Patients had a choice of meal, which for the day surgery ward included sandwiches and or soup.
- The in-patient menu had a wide choice and a pictorial menu was available if needed. The trust catered for patients with special diets and allergies and these meals were clearly identified on the menu.
- There was a red tray system for patients needing assistance. The red tray system alerted nursing staff to those patients who were at risk of malnutrition or those patients requiring assistance with feeding.
- A protected mealtime system was clearly advertised. Protected mealtimes allowed patients to eat without being interrupted and meant staff were available to offer patients assistance where required.
- We looked at three fluid and food charts on the surgical day case ward which were correctly completed. We saw where the patients' fluid and food intake for that day had been recorded appropriately.
- Newark Hospital did not have specific written guidance on fasting prior to surgery, based on best practice guidance. However, we observed patients being allowed to eat up to six hours prior to planned surgery and drink water two hours before.

Patient outcomes

- Before our inspection we asked the trust to provide evidence of local audit activity at Newark Hospital. We were provided with audits of the safer surgery checklist and cleanliness but were not made aware of any other audits that had been or, were in the process of being, completed. The British Association of Day Surgery guidelines include examples of audits to be carried out by services, such as patients failing to attend for surgery and patient experience of post-operative pain and other symptoms. Collecting and monitoring information about patients care and treatment and their outcomes should be used to improve patient care and identify where improvements in the service may be required.
- Newark Hospital's readmission rates for the top three surgical specialties, based on activity at this hospital, showed there were less readmissions in elective general surgery and ophthalmology when compared with the England average.

Competent staff

- Staff were supported to deliver effective care and treatment through the appraisal process. From April 2015 all clinical staff on the surgical day ward had received an appraisal or had one booked with their manager.
- Theatre staff raised concerns about becoming de-skilled following the reduction of surgery at Newark Hospital. Specialist nurses, for example orthopaedic trained staff, had moved to other hospitals. Staff were given the opportunity to work at Kings Mill hospital in order to maintain their skills when activity at Newark Hospital was low or operating lists were cancelled.

Multidisciplinary working

- Regular monthly multidisciplinary meetings took place which incorporated governance and an opportunity to escalate concerns or discuss local developments.
- Multidisciplinary meeting minutes were readily available and these indicated that meetings were well attended and actions reviewed.
- Patients received care from a range of different staff and services. We observed good communication between health professionals in planning and delivering individualised care.

Seven-day services

- Day case surgery took place over five days at Newark hospital with no patients admitted over the weekend.
- There was a range of services available for surgical patients five days a week including physiotherapy and occupational therapy.

Access to information

- Patients' medical and nursing records were readily available to staff. Up to date information about each patient was shared at staff handovers.
- Staff had no concerns about access to and availability of information such as patients' blood test results or reports of X rays and scans.
- Local and trust information was shared with staff at daily team meetings held at the communication board.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a procedure for obtaining consent for surgery. We looked at three consent forms for patients attending for eye surgery. These were comprehensively completed, including risks, and were clearly signed. A hospital based audit was completed in December 2014. It looked at consent forms for 62 patients from the day case ward and the endoscopy unit. The results showed 100% for 12 out of the 21 criterion. Two criteria scored less than 75% and six achieved more than 90% but less than the trusts compliance rate of 100%. An action plan was formulated and was to be monitored by the Newark Hospital clinical governance group.
- Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and had received training as part of mandatory training.

Are surgery services caring?

Good

The caring afforded to patients using the service was good.

Patients were extremely positive about the individual care and treatment they received both on the ward and within theatre. The Friends and Family test scores reflected this.

We observed exceptional care offered to patients and their family including one to one support of elderly patients attending for cataract surgery and considerate attention provided to anxious relatives.

There were processes in place to support patients living with physical or learning disabilities when coming to hospital for procedures.

Compassionate care

- Patients and visitors received respectful and compassionate care. We observed staff maintaining patients' privacy and dignity.
- Patients were accompanied to theatre by a ward nurse who remained with the patient until the patient appeared confident to be left. The nurse introduced the patient by name to the theatre staff and stayed with the patient, holding their hand, until taken through to surgery. The same nurse collected the patient after surgery wherever possible.
- We spoke to eight patients who were positive about the care they had received before, during and after their procedure and stated that they would always want to come to Newark Hospital for treatment whenever possible. They described the care as personalised and professional. They felt safe and well looked after.
- Staff told us they were informed in advance when a patient with a learning or physical disability was expected. Every effort was made to meet specific needs including being accompanied by a carer if required and a private recovery area could be provided.
- Friends and Family test results for Newark Hospital consistently reported high satisfaction with the care and treatment received. Scores were between 89%-100% of patients recommending the hospital.

Surgery

Understanding and involvement of patients and those close to them

- We spoke with eight patients attending for cataract surgery under local anaesthetic. They told us they were given plenty of information about the procedure, that they felt safe and that the facilities were clean. One patient told us, "I can't find fault with this hospital, they are all marvellous."
- Staff told us they enjoyed working at Newark because they were able to give patients the time that they deserved.
- Family and visitors were treated with the same compassion. We observed an anxious relative being comforted by a ward clerk whilst the patient underwent surgery. The clerk sat with the relative, offered reassurance and sought updates to keep them informed.

Emotional support

- There was a multi faith chapel available on site.
- We saw staff support anxious elderly patients by holding their hand and reassuring them during cataract operation under local anaesthetic. The ward nurse was able to stay with the patient if required.

Are surgery services responsive?

Good

The responsiveness of the service was good.

People's needs were met through the way services were organised and delivered. Once referred for surgery at Newark Hospital, patients were able to attend within a reasonable timescale. The surgical services met the national target for treating people within 18 weeks of referral. Patients were satisfied with their care and appreciated a local service.

Staff supported patients with individual needs and provided patients with useful information before their surgery. Although patients told us they did not know how to complain, they felt confident approaching staff and staff were aware of the complaints process and how to resolve concerns and complaints locally.

Service planning and delivery to meet the needs of local people

- Newark Hospital theatres carried out day case surgery Monday to Friday, 8am to 6pm. Patients with identified risks such as co-morbidities (the presence of one or more additional disorders) travelled to Kings Mill Hospital for their surgery.
- The Keogh review in 2013 raised concerns about facilities to manage surgical emergencies. Subsequently the amount of surgery carried out at Newark Hospital has greatly reduced. Patients who needed overnight admissions or who were having complex procedures attended Kings Mill Hospital, 22 miles from Newark Hospital.
- Patients we spoke with said they would prefer to be able to have surgery at Newark due to its locality and the quality of service provided.

Access and flow

- Referral to treatment time (RTT) rates for Newark Hospital was similar to the England average of 90%. This meant that patients received treatment by a consultant-led team within 18 weeks of referral by their general practitioner (GP). Data provided by the trust for RTT, in the planned care and surgery division, was 87%.
- Day case theatre use at Newark Hospital was reported to be 68% across all specialities for April 2015. Data provided showed that operating lists generally started on time and that 20% of lists finished early.
- The day surgery unit had the flexibility to provide two overnight beds if required for social reasons such as elderly patients living alone, without support.
- Patients who deteriorated in theatre or post-operatively on the ward were transferred by ambulance to Kings Mill Hospital for treatment. However due to the nature of the surgery being carried out at Newark hospital this was rare and staff could not recall an incident when this had occurred in recent months.
- Patient discharge from Newark Hospital was nurse led. Patient group directives (PGD) were in place to enable registered nurses trained in PGD, to prescribe a pre-set list of medications to assisted with timely discharge of patients.

Meeting people's individual needs

Surgery

- The ward had the 'This is Me booklet' for people living with dementia, which staff we spoke with were aware of. However, during our visit there were no patients with dementia having surgery so we were unable to observe the use of the booklet.
- Interpreters were available if booked in advance or alternatively the telephone interpreting service line could be used.
- There was access to a learning disabilities specialist nurse to provide support and advice to staff caring for those with specific needs.
- Information was provided for patients, such as leaflets about what to expect following surgery and anything patients.

Learning from complaints and concerns

- Complaints were recorded and managed through the trusts electronic incident recording system.
- Staff were encouraged by their line managers to aim for local resolution to avoid a concern escalating to a formal complaint. This might include a follow up telephone call to the complainant if required.
- The patient advice and liaison service (PALS) was available at Newark Hospital and information promoting its service was clearly visible in the form of posters and 'how to complain' leaflets.
- Patients on the ward told us they did not know how to make a complaint but stated that they would talk to the ward sister if they had a problem.
- Staff told us there were very few complaints about Newark Hospital and could not recall the last complaint that had been received.

Are surgery services well-led?

Requires improvement

The leadership of the service required improvement.

There was a lack of clear vision or strategy for Newark Hospital and limited communication from senior management to the staff working within Newark Hospital. Monitoring of quality and safety of the service was not always robust or effective. Staff did not always feel actively engaged or empowered.

Leadership at local departmental level was good. Staff showed commitment to implementing changes and improving standards which would help to secure the future of Newark Hospital.

Vision and strategy for this service

- The trust had a vision document for Newark Hospital, "A Vision and Strategic Direction for Newark Hospital- October 2013."
- The strategy was not meaningful to staff and there was little evidence of how this strategy was being implemented or how the service had moved forward.
- Staff working at Newark Hospital unanimously told us they were concerned for the hospital's future, stating that reduced workload following previous inspections was a key factor. There was an understanding amongst the staff that some additional surgical activity would be carried out at Newark Hospital, such as breast surgery, but this had not been confirmed.
- Trust wide updates were available on the hospital intranet and from staff forums. However staff told us information provided primarily related to Kings Mill hospital and the current financial situation.

Governance, risk management and quality measurement

- The lack of audit evidence for Newark Hospital meant that monitoring of quality and safety was not always robust or effective.
- There were monthly governance meetings for the Planned Care and Surgery division. Reports and data presented to the meetings rarely included specific reference to issues or performance at Newark Hospital. Minutes of the meetings were readily available for staff to read.
- Up until June 2015 Newark Hospital was a division in its own right. There were monthly Newark Hospital divisional clinical governance meetings. We reviewed

the minutes of three of these meetings. We found evidence that discussion took place about incidents, performance data such as patient harm data, infection prevention and control and HR data such as sickness.

- Records showed attendance at the governance meetings was patchy. Although the hospital manager and Matron were present for every meeting, key staff such as consultant medical staff, ward and department leaders were not present for many of the meetings.
- There was a divisional risk register which was discussed at the monthly governance meetings and regularly updated. There was also a risk register for Newark Hospital. There were no risks on either risk register that specifically related to surgery services at Newark Hospital.
- The communication board was in daily use for information sharing. We observed a meeting at the communication board and saw that information included details of an incident and the actions in place were discussed e.g. needle stick injury.

Leadership of service

- There was strong leadership at departmental level within the Planned Care and Surgery division.
- Staff reported good feedback and stated that they felt well supported locally, but felt detached from senior trust management. Staff told us senior trust managers visited occasionally but did not communicate with staff at Newark Hospital about future plans.

Culture within the service

- Staff felt respected and valued by their immediate line managers. However, staff felt communication between senior managers for the trust and staff working at Newark Hospital was minimal. This left staff feeling under-valued and disengaged with the remainder of the trust. Most staff told us about their fears and concerns for the future of Newark Hospital, middle managers also expressed that they too were unaware of definite plans for the hospital.
- Staff enjoyed working at Newark Hospital and were keen to promote Newark as a hospital of choice.

Public engagement

- Volunteer workers within Newark Hospital felt well supported, although they too felt 'out of the loop' regarding their future at the hospital. Volunteers worked in a variety of areas within the hospital.
- Staff told us of a recent local publicity event to promote Newark Hospitals and the services provided.

Staff Engagement

- There were monthly staff forums and team briefings, by video link, held in the boardroom at Newark Hospital. Some staff told us they were able to attend but others said it was difficult because of workload in the unit.
- Staff had been invited to participate in the 2014 NHS staff survey. The trust's score of 3.66 was worse than the average score for staff engagement.
- Staff felt that activity at Newark Hospital had reduced significantly over the last 12 months, they were aware of changes in the service, for example breast surgery, but did not feel involved in these changes and were not sure when the changes would take place.
- Staff told us that managers locally kept them informed on a daily basis but that trust wide information or future planning was not communicated with them. The majority of staff including medical, nursing and support workers reported feeling isolated and in the dark about the future.
- Staff satisfaction was mixed, with staff expressing pride in being able to provide good individual patient care but recognising that whilst workloads were relatively low the service may not be sustainable.

Innovation, improvement and sustainability

- Staff at department level were committed to improving standards as recommended from previous inspections. This was evident within theatres where clear improvements had been made in implementing the five steps to safer surgery.
- All the staff we spoke with demonstrated passion and commitment to Newark Hospital but we were not clear what the plans were for this service. At the time of the inspection the surgical service was underutilised.

Outpatients and diagnostic imaging

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

Information about the service

Outpatient services at Newark Hospital were provided from the main hospital site. Newark Hospital provided clinics for a range of specialties, including orthopaedics, ophthalmology, urology, neurology, ear nose and throat (ENT), podiatry, and therapy services. In 2014 Newark Hospital had 81,279 outpatient appointments booked.

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

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

We observed care and treatment. We reviewed information provided by the trust.

Summary of findings

The service was inadequate overall.

Systems for processing and learning from incidents were not used consistently or effectively. Learning from incidents was not always shared across the trust.

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

The time patients waited from referral to treatment was consistently worse than the England average and below the expected national standard. When attending clinics, some patients experienced long delays for their appointments. Patients' records were not always available when needed for clinics. A lack of storage facilities meant that records were sometimes stored inappropriately.

The vision and strategy for the outpatients and diagnostic imaging service was not clear or well developed. Governance structures were in place but did not always operate effectively to interact and share information across the trust.

Outpatients and diagnostic imaging

Patients were appropriately supported and involved in their care. Nursing and medical staffing levels and skill mix were adequate to keep patients safe. There were shortfalls in clerical and administrative staffing.

Systems and processes were generally reliable in keeping people safe, including safe management of medicines and infection prevention and control.

Staff felt locally well supported by colleagues and managers, though not by more senior managers. They felt the Diagnostics and Rehabilitation division, specifically at Newark Hospital, did not have a high profile within the trust.

Are outpatient and diagnostic imaging services safe?

Inadequate

The safety of the service was inadequate.

People using the outpatients service were at high risk of avoidable harm. Systems for processing and learning from incidents were not used consistently or effectively. Learning from incidents was not always shared across the trust. Not all staff had received training about reporting incidents.

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

Patients' records were not always available when needed for clinics. There were shortfalls in clerical and administrative staffing. Nursing and medical staffing levels and skill mix were adequate to keep patients safe.

In the diagnostic imaging service, safety incidents were appropriately reported, learning was shared and suitable action taken.

Systems for infection prevention and control and management of medicines in outpatients and diagnostic imaging services were generally reliable in keeping people safe. Most staff had completed their mandatory training, including safeguarding children and vulnerable adults.

Incidents

- The outpatients and diagnostic imaging service at Newark Hospital reported 35 patient related incidents between January and May 2015. All of these incidents related to the outpatients service.
- 25 of the incidents were classified as having caused no harm to patients and five as causing a low degree of harm to patients. Incidents included lack of patient notes, misfiling of patient records, and clinic appointment cancellations due to staff annual leave.

Outpatients and diagnostic imaging

- The severity of harm caused to patients had not been assessed in five incidents; these were classified as, 'In holding area, awaiting review' or 'Being reviewed.' Three of these incidents were reported in the first quarter of 2015.
- There was no record of investigations undertaken or lessons learnt for 13 of the 35 reported incidents. Ten of these incidents were assessed as causing a low degree of harm and three as causing no harm to patients.
- Staff told us learning from incidents had been shared in their departments at Newark Hospital. We asked staff if learning was shared from incidents which had occurred at Kings Mill or Mansfield Community Hospitals. Staff told us they were not always made aware of such incidents and so lessons learnt were not consistently shared across the trust.
- The majority of staff we spoke with were aware of the trust incident reporting system. However, not all staff had received training to report incidents and, in particular, administrative and clerical staff told us they did not report incidents and had not received training to do so.
- Staff in the diagnostic radiology team at Newark Hospital had recorded all incidents internally. Any notifiable radiation incidents were reported to the Care Quality Commission and the Health and Safety Executive as appropriate in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). All diagnostic imaging staff were aware of how to report incidents and what the reportable threshold was for radiation incident reporting.
- We saw that learning from radiation incidents was discussed at divisional governance meetings and appropriate action taken. Following numerous reportable incidents to the CQC involving the same type of error, the lead radiographer had developed a safe and effective method for radiographers in an attempt to reduce these errors. The use of the new method had seen errors reduce dramatically.
- Staff did not always fully understand the requirements of the Duty of Candour regulation. Providers of healthcare services must be open and transparent with people using services when things go wrong with care and treatment.

Cleanliness, infection control and hygiene

- We found clinics and waiting areas, including diagnostic radiology, were clean. Staff effectively managed, prevented and reduced the risk of infection.
- One exception was a flow meter, used by patients attending urology outpatient appointments, stored in the patient and public toilet in Newark Hospital main outpatients department. Staff told us this was routine practice. Hand towels had been placed in the funnel of the flow meter because people using the toilet had assumed it was a waste bin. The flow meter was not covered or segregated in the toilet as a piece of clinic equipment. Staff on duty in main outpatients were unaware of the risk of infection due to this practice. The trust infection control lead was unaware the flow meter was being stored in the toilet.
- We saw staff followed trust policies on infection control and hygiene in the clinics we visited at Newark Hospital. We observed staff using appropriate hand washing techniques and personal protective equipment, which included aprons and gloves.
- Hand alcohol gel dispensers were readily available in clinics and patient waiting areas at Newark Hospital.
- Staff completed cleanliness audits for clinic environments and equipment.
- The required trust mandatory training rate was 90% for infection control and hand hygiene. All nursing staff in outpatients had attended the training. However, allied health professional (AHP) staff in radiography and therapy services did not meet the trust target. Seventy five percent of AHP staff in radiography and 73% of AHP staff in therapy services had completed training in hand hygiene, while for infection control the take up was just about in line with the trust target of 90%.

Environment and equipment

- We found equipment and records were stored in the clean utility room in main outpatients. This included two patient trolleys and four large plastic boxes containing patients' medical records. The boxes were dated 16 June 2015. The medical records were due to be returned to medical records store but had not been at the time of our inspection. Staff told us there were no other available storage facilities in outpatients.

Outpatients and diagnostic imaging

- There were no trained risk assessors in Newark Hospital diagnostic imaging but risk assessments for new equipment and procedures were undertaken in conjunction with the medical physics service. We saw evidence of this at the time of the inspection.
- We saw equipment specific protocols throughout the department. Staff had access to these on the trust internal computer systems. A full quality assurance programme was in place and at the time of inspection no equipment was outside of tolerance levels for testing or performance. Staff did not raise any concerns about availability of equipment or how quickly repairs were carried out.
- Radiologists and medical physics staff were fully involved in the procurement of new equipment. We saw equipment training was in place for all operators, on each piece of equipment they were entitled to operate.

Medicines

- Medicine prescription pads were stored securely, audit processes were in place to check prescription pads and records were kept to track prescription pads to detect any losses. We found this in all outpatient clinics at Newark Hospital.
- Medicines were stored securely.

Records

- Staff told us patients' medical records were not always available when they attended outpatient appointments. Medical records were stored in several different areas within the hospital and so there could be delays in locating the required records. Temporary patient records had to be created for patients whose records were not available.
- Staff confirmed patients in the ear, nose and throat (ENT) and ophthalmology clinics were not seen if their medical records were unavailable. However, this was not the case for all outpatients clinics at Newark Hospital.
- In diagnostic imaging at Newark Hospital patients' records were held securely on the radiology information system. The trust had a picture archiving and communication system with secure access.

Safeguarding

- Staff had access to the trust safeguarding policy. Staff we spoke with were aware of the procedures to follow should they need to report a safeguarding concern.
- All nursing and AHP staff in outpatients had completed safeguarding adults and children training.
- However, 88% of AHP staff in radiography had completed training in safeguarding children, level two. This was just below the trust required target of 90%.

Mandatory training

- Mandatory training modules which staff were required to complete included moving and handling, health and safety and equality and diversity training. Mandatory training data for staff at Newark Hospital showed 83% of staff were compliant with mandatory training.
- Although most Newark Hospital staff and teams had completed mandatory training in line with trust targets, there were exceptions. AHP staff in radiography and therapy services had completed 88% and 82% respectively for both health and safety and moving and handling training.
- Staff also completed statutory training modules including information governance and fire training.
- Staff in outpatients and radiography had all completed information governance training, with the exception of two teams. These were additional clinical services staff in outpatients and administrative and clerical staff in radiography. Their training rates were 88%, just below the trust target of 90%.
- Fire training had been completed by the majority of staff in outpatients and diagnostic imaging at Newark Hospital. However, in radiography administrative and clerical staff only 50% had completed fire training.

Assessing and responding to patient risk

- In January 2015 the trust identified a significant number of patients, around 19,500 in total, where the outcome of their outpatient appointment was not recorded in the electronic system correctly or they were overdue for a review appointment. This included patients attending at Newark Hospital.
- Where the outcome of appointments was not recorded, patients were at risk of appropriate action not being

taken regarding the care and treatment they needed. Patients who were overdue for a review appointment were at risk of essential treatment being delayed and the adverse effect this could have on their health.

- The trust's response to the backlog of patients was not progressed in a timely way to ensure patients were reviewed and their follow up appointments booked.
- The clinical commissioning group (CCG) told us that when the problem was first identified, the trust did not believe there were any patient safety issues associated with the backlog. The trust had started a review of the backlog, but this did not follow a risk-based approach. This meant there was no recognition of which patients should be seen most urgently. The CCG requested the trust to undertake an urgent systematic review based on a risk-assessed methodology.
- In response, the trust started an outpatient improvement programme in April 2015. The programme board met weekly and the work was led by the deputy director of operations. Review of the patients whose appointment outcome was not recorded was completed in June 2015, though this took longer than originally projected by the trust.
- The trust reported that by 19 June 2015 nearly 83% of patients who were overdue for review had appointments booked. We had verbal assurance from a senior manager that these appointments were all before the end of August 2015, though the written information from the trust did not say this.
- The trust has reported that no patients have suffered harm because of the delay in their review.
- The diagnostic imaging team at Newark Hospital was well supported by medical physics at Nottingham. The trust had an appointed radiation protection advisor, radiation waste advisor and the support of medical physics experts.
- We saw local rules and Employers Procedures under Schedule 1 of IR(ME)R, all of which were regularly reviewed and revised. However we noted staff could have carried out more audits against Employers Procedures, in particular clinical evaluation audits for referrer evaluated exposures.
- National Diagnostic Reference Levels (DRL's) were displayed throughout the department and regular dose audit was carried out. There was consistent radiation protection awareness throughout the department and adherence to radiation regulations.
- Radiographers showed sound knowledge of the regulations with good adherence to departmental procedures.
- Pause and check procedures were in place and diagnostic imaging staff implemented these.

Nursing staffing

- Nursing staff were provided for clinics by the relevant divisions in the trust.
- Senior divisional management staff could not confirm if an acuity tool (a means of working out how many staff are required according to the needs of patients) was used to calculate required nurse staffing for all clinics.
- The nurse staffing levels and skill mix required were based on individual clinic lists at Newark Hospital.
- Staff told us there was minimal use of bank and agency nurse cover to fill shifts.

Medical staffing

- Outpatient clinics at Newark Hospital were staffed by consultants from Kings Mill Hospital. Other medical staff were based at Newark Hospital.
- Agency locum medical staff were used to cover annual leave and other absences.

Other staffing

- Agency staff were not used in the diagnostic imaging service. However, there was a high number of part time staff and reliance on bank staff was apparent.
- Staff were sent from Kings Mill Hospital to cover gaps in shifts at Newark Hospital due to sickness and annual leave.
- We were told there were shortfalls in administrative and clerical staff at Newark Hospital.
- Volunteers were used to support nursing and healthcare assistants in outpatients. We saw volunteers checking patients had arrived for their appointments before escorting them to their clinics.

Outpatients and diagnostic imaging

Major incident awareness and training

- The trust had a major incident plan in place.
- Staff told us Newark Hospital would act as an overspill for Kings Mill Hospital for walking wounded patients.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

There was a lack of information available about participation in local and national audits.

Staff continuous professional development (CPD) was encouraged. Staff told us they had received appraisals but the trust did not supply us with the data to analyse completion rates.

Staff were aware of the need to ensure patients gave appropriate consent for their care and all staff had received relevant training. There was effective multidisciplinary working for patient care. Implementation of the new patient administration system had caused difficulties; this was being addressed.

Evidence-based care and treatment

- Staff had access to trust policies and procedures. They used them to deliver care and treatment to patients in outpatients and diagnostic imaging.
- Policies referred to national and local guidance, including National Institute for Health and Care Excellence (NICE) guidelines. This included the policy on access to the service for patients with suspected or confirmed cancer.

Patient outcomes

- The diagnostic imaging service at Newark Hospital had completed quality and safety audits in 2014, including audits of the quality of chest x rays and the appropriateness of out of hours requests for the service.
- The diagnostic imaging service had not completed local audits for clinical evaluations made by referrers in order to test compliance against IR(ME)R requirements.
- Staff had not completed audits to monitor demand and capacity in diagnostic imaging. Following our inspection we were informed that this data was checked weekly at Kings Mill Hospital and there was trust oversight. It was unclear whether this information was made available to diagnostic imaging teams at Newark Hospital.
- We asked the trust to provide information on audits completed by outpatient teams at Newark Hospital. We did not receive this information and so could not be assured local or national audits were completed in Newark Hospital outpatients.

Competent staff

- Outpatient staff at Newark Hospital were clear about their roles and the work they completed.
- Three nurses in the ophthalmology clinic had been trained to use special equipment to test for the presence of glaucoma and tumours. This training was delivered by a member of the photography team from Kings Mill Hospital. However, competencies in the use of the new equipment had not been established. The nursing staff were due to train other qualified nurses in the ophthalmology clinic.
- There was no training specific to clinical roles for outpatients staff, other than clinical training which was included in the trust mandatory training programme, such as basic life support.
- Diagnostic imaging staff at Newark Hospital told us continuous professional development (CPD) was encouraged throughout the department.
- However, the lead radiographer told us numerous external events, conferences and study days were too expensive for the department.
- Written induction programmes were not in place for new diagnostic imaging staff or competency checks for staff returning to work.
- Staff in outpatients and diagnostic imaging told us they had appraisals with their line managers. We asked for data from the trust to confirm how many staff had received an annual appraisal, but we did not receive this in relation to staff at Newark Hospital.

Outpatients and diagnostic imaging

Multidisciplinary working

- Diagnostic imaging staff at Newark Hospital described good multidisciplinary working relationships in their services. However, we noted there was no formal rotation of staff between Newark Hospital and other trust sites.
- Therapies staff worked across Newark Hospital in a multidisciplinary approach with other teams in outpatients as required.
- We found good multidisciplinary working in outpatient teams. This included nursing, medical and administrative and clerical staff.
- Staff told us they worked well together and teams supported each other.

Seven-day services

- Outpatients at Newark Hospital did not provide seven day services.
- Diagnostic imaging staff provided on-call cover on a rota basis at Newark Hospital.

Access to information

- Staff in outpatients at Newark Hospital had access to patients' records via the trust information systems.
- A new patient administration system (PAS) had been implemented. Staff had received and continued to receive training in its use.
- Staff told us the implementation of the new PAS had created delays. Senior divisional management staff confirmed the implementation of the new PAS had created difficulties for staff using the system. They told us work was ongoing to improve use of the PAS.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging were aware of consent considerations to ensure patients gave appropriate consent for their care.
- Consent procedures for patients in outpatients worked effectively.
- Nursing and additional clinical services staff in outpatients had completed Mental Capacity Act (MCA) training.

Are outpatient and diagnostic imaging services caring?

Good

The caring afforded to patients using the service was good.

Patients spoke positively about how they were cared for. We observed patients were treated with kindness and respect. Patients were appropriately supported and involved in their care.

Compassionate care

- Patients at Newark Hospital were happy with the care they received from outpatients and diagnostic imaging staff.
- We observed staff spoke with patients respectfully, with compassion and reassured patients whose appointments were delayed.
- Patients had given positive feedback and comments on patient feedback forms.
- Patients told us they often experienced delays when attending outpatient appointments but they received good care when their appointments were completed.
- In diagnostic imaging we observed radiographers spoke to patients with respect and dignity. They maintained patient privacy and confidentiality throughout their appointments.
- Diagnostic imaging staff were courteous and informative in answer to patient queries about their treatment.

Understanding and involvement of patients and those close to them

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

Emotional support

Outpatients and diagnostic imaging

- Nursing staff in outpatients clinics provided emotional support to patients and those close to them if needed. They reassured and supported patients who were waiting for their appointments or who had been seen.
- A chaplaincy service was available to patients, who were able to access support from different religious faiths. Newark Hospital had a chapel on site, though did not have any separate prayer rooms for other faiths.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The responsiveness of the service required improvement.

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

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

Service planning and delivery to meet the needs of local people

- The trust worked with local commissioners to provide outpatient and diagnostic imaging services for local people at Newark Hospital.
- The facilities and clinic premises were appropriate to deliver outpatient and diagnostic imaging procedures. Staff were knowledgeable about the local patient population and their care needs.
- The main outpatient department at Newark Hospital was very busy. The waiting area was full and the environment was not calm for patients waiting for their appointments.
- Treatment and clinic rooms were clearly signed. However, signs were mostly in English. Newark Hospital serves a local population which includes Polish and other eastern European people.
- We found not all clinics were held on Friday afternoons, and evening and weekend clinics were not routinely scheduled.
- An advanced plain film radiographer worked on site at Newark to meet additional diagnostic imaging reporting demands.
- A new CT scanner had been provided by the trust. The trust and the diagnostic imaging service leads had assessed the needs of the local population in Newark and the demands on the trust overall and deemed that this service was still required.
- Car parking was available on site.

Access and flow

- Data provided by the trust relating to patient waiting times from referral to treatment was for all patients across the trust and not broken down for each hospital. Operational standards are that 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. For nine months between November 2013 and November 2014 the trust fell below this standard and was worse than the England average. The percentage of patients seen within 18 weeks deteriorated sharply between December 2014 and January 2015, and continued down to a two-year low in April 2015 (89.9%). There was an improvement in May 2015 to just over 93%.
- Operational standards are 92% of patients on waiting lists should start consultant-led treatment within 18 weeks of referral. Between April 2013 and November 2014 the trust met this standard except for one month. In the first quarter of 2015, the percentage of patients starting treatment within 18 weeks fell below standard and was worse than the England average . The statistics improved in April and May 2015 (to 91.4%).
- The standard for a patient appointment within two weeks of urgent GP referrals for all cancers was mostly met by the trust between April 2013 and March 2015. The standard for patients who waited at most one month from a decision to treat to a first treatment for cancer, for all cancers, was 96%. Between April 2013 and March 2015 the trust consistently met this target.

Outpatients and diagnostic imaging

- The 62 day operational standard from urgent GP referral to a first treatment for cancer is 85%. The trust had met this standard between April 2013 and March 2015, other than in February 2015 when the trust achieved 75%.
- Between July 2013 and June 2014 the percentage of patients who did not attend their appointments at Newark Hospital was better than the England average of 7%.
- Outpatient appointments were significantly delayed. During our inspection visit, patients attending orthopaedic clinic had wait times of 75 minutes. We observed two patients leaving orthopaedic clinic without being seen due to the excessive wait times.
- Ophthalmology clinics had wait times of an hour; ear, nose and throat, and podiatry clinics had wait times of 40 minutes.
- The trust had carried out an audit of waiting times within clinics at Kings Mill Hospital in May 2015, but not at Newark Hospital.
- The diagnostic imaging service at Newark Hospital had good procedures in place to manage patient access and flow in the departments and for their appointments. The majority of patients were seen at or before their appointment time.

Meeting people's individual needs

- Interpreting services were available as required for patients who did not speak English. If interpreters could not be booked, a telephone interpretation line was available for staff to use during appointments.
- Chaperone services were available for patients if they wished to use this during their consultations and appointments. However, we saw patients' records did not clearly document if patients had been asked if they wished to use the chaperone service.
- Outpatient staff were unaware if the trust chaperone policy had been updated.

Learning from complaints and concerns

- Information on contacting the Patient Advice and Liaison Service and making formal complaints to the trust was available in all clinics and departments.
- Staff told us complaints were recorded in their own department and efforts were made to resolve issues or concerns locally with the patient.

Are outpatient and diagnostic imaging services well-led?

Inadequate

The leadership of the service was inadequate.

The leadership, governance and culture did not always support the delivery of high quality care. The vision and strategy for the outpatients and diagnostic imaging service was not clear or well developed. Governance structures were in place but did not always operate effectively to interact and share information across the trust.

Staff felt locally well supported by colleagues and managers, though not by more senior managers. They felt the Diagnostics and Rehabilitation division, particularly at Newark Hospital, did not have a high profile within the trust.

Patients were asked for their feedback about the service. There were locally held listening and action groups to respond to people's views and concerns regarding the diagnostic imaging service.

Vision and strategy for this service

- The trust had a vision document for Newark Hospital, 'A Vision and Strategic Direction for Newark Hospital – October 2013'. The vision's summary stated that 'Newark Hospital will be a centre of excellence for a broad range of diagnostic, rehabilitation and treatment services – including urgent and planned care.'
- The strategy was not meaningful for the staff and we did not find any evidence of how this strategy was being implemented and how the service had moved forward. Outpatients staff had varying levels of knowledge about their service's vision and strategy.
- There was a lack of strategic vision for diagnostic imaging services at Newark Hospital. The radiology services manager told us they were aware a greater presence was required on the Newark Hospital site. Additionally more rotation of staff across the trust sites and more planning meetings with site leads at Newark

was required. The aim going forward was to have a radiology manager on site at Newark weekly to enable the two main trust sites, Kings Mill and Newark Hospitals, to be more cohesive.

Governance, risk management and quality measurement

- Concerns about the backlog of patients awaiting review were identified in January 2015 but the trust outpatient improvement programme board was not in place until April 2015. The board had not made substantial progress in addressing concerns in outpatients at Newark Hospital, including the patient appointment backlog, administrative processes and waiting times and access to services.
- In June 2015 the diagnostic imaging services at Newark Hospital were managed under the trust's Diagnostic and Rehabilitation division. Prior to this they were part of the Hospitals governance structure. It was too early to judge if this new governance system was working. Some staff were not clear about the changes that had just been brought in.
- Newark Hospital governance meetings were held monthly. However, there was no interaction or direct sharing of information with Kings Mill or Mansfield Community Hospitals divisional governance teams.
- There was a risk register for Newark Hospital showing the current identified risks. Only one of these related directly to the outpatients service – the issue of missing medical records due to the lack of storage available. Action was planned to address this risk, but there were no timescales for this or for when the risk would be reviewed. The register did not show who held responsibility for each risk identified. In the divisional risk register, there were two risks listed for outpatient and diagnostic services. Neither had a timescale for which to reduce the risk and only one had an identified accountable person.
- The hospital risk register was in the process of transferring to a new governance structure within the division of diagnostics and rehabilitation. It was too early to comment on the effectiveness of this new system. The senior leaders told us shadow arrangements were in place in the interim to ensure governance issues that were specific for Newark Hospital were not lost in the transitional period.

Leadership of service

- Staff in outpatients and diagnostic imaging at Newark Hospital reported good levels of local operational management support. They told us their local managers were approachable and available to discuss concerns.
- However, staff throughout the services at Newark Hospital told us they felt there was a disconnect between the trust and divisional senior management teams and themselves.
- The administration of Newark Hospital outpatient appointment bookings and patient booking teams was under the portfolio of the Newark Hospital Manager. Senior divisional management staff in the Diagnostics and Rehabilitation division confirmed patient booking teams were to be transferred to their division but no date had been set.
- Diagnostic imaging staff told us their service was well-led by an experienced senior radiographer. They told us the trust Chief Executive visited Newark Hospital but had not specifically visited diagnostic imaging teams.
- Diagnostic imaging staff told us their services' senior management team were more understanding and there was increased vision of senior management recently at Newark Hospital.
- Staff throughout the division reported they did not feel the Diagnostics and Rehabilitation division, specifically at Newark Hospital, had a high profile within the trust.

Culture within the service

- The diagnostic imaging lead attended listening events that were pertinent to Newark and it was apparent the team was cohesive and worked well together. Team brief was cascaded locally at staff meetings. Staff told us the lead radiographer had good oversight of diagnostic imaging services at Newark Hospital.
- Outpatient staff at Newark Hospital were positive about their working relationships with colleagues and in their local teams. Staff worked hard to deliver care which met patients' needs but were not always able to achieve this due to factors outside their control.

Outpatients and diagnostic imaging

- Newark Hospital outpatients was very busy. Staff dealt with patients in the busy clinic environment but the clinics were not conducive to positive patient experiences.
- Staff in outpatients told us they felt communication and information sharing between Newark Hospital and other trust sites, in particular Kings Mill Hospital, did not happen in a timely way to improve quality of services provided. This included communications about the trust senior management plans for the future of Newark Hospital.

Public engagement

- Patients and those close to them were asked for feedback.
- Staff in the diagnostic imaging service held listening and action groups for the local population, with the intent of responding to patients' highlighted needs.

Staff engagement

- There were monthly staff forums and team briefings, by video link, held in the boardroom at Newark Hospital.
- Staff had been invited to participate in the 2014 NHS staff survey. The trust's score of 3.66 was worse than the average score for staff engagement.
- Outpatients staff told us morale had deteriorated in individual teams, particularly because of the perception Newark Hospital was not high on the trust board's agenda. Staff said they had not been well informed or fully involved in the changes planned for the service.
- A series of staff briefing sessions with the Acting Chief Executive were planned throughout June 2015.

Innovation, improvement and sustainability

- The outpatient improvement programme board was set up in April 2015 to address issues in the outpatients service. The board had not made substantial progress to tackle and resolve these issues across the trust, including at Newark Hospital.
- Staff in outpatients and diagnostic imaging expressed their concerns in regard to the ongoing provision of services at Newark Hospital.
- They told us their perception was the trust were reducing delivery of services and divisional capacity for care to be provided at Newark Hospital.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

1. Ensure medicines are always safely managed in line with trust policies, current legislation and best practice guidance.
2. Ensure systems and processes to prevent and control the spread of infection are operated effectively and in line with trust policies, current legislation and best practice guidance.
3. Ensure staff understand the requirements of the Mental Capacity Act 2005 in relation to their role and responsibilities.
4. Ensure all equipment, including emergency lifesaving equipment, is sufficient and safe for use in the minor injuries unit.
5. Ensure safe care for patients with mental health conditions at the minor injuries unit and especially those who may self-harm or have suicidal intent.
6. Ensure staff have the appropriate qualifications, competence, skills and experience to care for and treat children safely in the minor injuries unit.
7. Ensure the inter-facility transfer protocol with East Midlands Ambulance Service is updated and is effective in providing safe and timely care for patients at the minor injuries unit.
8. Ensure there are effectively operated systems to assess, monitor and improve the quality and safety of the services provided in the minor injuries unit.
9. Ensure systems and processes are effective in identifying where quality and safety are being compromised and in responding appropriately and without delay. Specifically, systems and processes to identify and respond to outpatient appointment issues
10. Ensure robust and effective governance links and oversight are established and maintained between outpatient services at Newark and Kings Mill Hospitals.
11. Ensure the quality of the service provided by the specialist palliative care team is effectively monitored and reviewed to ensure the service is meeting the needs of patients throughout the trust.
12. Ensure risks for end of life care services are specifically identified, and effectively monitored and reviewed with appropriate action taken.
13. Ensure that pacemaker devices removed from deceased patients are safely and promptly disposed of.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

1. The trust should ensure effective communication between senior management and staff at Newark Hospital, engaging them in discussions regarding the future of Newark Hospital.
2. Ensure systems to share learning from incidents include learning from incidents at all trust locations
3. Ensure all staff are adequately and appropriately trained to use the trust incident reporting system.
4. Ensure all staff complete mandatory and statutory training in line with trust targets.
5. Ensure staff within the minor injuries unit are able to attend relevant training sessions, including when training is delivered at Kings Mill Hospital.
6. Ensure patients are offered fluids whilst in the minor injuries unit and that this is documented in their care records.
7. Ensure the minor injuries unit meets the College of Emergency Medicine Clinical Standards for Emergency Departments guidelines and the College of Emergency Medicine minimum requirements for Unscheduled Care Facilities
8. Ensure leaders within the minor injuries unit understand their responsibilities under Regulation 20 Duty of Candour.
9. Ensure patient records are available when patients attend outpatient clinic appointments.
10. Increased use of the theatres at Newark Hospital should be considered to improve service provision and patient outcomes.
11. Ensure there is a service level agreement for the provision of specialist palliative care to minimise the risks associated with this service being withdrawn.
12. Ensure there are sufficient resources to support the end of life care team to deliver an end of life care programme and roll out end of life care initiatives throughout the trust.

Outstanding practice and areas for improvement

13. Ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(g) Care and treatment must be provided in a safe way for service users by the proper and safe management of medicines. • Portable oxygen on Sconce Ward was not always stored securely. • A drug trolley and pill cutting equipment were not adequately cleaned. Regulation 12(2)(h) Care and treatment must be provided in a safe way for service users by preventing and controlling the spread of infections. • Infection control practices were not followed in line with trust policies on Sconce Ward. • Staff working in the mortuary did not have sufficient supplies of personal protective equipment. Regulation 12(2)(i) Care and treatment must be provided in a safe way to service users • There were delays in transferring sick patients from the minor injuries unit to acute hospitals because of a lack of ambulances. The transfer protocol with East Midlands Ambulance Service had not been updated and was not effective in providing safe and timely care for patients.

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

This section is primarily information for the provider

Requirement notices

Regulation 18(2)(a)

- Staff must receive such appropriate support, training, and professional development as is necessary to enable them to carry out the duties they are employed to perform.
- Not all staff understood the requirements of the Mental Capacity Act 2005

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(1)(a)(b) The care and treatment of service users must be appropriate and meet their needs** • Effective systems and processes were not in place to support patients with mental health conditions attending the minor injuries unit.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)** **Systems or processes must be established and operated effectively to assess, monitor and improve the quality and safety of the services provided:** • Systems were not effective in assessing, monitoring and improving the quality and safety of services in the minor injuries unit. • There was a lack of robust and effective governance links between outpatient services at Newark and Kings Mill Hospitals. • Systems and processes were not effective in assessing, monitoring or mitigating the risks regarding the outpatient appointment issues.

This section is primarily information for the provider

Requirement notices

- There was no system in place to ensure the safe and prompt disposal of pacemaker devices removed from deceased patients.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(2)(a)** **Staff did not always have the appropriate qualifications, competence, skills and experience to provide care and treatment for children in the minor injuries unit.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(d)** **Care and treatment must be provided in a safe way for service users by ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way.** • The ligature risk posed by the use of non-collapsible curtain rails in the minor injuries unit had not been properly assessed or addressed. • Equipment in the minor injuries unit, including emergency lifesaving equipment, was missing or out of date.