# Mid Staffordshire NHS Foundation TrustMid Staffordshire NHS Foundation Trust

## Quality Report

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This report describes our judgement of the quality of care at this trust. 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.

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## Overall summary

### Letter from the Chief Inspector of Hospitals

The key question we were asked to consider whether Mid Staffordshire Hospital NHS Foundation Trust (MSFT) is currently providing safe care and whether safety was likely to be sustainable in the future. We were aware that the planned date for the dissolution of MSFT and transfer of responsibility for services to University Hospital of North Staffordshire NHS Trust (UHNS) and Royal Wolverhampton NHS Trust (RWT) is 1 November 2014. We therefore considered whether safe provision of services was likely to be sustainable over the next four months and beyond that over winter 2014/15.

### Our approach

To undertake this task within a very short timescale we modified our new approach to inspection of acute hospitals. We concentrated particularly on the first of CQC's five key questions i.e. Safety. Within this we looked very closely at staffing levels for nurses, doctors and allied health professionals in key clinical services and the approaches that Trust Special Administrators and Mid Staffordshire Hospital NHS Foundation Trust has made to recruit and retain staff. We also looked at the impact of any deficiencies in staffing levels on the quality of care being delivered by staff at MSFT. Finally we considered the leadership of services at MSFT.

During the pre-inspection phase we looked at the report from the Trust Special Administrators (TSAs) regarding future configuration of services currently provided at MSFT. These recommendations have been accepted by the Secretary of State for Health and we were not asked to reopen the debate on these recommendations. Rather, the report provided us with the agreed direction of travel for different clinical services. We are also aware that a further review into the configuration of maternity services is being commissioned. We reviewed the safety and sustainability of services at this trust in this context.

We were given access to the minutes of the Sustaining Services Board, chaired by the TSA representative, which brings together leaders of the local health economy around MSFT and to a copy of the due diligence report commissioned by the Board of UHNS. The Chief Executive of MSFT and her staff were extremely helpful in providing detailed information on current and projected staffing levels and other recent performance management information for the trust.

In this process, we are not providing ratings on the trust as we normally would do. This is deliberate and reflects both the bespoke nature of the remit and the planned disaggregation of the trust in November.

### An overview of our findings

The commitment of staff at all levels to the delivery of high quality care at MSFT was evident throughout the hospital. However, it is important also to recognise the degree of fatigue reported by staff. This relates both to the relentless external scrutiny focused on MSFT and from uncertainty about the future.

The trust is facing major difficulties in recruiting and retaining medical and nursing staff both because of the continuing uncertainties about the future and because of the previous poor reputation of the trust outside the local area. These factors are creating a large destabilising influence across the organisation.

The senior managers at MSFT, including the Chief Executive, are spending inordinate amounts of time ensuring that individual nursing shifts are adequately filled and that sufficient numbers of medical staff will be available for different services. To date they have just been able to do this, but the emphasis here is on the word just. This has resulted in a significant reliance on temporary medical and nursing staff, which has a resultant impact on permanent staff working in the relevant clinical areas. In addition, there is an almost complete dearth of formal medical service level clinical leadership at MSFT. While additional staff have been supplied by UHNS in some clinical areas, in other areas the movement of staff has been from MSFT to UHNS.

Our inspection team members judged that safe care is currently being delivered in each of the clinical areas except for medical care which required some improvement. Staffing levels are only just adequate in

# Summary of findings

some areas, particularly on the medical wards and of these, the winter escalation ward, (ward 11) was still open and gave the most cause for concern. Medical and nursing staffing pressures make this ward unsustainable.

The inspection team members were, however, much less assured about the sustainability of some services, even over the next four months. Should staffing levels fall by even one or two people in some key posts, services would become unsafe. The only option for handling such an eventuality identified to us either by the TSA or the trust management would be to reduce the bed base and almost certainly to restrict admissions to the hospital (unless flow through the hospital can be substantially improved). Indeed there have already been occasions when the West Midlands Ambulance Service has been asked to divert emergencies to UHNS or RWT. Undesirable as this is, this does indeed appear to be the only option available. The fragility of the provision of acute services cannot be overemphasised

The TSA and the trust management have proposed a reduction in the opening hours of A&E as a means of reducing the burden on acute services and thus maintaining safety. My inspection team had concerns about this approach. In particular they were concerned that it might not achieve the desired reduction in emergency admissions to the hospital and that it might render the junior doctor rotas unviable. This would at the very least need to be discussed with colleagues at Health Education England.

Looking beyond the planned date of transition in November 2014, inspection team members were unanimous in their view that services would be unsustainable should any degree of winter pressures arise. It is therefore imperative on safety grounds that the transition should not be delayed.

## Transition

We were both surprised and very concerned that a clear transition plan has yet to be developed to ensure the safe transition of responsibility for clinical services to the agreed model of care over the next four months. This clearly requires full involvement of MSFT and other organisations in the wider health economy. Although the Sustaining Services Board has provided a useful forum for bringing together the relevant stakeholders it is not a decision making group and has no authority to take action. In addition the workforce at MSFT needs clarity as soon as possible about what is going to happen and when. The current uncertainty is contributing to the fatigue and fragility amongst staff. The transition plan should therefore include a commitment by the acquiring organisations to actively support medical and nursing staffing levels at Mid Staffs over the next four months so that services remain safe.

It is now imperative that a clear and timetabled transition plan should be developed and implemented without delay. This should set out the steps that will be taken to ensure services remain safe, effective, caring and responsive to patients' needs. Leadership responsibilities and accountabilities need to be clearly defined. This will require high level input and commitment from TSA/MSFT, UHNS and RWT and from CCGs and WMAS. No single organisation can achieve this on its own. High level oversight from Monitor and TDA, as the organisations which oversee the various providers will be essential.

Yours sincerely

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

**Are services safe?**

The inspection team found that services at the trust were currently judged as safe, but in many cases staffing levels were only just safe. Services, particularly in the medical and surgical areas were very fragile and the impact of even one or two staff leaving could be significant. We were specifically concerned about the fragility of ward 11. Consequently, the inspection team were less assured about the sustainability of the current level of care in the future. The trust had set up a number of processes to monitor safety and had developed a range of tools to help them assess levels of safety across the trust.The biggest impact on safety was the high number of temporary workers at the trust, who were not familiar with ward procedures and processes and the lack of continuity on the wards this created. The senior management team were aware of this and doing what they could to mitigate some of these risks, mostly by being aware of the detail of service delivery. Staffing levels were monitored on a shift to shift basis. These factors have created a culture of uncertainty and instability which staff are working with on a daily basis.The trust management team shared with the inspection team plans to further reduce the opening hours of the A&E department to attempt to address patient flow issues and allow them to reduce capacity. We were concerned about the impact on the quality of care delivered by this change on the department.

**Has care been safe in the immediate past?**

- The trust monitored its performance through the NHS Safety thermometer.
- 4882 patient safety events were reported in the 12 months up to May 2014. 34 (0.7%) were assessed as severe.
- 72 serious incidents had been reported to the National Reporting and Learning System (NRLS) by the trust in the 12 months to May 2014. Approximately one-third of these incidents were related to ward and/or unit closure.
- The trust reported no never events (these are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) in the period May 2013 to April 2014.
- Staff we spoke to knew how to report incidents and were able to give us examples of where they had received feedback.
- The trust has developed a nursing forecast tool which enables them to monitor actual staffing levels against target levels. This also enables them to forecast ahead and anticipate where staffing issues may arise.

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- In January 2014, the Trust developed a series of identified scenarios where they would consider wards were at risk and the point beyond which the trust was not prepared to go. These were locally developed based on key trust measures and were known as “Tipping Points”. These were:

- A trust employed nurse is not in-charge of the ward

- There are less than two registered nurses on the shift

- There is more than one registered nurse role unfilled on a shift

- There are more than 50% outliers on a ward

- The ratio of staff to patients is higher than 1:8

- Summary of points from core services reports

- One or more of these triggers would escalate the situation to the trust senior management team who would then manage the situation. The trust acknowledged that this is highly subjective and admit to overriding these limits on occasion but feel this is a valuable tool to them in identifying and escalating issues.

**Is care safe now?**

**Nurse staffing levels and skill mix**

- The trust is extremely challenged in terms of nursing resource. 75% of substantive registered nurses in post were available to work. The 25% unavailable are due to a combination of vacancies, long term sickness, maternity leave and suspension.
- Additional cover is made up from bank nurses and agency workers, which potentially impacts on the quality and continuity of care and temporary staff are not familiar with trust processes and procedures.
- The trust’s agency spend was £9.4million between 1 April 2011 and 30 March 2012. This, when compared to national agency spend is more than double other NHS organisations.
- The trust matrons have retained a supernumerary role, despite the pressure on staff numbers. The trust have done this to mitigate the risk associated with high number of temporary staff, providing support, supervision and training where necessary.
- The trust have proactively undertaken a number of activities to fill the current vacancies. This has included:

- Financial incentives

- Open recruitment days

- Rolling adverts in the local press, supermarkets and other public areas

- In February 2014, UHNS provided the trust with 20 registered nurses of Band 6 and above who had the necessary competences to be in charge of a ward. This was for a 3-month period and initially was successful. When the 3 month period concluded in May, half of the nurses returned to UHNS. The trust told us that UHNS replaced these 10 nurses, but not like for like; so the trust feel they do not have the extra help in the areas where it is really needed. Although this support has been helpful the trust were disappointed that the initial support could not be sustained.

### Medical staffing levels

- There are approximately 50% vacancies in medical staff.
- These are covered by a high number of locum doctors. The trust has difficulties attracting and retaining good quality permanent or locum doctors because of the previous poor reputation and the uncertainty around the future.
- Some consultants have left MSFT because of the uncertainty and have been recruited directly to UHNS which compounds many of the issues they are facing. The trust expends significant additional management and clinical effort in managing this issue.
- UHNS have been able to offer limited support.
- The trust has four clinical director posts in the current structure, at the time of the inspection there were two directors in post one of whom was on sick leave, and the other will be leaving the trust in August. There will be one clinical director working at the trust from August onwards.

## What is the impact of staffing on caring and responsiveness?

- During our inspection, the commitment of all the staff we met was evident. We observed care was delivered in a compassionate, respectful and kind manner.
- Some people did contact us stating they felt they had been ignored whilst on the wards, but patients and relatives we spoke with were mainly positive about how caring the staff were and how the service was able to respond to their needs.
- On the whole, across the wards and departments we visited, there were enough nurses to meet people's needs.
- There was a high percentage of medical patients on surgical wards (referred to as outliers). On day one of our inspection

there were 32 medical outliers and day two there were 26 at Stafford Hospital. Staff on surgical wards felt that this was impacting on the quality of care given to patients and that senior managers did not acknowledge this.

- There were also enough doctors but staff told us that there was sometimes a delay getting medical staff to review a patient or prescribe medication especially at the weekend or out of hours.
- A&E regularly breached the target for patients to be seen within 4 hours. In the period April-June 2014, the trust had achieved 85.6% against the 95% target. On the first day of our visit there had been 125 attendees. When we left the department at 22.30, there had been 25 breaches of the four hour target.
- The A&E department closed to patients every night at 22:00. Staff we spoke with told us that there was usually an influx of patients in the last hour. When we visited at 21.00, the minors area had only 1 patient. By 22.00 it was full, with patients in the waiting room. This put a lot of pressure on the service in short time frame. We understood this to be a typical pattern.
- In maternity, the department was generally well staffed although concerns were raised around the lack of middle grade doctors but that cover was being arranged using existing Consultants. There were sufficient numbers of consultants to ensure each shift had adequate cover.
- There were sufficient midwives for the labour ward to deliver care and respond to patient's needs.
- The skills and experience of temporary staff differed and it was not always possible to provide care from the same staff. This was having an impact on the continuity of care on the wards.
- Ward 11 was staffed with nurses from UHNS, bank and agency staff and staff from other wards were allocated to this ward on a short term basis. Patients expressed their concern about staff continuity stating that if they go to ask the staff something about their relative they say they don't know because they are from an agency.
- Provision of care and timely diagnostics was not affected by the shortage of radiologists. National report turn around timescales was met.
- Radiologist staff shortages sometimes resulted in no representation at multidisciplinary team meetings, meaning there were gaps with radiology information about patient's care and treatment which made inter departmental communication more difficult.

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### Is care in the future likely to be safe?

- Services are due to be transferred to new providers from 1 November 2014. No plan was made available to us that identified how and when the transition would take place to ensure safety was not compromised.
- If the current opening hours for the A&E department are maintained, we considered it to be safe and sustainable. Any reduction in the hours that the A&E is open might compromise the sustainability and safety of the service. We initially had concerns that the reduced opening hours could result in the removal of trainees from the department, however we have since been informed by the trust that they have been assured by Heath Education England that this will not occur.
- The persistent attrition rate amongst staff in surgery will increase the risks to patients. Crucially, the nurses that are leaving the trust are the most experienced and if they leave before the planned transition, this could potentially have a significant impact on patient safety.
- Likewise, in medicine, trained staff told us they were coping on 'shift to shift' basis and that this had become normalised. Should staffing fall by even one or two people in some key posts, services would become unsafe.
- We were less concerned about the safety of the critical care department. There was good retention of nursing staff and they reported recruiting good quality staff. The flexible management of the beds gave the department scope to deliver services effectively.
- Current arrangements for the maternity department worked well, but the lack of staff engagement and absence of plans for the transition period or post transition period was having a de-stabilising effect on staff and patients.
- In the near future radiologist staffing levels were due to fall to inadequate levels. However, plans have been implemented to address these concerns which included discontinuing elective radiology with only urgent services continuing to be accepted at Mid Staffordshire.

### What alternatives to staffing on site have been considered and/or implemented?

- Reduce A&E opening hours to 08:00 to 19:00 daily.
- Ambulance diverts to other hospitals.
- Close ward 11, the winter pressures ward.
- Ongoing provision of nursing staff from UHNS. (Originally approximately 20 experienced nurses from UHNS, half of these nurses have now returned).
- Provision of medical cover at Cannock Chase Hospital by RWT.

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- Increased provision of beds at RWT. (to date 15 beds have been made available).
- Asking neighbouring trusts to recruit on their behalf.

**Are services well-led?**

The impact of the trust being under Trust Special Administration has a profound impact on the shape of the leadership of the trust. In effect the TSA takes on the traditional role and responsibility of the board. Accountability for the quality and safety of the care provided at MSFT trust is dissolved is with the TSA. However the trust does still have a CEO, DoN and Medical director who instead take on a much more operational role. The vast majority of their time is spent securing and maintaining adequate staffing levels.

Strategic direction for the trust has largely already been determined and the trust is due to be dissolved on 1 November 2014. However, we were not assured that effective arrangements had been made to secure safe transition of the services of the coming months. We were not provided with a clear transition plan. WE were aware of the existence of a Sustaining Services Board (SSB) however this did not appear to have a decision making function. Consequently staff at MSFT remained very uncertain regarding their future roles.

**Governance, risk management and quality measurement.**

- The trust senior management team report to the three TSAs and link to the TSA governance team who are primarily tasked with coordinating the disaggregation and transition of services
- Externally, there are transition boards, working with RWT and UHNS
- “Business as usual” is managed on a day to day basis by the senior management team at the trust. The TSA have little involvement in this.
- The Trust has a number of processes in place to monitor risk and measure quality
- Regular audit takes place and the trust compiles a balanced scorecard for each ward which describes progress against a number of key targets
- The trust participated in the NHS Safety Thermometer.
- Structured monthly governance meetings were held within the divisions. Complaints, incidents, audits and service performance information were discussed and actions agreed.
- Each division had a quality dashboard for each service and ward area this showed performances against quality and performance targets and these were presented monthly at the clinical governance meetings.

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- The trust participated in a number of national audits and quality indicators for critical care were externally validated
- In surgery, learning from incident investigations was fed back to staff at monthly meetings and direct e mail feedback to the staff who reported the incident is mandatory within the trust.
- Staff in medicine were not confident that there was a robust system to ensure changes to practice were communicated to all staff within the division particularly during a time when there was a heavy reliance on temporary staff.
- In May 2014 it had been noted that improvements were made in relation to mortality reviews within the Surgical Division. Additional reviews were planned to reduce the backlog within the division. The surgical division currently had 32 mortality reviews outstanding.

**Leadership of services**

- The trust senior management team, including the chief executive are excessively involved in a day to day basis managing the risks associated with the staffing issues at the trust. This is frequently referred to as “business as usual”. To date, they have achieved this but it has taken a huge amount of effort and commitment.
- By being involved with this level of detail, it allows the team to mitigate some of the risk and provide support on the wards and in departments.
- The Chief Executive is fully occupied by the operational working of the day to day activities of the hospital. This left little time for involvement in the strategic direction of MSFT.
- In addition this left little opportunity for longer-term planning and many staff commented on the general lack of strategic leadership and limited vision. This may be seen as an inevitable consequence of disaggregation, but this has the potential to increase uncertainty and destabilisation in an already anxious workforce.
- We were unable to identify a clear plan to explain how and when services would be transferring to the new providers.
- The Chief Executive is well known to the staff and she regularly holds briefing sessions with staff. However the Director of Nursing and Medical Director are less well known amongst the staff
- The Director of Nursing recently implemented a weekly meeting with the senior nursing team to discuss issues.
- We saw many examples of positive leadership at ward or department level in maternity, radiology and critical care.
- The operating theatres at Stafford and Cannock were found to be well run and efficient with good leadership.

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- Nurse leadership of shifts in A&E was effective, and staff felt supported within the department.
- Senior clinicians and nurses were already coming to the A&E department from UHNS to commence integration. This was viewed positively by staff.
- We found that there was a lack of continuity of leadership arrangements on some medical wards. Relatives on wards 11 and 12 reported a series of ward managers/ matrons since their relative had been a patient.
- The trust has four clinical director posts in the current structure, at the time of the inspection there were two directors in post one of whom was on sick leave, and the other will be leaving the trust in August. There will be one clinical director working at the trust from August onwards.

### Culture within the service

- Staff spoke positively about the service they provided for patients but recognised the challenges to ensure this continued.
- As expected, the recent history of the trust has had a significant impact on the culture of the organisation.
- Many managers and staff described it as being in a "goldfish bowl", creating additional pressure for all staff to work within.
- Staff not been nurtured and many used words like "brow-beaten", "weary" and "bruised" to describe the culture.
- Staff told us there was a lack of openness and clarity at trust level. They felt that there was a feeling of 'get on with it' to ensure quality care and patient pathways were maintained.
- Morale was decreasing, staff told us that there was little or no capacity to learn and innovate and the lack of information about the future of services was also having an impact.
- We saw many examples of positive teamwork. Staff worked well together in teams, there was obvious respect between staff at all levels
- Some staff told us that they had felt under considerable work pressure, particularly when there were high levels of temporary staff working.

### Public and staff engagement

- Many staff described themselves as tired and morale was low. The level of constant scrutiny had taken its toll and the level of uncertainty about the future was unsettling for many staff.
- Staff told us they did not feel listened to or engaged with on the plans around transition.

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- All of the staff we spoke with told us they had not received any communication from the TSA about the future of the organisation and more specifically their ward or department which was a source of frustration for many staff.
- We were told that communication from trust leaders was not always easily understood but the Deputy Director of Nursing had developed positive and supportive relationships with the nursing staff.
- Some staff commented that the lack of clarity surrounding the future had influenced colleague's decisions to leave the organisation and that was why recruitment had been unsuccessful.
- The delay in the final date for transfer of services was also adding to the concerns felt by staff.
- The union representatives reported that they have weekly meetings with TSA and are able to present them with questions but do not always get a response.
- Patients we spoke with were very happy about the care they received in the wards and departments and were very anxious about having to travel to other hospital.
- One of the concerns was the long distance to travel to other hospitals with many people reliant on public transport.
- There appeared to be a limited public understanding of how services would look following the integration of services. Many people thought that the hospital would close. This uncertainty was causing a high level of stress and anxiety in the local community. The result of this was to create polarised views and expose concerns.
- The trust had very close links with the local commissioners, who were very involved with the day to day operations of the trust. This was unusual and had the potential to blur boundaries, however some managers felt this was a positive relationship and welcomed the support they provided.

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## What people who use the trust's services say

At our listening event, we heard from many people about their recent views and experience of care at the trust. Their views were overwhelming positive. People who had used the service told us they felt they had received good care and praised the staff. Many people commented that Stafford hospital was very busy but they felt staff coped extremely well and were very supportive of the nurses. A number of people commented on the low staffing numbers and told us about the impact that had had on their care.

There are strong feelings about the trust in the local community and a number of local community groups have been set up. We met with groups who support the trust and are proactively campaigning for as many services as possible to stay in Stafford. We also met groups and individuals who were concerned about safety at the trust. We were also contacted after the inspection by a number of individuals who were both supporting the trust and expressing concerns.

Many people at the listening event expressed concern about the future of the trust and what would happen when UHNS and RWT took over providing services. In the main, views were stronger regarding Stafford Hospital.

Between September 2013 and January 2014, a questionnaire was sent out to people who had been an inpatient at the trust during June, July and August, as part of CQC's Adult Inpatient Survey 2013. Overall the trust was rated as the same as other trusts in the survey but rated better on questions about waiting lists and planned admissions.

The Cancer Patient Experience Survey (CPES), showed that the trust rated as average in the vast majority of questions posed. However, the trust scored in the lowest 20% of all trusts for patients having confidence in the doctors treating them and whether or not they felt there was enough nurses on the ward.

CQC's Survey of Women's Experience of birth in 2013, showed that the trust was about the same as other trusts on questions about labour and birth and staffing but was better than other trusts on questions about care in hospital after the birth.

The Friends and Family Test for A&E for May 2014 had a total response rate of 31% with 682 responses, 434 of which said they were extremely likely to recommend the service.

During the inspection we spoke with many patients and their relatives. They told us they were very satisfied with the care provided and told us staff were kind, caring and compassionate.

# Mid Staffordshire NHS Foundation Trust

## Background findings

**Hospitals we looked at**
Cannock Chase Hospital and Stafford Hospital

## Our inspection team

**Our inspection team was led by:**

**Chair:** Dr Andy Welch, Medical Director and Consultant ENT Surgeon, Newcastle Upon Tyne Hospitals NHS Foundation Trust

**Head of Hospital Inspections:** Tim Cooper, Care Quality Commission

The team of 28 included CQC inspectors and a variety of specialists: consultant radiologist and radiography manager, consultant surgeon, ex divisional surgery manager, specialist registrar in anaesthetics and intensive care medicine, emergency department matron, emergency medicine consultant, midwife and supervisor of midwives, consultant physician, respiratory specialist registrar, deputy director of nursing, chief operating officer, director of nursing and two experts by experience.

## Background to Mid Staffordshire NHS Foundation Trust

Much has been written about this trust in recent years. This is a different organisation to that from 2009 and the challenges it is facing are exceptional.

Mid Staffordshire Hospital NHS Foundation Trust (MSFT) serves the population of South Staffordshire. It is based on two sites, Stafford Hospital and Cannock Chase Hospital. There are approximately 350 beds, last year the trust had approximately 28,000 inpatients, there were 1800 births and over 45,000 people came to Accident and Emergency.

In 2013 the trust was declared clinically and financially unviable and the Trust Special Administrators (TSA) were appointed by Parliament in April 2013. In addition to taking on accountability for the day to day running of the Trust, the administrators were required to develop a plan for ensuring that clinically and financially sustainable services can be delivered for the local population currently served by the trust. The plan recommended that the trust be

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dissolved and responsibility for Cannock Chase hospital should be given to Royal Wolverhampton Hospital NHS Trust (RWT) and Stafford Hospital to University Hospitals of North Staffordshire NHS Trust (UHNS).

In January 2014, Monitor confirmed approval of the proposed dissolution of the Trust and passed the report to the Secretary of State for consideration, who approved the principal recommendation that the trust should be dissolved. The date for dissolution of the trust is currently set for 1 November 2014 and services will transfer to the new providers from that date.

This inspection has been requested by Monitor, the Trust Development Agency (TDA) (as both UHNS and RWT are not foundation trusts) and the TSA. All of these agencies have expressed serious concerns about the sustainability of safe staffing levels at MSFT and they have jointly asked for an independent review by CQC. We have carried out this focused inspection in response to this request.

## Why we carried out this inspection

We were asked to consider whether Mid Staffordshire Hospital NHS Foundation Trust (MSFT) is currently providing safe care and whether safety was likely to be sustainable in the future. We were aware that the planned date for the dissolution of MSFT and transfer of responsibility for services to University Hospital of North Staffordshire NHS Trust (UHNS) and Royal Wolverhampton NHS Trust (RWT) is 1 November 2014. We therefore considered whether safe provision of services was likely to be sustainable over the next four months and beyond that over winter 2014/15.

## How we carried out this inspection

As this was a focused inspection we did not cover all of the five key questions across all core services. The main focus of the inspection was on the safety of current staffing levels in acute services and on the likelihood of these being sustainable over coming months.

Due to the specific focused nature of the inspection, we have relied on the trust to provide us with key performance metrics and we have reviewed specific documents from the TSA, local Sustaining Services Board, along with minutes from the Transition Board and other key documents. Additionally, we have engaged with key stakeholders from the local community and representatives of local health organisations.

We held a listening event, in Stafford, on 30 June 2014, when over 100 people shared their views and experiences of Stafford Hospital. Some people who were unable to attend the listening events shared their experiences in other ways, including via letter, email or telephone.

We carried out an announced inspection visit on 1 and 2 July 2014. We held focus groups with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, administrative and clerical staff, theatre staff, physiotherapists, occupational therapists, pharmacists, radiographers, domestic staff and porters. We also spoke with staff individually as requested.

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