

Burton Hospitals NHS Foundation Trust

Queen's Hospital, Burton Upon Trent

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Queen's Hospital is part of Burton Hospitals NHS Foundation Trust. The hospital provides a full range of district general hospital services and also has a treatment centre which provides day case ophthalmology, outreach and community-based clinics to the population.

We inspected this hospital in July 2015 as part of the comprehensive inspection programme. We inspected all core services provided by the trust.

We visited the hospital on 7, 8 and 9 July 2015 as part of our announced inspection. We also visited unannounced to the hospital on Friday 24 July 2015.

Overall we have rated this hospital as requires improvement. We saw that services were caring and compassionate. We also saw that people have good outcomes because they receive effective care and treatment that met their needs. We saw a number of areas that required improvement for them to be assessed as safe and responsive. We saw that leadership of services in some areas also required improvement.

Our key findings were as follows:

- The hospital had made significant progress since our last inspection in April 2014. Improvements in safety and leadership were evident, but there was still more work to be done.
- Staff were caring and compassionate towards patients and their relatives. Patients' dignity and privacy was ensured and we saw many examples of good care right across the trust for staff at all levels.
- There was a strong open culture and staff were encouraged and supported to report incidents. There were clear systems in place to ensure lessons were learnt and services developed as a result.
- The pathway for patients requiring emergency gynaecology care was ineffective.
- End of life care services had improved and there were clear plans in place to develop the service further.
- Nurse staffing was a challenge in some areas of the trust. There was heavy reliance on agency staff to ensure staffing levels were kept safe. The trust was working hard to address this.

We saw several areas of outstanding practice

- Critical care had developed an organ donation group to improve and promote organ donation within the hospital and the local community.
- The maternity service was awarded the Excellence in Maternity Care award by CHKS in 2014. The quality of care at Burton Hospitals NHS Foundation Trust was judged to be the best out of 148 NHS maternity providers in England, Wales and Northern Ireland.
- Innovative practice to increase hand hygiene, using the latest technology monitoring the use of alcohol sanitising gel.

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

Importantly the trust must:

- The trust must ensure that ward assurance targets, such as hand hygiene practice and recording of patient observations, is achieved at a consistent level in the emergency department.
- The trust must review the use of agency staff on surgical wards to ensure staffing levels and skills mix are maintained and all staff have access to the relevant records.
- The trust must develop a clear vision and strategy for critical care services which is shared with staff and clinical leaders and demonstrates how the service will develop in the medium and long term.
- The trust must ensure that all identified learning points from the investigations into recent Never Events are fully implemented and signed off to ensure that learning and changes to practice have been put in place.

Summary of findings

- The trust must develop a strategy and long term vision for gynaecology services at the trust to ensure that patient services can improve and develop.
- The trust must ensure that a rapid discharge pathway for end of life patients is formalised to ensure that people can leave hospital in an effective way that meets their wishes.
- The trust must review policies and procedures for planning and booking outpatient clinics to ensure that waiting times for appointments are minimise and patients are not subject to long delays in waiting for appointments. Waiting times in outpatient clinics should be re routinely monitored.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

The Emergency Department (ED) checked its own safety performance monthly, some systems were consistently safe but others varied. Updates on training such as safeguarding were patchy for staff. The ED was working on improving the time it took to assess and to treat patients but it still struggled to consistently achieve some safety targets. The layout of the ED was not as safe for patients with mental ill health as it could be. Staffing levels had been improved and all nursing vacancies were being filled but the ED was struggling to replace the locums with permanent staff.

Staff reported incidents and local leaders ensured there was a system in place to learn from incidents and improve practice including regular safety briefings for staff. We found some changes had not been completely followed through. Staff treated patients with kindness and took care of their dignity throughout their treatment.

The trust had taken some new action to help the ED to respond to increasing numbers of patients but had more work to do with other organisations in the wider community to contribute to this. Managers were making sure the whole hospital system was working more efficiently to help the ED especially at busy times. The trust experienced delays in getting patients with poor mental health reviewed and moved on to other services to help them.

The ED was struggling to regularly meet some of the government targets for the time taken to see and discharge or admit patients but it had a system for prioritising patients according to the seriousness of their condition and into different areas so they could be seen as quickly as possible. We found the ED service was well led at the hospital.

Medical care

Good



Staff within the medical care services were caring. Patient care was monitored to show acceptable standards were maintained with good outcomes. All areas we visited were clean, tidy and well maintained. We saw that patients were risk assessed on admission and on an on-going basis;

Summary of findings

they were protected from harm. We found that medical care services were effective using evidence-based national guidelines and trust policies and procedures.

Staff felt they were well managed at ward level but the disconnect between them and the senior executive team was improving and not fully resolved. It was acknowledged that staff shortages had impeded some initiatives such as dementia care. Medical staff shortages had also caused workforce issues including lack of training time. Staff understood their role and responsibility to report concerns and safety incidents.

Discharge facilities had improved with the opening of the discharge lounge in July 2015; however the amount of medical patients in the hospital exceeded the bed spaces which caused medical patients to be nursed in other speciality beds. Some patients had experienced a number of bed moves including at night which was unsatisfactory. We identified that patients on ward 44 lacked rehabilitation support due to reduced involvement of the physiotherapy service. The ward lacked service planning for staff that were not available to work and service input was less than that expected at the main site, for example physiotherapy sessions and MDT review.

Surgery

Good



We saw large number of vacancies for registered nurses and heavy reliance on agency nursing hours in some areas. The service had successfully filled some nursing vacancies with overseas nurses. The managers described their reliance on agency staff for nursing and medical staffing as a major challenge for the service.

We noted a high number of medical outliers on the surgical wards. Staff shared their concerns that they lacked the skills and experience to care for these patients. However, we saw staff were skilled and competent to care for surgical patients.

Staff knew how to report an incident. The service was compliant the World Health Organisation (WHO) safer surgery checklist. Overall we saw good evidence of staff responding to patient risks.

We observed patients being treated with compassion, dignity and respect. The Friends and Family Test (FFT) showed expected results which

Summary of findings

were similar to the England average, with the exception of ward 30 which was better. Patients were involved in their care, treatment and discharge.

There was a clear vision and strategy for the service supported by an up to date business plan. Managers had a vision of key areas for development and were aware of their strengths weaknesses. We saw the culture throughout the division was very positive and there was a good level of engagement with staff.

Sound governance and quality measures were in place. We saw strong leadership from the board to divisional managers to local managers. Much work had been done to review the sustainability of the service and much improvement had taken place since last year.

Critical care

Good



There were effective processes in place to learn from incidents. The environment was clean and staff followed infection control procedures. Medicines, including controlled drugs, were safely and securely stored.

Patients received treatment and care according to national guidelines. Critical care was obtaining good quality outcomes as evidenced by its ICNARC data. We found there was good multidisciplinary team working across the unit.

Staff cared for patients in a kind, compassionate and professional manner. Patients spoke very highly of staff and said they were always treated with dignity and respect. Patients and relatives were kept fully informed and staff treated them with kindness and understanding. Staff were supportive and responsive to patients' individual needs.

Critical care was responsive to patient's needs. The overall capacity in the critical care unit meant that patients received timely care. The outreach team had developed and implemented a rehabilitation pathway which used a structured, team approach to monitoring events both during and following step down from critical care, to ward based care and through to follow up post discharge from hospital.

There was strong medical and nursing leadership within critical care. Staff felt well supported within

Summary of findings

an open, positive culture. There was a clear governance structure with on-going monitoring of the quality of care delivered. Innovative practice within critical care included their rehabilitation pathway, a new system for monitoring mortality and their organ donation system.

Maternity and gynaecology

Requires improvement



The pathway for gynaecology patients was inefficient and we saw that the gynaecology ward was shared with other surgical patients and medical outliers. This sometimes prevented women with gynaecological conditions being admitted to the ward. We were told that women experiencing miscarriage could not always access a side room and this affected their privacy and dignity at a difficult time.

Two never events, both retained objects post procedure, were reported in October 2014. We saw that for each of the never events, an investigation had taken place, learning points had been identified and shared and an action plan had been developed.

There was a clear statement of vision and strategy, driven by quality and safety. However, staff we spoke with did not demonstrate awareness or understanding of the vision and strategy. People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice. For example, we observed that policies were carried out in accordance with The National Institute of Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Women told us they had a named midwife. The ratio of clinical midwives to births was 1 midwife to 29 women. We saw documentary evidence that 99% of women received one to one care in labour. Women told us that they felt well informed and were able to ask staff if they were not sure about something.

There was an active maternity services liaison committee (MSLC) which met quarterly and provided input into service developments

Summary of findings

The governance arrangements facilitated discussion and review of quality and safety matters, with dissemination of learning. There was oversight of quality and safety at the trust board meetings. The maternity service was awarded the Excellence in Maternity Care award by CHKS in 2014. The quality of care at Burton Hospitals NHS Foundation Trust was

Services for children and young people

Good



Incidents were reported and investigated appropriately with learning from incidents shared with staff. Staff were open and honest with patients when things went wrong and when errors were made. Staff had appropriate paediatric life support training relevant to their role and there was equipment and facilities available to respond to patients who became seriously unwell. The service conducted local and national audits to measure performance against national and local guidance. There was learning and action taken to improve services. Transitional arrangements were in place for young people moving into adult services. Staff were caring. There were clear discharge pathways and procedures to ensure patients received the appropriate care and treatment after their stay in hospital. The service was responsive to patient's needs. There were resources in place to communicate with patients and their families. There was a clear vision and strategy for the service with both staff and managers aware of key priorities. Staff felt engaged and involved in improving and developing services.

End of life care

Good



Overall we judged end of life care services at Burton Hospitals NHS FT as good. Patients and relatives were treated with dignity, respect and compassion in the time leading up to the end of patients' lives and after their death. The service was supported by proactive, dedicated and passionate members of the specialist palliative care team who were working to improve the structure of end of life care services and to embed the key areas of end of life care into the hospitals' culture.

Summary of findings

Medical and nursing staff on hospital wards told us they were well supported in decisions about the care of dying patients and that they knew when and where to find specialist advice.

Partnership arrangements with local hospices were well-managed and effective.

Managers of the service were aware that work was needed to further develop the quality of end of life care and plans were in place to progress further.

During our inspection we spoke to seven patients, three patients' relatives and 45 staff. We visited twenty wards, three specialist teams and the hospital mortuary.

Outpatients and diagnostic imaging

Requires improvement



Whilst we found that the service was responsive to the local community we identified issues with the appointments system. Overbooking of appointments had become common practice which led to clinics over running and frustration for patients who experienced long waits. Five percent of patients failed to attend appointments. The hospital cancelled 10% of appointments and patients cancelled 11% of appointments.

Formal complaints processes were embedded however we did not see evidence that informal complaints were being recorded in line with the trust complaints policy.

Local leadership was good. Managers understood their staff and provided an environment where they could develop.

Patients, visitors and staff were kept safe as systems were in place to reduce and monitor risk. Services followed recognised pathways of care and were completed by trained and skilled staff. Patient outcomes were audited and benchmarked against national standards. Staff were caring and involved patients, their carers and family members in decisions about their care.

Queen's Hospital, Burton Upon Trent

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

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Background to Queen's Hospital, Burton Upon Trent

Queen's Hospital is part of Burton Hospitals NHS Foundation Trust. The hospital provides a full range of district general hospital services and also has a treatment centre which provides day case ophthalmology, outreach and community-based clinics to the population.

The hospital serves a population of more than 360,000 people in Burton upon Trent and surrounding areas, including South Staffordshire, South Derbyshire and North West Leicestershire.

The hospital employs over 2,000 staff and has 453 inpatient beds. There were 39,329 inpatient admissions between April 2014 and March 2015 and over 160,000 outpatient attendances in the same period. There were 59,730 attendances at the accident and emergency department.

The trust was included in Professor Sir Bruce Keogh's review of trusts in 2013. The overview report Review into the Quality of Care and Treatment provided by 14 Hospital Trusts in England is available on the NHS Choices website. A number of areas of good practice were identified as part of the review; the report also identified a number of areas of concern. The trust was inspected by CQC in April 2014, where it was found that progress against some of the key action from the Keogh review had been slow.

This inspection follows up the recommended actions from the Keogh review and also considers the findings from our inspection in April 2015.

Our inspection team

Our inspection team was led by:

Chair: Dr Mike Lambert, Consultant, Norfolk & Norwich University Hospitals NHS Foundation Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

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

director of nursing, emergency department head of nursing, matron for surgery, senior nurses, senior

paediatric nurse, critical care consultant nurse, supervisor of midwives, staff nurses, lead paramedic, chartered physiotherapist, operational managers, governance and quality experts, consultant in clinical oncology, consultant physicians, consultant paediatrician, critical care consultant, specialist gynaecology consultant, consultant urologist, consultant general and vascular surgeon and medical registrar.

Detailed findings

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

How we carried out this inspection

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

We visited the hospital on 7, 8 and 9 July 2015 as part of our announced inspection. We also visited unannounced to the hospital on Friday 24 July 2015.

We did not hold a public listening event prior to this inspection, we did meet with Staffordshire Healthwatch and a number of people contacted CQC directly to share their views and opinions of services.

During our visit to the hospital we held 8 planned focus groups to allow staff to share their views with the inspection team. These included all of the professional clinical and non-clinical staff. Through these groups we spoke to over 300 members of staff.

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

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

Facts and data about Queen's Hospital, Burton Upon Trent

As at April 2015, the hospital employed over 2,000 whole time equivalent staff. Of these, 308 are medical staff and 887 are nursing staff. At Queen's Hospital, there are 8 critical care beds, 48 maternity beds and 397 general medical and surgical beds. There were 41,147 total inpatients admissions between April 2014 and March 2015 and 226,595 outpatient attendances across all three sites. There were 114,390 attendances at the accident and emergency and minor injuries units.

The trust serves a population of more than 360,000 people in Burton upon Trent and surrounding areas, including South Staffordshire, South Derbyshire and North West Leicestershire. East Staffordshire district was ranked 124th of 326 local authorities in the English indices of deprivation in 2010.

The trust had revenue of £183 million with a budget deficit in 2014/2015 of £10.6 million.

During 2014/2015 there were two Never Events reported by the trust, both relating to maternity services.

There were a total of 90 serious incidents reported between May 2014 and April 2015, 29% were slips, trips or falls and 11% were grade 3 pressure ulcers. There were a total of 4,091 incidents reported via the NRLS (national reporting and learning service), 91% of these were classified as "no harm" or low harm incidents. The trust reports a relatively low number of incidents per 100 admissions when compared to the England average. In the period August 2013 to March 2015, there were 3 cases of MRSA reported. There were 31 cases of C-Diff in the same period.

The emergency department's performance against the 4-hour waiting time target was generally similar to the England average. The percentage of patients waiting 4 to 12 hour from decision to admission was lower than the England average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Urgent and emergency services

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

Information about the service

Urgent and Emergency services were provided from Queens Hospital Burton which was the main emergency department (ED) along with minor injuries units (MIU) at two hospitals in the community. The ED at Queens Hospital was part of the Emergency Services Directorates of the trust and the two MIU's were part of the Community Services Directorate.

The trust serves a population of approximately 360,000 people in South Derbyshire and North West Leicestershire. The ED at Queens Hospital was purpose built in the 1980's for a footfall of 45,000 patients. The ED does not receive major traumas which would be transferred to Royal Stoke University Hospital.

Between April 2014 and March 2015, emergency and urgent care services at the trust, including the two minor injuries units at the other sites 114,438 patients. The ED at Queens Hospital saw a total of 59,730 patients.

Attendances resulting in an admission have been over 25% fewer compared to all trusts in England during 2013/14 and 2014/5 with a half percentage drop from the trusts own admission figures in 2014/15.

We visited the ED announced on 7, 8 and 9 July 2015 and unannounced on Friday evening 24 July 2015. During our inspection, we spoke to approximately 21 patients and 27 staff across a wide range of roles.

Summary of findings

The ED checked its own safety performance monthly, some systems were consistently safe but others varied. Updates on training such as safeguarding were patchy for staff. The ED was working on improving the time it took to assess and to treat patients but it still struggled to consistently achieve some safety targets. The layout of the ED was not as safe for patients with mental ill health as it could be. Staffing levels had been improved and all nursing vacancies were being filled but the ED was struggling to replace the locums with permanent staff.

Staff reported incidents and local leaders ensured there was a system in place to learn from incidents and improve practice including regular safety briefings for staff. We found some changes had not been completely followed through. Staff treated patients with kindness and took care of their dignity throughout their treatment.

The trust had taken some new action to help the ED to respond to increasing numbers of patients but had more work to do with other organisations in the wider community to contribute to this. Managers were making sure the whole hospital system was working more efficiently to help the ED especially at busy times. The trust experienced delays in getting patients with poor mental health reviewed and moved on to other services to help them.

Urgent and emergency services

The ED was struggling to regularly meet some of the government targets for the time taken to see and discharge or admit patients but it had a system for prioritising patients according to the seriousness of their condition and into different areas so they could be seen as quickly as possible. We found the ED service was well led at the hospital.

Are urgent and emergency services safe?

Requires improvement



Compliance with mandatory staff training was varied. Staff understood their responsibilities with respect to child protection and adult safeguarding but medical and nursing staff compliance rates with level 2 and 3 training was below trust targets and needed to improve.

Levels of clinical staffing had been improved and the trust was confident of filling all nursing vacancies by September 2015 but was finding it challenging to replace the locum consultants being used with permanent staff.

Staff reported incidents and local leaders ensured there was a system in place to learn from incidents and improve practice including regular safety briefings for staff. Following our 2014 inspection, no revised pathway had been put in place to address a missed fracture error, some ligature points remained in place despite the attempted suicide of a patient earlier in the year.

The trust had recognised the risk of having no accommodation appropriate to support patients with mental ill health while they waited for assessment but there was no clear plan in place to move this forward.

Performance against time to assessment and time to treatment targets showed a general trend towards improvement from December 2014 to March 2015. There were individual days during this period where the targets were not met and improvements were needed.

Systems to handover, stream, track and monitor patients including children were in place and the ED was auditing these on a monthly basis. New measures were being piloted to improve the patient flow and safety through the ED. However it was struggling to demonstrate that it achieved compliance with its target for frequency of observations.

The ED audited and produced monthly assurance data on its safety performance. Some systems had been consistently safe for example, medication storage and administration while others such as hand hygiene and

Urgent and emergency services

infection control varied month by month against trust compliance target for safety. The ED was not sighted on the risk of the Middle East respiratory syndrome coronavirus (MERS).

Incidents

- The trust had a system of electronic reporting and tracking for incident investigations. We noted that the front screen of the ED computer monitors had an icon to click to access the incident reporting pages of the trust intranet. Staff confirmed they used the system to report incidents and the matron looked into them. They said lessons learned and ideas for improvement were discussed at department meetings. We found that although reception staff knew about on line incident reporting they said they had not had to use it and had no training for it.
- There were five incidents reported by the trust through STEIS for the ED from May 2014 to April 2015. They comprised of two slips, trips and falls; one hospital acquired pressure ulcer grade 3; one failure to act on test results and one failure to obtain consent.
- The Safety Thermometer showed very few category 2 to 4 pressure ulcers, falls with harm or C.U.TIs over a 13-month period from December 2013 to December 2014.
- We saw a copy of the staff monthly ED newsletter for May 2015. It was simply laid out and showed key performance information for that month including incident management. The 'top incidents' staff reported on the newsletter from and about the ED out of a total of 53 were about, clinical care and aspects around assessment (11 reported); communication (8); community acquired pressure ulcers (5) and violence and aggression (5 reported).
- Local leaders told us feedback to all staff on incidents and performance and quality indicators was discussed at safety briefing three times each week on a Tuesday, Thursday and Friday.
- Incidents and performance indicators were then discussed at the emergency medicine divisional monthly board.
- Emergency nurse practitioners (ENP) we asked confirmed that outcomes from investigations of incidents were fed-back in the monthly ENP meetings

and reflection took place about ways to improve practice. They said that where appropriate, (for example an incident of a missed fracture) the trust had provided funds for extra training.

- The paediatric lead nurse also confirmed the process of reporting incidents and errors, getting feedback. This was achieved through one to one supervision, direct e-mails and team reflection.
- We observed a handover on 7 July 2015 and noted that it did not include a safety briefing. Safety briefings were not routinely included in handover and this meant that staff not attending the three safety briefings each week may not be aware of some key messages.
- We saw a sample of two sets of minutes from the emergency medicine divisional board meetings in April and May 2015 and noted they addressed incidents, errors and complaints investigations underway.
- We found that local leaders and staff did not recognise the term Duty of Candour. We were given assurance later in our visit that the trusts policy of 'being open' addressed this requirement and was a standing order in any investigation of an incident that related to harm.
- When we looked around the ED we noted a number of points and structures to which a patient with suicidal intent could attach a ligature unobserved. The ED had an incident of attempted suicide in this manner in 2014. This meant the preventative learning from this incident had not been completely effective. We raised this with the trust while we were on site and it took steps to make these areas safe.
- The Trust had a mortality database which was a software tool kept on a server drive. Department staff told us mortality meetings were not routinely minuted, it was a case-by-case discussion exercise to review specific deaths. The most recent report from a local meeting was dated May 2015. The last minuted meeting before then was September 2014.

Cleanliness, infection control and hygiene

- The trust had policies and procedures in place for hygiene and control of infection.
- There were systems in place to keep the environment clean and cleaning staff we observed and spoke with confirmed the schedule of arrangements. They told us they had regularly updated training on hygiene and infection control and they understood and were proud of the importance of their role.

Urgent and emergency services

- The ED ward assurance data sent to us by the trust for March 2015 showed hygiene and prevention of infection at 80% compliance with the trust target of 100%. To improve compliance, the department implemented weekly environmental audits carried out by senior sister in ED. Performance improved in April to 89% but deteriorated in May 2015 to 77%. ED ward assurance data showed that compliance was at 100% for June 2015.
- The ED and its external entrance and surrounding pathways and ambulance slip road and bay were clean and uncluttered.
- The medical equipment library was used as a store room and this was cluttered with equipment stored on the floor.
- Staff told us the ED had been recently repainted throughout. We noted that cubicle curtains appeared to be new. In one large treatment area we noted however that only two of the four cubicle curtains had dates filled in on their labels as they should in order to indicate when they needed to be routinely removed and cleaned.
- There were no cases of MRSA, C.Diff, MSSA and E coli were reported for the ED in the 20 months ending March 2015.
- We saw arrangements in place to isolate and treat patients with potentially infectious diseases including a cubicle set up to effectively manage this.
- There was information posted and treatment pathways agreed for the risk of Ebola but we found the ED was not sighted on the risk of the Middle East respiratory syndrome coronavirus (MERS). There was no alert or agreed pathway for this. Following our visit, the trust told us in the event of a patient fitting the profile, the trust would utilise the PHE 2012 guidance.
- We saw that staff at all levels and roles complied with the policy of 'bare below the elbows' and no neck ties. There were dispensers with hand cleaning gel situated around the ED walls under clear signs alerting people to stop and clean their hands. This included in the main waiting area and reception. There was clear information on display inside the ED on corridor picture board about the significance of hand washing.
- The trust audited staff hand hygiene in the ED. During March 2014 to March 2015 compliance levels were reported at between 93% and 96% for each quarter except quarter three (October to December 2014) when it was only at 78%.
- We observed during our visits that staff hand hygiene practice was patchy. Some, but not all staff did regularly cleanse their hands as they moved around the ED from one area to another or left or entered it.
- Most staff wore gloves and aprons when they treated patients although we observed a staff member on one occasion attaching a cannula to a patient without wearing gloves.

Environment and equipment

- We noted that the ED was well equipped and staff confirmed they had access to the equipment they needed to do their job. This included a stock of equipment to support the team of occupational therapist to facilitate safe discharge of ED patients.
- The ED ward assurance data sent to us by the trust for March 2015 reported resuscitation equipment safety at 100% compliance with the trust target, we noted it was the same level of compliance for April, May and June 2015.
- We saw resuscitation equipment was readily available around the department to staff, the trolleys were appropriately equipped and clean and we saw records of regular checks.
- All emergency kit was clearly marked and ready to use.
- Staff confirmed the security had been recently upgraded so that front and rear doors of the ED had controlled access.

Medicines

- The ED audited its compliance with safe management of medicines standards.
- Audit data showed 100% compliance with controlled medications audits for March to May 2015.
- We saw that medicines, including controlled medications were securely and appropriately stored in the ED.
- The ED ward assurance data sent to us by the trust for March 2015 showed medication prescribing and administration was at amber compliance of 89% against the trusts target of 100%. When we visited we noted this had improved over time and achieved 96% in April, 93% in May and was at 100% in June 2015.

Records

Urgent and emergency services

- We looked at 11 sets of patient's records covering 6 and 7 July 2015 including the records of four children. We noted they were all fully and appropriately completed including a triage assessment and use of national early warning score (NEWS).
- Staff told us the current electronic records system could not flag up particular patients who were regular returners or people known to be a special security risk. This information was kept in a special file on the reception desk. We found however that this file was not on the reception desk and had gone missing within the ED for most of our visit.
- A new electronic system was due to be installed in November 2015 with the capability to flag these patients.

Safeguarding

- We noted standardised safeguarding prompts were responded to at the triage stage of a child attendance when a social assessment was completed by the nurse.
- The trust target for safeguarding training was 90% of all staff to have completed it. Medical staff compliance for statutory child protection training at level 3 stood at 88%; level 2 at 89% and level 1 at 97%. Compliance was poorer for nursing staff at 66% for level 3; 87% for level 2 and 100% for level 1. Administration staff were 100% compliant with level 1 statutory child protection training. Safeguarding adults training at level 2 stood at 81% for medical staff (only 87% for level 1) and 93% for nursing staff (100% at level 1). Administration staff were 100% compliant with level 1 safeguarding adults training.
- PREVENT training compliance for all of those groups of staff exceeded 91%. PREVENT is part of the Government's counter-terrorism strategy and raising awareness of it in healthcare is a key component of it.
- Staff that we spoke with in all roles understood their responsibilities in relation to safeguarding.

Mandatory training

- Figures given to us by the trust to June 2015 showed in the ED 93% of medical staff had updated their advanced life support (ALS) training. ALS for nursing staff is mandatory for Band 6 and above, 61% of nursing staff had updated their training.
- Advanced paediatric life support had been updated by 100% of nursing staff but only by 78% of medical staff.

- We noted this was shown as an upgraded risk to 'high' risk on the register in the April 2015 Emergency Medicine Governance Report to the Board.
- Infection control training compliance was 81% for medical staff; 95% for nursing staff and 100% for administration staff.
- Fire safety training for medical staff was at 81% compliance; for nursing staff it was 97% and for administration staff 88%.

Assessing and responding to patient risk

- ED dashboard data supplied to us by the trust before our visit showed the time to initial assessment of patients improving towards meeting the 15 minute national target between December 2014 and March 2015. Time to assessment target was breached on only four days in February 2015 (to a maximum of 27 minutes on one day) but March showed seven breaches with two days of over 40 minutes.
- The time to treatment national target of 60 minutes showed an improvement during January and February 2015 from December 2015, with a breach of only three days in each of those months, the longest being 73 minutes. However there were 12 breaches in March 2015 with the longest wait at 85 minutes.
- The ED performance staff bulletin for May 2015 reported average time to assessment for that month at 11 minutes and average time to treatment at 51 minutes. The June 2015 briefing sent to us by the trust reported an improvement of 9 minutes to assessment and to 42 minutes to treatment.
- There was a Rapid Assessment and Treatment (RAT) cubicle near the ambulance entrance. Senior nurses told us this had helped with ambulance turn around. Observations were taken and the patient was then moved on into a different part of the ED. We saw this in use after patients were handed over by ambulance staff. However senior nurses told us there was no dedicated RAT team, that the clinical nurse in charge took responsibility.
- The ED audited from nursing records the compliance with frequency of observations of patients. The audit data sent to us by the trust for March 2015 reported frequency of observations adhered to at 84% compliance with the trust target of 100%. This improved

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to 91% in April but deteriorated in May to only 86%. Further monitoring was planned to ensure increased compliance. Data for June 2015 showed compliance at 98%.

- We looked at eleven sets of patient records dated 5 to 7 July 2015 including four children. We found that observations were recorded at the appropriate frequency for all patients for whom this was relevant.
- Ward assurance data for April and May 2015 showed that falls risks assessments stood at 91% and 90% compliance with the trust target set at 100%. This was rated as an 'amber' risk. There an action plan was put in place to improve this and compliance for June was recorded as 100%.
- The paediatrics ward was adjacent to the ED and local leaders confirmed an arrangement in place for ED to put out a paediatrics alert if they needed additional support with stabilising a very sick child.
- Local leaders told us there was a paediatric intermediate life support trained nurse rostered on each shift including overnight. When we visited unannounced on the evening of 24 July 2015 the matron confirmed there was one on duty at that time and on the night shift.
- We observed there were streaming/triage arrangements in place beginning at reception. We tracked the attendance of 17 patients on the morning of 8 July 2015 including three paediatrics patients. We noted that receptionist staff followed a protocol for fast tracking patients reporting certain symptoms such as chest pain to triage nurses.
- We observed that one child reporting a head injury was immediately seen by a senior sister and taken through to a major's cubicle within five minutes of booking in. Another patient arrived by ambulance with chest pain and was handed over to a senior sister and then to an allocated nurse and into a cubicle within three minutes of arriving.
- Senior nurses told us that when arriving ambulances were stacked the policy was to allow no more than four patients to be 'off loaded' by ambulance crews and waiting in the corridor at any one time. Others remain on the ambulance, clinical handover happens when a senior sister accepts responsibility for a patient.
- We observed competent handovers between ambulance and nursing staff. All of the ambulance crew that we spoke with expressed confidence in the systems in place.
- Records of tissue viability assessments were audited by the matron and the ward assurance data for April 2015 reported 100% compliance, there was 93% compliance in May and back up to 100% for June 2015.
- Local leaders confirmed the trust responded with a whole hospital approach to the risk of overcrowding in ED when it became busy.
- There were internal triggers for escalation for example delays of more than 15 minutes in offloading patients from ambulance crew or if ED was looking after majors patients in the minor's cubicles. There was a criteria for moving patients to minors and escalate for further staff.
- A delay in waiting over 60 minutes to access speciality doctors was also a trigger. We pointed out however that the Royal College of Surgeons recommends this trigger should be at 30 minutes.
- The trust risk register shows as a red (high) risk no suitable assessment room in the ED for patients with mental health issues. The trust identified this needs to be a room in a secure location with two exits and panic alarms. The register notes at March 2015 that discussion had taken place with Estates, but no rooms were available. There had been no other effective actions taken to mitigate this risk except for the discussion of any incidents at ED meetings at the time of our inspection.
- When we visited staff told us the risk control measures in place remained the same. We however found a number of ligature potential points around the ED and these had not been addressed by a risk assessment. We raised this with the trust and immediate action was taken to remove some of these ligature points immediately and the trust re surveyed the department to make urgent plans to address others. When we returned for an unannounced visit on the evening of Friday 24 July 2015 we found that one area remained unsafe. Local leaders told us that this was a more difficult problem to resolve and the plan was to deal with it 'in a couple of weeks' time'. We found however there was no evidence of an interim assessment of control measures needed while the work was scheduled.

Nursing staffing

- We observed that there were sufficient nursing staff on duty to meet the needs of the patients at that time.

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- There were seven registered nurses rostered for duty in ED during the day and seven overnight plus health care assistants and a patient flow co coordinator. This was part of an initiative being piloted on the majors side of the department.
- We noted on the first day of our visit that there was a nurse in charge, a nurse coordinator, a triage nurse, three nurses for the major's, two nurses in resuscitation and two nurses in minors plus two health care assistants on duty for the early shift. A band 6 nurse was in charge overnight. Matrons worked 9am to 5pm five days a week.
- We observed a handover process and noted the nurse in charge allocated a nurse to a team and each nurse went to an area and got a patient to patient handover.
- The nursing roster was generally covered on the days of our visits including when we went unannounced on a Friday evening. The matron confirmed that weekend was covered and only one agency nurse was being used.
- The ED had improved from 10 vacancies in September 2014 to anticipating that all vacancies would be covered by the end of September 2015 including some newly qualified nurses. Some nurses had been recruited from Italy and the trust had arranged English language lessons for them.
- The trust risk register recorded for ED as an 'amber', moderate risk, lack of experienced staff. There were control measures identified to manage this including use of bank and agency staff, supervisory sister working alongside staff two days per week, three band 5 posts converted to band 6 posts to aid recruitment and retention and provide support and leadership on the unit, 'weekly meetings discussing skill mix' and proactive recruitment into vacant posts.

Medical staffing

- Data at September 2013 showed the ED had potentially proportionally fewer foundation-year doctors and more consultants than England average.
- The ED had seven consultants at the time of our inspection and medical staff confirmed this had been improved recently from four consultants and there was now effective weekend cover.
- Consultants told us the rosters gave them sufficient time for their clinical and non-clinical work as well as delivering teaching.
- Local leaders told us they had introduced a third shift to address the third peak of activity in the day at midnight

and added extra SHO's. This has achieved by changing the shift patterns slightly and rostering a SHO and middle grade until 2am, a further SHO until 6am and an ENP until midnight.

- Nursing staff we spoke with told us they got the support they needed from consultants and had no difficulty accessing them over night and at weekends.
- When we visited the service on 8, 9 July and unannounced on Friday evening 24 July 2015 we observed there were sufficient medical staff to meet the demand.
- The trust risk register recorded for ED as an 'amber', moderate risk, the recruitment and retention of consultants. The action taken by the trust was noted as, 'existing consultants doing extra hours; locums used'.
- This was confirmed when we visited unannounced and found the ED was one SHO short from the planned roster. The clinical director told us that this had been covered by expanding the shift of one SHO by an hour until an extra consultant came on duty.

Major incident awareness and training

- There was a major incident policy. Staff were aware of the major incident and business continuity policy, and understood their roles and responsibilities in the event of a major incident. Staff were informed when the level of need at the trust was high and major incident drills were held annually.
- Local leaders told us there had been an internal major incident in December 2014 and the plan to respond to it in ED had worked effectively.
- Reception staff told us that security personnel were on duty in the hospital from 6pm to 6am seven days a week and 24 hours at weekends. Reception staff contacted them by 'phone there was no panic alarm.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



Standardised guidance and best practice were used for care pathways were appropriate. The ED carried out regular assurance monitoring. This had resulted in action

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to improve pain relief including identifying improvement needed for patients with dementia. The ED participated in college of emergency medicine national audits each year.

The trust was committing resources to improve the skills of existing nursing staff such as training emergency nurse practitioners and increasing paediatrics competence. Medical staff and senior nurses received regular support and professional supervision from their managers.

We found good examples of multidisciplinary working such as therapists to aide early, safe discharge of patients particularly those over 75 years old. The mental healthcare pathway was not effective and the trust had already acknowledged delay in reviewing psychiatric patients.

The trust was rolling out training to staff in mental capacity and deprivation of liberty safeguards and assessment of patient's capacity was part of the ED rapid assessment.

Evidence-based care and treatment

- Treatment and care pathways were based on recognised national guidance and best practice. The trust had a NICE guidance committee that ensured services were using the most up to date relevant guidelines.
- We noted use of a standardised emergency department observation chart and a modified early warning observation and fluid balance chart.
- The ED audited its performance and compliance with thirteen key standards and indicators on a monthly basis. This was referred to as the ward assurance report. Action plans were put in place to improve compliance following each report to address any shortfalls in performance. Items assessed included tissue viability, pain management, falls assessment and nutritional assessments. Latest results (for June 2015) showed that the department had achieved 100% compliance in ten out of the thirteen indicators reviewed. Nutritional assessment, moving and handling and continence all fell short of the target.
- We observed a patient referred through their GP with suspected sepsis and saw use of a standardised sepsis screening flow chart.

- We looked at the records of 11 patients including four children and noted the care pathway was appropriate for each patient.

Pain relief

- The ED ward assurance data sent to us by the trust for March 2015 showed pain relief at compliance of 90%. The trust target was 100%. Actions to improve were implemented and it increased to 94% in April and May. Compliance for June was 100%.
- We saw from the records of 11 patients who came to the ED on 6 or 7 July 2015 including four children, that all were asked about their pain level and offered analgesia. The ED followed the recommendation of the College of Emergency Medicine Pain in Children audit 2011/2012.
- On 8 July 2015 we spoke with patients being treated in five cubicles in ED at that time. All but one reported or their relatives reported, they were offered analgesia and were happy with their pain management.
- Specific areas identified by the trust where it could continue to improve on its care to patients with a diagnosis of dementia included assessment of pain. An audit in July 2015 of use of the dementia care bundle in place found emergency care areas (ED and acute assessment unit) found no awareness of the dedicated pain assessment tool for people with dementia. The audit report concluded 'The Abbey pain scale is not something that has had a specific focus in training so it is not surprising that this has not been embedded. The Abbey pain scale is not the only tool for assessment of pain in patients with dementia and recent studies have highlighted tools that would be more suitable. As a consequence of this audit consideration is being given to implementing a new tool with robust education surrounding its introduction.'

Nutrition and hydration

- The ED audited nutritional assessment from nursing records. Ward assurance data for May 2015 rated compliance at only 61%. The action plan put in place inferred this was a matter of inconsistent record keeping rather than poor practice. Nutritional assessment remained rated as a 'red' risk in the ED ward assurance data for June 2015 although the compliance rate had improved considerably to 82%.

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- We noted there was a drinks trolley permanently available in the ED vending tea and coffee and cold drinks free of charge. We heard an ENP invite a patient with a minor injury who was waiting for a test result to help themselves to whatever they wanted.
- Housekeeping staff confirmed that they contributed to 'comfort' rounds and offered patients food and drink where that was permissible to their condition or stage of treatment.

Patient outcomes

- The trust had previously taken part in several College of Emergency Medicine College of Emergency Medicine (CEM) audits including ones into assessment and treatment of feverish children, fractured neck of femurs and vital signs. However, these are related to care prior to April 2013.
- The trust had a good performance in the Severe Sepsis and Septic Shock audit from 2011/2012. Of the thirteen standards reviewed, nine were better than similar trust, two were the same and one was worse.
- The trust performed poorly in CEM 2012/2013. Renal Colic audit. Only 64% of patients had a pain score recorded, against a standard of 100%. For standards relating to appropriate investigations being recorded as carried out, the trust scored below the standard for all listed. As a result of this, the department revised its documentation to ensure that a pain score is a standard part of routine observations.
- The Fractured Neck of Femur audit for 2012/2013 showed that the trust was worse than other similar trusts in regard to prompt provision of analgesia and time to imaging. The action plan developed by the department following the audit included refreshing awareness amongst all staff in the department and introduction of an alternative analgesia delivery system.
- The ED at Queens Hospital participated in three other audits carried out by the CEM during 2014/2015. These were; older people clinical audit, mental health in the ED clinical audit and fitting child clinical audit. Again, the results were mixed. The trust performed poorly in the older people and mental health audits but better in the fitting child audit.
- The trust provided us with the results of two internal audits for 2015/16 regarding ED medical record keeping and management of patients with urinary retention. The

outcomes from both audits showed that improvements needed to be made in documenting care, especially by junior medical staff. Action plans were in place and ongoing to address these issues.

- The unplanned re-attendance rate remained at 6% for December 2014 to March 2015. This is worse than the target of 5% but better than the England average of 7.5%.
- Queens Hospital ED did not participate in the CEM national audit of consultant sign off for 2013 so no recent data is available. It had a mixed outcome in the 2011/2012 audit. Of the six standards reviews, two were rated as better when compared to other similar trusts, one was rated worse and the other three were about the same.

Competent staff

- Staff had the right qualifications, skills and knowledge to do their job. Nurse managers told us that one band 6 and one band 7 nurse were fully trained paediatric nurses in the ED team at the time of our inspection. Six other nurses including an ENP had some paediatrics modular training and six further nurses were booked onto that training.
- Three members of staff had completed an ENP training programme since 2013. Two of these staff developed into additional full time ENPs. Another member of staff is due to complete their training during 2015. The ENP staff had their own mentor.
- Data sent to us by the trust reported annual appraisal compliance rated for medical staff in the ED at 92% as of June 2015. Data for ED nursing staff was not provided.

Multidisciplinary working

- ENPs told us they get good support from specialities consultants and registrars and could refer patients directly to speciality doctors within the hospital. This was confirmed in practice by a patient whose care we followed through the hospital.
- We noted there was a hospital's liaison officer (HALO) on duty of the first day of our visit. This was West Midlands Ambulance Service personnel. They confirmed they had a good working relationship with Queens Hospital, were involved in bed management and capacity meetings,

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provided forecasts on ambulance arrivals and reviewed retrospective attendances and worked with the ED coordinator during busy periods to ensure the safety of patients.

- We spoke with an occupational therapist (OT) who confirmed that a dedicated team of OT's, and physiotherapists and advanced nurse practitioners (ANP) from the Frailty team covered the ED, AAC and a short stay ward. They had access to speech and language therapists and dieticians and were responsible for aiding safe, early discharge of patients.
- Local leaders told us that their participation in the ambulatory care network locally had increased the number of patients they discharged each day through ambulatory care.
- The trust risk register showed as 'amber,' moderate risk, delay reviewing psychiatric patients. Actions taken by the trust were listed as, 'two psychiatric specialist nurses in post 07:00-15:00; crisis team cover from 17:00 until the following morning; dementia nurse specialist on site during office hours; staff undertaking conflict resolution training'
- The medical director told us the policy of psychiatrists waiting until a patient was 'medically fit' before they would see them was beginning to change to a model of parallel assessment.
- The trust had developed a multi-disciplinary 'frailty team', this included therapists and access to other therapists to reduce the need for admissions of patients over 75 years. ENP's and flow coordinator nurses could send patients from minors to the Acute Assessment Centre.

Seven-day services

- Occupational therapists confirmed that a dedicated team covered the ED, AAC and a short stay ward from 7am to 7pm week days and from 8am to 7pm weekends to support safe discharge of patients.
- The minor's stream, staffed by ENP's provided a service between 8am to midnight seven days a week.

Access to information

- Staff reported no concerns to us about the access they had to information they needed about patients or about trust policies and procedures and national good practice guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with showed awareness of the Mental Capacity Act (MCA) 2005. The trust had been rolling out dementia training for all staff since March 2014. Attendance rates for ED staff was not available.
- When we visited unannounced on the evening of Friday 24 July 2015 we observed a mental capacity assessment being undertaken as part of the RAT, in line with CEM audit report recommendations.

Are urgent and emergency services caring?

Good



We found services were caring. The trust audited performance for patient privacy and dignity and we found the ED reached a consistently high level of compliance with the trust standard. We found staff in all roles treated patients with kindness and supported their dignity throughout treatment. The ED scored well in the Friends and Family Test and was consistently better than the national average last year.

We found the trust was taking steps to improve the involvement of carers in significant medical decisions for patients with dementia. We found good examples of staff involving patients in their treatment plans, listening to their views and being flexible in their approach.

Compassionate care

- Privacy and dignity good practice was audited in the ED by the trust. The ED ward assurance data sent to us by the trust for March 2015 showed privacy and dignity at 100% compliance with the trust target. This level of compliance was reported as remaining the same for the April and May 2015 audit but dropped slightly to 97% in June 2015.
- We saw staff at all levels and in all roles treating patients and their relatives/friends with respect, warmth and kindness and communicating with them well.
- National data sources reported the ED Friends and Family test scores as consistently better than England average between December 2013 and November 2014.

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- Friends and Family test results for ED as reported by the trust showed in April 2015 85% would recommend the service to others, no data reported for May 2015 and 92% would recommend in June 2015.
- The Care Quality Commission inpatient survey result for November 2014 showed the ED performance “about the same” as other trusts.
- We observed only positive interactions between staff in all roles and patients and saw no breach of a patient’s privacy or dignity, including patients whose behaviour was challenging to staff.

Understanding and involvement of patients and those close to them

- Patients and their family members and friends we spoke with told us that staff had involved them with their care, explained plans and procedures clearly and listened to their views about the treatment plan. Patients told us they felt safe and any of their fears had been alleviated by the nursing and medical staff.
- We observed staff interacting with patients and family members. Staff talked to them in a way that patients could understand and described what they were going to do. Staff also checked with the patient that they understood what they’d been told and where they were.

Emotional support

- The ED had a dedicated dementia nurse specialist available five days each week during office hours to support staff, patients and relatives.
- Chaplains were available 24 hours a day seven days a week. They represented different denominations and had contact with all the major faith communities.
- We observed reassurance being given to patients and nurses offering emotional support. Relatives were able to remain with patients throughout their stay in the ED to ensure they were supported.

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

Good



The trust had undertaken some initiatives to support the ED’s response to increasing demand but had further work to do with community stakeholders.

The trust had a dementia care strategy and trust audit results were very positive for the ED with the exception of pain assessment, which was under review.

The trust was struggling to maintain achievement of the national 4 hour target for seeing, treating and discharging or admitting patients. The ED recovery plans for this included action from the whole hospital system and the executive and middle managers supported the ED.

Ambulance turnaround target time was patchy between January and June 2015 with the trust struggling to maintain the target consistently. The percentage of admissions waiting 4-12 hours from decision to admit to admission had been generally lower than the national average from March 2013 to January 2015.

The ED operated a triage and streaming system with majors, minors and resuscitation stream and paediatric area. GP’s could refer patients directly to the acute assessment centre and by pass ED. Although we did not see ED under real pressure when we visited we found the flow system was responsive and patients were seen in a safe and timely way.

The ED had arrangements in place to address the needs of individuals including providing written information in local minority languages and developing a ‘dementia care bundle’.

Access and flow was closely monitored by operational and clinical staff working together on capacity management. New roles had been created to address blockage in the ED and others were being piloted.

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We found information on how to complain about the service was prominently displayed and trends in complaints were published for staff and patients on a monthly basis. Complaints were investigated and used to improve practice.

Service planning and delivery to meet the needs of local people

- Local leaders told us the ED was seeing in excess of 200 patients each day and that this represented a rise of 4% across the service. Approximately 35 of these were children's attendance.
- A recent initiative to address the pressure on the ED was building the Acute Admissions Centre, situated next to ED, local GP's could refer to this directly and nurse coordinator and ENP's could direct some patients there.
- Forty five percent of admissions through the ED were for patients aged 75 years and above. In response to this the trust had developed a multi-disciplinary 'frailty team'. Local leaders told us this team could prevent the admission of 50% of these patients.
- Local leaders told us the ED was working to improve its relationship with the Community Intervention Team to make it more effective.

Meeting people's individual needs

- There were a low number of BME residents in the area (around 4%) mainly South Asian but there was a growing Polish community.
- We saw information written in a number of South Asian languages and also in Polish available to patients in the main waiting area. This included the patient advice and liaison service (PALS) leaflet and feedback form.
- Staff confirmed they had access to translation services through the trust if they needed them.
- All trust staff received learning disabilities awareness training during 2011. This is now included in induction training for all staff.
- For ED services the audit demonstrated that dementia care started at the front door in emergency care when patients arrived.
- The audit found Emergency care areas (ED and acute assessment unit) demonstrated good attention to dignity and modesty, nutrition and hydration but neither area were aware of the dedicated pain assessment tool identified within the dementia care bundle.

- We saw the "this is me" document was available in the ED ready for family/carers to take away and complete.
- Dementia awareness training is part of all staff's mandatory induction training plan.
- There was a psychiatric liaison officer within the hospital funded by the local mental health trust through which referrals could be made between 9am and 3pm. Staffordshire crisis team took over out of office hours.
- The trust noted it had difficulty in accessing out of hours crisis team, (only 2 staff normally covering Staffordshire) and delays transferring to an EMI. All incidents were to be escalated to ED Governance meetings.
- We noted the environment was poor for patients with mental ill health; there was no dedicated area where an agitated or highly distressed or self-harming patient could wait for an assessment in comparative safety and away from other patients. Local leaders told us they had looked at providing a further cubicle but there was just not sufficient floor space.
- We observed staff caring for a patient who was challenging the service with their behaviour. Staff told us the patient was known to them as a regular attender, had mental ill health and presented on that day with a 'new' physical condition. The plan was to systematically rule out any organic cause to the presenting condition then transfer the patient to the clinical decisions unit for a psychiatric review.
- There was a paediatrics waiting room separate from the main reception area, a paediatrics resuscitation bay and the dedicated paediatrics cubicles were child friendly .

Access and flow

- The department's performance against the national standard of seeing, admitting or discharging 95% of patients within four hours of their arrival was generally similar to the England average during 2014/2015. The standard was achieved in quarter 1 and quarter 2 but the trust fell just below in quarter 3 (93.8%) and in quarter 4 (94.3%). Quarter 1 for 2015/2016 was also slightly below the standard at 94.6%.
- The mean average total time patients spent in the ED was consistently much lower than the England average for January 2013 to September 2014.
- The chief nurse/chief operating officer presented to the Board in early July 2015 a Trust Performance Recovery Plan to ensure future sustained achievement of the 95% of patients seen in under 4 hours access target.

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- We noted that the actions identified focused on the whole hospital, for example 'exploration of surgical and medical direct admission pathways', and the local health community with other stakeholders for example 'improve access to nursing home capacity and domiciliary care provision', as well as improvements within ED systems, for example 'improve patient tracking throughout the emergency pathway' and targeted resources, for example 'continue winter increased consultant staffing in medicine' and governance arrangements, 'weekly breach review meeting to be reinstated and chaired by operations director'.
- We noted at the time of our visits that a pilot was running to have a 'flow coordinator' on duty for majors. Staff told us that this role had made a positive difference to patient movement through the ED in busy periods. The trust had still to make a decision on whether this would be continued.
- The percentage of admissions waiting 4-12 hours from decision to admit to admission was generally lower than the national average from March 2013 to January 2015, although peaked slightly above it during September to November 2014.
- The number of patients leaving the ED without being seen had been significantly lower than the England average between September 2013 and September 2014.
- The ambulance turnaround target time within 15 minutes went below the national target of 85% on 13 days in January 2015, improved to eight days below target in February and rose again to 15 days below target in March 2015. Data showed improved performance in May 2015 at an average of 86.7%, just above the target and the briefing sent to us by the trust reported 87.8% for June 2015.
- Number of hand-overs delayed over 30 minutes during the winter period 2014/2015 compared with other trusts was very low.
- Nursing leaders told us the ED had seen 207 patients on Monday 6 July 2015, the day before our visit including 72 ambulance handovers from both west and east midlands ambulance services.
- Although the ED was not particularly busy for a Tuesday (7 July 2015) senior nurses told us they were still struggling with capacity in the hospital when we arrived at 5pm. They had 27 beds potentially available approaching that night, "any less than 10 would be a worry".
- Local leaders told us that the trust 'owned' the flow problems in ED and they were not viewed as only an ED issue to solve. Operations meetings were held in the control room at 8.30am, 11 am, 2pm and 4pm each week day.
- We attended two operations meetings including a Friday afternoon meeting. We noted that the operational team worked with the clinical team and had a clear grip on what was happening through the hospital, each patient and their needs and what needed to be achieved to free up capacity and keep the flow moving.
- On the morning of Wednesday 8 July 2015 the ED was busy but not crowded. At 10.15 am for example there were 12 people (not all patients) including parents with two children waiting in the reception area, not all cubicles for treating minor injuries were occupied.
- We followed the 'flow' of 12 patients who came on foot and through ambulance arrival from 09.20am and noted that each patient was seen through the treatment in a timely way according to their needs and risk.
- For example a stroke pre alert was made at 10.40 with an estimated time of arrival at 11.00. The patient was admitted to the ED at 11.05 and taken straight to resuscitation, attended by two staff nurses and a stroke co coordinator, the ambulance crew handed over at 11.06 and rapid assessment was carried out. The ambulance crew were released at 11.10 and the patient had a CT scan at 11.25.

Learning from complaints and concerns

- We noted that PALS leaflets, including a feedback form, were available throughout the ED and a notice board display explained its purpose. The leaflet included advice on how to make a formal complaint.
- The ED performance briefing news sheet for May 2015 reported there were eight complaints via PALS and NHS Choices about its service.
- We noted in the data sent to us by the trust that 'communication' featured in a significant number of complaints about the ED service during the 12 months prior to our inspection.
- We saw from a sample of ED Governance meeting minutes that complaints were discussed and staff gave us examples of how investigations had changed practice.

Urgent and emergency services

Are urgent and emergency services well-led?

Good



We found the service was well led. Staff in all roles were aware of the trust vision and highly motivated to improve the safety and quality of the ED services. The executive and senior leaders were visible and engaged with the challenges faced by ED on a daily basis.

There were local governance arrangements in place to monitor performance and resources such as staffing, assess and manage risk and put in place recovery plans. Staff were engaged with this process. ED performance issues were escalated to executive and Board level. However not all aspects of audited practice improved between March and May 2015 and some deteriorated. This suggested the actions identified to achieve improvement were not always effective.

Staff felt supported in their roles and new roles were being developed. Operational managers and clinical staff worked together as a team to manage the capacity in the hospital and address the challenges faced by the ED on a daily basis.

There was an open culture so staff could raise concerns and staff felt the trust was investing in them. Staff sickness however had meant that a lot of seniors were acting up into posts and it was too soon to judge whether new the measures put in place to improve the safety of the service in ED are embedded.

Vision and strategy for this service

- Staff that we spoke with in all roles and at all levels told us the vision for the service was to improve the safety and quality of patients experience and that they were aware they had an important part to play in that on a day to day basis.
- Everyone wanted to move the trust out of 'special measures' and felt proud of the improvements that had been achieved.
- We noted mission and values statements displayed prominently around the ED walls.

Governance, risk management and quality measurement

- The ED had monthly governance meetings and produced a monthly report for the Board. We noted from these reports that incidents and established and emerging risk were discussed, evaluated and monitored.
- The ED undertook monthly audits of its compliance with safe good practice and these ward assurance results were displayed where staff and visitors could easily see them.
- The ED produced a monthly safety bulletin for staff and we saw these around the department. Staff confirmed on Tuesday, Thursday and Friday at 8am a safety briefing was delivered to all staff on duty.
- Ward assurance was set as a standing agenda item at ward meetings with identified improvement actions recorded.
- There was alignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'.
- Many aspects of practice benefitted from audit and achieved improvement. However not all aspects of audited practice improved between March and May 2015 and some deteriorated. This suggested the actions identified to achieve improvement were not always effective. Overall ward assurance recovered from a dip in May of 89% compliance to 97% in June.
- Capacity was closely monitored by operational and clinical staff working together to keep the ED safe and new roles were in place or in development to assist this. Nursing staff vacancies had been substantially filled and the trust had put in measures to better support overseas recruits in order to keep them. The trust acknowledged that although the ED was staffed medically it was difficult to sustain this. The trust had to find alternative ways to get the right staff in and to keep them. Local leaders believed there was a role for non-medical practitioners and the trust had put resources in to training up some nurses to become emergency nurse practitioners.

Leadership of service

- Staff we spoke with at all levels and roles within the ED told us senior managers, the executive team and Chair of the trust were visible, aware and supportive. Local managers were also visible and proactive.

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- We noted when we visited the ED unannounced on Friday evening 24 July 2015 that the clinical director was on duty working a shift in the department.
- The trust had worked at supporting and developing operational managers and clinical staff to work together as a team to manage the capacity in the hospital and address the challenges faced by the ED on a daily basis.
- Staff sickness had meant that a lot of seniors in the ED were acting up into posts. They told us they received good support from their managers and reported that communication had improved between ward and Board, 'time has been taken to put a structure in place; there has been a big shift'.

Culture within the service

- Senior nurses told us morale had improved within the ED in recent years.
- Nursing staff at all levels told us there was an open culture to raise any concerns and they felt the trust was investing in them.
- Staff recruited from other parts of the European Union said they felt well supported.

Public engagement

- We saw Friends and Family Test cards and boxes available at different points around the ED.
- Monthly ward assurance data was posted in the main reception area where it could be seen by the public.

Staff engagement

- We saw staff were provided with 'at a glance' feedback on ED performance and governance issues through a monthly briefing sheet.
- There was a system of quality ranking wards and services within the trust and ED local leaders told us staff were motivated to want to be at the top.

Innovation, improvement and sustainability

- The trust had recently developed a Frailty team in response to the increasing number of patients over 75 years old that it sees in the ED. The aim was to avoid admissions where possible.

Medical care (including older people's care)

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

Information about the service

Medical care services at Queen's Hospital Burton provided an acute assessment unit and 148 medical beds within nine wards. There are 20 trolleys and eight beds on the acute assessment unit (AAU). Ward 44 was based on the Outwoods site, across the road from the main hospital. Medical care is also provided at the trust's two community based hospitals.

The AFU provided timely assessment and a short stay facility (usually up to 72 hours) for patients presenting as an emergency who meet the unit's acute frailty inclusion criteria. The unit is designed to deliver early, complex geriatric assessment and immediate involvement of a dedicated social care team to deliver holistic, integrated discharge planning at the earliest opportunity.

25,725 patients were admitted across the three hospital sites between July 2013 and June 2014. Patients were supported by therapy services including speech and language, physiotherapy, occupational therapy (OT) and dietetics.

The inpatient diabetes centre offers a wide range of general and specialist diabetes services. The outpatient haematology department offers a service for the diagnosis and treatment of a broad range of haematological disorders, in line with best practice national guidelines. In addition to providing chemotherapy for haemato-oncological diseases they also manage general haematological diseases.

The laboratory provides a diagnostic service to the hospital and the local General Practitioners (GPs) and also provides a telephone and postal anticoagulation service for patients. Anticoagulants are medicines that reduce the ability of the blood to clot.

We visited nine wards and spoke with 32 patients and those close to them. We spoke with 72 staff, including physiotherapists, doctors, nurses, occupational therapists and pharmacists. We observed staff interacting with patients on the wards including during meal times. We also visited the discharge lounge and pharmacy department.

Medical care (including older people's care)

Summary of findings

Staff within the medical care services were caring. Patient care was monitored to show acceptable standards were maintained with good outcomes.

All areas we visited were clean, tidy and well maintained. We saw that patients were risk assessed on admission and on an on-going basis; they were protected from harm. We found that medical care services were effective using evidence-based national guidelines and trust policies and procedures.

Staff felt they were well managed at ward level but the disconnect between them and the senior executive team was improving and not fully resolved. It was acknowledged that staff shortages had impeded some initiatives such as dementia care. Medical staff shortages had also caused workforce issues including lack of training time. Staff understood their role and responsibility to report concerns and safety incidents.

Discharge facilities had improved with the opening of the discharge lounge in July 2015; however the amount of medical patients in the hospital exceeded the bed spaces which caused medical patients to be nursed in other speciality beds. Some patients had experienced a number of bed moves including at night which was unsatisfactory.

We identified that patients on ward 44 lacked rehabilitation support due to reduced involvement of the physiotherapy service. The ward lacked service planning for staff that were not available to work and service input was less than that expected at the main site, for example physiotherapy sessions and MDT review.

Are medical care services safe?

Good



Staff understood their role and responsibility to report concerns and safety incidents. We saw evidence of shared learning from safety incident reporting.

All staff we spoke with showed a clear understanding of safeguarding and were aware of their roles and responsibilities to safeguard vulnerable adults from abuse.

All areas we visited were clean, tidy and well maintained. Resuscitation equipment was found to be accessible and in good working order.

We found that controlled drugs (medicines which require additional security and storage) were not always stored in line with good practice guidance; however these issues were resolved during our visit. The quality of record keeping was good in relation to care planning and observations.

There was a shortage of permanent nursing staff, which resulted in the trust using bank nurses and agency staff. Staff recruitment was on-going and the vacancy rate was predicted to be reduced to 3% by September 2015.

Incidents

- There had been no Never Events reported between May 2014 and May 2015. Never Events are serious incidents that have the potential to cause serious patient harm or death and are wholly preventable.
- There were 14 serious incidents during the same period which included six falls, two delayed diagnosis, two sub-optimal care of the deteriorating patient and one Clostridium.Difficile (C. diff) healthcare acquired infection.
- Between December 2013 and December 2014 there were 11 grade two to four pressure ulcers reported, and six falls with harm. Between December 2013 and December 2014 there was a small but persistent prevalence of catheter acquired urinary tract infections with 48 occurrences reported.
- Staff across all medical wards told us they were encouraged to report safety incidents and were able to access the trust's electronic reporting system. Staff were confident to report incidents and told us there was a 'no

Medical care (including older people's care)

blame' culture. Root cause analyses were carried out for any incidents where serious harm had been caused to a patient, and an action plan was produced from the evidence. The action plan was then discussed with the ward staff and presented to the trust's board for monitoring.

- A robust process was in place to review mortality and morbidity information in line with nationally recognised methods and indicators. The Hospital Standardised Mortality Ratios (HSMR) and Standard Hospital Mortality Index (SHMI) are indicators that measures whether the mortality rate at a hospital is higher or lower than you would expect. The HSMR has been improving since May 2014 (as at February 2015, the index score was 104) and the SHMI is also improving and continues to be as expected (as at January 2015, the index score was 98).
- We were told that feedback from mortality and morbidity meetings was discussed with the staff where applicable. Monthly mortality meetings were attended with the consultants when relevant. Senior sisters meetings were held to discuss action plans, investigation findings and highlight lessons learnt.
- We spoke with staff about the duty of candour in relation to reportable patient safety incidents. We heard that the serious incidents which had occurred on the ward had been discussed with the patient and their relatives in accordance with the trust policy and procedure.

Safety thermometer

- The safety thermometer is a tool used to measure, monitor and analyse patient harm and harm free care. The information on the safety thermometer included pressure ulcer incidence, falls, venous thromboembolism (VTE or blood clots) and catheter-acquired urinary tract infections (CAUTI), Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C.Diff), medication incidents, complaints and 'Friends and Family Test' returns. For example the VTE score on ward three was 100%, the overall medicine VTE score was 99%.
- We were provided with a summary of the results of the monthly safety thermometer audit up to the end of May 2015. This information along with performance against the trust's own safety and patient satisfaction targets was displayed on ward notice boards. The data provided across medicine showed that the performance of wards three, four, five, six, eight, AAU and the

coronary care unit (CCU) had all achieved or exceeded the trust target. Ward seven scored 91% and ward 44 had scored 90%; action plans were in place to address the shortfall.

- In May 2015, 43 falls without harm were recorded on the safety thermometer; of those there were 10 reported on ward seven and 11 reported on AAU.
- We saw consistent evidence of the use of falls mapping on all wards to identify trends and manage risks that this information had been effective in reducing the number of falls.

Cleanliness, infection control and hygiene

- The ward areas we visited were clean and well maintained. Each ward had a designated domestic team who had responsibility for ward cleanliness and cleaning products.
- Staff were seen to be using protective personal equipment including specialised clothing such as gloves and disposable aprons. Hand hygiene was observed and signage was visible. Hand gel dispensers were sited at the entrance of the ward and in the patient bays. Staff adhered to 'bare below the elbow' policy; this meant that all staff in contact with patients were able to wash their hands and wrists effectively without the restriction of cuffs or jewellery.
- The records showed that patients had been MRSA screened on admission and isolated until the results were confirmed. Side rooms were used as isolation rooms for patients identified as an increased infection control risk, for example, patients with MRSA or low immunity. Outside the rooms there was clear signage so that staff and visitors were aware of the increased precautions they must take when entering and leaving the room.

Environment and equipment

- Resuscitation equipment was found to be accessible and in good working order. Equipment had been checked daily and checks were documented, meaning it was ready for use. Staff training in this area was fully compliant.
- Equipment was serviced and tested in accordance with the trust policy and procedure. We were told that when equipment was faulty the item was labelled and returned to the equipment store or supplier for repair or replacement.

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- All medical wards had a good supply of moving and handling equipment such as hoists, slings, and sliding sheets. We also observed a good supply of condition-specific equipment such as equipment to control the flow of medicines and clinical monitoring equipment, which was well maintained. Pressure-relieving mattresses and cushions for people at risk of developing pressure damage were in place. The staff accessed the hospital equipment store for bariatric and other specialist equipment.

Medicines

- The trust recorded medication errors within the safeguard risk management system and participated in the medication safety thermometer project for 12 months until March 2015. The risk management process had identified that insulin was regularly the subject of medication incidents. The trust's medication safety officer told us they had commenced reviewing incidents involving insulin and how the trust could make improvements in prescribing.
- There were suitable arrangements in place to store and administer controlled drugs in most areas. We saw patients' own controlled drugs stored in the same area as the ward stock of controlled drugs. This meant that a patient's own medicines could have been used in error. This was brought to the attention of the nurse in charge who approached pharmacy about the issue and took corrective action. Stock balances of controlled drugs we looked at were correct. Two nurses checked the dosages and identity of the patient before medicines were given. Twice daily checks of controlled drugs balances were seen to be recorded and correct.
- We saw that temperatures of refrigerators used to store medicines were regularly checked, recorded and adjusted as appropriate. Rooms used to store medicines were accessed by swipe card entry which ensured security.
- During July, August and September 2014 an audit of missed medicine doses was carried out by three junior doctors, and supervised by a medical consultant. 1066 missed doses were reported within the medical care services. For example ward four scored 73%, and the discharge lounge scored 80%. The most common reason for non-compliance was 'not recorded as given' followed by clinical reasons. The most frequently missed medicine dose was Paracetamol. The audit recommended that staff recorded the reason for missed dose, asked the patient for the reason for refusal and to re-audit in 12 months' time.
- There were 30 nurse and non-medical independent prescribers in the trust; they attended a safe medication practice group monthly to discuss issues and practices.
- We spoke with the chief pharmacist who was also the controlled drug accountable officer. We heard that the electronic pharmacy system was due to be replaced in October 2015. The trust had employed a medicines safety officer who reviewed staff fitness to practise, including individual competencies and undertook a wider review of patient's holistic treatment. We were told that the pharmacy teams were now aligned the divisions which had improved communication.
- The medicines administration records we looked at demonstrated that patients' medicines were prescribed, supplied and administered as instructed. An electronic prescribing system was in place and the wards had support of a daily visit from a designated pharmacist.
- A self-administration policy was in place for those patients who preferred to self-medicate.

Records

- We saw that care records and documentation, such as risk assessments and fluid balance charts were fully completed, dated and signed in accordance with trust policy.
- Patient notes were stored in newly supplied lockable cabinets on AAU. On other wards we also found patient records to be stored safely.
- We saw comprehensive timely assessments of pressure ulcer risks using the Waterlow score (a tool to measure patients' risk of developing pressure ulcers), and skin and nutritional assessments. When patients were assessed as being at risk of or had a pressure ulcer, appropriate repositioning, care plans and use of equipment to minimise damage and promote healing was documented.

Safeguarding

- Staff demonstrated a good knowledge of the trust's safeguarding policy and the processes involved for raising a safeguarding alert. Staff knew the name of the trust safeguarding lead. They told us they were well-supported and would seek advice if they had safeguarding concerns.

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- The trust target level for training was 90%. Figures provided by the trust showed that 100% had attended safeguarding adult's level one and 93% had attended safeguarding adults level two training. 100% of nursing staff and 85% of medical staff had attended child protection level one and two training.
- Staff we spoke with were able to describe situations in which they would raise a safeguarding concern, and how they would escalate their concerns.

Mandatory training

- Mandatory training covered a range of topics including moving and handling, basic life support, hand hygiene, safeguarding adults and children, and health and safety. Staff also completed training in dementia awareness, tissue viability and medicines assessments. Attendance at mandatory training was recorded and revised monthly as training was on a rolling programme. Nursing staff attendance for mandatory training was 85%. On ward three manual handling training attendances was 93% with new starters completing their training at trust induction. Conflict resolution training attendance was 93%.
- The ward managers told us they monitored staff training requirements and ensured staff were released from the ward to attend training, or were given time to complete on line training.

Assessing and responding to patient risk

- The trust used the Modified Early Warning Score (MEWS) to monitor patients and identify any deterioration in their condition. Staff told us that the medical staff supported them to monitor the patients for early recognition and response to concerns.
- Track and trigger records used to monitor a patient's condition and manage pain, were completed accurately. Appropriate equipment was used to monitor and support patients.
- All patients were assessed on admission. These assessments included, nutritional screening, falls risk assessment and a mobility assessment as appropriate. The records we looked at showed these had been completed and were reviewed and updated.
- Each ward had a tissue viability link nurse who attended further training and advised the staff on tissue viability

issues. Tissue viability is the term used to describe skin integrity and the management of patients with acute and chronic wounds and prevention and management of pressure damage.

- The records we saw on the wards identified that routine changes had been appropriately documented and actioned. This meant that staff took the required action when an observation indicated that a patient's condition was deteriorating.

Nursing staffing

- Nursing staffing levels were assessed using the national Safer Nursing Care Tool and there were identified minimum staffing levels. The safe staffing levels were displayed at the entrance to every ward, showing planned and actual numbers.
- We saw the rotas for nursing staff on the wards we visited. We looked at actual versus rostered staffing levels on wards and found them to be identical on the day of our visit for all three shifts. Actual versus establishment staffing levels were displayed near the entrance to the wards for patients and their visitors to see. The wards was staffed with a ratio of one registered nurse to eight patients during the day shift, and one registered nurse to 12 patients at night. Agency and bank staff (temporary staff) were used on a daily basis to ensure safe levels were maintained.
- The trust's enhanced care team provided additional support on the wards for those patients who required one to one support. There was a standard operating procedure in place for staff to risk assess and request additional nursing support for patients.
- The trust had an escalation process in place that ward staff followed when shortfalls in nursing numbers were identified. This included utilising bank or agency staff to ensure that there were adequate numbers of registered nurses to meet patients' needs. When bank and agency staff were used they received local induction prior to working in the department and their competency was checked. We saw evidence of the induction for one agency staff nurse during our visit to the trust.
- Staff on the wards said they had a flexible shift rota that took into account their work- life balance by ensuring that they had time with family and friends.
- We observed nursing handovers on a number of wards, during the day time. We saw nursing handover sheets

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that contained information about care needs, past medical history and plans for discharge. A full discussion took place for each patient, which included information about their progress, plan of care and any concerns.

- We met and spoke with student nurses who were undertaking placement learning in the wards. They told us they felt well supported by their mentors and had met and spoken with the ward managers and senior nursing staff.

Medical staffing

- There was 78 whole time equivalent (WTE) medical staff employed at the trust. 37% of those were consultants which was above the England average of 33%. There were 8% middle grade doctors which was also above the England average of 6%. There were 21% within the registrar group which was below the England average of 39%; this was counter balanced with 34% junior staff which was above the England average of 22%.
- The shortfall in medical registrar staffing levels caused workload issues for those on call such as delays in responding to ward staff requests and completing tasks identified during ward rounds. We identified that support from other members of the multi-disciplinary team (MDT) ensured this system was safe.
- Medical handovers took place throughout the day. At 9.00am a board round was attended where all the patients were discussed prior to the ward round. Late afternoon a 'patient review plan' was discussed to support the hospital at night team and those on call.
- Cardiologists had withdrawn from the acute on-call rota and were now part of a specialist cardiology rota. Two new cardiologists were due to commence at the trust in September 2015 bringing the numbers to five. This meant that the needs of cardiology patients would be addressed by a specialist at all times. The use of locum (temporary) doctors was seen in all areas. They supported the permanent staff to meet the workload within the medical care services. We heard positive feedback about their commitment to the hospital and positive outcomes of team work.

Major incident awareness and training

- A revised business continuity plan had been introduced and was available in a paper copy and on the intranet.

The staff were informed when the level of need at the trust was high. Staff understood the importance of appropriate safe discharge at this time to release beds for new admissions.

- We were told that the ward had been utilised during the winter pressure arrangements. During this time the suitability of patients for discharge was reviewed more frequently by the bed management team to allow increased bed flow.

Are medical care services effective?

Good



Evidence-based national guidelines were followed. National guidelines and pathways were used to monitor and manage patient care.

Policies and procedures were accessible to staff, and care was monitored to show acceptable standards were maintained with good outcomes for patients.

Patients' nutritional and hydration needs were assessed and referred to a dietician if required. We heard and observed that patients received pain relief in a timely manner.

Staff had access to training including specialist training and participated in annual appraisals. We observed robust multidisciplinary working which coordinated effective patient care.

Evidence-based care and treatment

- The medical care service participated in all national clinical audits that it was eligible for. The service had a formal clinical audit programme where compliance with the National Institute for Health and Care Excellence (NICE) guidance was assessed. For example CG42 Supporting people living with dementia. This guideline makes specific recommendations that apply to all types of dementia.
- We saw care pathways based on NICE guidance for stroke, heart failure, diabetes and respiratory conditions. The trust had a pathway for patients with sepsis to enable early recognition, prompt treatment and clinical intervention.
- Pressure ulcer prevention and management policies were followed in line with national guidelines. Staff we

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spoke with was aware of these policies. Particular emphasis was placed on nursing and therapy staff that had a direct role in assessing risk factors and repositioning patients.

- The forget-me-not scheme in use across the hospital supported patients living with dementia; environment enhancements to enable reminiscence had been introduced in some areas to support the scheme. The blue flower symbol is at the centre of the scheme; put in patients' case notes and above their beds. This helped to ensure people living with dementia were easily identified by staff and their care was planned accordingly.

Pain relief

- Patients told us they were given pain relief when they needed it, and nursing staff always checked if it had been effective. The track and trigger document used by the trust helped to monitor patients' pain, and when a doctor's input was triggered by the on-going assessment, people were seen and the intervention had been recorded.
- Staff accessed support and advice from the pain management team when required.
- The Abbey Pain Scale was used for the measurement of pain in patients living with dementia or those who were unable to clearly articulate their needs.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patients' nutrition and hydration where applicable. We observed that fluid balance charts were completed to monitor patients' hydration status including the previous day's totals for monitoring purposes. We saw that patients' nutritional state had been monitored and we saw referrals to the dietician were made and acted upon when necessary.
- We saw that patients were given a choice of food and had access to drinks by their bedside. The quality of the food available was described on several occasions as good.
- The handover sheets and name boards identified when a patient required support with eating and drinking or required a specialist diet.
- Referrals to the dietician were carried out promptly and patients' weights were recorded weekly or as necessary. Patients were referred to the speech and language therapists (SALT) in a timely manner when swallowing

problems (dysphagia) were identified; the SALT assessed patient safety whilst eating and drinking and recommended suitable consistencies of food and fluids. Dysphagia champions had been trained by the SALT to support staff on the wards, for example with the thickening of fluids for patients with swallowing defects.

- The wards had introduced protected meal times when open visiting was not allowed. However, during our inspection, we observed patients being supported with their meals by close relatives who attended, by previous arrangement with the nurse in charge. This was seen to give the patient encouragement from someone close to them assisting with their recovery.
- There were 'red tray liners' to identify patients who needed support with eating. We observed patients being discreetly supported by members of staff at meal times and with drinks.

Patient outcomes

- Sentinel Stroke National Audit Programme (SSNAP) allows comparison of key indicators that contribute to better outcomes for patients. Overall performance is rated from A (highest) to E. It is acknowledged by the audit that very stringent standards are set; however, data shows that performance level between January to March 2015 was grade E. Scanning and occupational therapy were both graded A with physiotherapy and multidisciplinary working both graded B.
- Myocardial Ischaemia National Audit Project (MINAP) looks at how the NHS cares for patients with a heart attack in England. During 2013/2014 177 patients were seen by a cardiologist or a member of team and were admitted to a cardiac ward which scored 96%, above the England average of 94%. Of the 177 patients 116 were referred for or had angiography which scored 97%, above the England average of 77%.
- Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE). Risk of and prevention of VTE was considered on admission for all patients. VTE was well managed at the trust; treatment scores were recorded at above the trust target of 95%, for May 2015 they were 99%.
- The trust had a mixed performance in National Diabetes Audit (NaDIA) from September 2013 which showed the trust was worse than the England & Wales median for prescription errors, insulin errors and the 'foot

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assessment' indicators. A podiatrist had since been recruited and in post for 18 months; they offered a foot care assessment and plan of care for in patients with diabetes. This meant that the foot assessments would improve patient outcomes. Performance was better than the England & Wales median for food/meal indicators and staff knowledge indicators. Overall satisfaction was 93%, compared to the England & Wales median of 86%.

- There was a mixed performance against the latest heart failure audit; 50% of patients had input from a specialist against the England average of 78%. Evidence from clinical trials demonstrates that patients with heart failure, due to left ventricular dysfunction, show an improvement in symptom control and a reduction in morbidity and mortality when treated with an ACE inhibitor (ACEI). 95% of patients were discharged on ACEI against the England average of 73%.
- We saw that comprehensive geriatric assessments were completed by the lead consultant or advanced nurse practitioners prior to placing a patient on the frailty pathway. The team aimed to reduce the length of patient stay with increased multidisciplinary input and early recognition of social care input or accommodation.
- Standardised risk of readmission for elective patients was reported as good. There was variable performance compared to England average for elective length of stay. Standardised risk of readmission scored higher for Cardiology.
- There was a shorter length of stay for non-elective geriatric medicine compared to the England average.

Competent staff

- Staff told us that they were encouraged to develop their individual skills and there was a strong emphasis in the trust on personal professional development.
- Annual staff appraisals were based on the trust vision. The trust target was 90% completion. In the areas we visited records showed completion was 100%. All staff we spoke to confirmed they had had an appraisal.
- Link nurses had provided talks and updated the staff on current issues and policies. Link nurses are nurses who provide two way communications between the trust specialist nurses and staff in the clinical area. The ward had resource folders providing information about specialties for staff to refer to.

Multidisciplinary working

- Multi-disciplinary working was embedded on both wards. The ward based physiotherapists and occupational therapists (OT) supported the nurses in the patient rehabilitation pathway and promoted safe patient independence during their rehabilitation programme. We saw that the team discussed patients' progress and reviewed and updated documentation as necessary. The therapists joined the consultant ward rounds to give 'patient progress' feedback.
- Daily board rounds attended by nurses, doctors and therapists encouraged collaborative planning and strong working relationships. There was an obvious professional respect between nurses and therapists which made communication of patient information at handovers, ward rounds and MDT meetings effective and efficient.
- Physiotherapists held mid-day meetings to assess the acuity of the patients on specific wards and offer support to colleagues where needed.
- The in-patient diabetes specialist nurses focused on patient support and education. The nurses liaised with other health care professionals when required; and visited inpatient and outpatient departments to provide specialist advice for staff and patients.
- The department of pathology provided laboratory services in biochemistry, haematology, blood transfusion, microbiology, histopathology and cytology to the trust.
- The cardiologists told us they met with experts from other local hospitals to discuss clinical issues and outcome of treatments. External MDT working was also evident with cross-site discussions taking place to ensure the patients were receiving the optimum care from the service.

Seven-day services

- Physiotherapists offered a seven day service with priority work being identified and provided at weekends. For example continued therapy to enable the safe discharge of patients.
- Pharmacy was open on Saturdays but closed on Sundays. This meant Saturday dispensing was available and they were able to support the ward staff to supply medicines for patients discharged on Saturday's and organise patients medicines discharged on Sundays.

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- During weekends there were four medical consultants available. 'Consultant of the week' had been developed and this process had promoted the consistency of patient care and allowed medical training time. A consultant rota identified which consultant had overall responsibility for the patients during a particular week.
- Availability of out of hours imaging, pharmacy, occupational therapy and physiotherapy were through an on call system during the evenings and outside core working hours at weekends.

Access to information

- Staff told us they had easy access to patient-related information and their records whenever needed. We saw that agency and locum staff had access to patient information in care records they told us it enabled them to care for patients appropriately
- Nursing staff told us that, when patients were transferred between wards, staff received a handover about each patient's medical condition. We saw that ongoing care information was shared in a timely way.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with showed awareness of the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLS). We saw a DoLS had been put in place for one patient on ward three. The patient was supported by one to one care and relatives told us they were fully involved in the care plan. Ward staff were clear about their roles and responsibilities regarding the MCA.
- When patients did not have capacity to consent, staff were able to demonstrate they had applied best interest in deciding the treatment and care required.
- We saw that patients were asked for their permission for care delivery and consent gained for treatment. The records, when applicable, showed clear evidence of informed consent that identified the possible risks and benefits of care.

Are medical care services caring?

Good 

Patients and relatives we spoke with were all satisfied with the care they received, we heard no negative feedback.

Friends and Family Test (FFT) response results were positive. Ward managers encouraged all staff to ask patients for their feedback prior to being discharged.

Patients and relatives told us that staff were kind, caring and available to talk to. Patients told us they were informed about their care and knew what was happening to them.

Compassionate care

- Friends and Family Test (FFT) response score trends were all above 92 (score out of 100). Four wards scored 100.
- CQC inpatient survey results scored 'about the same as other trusts' for all areas and better than other trusts for timely discharge home.
- We witnessed many examples of the staff being caring and protecting patients' privacy and dignity. For example, in the discharge lounge we heard a distressed patient living with dementia spoken to and cared for in a compassionate and sensitive manner. The staff gained the patient's trust and we saw the patient soon became settled and responsive.
- Patients told us they had been well cared for. We observed staff protecting patients' privacy and dignity, shutting curtains around bed areas securely and lowering their voice to discuss personal information.
- We observed staff supporting people's mobility, giving them encouragement and praise. We saw staff introduce themselves to patients and relatives.

Understanding and involvement of patients and those close to them

- Patient's relatives told us they felt informed about the plan of care and that all the staff had been supportive. There was evidence written in care records and discharge plans when a patient's family or those close to them had been involved.
- All the patients we spoke told us they were aware of what was happening to them; they told us they felt involved with their care. Patients told us they felt safe and any of their fears had been alleviated by the nursing and medical staff.
- We saw that patients and those close to them were included in multi-disciplinary meetings and ward round discussions.

Emotional support

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- Clinical nurse specialists offered emotional support and advice for patients and they gave guidance and explanations to staff. The trust was able to refer patients for emotional and psychological help in their programme of supportive and psychological therapies. The mental health team were available on call.
- Chaplains were available 24 hours a day seven days a week. They represented different denominations and had contact with all the major faith communities.
- The staff on the wards described how they provided a caring and compassionate service, offering support and reassurance, particularly information and guidance to families when patients died.

Are medical care services responsive?

Requires improvement



Discharge facilities for medical patients had improved with the introduction of the discharge lounge in July 2015; however the amount of medical patients in the hospital exceeded the bed spaces which caused some medical patients to be nursed in other speciality beds.

Some patients had experienced a number of bed moves including at night, which they told us felt unsettling and was unsatisfactory. Some patients had their discharge delayed due to difficulties accessing social care or home care packages.

We identified that patients on ward 44 lacked rehabilitation support due to reduced involvement of the physiotherapy service. The ward lacked service planning for staff that were not available to work and service input was less than that expected at the main site, for example physiotherapy sessions and MDT review.

There was support for vulnerable people such as people living with dementia. An interpreting service was available and used when necessary. The trust had developed patient flow initiatives such as a daily board round to coordinate patient care, promote safe patient discharge and reduce the inpatient stay.

There was a proactive approach to encouraging and learning from patient complaints. Patients we spoke with told us they knew how to complain should the need arise.

Service planning and delivery to meet the needs of local people

- Intermediate care services on ward 44 were not planned in a proactive way to respond to patient's rehabilitation needs. For example, the trust told us there were formal arrangements in place to backfill for two registered nurses but we saw no evidence of this on the ward. Additionally, the physiotherapy service attended the ward two to three times a week but staff were unsure which days that would be. A physiotherapy assistant had retired a month previously and had not yet been replaced and no action taken for the lack of input.
- On ward 44 the dietician, OT and SALT attended when telephone referrals were made. We were told that at times of escalation the medical bleeps were answered by the doctors, however on occasions it had proved difficult to get a doctor to attend. Pharmacists attended weekly, MDT occurred three times a week, the discharge team attended on a Monday and social workers attended intermittently. We also found on ward 44 that the bed spaces were not numbered in line with the name board which could be confusing for agency staff, newly recruited staff, patients and visitors.
- We identified that patients were at risk of having multiple bed moves when there was an increased number of medical outliers in the hospital. One patient told us and we found evidence that they had experienced six bed moves since admission. The trust had identified this as an issue and used a bed move document in patient's notes.
- Since our previous inspection the service had acknowledged that discharge planning needed to be improved. A newly opened discharge lounge had proved successful offering improved patient experience and increased patient flow. This was a five day service which was open from 8.00am to 6.00pm. The manager was considering staffing the lounge until 8.00pm as on occasions late arrival of the hospital transport had meant that the lounge stayed open. There was a designated pharmacist who attended daily and food orders were arranged as required from the kitchen. The service had opened before completion of the facilities and some further work was planned.
- The newly formed frailty team had been in place for six months. The purpose of the team was to promote the pathway for frail elderly patients to ensure the pathway becomes more integrated and increases its

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effectiveness. The team consisted of three advanced nurse practitioners (nurses who have completed additional training), OT, physiotherapists and social workers.

Access and flow

- Referral-to-treatment (RTT) 18 week performance was consistently above the target and better than the England average between June 2014 and May 2015.
- Medical bed occupancy for medical care services exceeded 100% meaning there were more medical patients than there were medical beds available. Consequently, medical patients were placed on other speciality wards such as surgery.
- The target number of moves to a different ward or unit after 9.00pm was zero however we saw between April 2014 and March 2015 the actual number of moves was 373.
- Patient flow was disrupted by medical outliers who were placed in surgical beds across the trust. Medical outlier is the term used to describe patients who are admitted to a ward different from the internal medical ward. Medical outliers were identified on a computerised list which listed their consultant. During our visit there were 28 medical patients being treated on surgical wards. Data shared with us by the surgical team showed there had been 512 medical patients receiving care on the surgical wards in the past three months.
- There was an established medical team who specifically looked after medical patients being cared for on non-medical wards but ward managers on the surgical wards shared concerns that these patients were not consistently reviewed and told us they had raised this with medical staff in the past.
- Operational meetings were held up to five times a day to establish the availability of beds on the wards. The aim was to discuss the availability of beds, the flow of patients and to instigate any changes that might facilitate more timely patient transfer or discharge. We observed a meeting where decisions were made to manage the bed situation, discuss medical outliers and agree the plan for the next few hours. The director of operations was completing a project on bed allocation and resizing of units to deal with outliers.
- We were informed that discharge planning started soon after admission. However, it was difficult to identify in some of the patient records we read when a patient's discharge planning began.

- We saw that 'days since admission' were displayed on the whiteboard on each ward next to each patient's name. Discharge for some patients had been delayed because of a lack of suitable accommodation for people to move on to, or funding for specialist placements. The trust was engaged with partner organisations in managing these delays to minimise the impact on individual patients and the service overall. One patient on the short stay unit had been an inpatient for 77 days due to their complex needs and best interest discussions, including a mental capacity assessment.
- The trust had developed initiatives to improve patient flow such as a daily board round each morning and afternoon to coordinate patient care and prioritise discharge at the patient board and members of the discharge team now attended ward rounds.
- The discharge lounge was situated on the first floor of the hospital close to pharmacy and the main entrance of the hospital. Relatives received 20 minutes free parking when they collected a patient. There were two beds and nine chairs available for people waiting for discharge. Currently staffed up to 18.00hrs but staff often had to stay late due to delays in the arrival of transport.

Meeting people's individual needs

- Patients with complex needs were risk assessed by specialist nurses, physiotherapists and OTs. We saw patient care plans based on risk assessments and that specialist advice was sought and acted upon in a collaborative way.
- On ward 44 we found evidence that patients had reduced support from physiotherapists. The trust told us that patients who require exercises are given "physio tool" exercise sheets but acknowledged these are not shared with ward staff. We did not find evidence of written exercise instructions available for the staff or patients. We overheard a patient say, "No-one tells you how to do your exercises." This meant that in some instances a patient's length of stay could be increased.
- Interpreting services were available for people whose first language was not English.
- The 'This is Me' document was fully implemented in the wards. The document was usually completed by relatives and enabled the staff to meet the patients

Medical care (including older people's care)

individual needs when they were unable to communicate with the staff. Carers were encouraged to be present on the ward to assist with rehabilitation process.

- The use of the 'forget me not' care bundle supported people living with dementia. The enhanced care team delivered intensive training for staff to look after patients with dementia. Activity boxes were available on each medical ward for use by patients including those on one-to-one observation.
- In November 2014 a three year dementia strategy was launched by the trust, building on existing work to improve care and experience for people living with dementia. The strategy, informed by patients, carers, staff and stakeholders, responded to the needs of local people as well as the priorities set out in the National Dementia Strategy and the Prime Minister's Challenge on Dementia. The trust dementia strategy was welcomed by staff and showed signs of being embedded in all areas. Some areas required further development, for example nutrition and hydration as adaptive equipment such as cutlery and assistive plates had not yet been purchased.
- A reminiscence room was available for people on the short stay unit. We observed a patient settled in the room and enjoyed finger foods which were available. Their relative who was in attendance told us they felt that the staff had been very attentive to their loved one's needs.
- Discharge summaries were given to GPs to inform them of patients' medical conditions and the treatment and care delivered before discharge.
- A dementia champion's forum was held monthly to discuss the progress of the dementia strategy within the trust; they invited guest speakers to meet with staff to raise awareness. A dementia champion encourages others to make a positive difference to people living with dementia. They do this by giving them information about the personal impact of dementia, and what they can do to help.
- We observed reassurance being given to patients and we saw that patients had their call bell within reach. Patients told us that they thought the call bells were responded to within good time scales and they had not had to wait an unreasonable amount of time for attention.

- We saw a range of advice and information leaflets available for patients and relatives to read about self-help, medical conditions and access to services.

Learning from complaints and concerns

- We were told that a greater emphasis had been placed on complaint avoidance to improve the patient experience overall. The staff were encouraged to seek a patient's view throughout their in-patient stay and resolve issues at the time, rather than leave them to escalate in to a formal complaint. This had proved successful and a reduction in complaints was demonstrated.
- Four complaints had been received about medical care services in May 2015. Patients we spoke with felt they would know how to complain to the hospital if they needed to; they told us they felt that the staff considered their experience at all times. Patient Advice and Liaison Service (PALS) contact details was visible on noticeboards.
- We were told that when a complaint was received the ward staff were informed about the issues and the findings of the investigation were discussed at ward meetings. We saw this documented in the meeting minutes.

Are medical care services well-led?

Good



We spoke with staff that were aware of the trust vision and values. Staff told us about the newly energised open culture in the trust that they hoped continued. They felt they were well managed at ward level. The disconnect between them and the senior executive team was improving but not there yet.

We found the service to be open and honest with us, providing examples of weaknesses and how they were planning to enhance the service.

It was acknowledged that staff shortages had impeded some initiatives. Shortages in medical staffing levels had also caused stress and anxiety for the workforce.

Ward level leadership was found to be effective and well managed in most areas. However, Ward 44 lacked strategic direction and this had resulted in poor service planning.

Medical care (including older people's care)

Vision and strategy for this service

- The executive team had told us that the trust vision was to become the local healthcare provider of choice, providing excellent community and secondary healthcare services close to and for local people. They ensured that the interests of the patients were at the heart of everything they did whilst providing the best possible care to them.
- Staff were familiar with the trust vision and realised the importance of promoting it.

Governance, risk management and quality measurement

- Quarterly governance meetings were held within the directorate and all staff were encouraged to attend, including junior members of staff. Complaints, incidents, audits and quality improvement projects were discussed.
- The trust reported risks relating to insufficient medical and nursing staff which could lead to an inappropriate skill mix being available and the lack of bed capacity in medicine was seen as a persistent risk.
- The impact of a reduced physiotherapy service for the patients on ward 44 had not been identified or reported as a risk within the rehabilitation facility. It was not clear what actions had been taken to remedy this.
- A quality dashboard was presented so that all levels of staff understood what 'good looks like' for the service and what they were aspiring to provide.

Leadership of service

- We were told by a member of staff of perceived improvements at the hospital during the previous 12 months; increased focus on the service and patient experience has been promoted. Staff morale was improved and senior management were visible and were now listening to the staff and acting upon their suggestions.
- Staff felt they were well managed at ward level and the disconnect between them and the senior executive team was improving but not there yet.
- The trust acknowledged Ward 44 needed a clear strategy and future vision. The lack of clarity regarding the direction of the service was having an impact on the leadership.

Culture within the service

- Staff sickness rate had been reduced from 13% down to 2%. Staff told us this was due to a reduction in staff vacancies so that ward staffing had increased which had improved staff morale. Staff told us they felt listened to and could influence change such as requesting an outside area for patients to sit; this had now been actioned and was being enjoyed by all who used it.

Public engagement

- Monthly patient experience surveys were completed every month by asking inpatients questions about the quality of their care. The results and comments from these surveys were shared widely with all staff and managers in the trust and used to make improvements.
- The trust dementia champions visited local schools to work with children so that they developed an early understanding of dementia and the effects of the disease. We were told of an article that was printed in the local press (May 2015) telling the public about the dementia champions on each ward at the hospital and the benefits of their role.
- During July 2015 'John's Campaign', an initiative for open visiting named after a patient, was being trialled in some areas over a four week period and had so far proved successful.

Staff engagement

- We saw that wards had a communication folder which held the news bulletins and weekly communication sheets. Staff told us that during the last 12 months they felt much better informed and involved with what was happening at the trust.
- Staff received a monthly, medicine division newsletter which was accessible on the intranet and as a paper copy. This updated staff on recent events, training dates, incident data and staffing issues. Staff were encouraged to submit information to be included in future editions.
- We were told that the induction programme for nurses recruited from overseas had improved and as a result the retention was better. Staff recruited from overseas told us they had received a warm welcome and had settled in quickly. The trust had been contacted by other hospitals to see how their induction had improved.
- Staff told us they enjoyed working at the hospital and they felt valued; they were encouraged to complete the NHS staff surveys and local surveys. The NHS staff survey showed the results of staff satisfaction were within expectations.

Medical care (including older people's care)

Innovation, improvement and sustainability

- There was a culture of innovation. Staff told us they were given opportunities to implement ward level

changes without going through the senior management structure. Staff told us that they felt that they could contribute and generate ideas for improvement and sustainability.

- Robotic pharmacy dispensing was due to commence when funding and final arrangements were in place.

Surgery

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

Information about the service

The Queen's Hospital surgical services provides more than 16,000 surgical cases, 53% of which were day case, 16% elective and 30% emergency surgery.

The service employed around 1,000 WTE staff across a range of specialties: theatres, outpatients, general surgery, colorectal, urology, breast surgery, ear, nose and throat (ENT), trauma and orthopaedics; plastics, maxillofacial and orthodontics, ophthalmology, emergency surgery and gynaecology, maternity and obstetrics. Gynaecology, maternity and obstetrics was inspected as a part of the maternity and gynaecology CQC report. From data submitted by the hospital we saw 37% of the surgery was general, 22% trauma and orthopaedics, 16% ophthalmology and 25% was a mix of 'other' specialities.

The surgical division also included maternity, gynaecology and critical care within this directorate. The adult surgical service had approximately 120 inpatient beds and a day-case centre known as the 'Treatment Centre' which had an additional eight beds.

We inspected ward 11 (dedicated male surgical ward), ward 12 (female surgical ward), ward 14 (ENT, a gynaecology and general surgery ward), ward 19 and 20 (trauma and orthopaedics), ward 30 (general surgery), five main theatres with one theatre (theatre 2) being identified as the emergency theatre, recovery, anaesthetic rooms, the pre-assessment lounge, discharge lounge and the day-case unit known as the 'Treatment Centre'.

During the inspection we spoke with 32 patients who had used the service. We spoke with five surgical divisional leads and managers, 27 medical staff, 47 nurses and healthcare assistants and 11 allied health staff and non-clinical staff. In total we reviewed ten care records.

Surgery

Summary of findings

We saw large number of vacancies for registered nurses and heavy reliance on agency nursing hours in some areas. The service had successfully filled some nursing vacancies with overseas nurses. The managers described their reliance on agency staff for nursing and medical staffing as a major challenge for the service.

We noted a high number of medical outliers on the surgical wards. Staff shared their concerns that they lacked the skills and experience to care for these patients. However, we saw staff were skilled and competent to care for surgical patients.

Staff knew how to report an incident. The service was compliant the World Health Organisation (WHO) safer surgery checklist. Overall we saw good evidence of staff responding to patient risks.

We observed patients being treated with compassion, dignity and respect. The Friends and Family Test (FFT) showed expected results which were similar to the England average, with the exception of ward 30 which was better. Patients were involved in their care, treatment and discharge.

There was a clear vision and strategy for the service supported by an up to date business plan. Managers had a vision of key areas for development and were aware of their strengths weaknesses. We saw the culture throughout the division was very positive and there was a good level of engagement with staff.

Sound governance and quality measures were in place. We saw strong leadership from the board to divisional managers to local managers. Much work had been done to review the sustainability of the service and much improvement had taken place since last year.

Are surgery services safe?

Requires improvement



We saw large number of vacancies for registered nurses which led to many nursing hours being unfilled. We saw the total number of agency nursing hours used was high. The hospital had recently filled some nursing vacancies with overseas nurses.

The managers described their reliance on agency staff for nursing and medical staffing as a major challenge for the service. The risks that were identified were recruitment and retention of nursing staff, supporting preceptorship programmes for newly qualified nurses and the national and overseas recruitment programme.

All staff told us they knew how to report an incident except for some non-clinical staff who told us they would inform their line manager of incidents instead. The hospital calculated the NHS safety thermometer percentage of harm free care for the surgical division we saw they were complaint with this target. The hospital was compliant the World Health Organisation (WHO) safer surgery checklist. The checklist was now being assessed both quantitatively and qualitatively. These were all improvements since that last CQC inspection (2014).

Incidents

- No 'Never Events' had occurred within the service between April 2014- March 2015.
- There had been 21 serious incidents between May 2014 – April 2015, seven of which were falls, three were pressure ulcers greater than grade three, three ward closures, one unexpected death, one communication issue and six were still remaining to be reviewed. We saw eight of these had occurred on ward 20 (trauma and orthopaedics).
- Learning had been disseminated trust wide to reduce the number of falls. All ward managers were aware of how many falls they had on their ward and what they had put in place to reduce risk, for example, non-slip socks and posters by baths reminding patients not to stand without the support of the staff.

Surgery

- We saw evidence that serious incidents were discussed at the executive review meetings and a root cause analysis had been completed with the support of the governance team.
- We reviewed some of the root cause analysis (RCA) reports from governance teams we noted they were of good quality but some were medically focused and would have benefited from more focus on what the nurses did in response to the increasing observational scores and the deteriorating patient.
- Staff reported incidents via electronic information systems, managers were clear about their responsibilities for reviewing and escalating incidents. All staff told us they knew how to report an incident except for some non-clinical staff who told us they would inform their line manager of incidents instead. This had been an improvement on the service since the 2014 CQC inspection.
- We saw evidence from the theatre governance review (2014) that staff did not feel comfortable in raising concerns and had concealed serious incidents. Throughout the inspection we observed examples in theatres where staff were comfortable in raising concerns, reporting incidents and challenging senior members of the team. One example was a patient who may not have been fit for surgery where an anaesthetist challenged senior theatre staff appropriately to ensure the benefits outweighed the risks. Consultants and medical staff responded well to this and they all had an open discussion until a mutual decision was reached.
- Ward managers maintained governance folders which were easily accessible on the ward and were available for all staff to read. The folder contained information on the importance of governance, held records of previous incidents (trust wide and local) as well as the risk register in order to disseminate information to staff. Ward managers kept a log of who had read recent incidents in order to encourage those who didn't.
- The ward manager told us they would hold ward meetings every eight weeks and would discuss trust wide and local incidents. Staff provided us with examples of where they had learnt from incidents including near misses and were able to tell us about a recent never event that happened in the maternity theatres.
- Most staff were not able to explain duty of candour but understood the importance of reporting incidents. The duty of candour regulations require a provider to be

open and transparent and follow specific requirements. These included informing the person and or family. Staff did not include apologising to the patient as one of their steps when explaining what they do when 'things go wrong'. The hospital had recently advertised that training days were available to all staff on how to complete a root cause analysis and the importance of duty of candour. A policy of "Being open when patients are harmed" (2015) policy was in place incorporating requirements of duty of candour.

Safety thermometer

- The trust used the NHS Safety Thermometer which was a tool for measuring, monitoring and analysing harm to patients and harm free care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters and venous thromboembolism (VTE or blood clots). We noted nursing staff conducted audits on harm-free care, patient experience and the environment. The hospital calculated the NHS safety thermometer percentage of harm free care for the surgical division was 98% (April 2014 - March 2015) compliant with a target of 95%. We found the trust had low numbers of pressure ulcers and falls with harm. We saw results of the safety thermometer were displayed within the wards we visited.
- Hospital data showed that 98% (April 2014 - March 2015) of all surgery inpatients had received a VTE risk assessment on admission, against a trust target of 95%.

Cleanliness, infection control and hygiene

- Guidelines on infection control were in use, including: care of patients with suspected or confirmed contagious and communicable diseases and/or suppressed immune systems, including patient care before, during and after their procedure and decontamination of equipment and environment.
- We found ward closures classified as serious incidents were due to infection outbreaks in which the wards followed the correct national guidance in line with infection control procedures.
- Ward areas and theatres appeared to be clean and personal protective equipment, such as gloves and aprons, were available for use in all clinical areas. Staff were 'bare below the elbows' in line with trust policy

Surgery

and national guidelines for best hygiene practice. We observed staff in all surgical areas adhering to guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps).

- There were no methicillin-resistant staphylococcus aureus (MRSA) infections within surgery and two reported cases of Clostridium difficile (C. difficile) within the past year.
- Staff conducted C.difficile audits and infection control environmental assurance audits every quarter; we saw these figures were around 98% complaint in all areas.
- The unit participated in on-going surgical site infection audits run by Public Health England. The last published results for April 2013 to March 2014 showed that there were zero surgical site infections for the hospital relating to hip replacements.
- We observed staff regularly washed their hands between patient interventions. Hand hygiene audits were maintained on every surgical ward, figures showed most areas were 100% over the past year except for theatres in the last quarter, at 74%. Infection control nurses had worked with staff to raise hand hygiene compliance rates and implemented innovative technology which calculated alcohol gel use against the target.
- We saw patients were screened for MRSA and we were told by staff that patients were isolated in accordance with infection control policies however, we found one occasion where this had not happened. We noted one patient who had been screened and was MRSA positive, five days had passed from screening to result. In addition to this there was a delay in informing the ward of approximately 20 hours. This led to a delay in the patient being isolated which put other patients at risk. In addition to this there was no record available to confirm that the bed space had been cleaned. The ward manager acted appropriately when informed and had the bed space cleaned. We spoke with the infection control manager who confirmed that results were usually provided within 48 hours.
- Full tracking and traceability of surgical instruments was provided which offered a full audit trail ensuring that each decontamination process was followed correctly and according to international standards.

Environment and equipment

- Staff reported having sufficient equipment to enable them to carry out their duties. Replacement items or

new equipment could be obtained if required, with relative ease. We found equipment was regularly checked and maintained, with the exception of two pieces of ultrasound equipment in theatres. Equipment used for monitoring patients had been safety tested and stickers indicated the next date for checks to be made.

- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedure.
- There were effective systems to ensure that resuscitation equipment, including emergency drugs, were readily available in all surgical areas, including theatres. Records showed that resuscitation trolley checks were completed each day.
- Feedback from patients had resulted in changes to the Treatment Centre environment and looking at ways to reduce noise at night for those on the ward (23hrs ward facility).
- Ward staff told us they had a sufficient number of side rooms for patients requiring privacy or isolation due to infection. Ward staff commented that some bathrooms lacked ventilation. Patients on ward 19 (trauma and orthopaedics) told us there were not enough commodes especially during the night.

Medicines

- Correct storage arrangements were in place for the different types of medicines, including items which required refrigeration. We saw temperature checks had been carried out on fridges, ensuring correct, safe storage. Suitable disposal arrangements were in place for medicines that had expired.
- Stock balances of medicines were regularly audited and confirmed to be correct. Ward managers completed regular monthly medication audits which reviewed their compliance with best practice and CQC regulations. From the latest May 2015 audit we noted all surgical wards were compliant.
- We saw the service had 206 medication errors (April 14-March 15).
- During July, August and September 2014 an audit of missed medicine doses was carried out by three junior doctors, and supervised by a medical consultant. 744 missed doses were reported within surgical services. The audit recommended that staff recorded the reason for missed dose, asked the patient for the reason for refusal and to re-audit in 12 months' time.

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- We noted that controlled drugs (CD) were handled appropriately and stored securely demonstrating compliance with relevant legislation. We saw that the preparation and administration of controlled drugs was subject to a second independent check.
- Ward staff told us this was problematic on nights with only two nurses if one nurse was agency. Half of agency nurses could not access electronic medication records. One staff nurse told us they had to leave an agency nurse in charge of a ward whilst they checked medication on another ward which also had an agency nurse working nights. A patient deteriorated whilst the nurse was gone and the agency nurse was not able to respond in a rapid manner. Staff told us they raised this with the ward manager the next day. Immediately following our visit, the trust took action to review agency nurse access to electronic reporting systems.
- Most patients had received sufficient information from staff about their medicines and were prescribed their long term medication on admission. We found one example where staff did not explain to the patient that they needed to stop anticoagulation therapy before surgery as a result the patient had to receive an unnecessary transfusion during surgery. This patient was reviewed by four different teams and no one had noticed that the patient should have discontinued this prior to surgery.
- One patient told us that they liked that staff promoted their independence and they were able to administer their own insulin and when they suffered low blood sugar, staff were quick to react.

Records

- Staff on the wards maintained electronic records; we saw these were comprehensive and regularly reviewed. The system allowed staff to be able to review all multi-disciplinary notes very easily, review the amount of times the patient had moved wards and would indicate to nurses when certain referrals needed to be sent for example to the tissue viability nurse or dieticians. Specialist staff were able to select records of all the people they needed to review which ensured patients were not overlooked. We were told of an example where tissue viability nurses were able to select and review all patients with high Waterlow (skin risk assessment) scores.

- Surgical wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers, VTE and malnutrition.
- Care pathways were in use for patients undergoing elective surgery. The pathway incorporated the patient journey from pre-assessment, admission, surgery, recovery and discharge. Records we looked at were completed accurately.
- Record audits were completed on all wards; we noted surgical wards were complaint most of the time over the past year.

Safeguarding

- There were safeguarding policies and guidelines for the protection of vulnerable adults and children. The hospital had a designated safeguarding lead who provided advice for staff.
- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and had an awareness of the hospital safeguarding systems and processes.
- Medical staff from the surgical division were 85% compliant with safeguarding level two training whilst nursing staff were 94% complaint.

Mandatory training

- Records provided by the trust showed that most staff had completed a programme of mandatory and statutory training which included fire safety, information governance, equality and diversity, infection control, advanced life support and conflict resolution. The trust target for compliance was 90%. Overall average compliance for admin staff was 97%, 92% of nursing staff and 89% for medical staff.
- From the risk register (2015) we saw managers identified low compliance rates with medical staff attending their mandatory training. Managers have been working with medical staff to ensure they attended and have seen improvement from the previous overall compliance position of 67%.
- Resuscitation training compliance was monitored regularly for the whole of the surgical division we found the figures were 83% (April 2014- March 2015) against the target of 100%.

Assessing and responding to patient risk

- Pre-operative assessments were completed for all patients prior to scheduled surgery.

Surgery

- Early Warning Score (EWS) observations were monitored for patients and we saw evidence of staff responding to deteriorating patients.
- We saw the surgical division monitored their use of VTE risk assessments and patients confirmed they had been informed about how to reduce risks of blood clots for example, by staying mobile and wearing stockings.
- Where patients suffered pressure ulcers, those classified as a serious incident they were appropriately risk assessed and referred to the tissue viability nurse for further guidance.
- The World Health Organisation (WHO) five steps to safer surgery checklist was embedded across all surgical areas and was subject to regular audit. The checklist was assessed both quantitatively and qualitatively. In addition there were random unannounced observations of team briefings by the theatre manager.
- The WHO checklist compliance report for June 2015 showed compliance for the past three months were between 95% and 100%. Quantitative results showed 16 out of 1084 (1.4%) elements were missed. Qualitative results showed four out of five for the question regarding involvement of both the anaesthetist and the OPD during 'SIGN IN'. This was because the full 'SIGN IN' was not carried out whilst both team members were present. This was resolved following discussions within the ODP team.
- Surgical ward staff told us one of their main concerns was managing medical outliers, these are patients who are admitted to a ward different from the internal medical ward. Data shared with us by the surgical team showed there had been 512 medical patients receiving care on the surgical wards in the past three months. During our visit there were 28 medical patients being treated on surgical wards.
- There was an established medical team who specifically looked after medical patients being cared for on non-medical wards but staff reported they struggled to get hold of these doctors and spent considerable time chasing them up. Ward managers shared concerns that these patients were not consistently reviewed and told us they had raised this with medical staff in the past.
- The 2015-2016 surgical business plan identified staffing resources as a key risk. From the business plan, we saw a review of the nursing establishment had taken place to ensure a consistent safe level of staffing was applied across all wards.
- The latest vacancies figures showed 27 whole time equivalent (WTE) vacancy for registered nursing roles. The hospital had recently filled some of these nursing vacancies with overseas nurses but they were not yet in post. During the same period there were seven WTE healthcare assistant vacancies.
- To cover these shortfalls we saw a high number of agency nursing hours for ward 20, ward 14, ward 11 and in particular ward 19. The total number of agency nursing time accumulated between April 2014 and March 2015 was 1,046,374 hours.
- Senior managers described their reliance on agency staff for nursing and medical staffing as a major challenge for service. Ward managers also expressed concerns over the use of agency staff as well as the lack of experienced nurses for skill mix. Ward managers told us half of agency staff did not have access to electronic records.
- During discussions some also nursing staff expressed concerns about agency staff working at night as they had to work autonomously on occasion and did not have access to the electronic records used by the hospital. This meant they were unable to see medication charts and care plans. Managers assured us that agency staff do not work alone at night and are always supported by permanent staff. We fed back our concerns about agency staff not accessing records and the trust implemented an immediate review.
- Data provided by the trust showed that for the six weeks up to our inspection, agency staff made up on average 12.3% of the nursing workforce at night. On three night shifts during this period, agency staff made up over 20% of the workforce.
- Patients noted a difference in the response times of staff during the night. Staff confirmed they were not able to be as quick to respond to patients during the night due to their workload. Patients told us they had to wait an unacceptable time to go to the toilet.
- We saw some examples on the rota of where agency nurses were working with inexperienced members of staff. Some of the ward managers developed rotas which separated experienced staff and inexperienced

Nursing staffing

- All ward managers completed an acuity tool on a daily basis to ensure their established nursing numbers reflected the needs of the patient.

Surgery

staff and made sure there was always one experienced staff member on the ward at all times. However the nursing staff told us the experienced staff were not always available to support the agency nurses.

- Senior managers assured us that a robust escalation process was in place to ensure staffing levels are kept to safe level.
- Each ward had a local induction checklist for agency staff. We spoke with one agency nurse who told us the ward provided very robust handovers which they thought were sufficient enough to care for the patients.
- We saw minutes of a trust board meeting from December 2014 where the board reviewed trust wide incidents. We noted that five of these were in relation to staffing levels on ward 19 (trauma and orthopaedics). Causes identified were described as “unsafe nursing and excessive workload.”
- The trust’s enhanced care team provided additional support on the wards for those patients who required one to one support. There was a standard operating procedure in place for staff to risk assess and request additional nursing support for patients.
- Advanced nurse practitioners were in place to support surgical staff and would attend ward rounds and communicate with the other nurses. This aimed at reducing the communication gap between doctors and nurses.

Surgical staffing

- From the current surgical business plan the three risks identified were the sustainability of the medical rota; use of long term locums and management of sickness/absence. The action plan for this was to discuss dual roles and service provision with paediatric surgery, ophthalmology and ENT. Surgical staff we spoke to did not share concerns over staffing levels.
- We found handovers were consultant led, robust and comprehensive. Electronic and paper records of the handover were maintained.
- Surgical services were overseen and led by consultants for each 24-hour period. Arrangements were in place to ensure that the surgical directorate had access to the support of consultant surgeons and anaesthetists during normal hours and out of hours, with on-call access if needed.
- Junior doctors shared concerns over their rota being “Haphazard”. They told us they would be swapped around onto different specialties on a daily basis, they

told us one day the breast speciality junior doctor could be covering the colorectal junior doctor’s work but then the colorectal doctor was covering the breast speciality work. They told us this impacted on their learning. Meetings with the rota lead or discussions had not taken place. They felt this was also poor continuity of care for patients.

Major incident awareness and training

- Staff were aware of the major incident and business continuity policy, and understood their roles and responsibilities in the event of a major incident.
- From the major incident policy (reviewed May 2015) we found protocols for deferring elective activity to prioritise unscheduled emergency procedures plans were recommended. There was an identifiable responsible person to lead on ensuring staff followed the procedures and protocols for a major incident.

Are surgery services effective?

Good



We saw evidence that staff utilised guidelines and all care and treatment was evidence based. Patient outcomes were mainly positive, most national audit results (2014) were generally better than the England average. Where the hospital had areas for improvement we saw work had been done to improve figures.

There was effective multidisciplinary team working on the wards, theatres and the Treatment Centre. This was a significant improvement from the external theatre governance review undertaken in 2014.

Patients told us their pain was well controlled. We saw mealtimes were protected on wards, except for those patients who were identified as needing support, families were encouraged to be involved. Patients were all impressed by the quality of the food and said they had a good choice and sufficient drinks throughout the day.

We noted a high number of medical outliers on the surgical wards. Staff shared the concern that they didn’t feel as though they had the skills and experience to care for medical outliers. However we saw staff were skilled and competent to care for surgical patients.

Evidence-based care and treatment

Surgery

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons. This included guidance for acutely ill patients in hospital.
- The emergency surgery theatre followed guidance in line with National Confidential Enquiry into Patient Outcome and Death.
- Patients followed an enhanced recovery programme for hip and knee replacement surgery and an enhanced pathway for colorectal patients. This was an evidenced-based approach which allowed patients to play an active role in their care, helped them to recover more quickly following major surgery and return to a normal life as soon as possible.
- The endoscopy unit received Joint Advisory Group (JAG) Accreditation for Gastrointestinal Endoscopy in Feb 2015. This is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in endoscopy standards. Following the JAG Accreditation visit to the endoscopy May 2014 several issues were identified that required resolution before JAG Accreditation could be considered. We saw the unit had worked hard to gain this accreditation.
- Surgery carried out local audits to monitor quality of care. For example, actions had been identified following an audit of readmission rates after general surgery, which included reviewing discharge advice to patients, especially after inguinal hernia repair.
- Cancer pathways were in place to ensure staff follow best practice.

Pain relief

- Patients confirmed they were regularly asked about their pain levels and these were recorded on a pain scoring tool. Patients told us their pain was well controlled. We reviewed a number of care pathway records and saw that pain relief for patients undergoing a variety of procedures was documented.
- An enhanced recovery pathway was in place for patients admitted for orthopaedic procedures. Patients who underwent surgery followed a pathway developed to ensure they were provided with defined pre-operative, perioperative and post-operative analgesia, which meant early patient mobilisation, independence and earlier hospital discharge.

Nutrition and hydration

- Processes were in place to ensure that patients' nutrition and hydration were effectively managed prior to and following surgery. Patients received fasting instructions according to the Royal College of Nursing pre-operative fasting guidelines, 2005.
- Fluid input and output records were used appropriately to monitor patients' hydration. We looked at ten sets of patient's records and found these were completed to a good standard.
- A nutrition screening tool for inpatients was reviewed regularly. The electronic records system effectively prepopulated a referral for nurses to send to the dietician if the patient scores highly on the malnutrition screening tool. Patients requiring specialist dietary advice were also referred to the dietician and offered the most appropriate menu for example pureed, low sodium, gluten free, or halal. We were told pureed food was blended separately to look and taste more pleasing for patients.
- Mealtimes were protected on wards, except for those patients who were identified as needing support; families were encouraged to be involved.
- Patients were all impressed by the quality of the food and said they had a good choice and sufficient drinks throughout the day.

Patient outcomes

- The surgery division took part in all the national clinical audits they were eligible for, and had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified. The hospital took part in 54 different clinical audits across all surgical specialties. We reviewed the dashboard of all the audits with recommendations and conclusions however this did not detail any actions taken to improve patient outcomes.
- We saw good bowel cancer audit results (2014). The case ascertainment rate was 98% compared to the England average of 94% and data completeness for patients having major surgery was 97% compared to the England average of 87%.
- The national hip fracture database audit showed that the trusts performance had improved between 2013 and 2014. Of the seven indicators measured in the audit, the

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trust performed better than England average in six. This included shorter length of stay (16.3 compared to 19 days) and surgery on the day or day after admission (84% compared to 74%).

- The lung cancer audit (2014) results were similar to that of the England and Wales average.
- We found mixed performance against latest national laparotomy audit (2014).
- The hospital outcomes for the Patient Reported Outcome Measures (PROM) (April 2013 to March 2014) for hips, knees and groin hernia repair showed that the percentage of patients that had improved for each procedure was in line with those reported nationally.
- We noted good standardised readmission rates for surgery (June 13-May 14). For general surgery the ratio was 80, trauma and orthopaedics 94 and urology 99. Value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected.
- We saw average length of stay for elective and non-elective surgery patients was shorter than the England average (2.3 days compared to 3.3 days).
- For trauma and orthopaedics patients average length of stay was in line with the England average (3.3 days compared to 3.5 days). Orthopaedic staff they had told us work had been done on this to reduce these figures and an enhanced recovery pathway helped to speed up patient's mobility which meant they were able to be discharged sooner.
- We saw there were a small number of patients suffering pressure ulcer harm, falls with harm and urine infections for 2014.

Competent staff

- Staff had the right qualifications, skills and knowledge to do their job. Theatre staff undertook competency-based assessments to show they met the requirements of their role.
- Nearly all staff had regular appraisals; the compliance rate was 92% for the whole of the surgical division.
- Ward staff had an array of link nurses from tissue viability, diabetes, acutely ill, dementia, mental health and infection control. They attended regular update meetings and disseminated this information to staff on the ward/ units.
- Medical staff told us they have weekly lunchtime teaching sessions but these were not bleep protected so were often interrupted.

- Theatre staff told us they underwent human factor training which aimed at building awareness of the importance of human factors in making changes to improve patient safety. The hospital had a good level of engagement from senior staff attending training in how to complete a root cause analysis report. Adverse incident reporting training had recently been scheduled.
- From data submitted by the hospital, we saw preceptorship learning packs and support was in place for training staff about the WHO safer surgery processes. Staff would review the competences for long-term agency staff annually. During the 2015 external theatre governance review it was highlighted that the hospital needed to further clarify whether the agency would confirm to the Hospital annual compliance for those staff on long-term placements.
- We found overseas staff had a comprehensive preceptorship programme and had on-going support on and off the ward. They had a named clinical support who would provide on the ward training as well as an external buddy that they could discuss issues or concerns with. Overseas nurses told us the hospital went above and beyond to make them feel welcome, for example, doing their first shop with them, providing three months free accommodation and organising dinners in order for them to develop friendships and networks.
- Surgical ward staff told us one of their main problems was medical outliers, we saw there had been 512 medical patients receiving care on the surgical wards in the past three months. We were told ward managers have recently been preferring staff with mixed medical and surgical experience during recruitment in order to better meet the needs of these patients. Although we saw there was still a concern that some nurses raised about not feeling confident as they had no medical experience only surgical.

Multidisciplinary working

- There was effective multidisciplinary team working on the wards, theatres and the Treatment Centre. Daily ward rounds were carried out where the clinical care of every patient was reviewed by members of the multidisciplinary team. Medical handovers often had a nursing representative and we saw operational leads would also engage.
- Multi-disciplinary staff meetings took place on Thursday mornings on the main theatre site and in the Treatment

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Centre. The operating practitioners had a specific team meeting on a Tuesday and theatre recovery staff met monthly. We were told consultants attended the nursing handover before attending the medical handover.

- Staff told us there was effective communication and collaboration between teams. We noted electronic records supported effective team communication; we saw doctors were able to review all MDT notes very easily and quickly. The allied health professionals that we spoke with told us they felt a part of the team.
- We were told length of stay meetings were multidisciplinary and involved medical staff, nursing, social services staff, discharge coordinators, occupational therapy and physiotherapy staff. All inpatients with a length of stay over seven days were discussed and complex issues addressed such as packages of care. Appropriate support plans were developed and patients referred to other specialisms such as palliative care, social services, nursing and residential care.
- Effective team working between ward and theatre staff was observed; interactions, interventions and treatment were recorded. This was a significant improvement from the external theatre governance review in 2014 where the external reviewers had commented that staff did not work as a team and they did not communicate effectively with one another.

Seven-day services

- Surgical services were available 24 hours a day, seven days a week, with emergency access to operating theatres outside of normal working hours.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. The service provided a nurse led surgical assessment seven days a week.
- Access to diagnostic services was available 24 hours a day seven days a week, with an on-call service outside normal working hours for ultrasound examinations.
- Physiotherapy and occupational therapy staff were available 8.00am-7.00pm seven days a week.

Access to information

- All local policies and guidelines could be accessed electronically on the trust's intranet. Local policies were written in line with national guidelines. Staff demonstrated they knew how to access this.

- We saw that staff were able to access up to date information about their patients via the electronic notes system. It was also very easy to see which professional had interacted with each patient via the system.
- During the review of the theatre list prior to its commencement, we observed the meeting with the medical staff, they were able to access patients diagnostic results such as x-rays via the electronic system to help make clinical decisions.
- Patient notes were kept close to the nurses' station so they were easy to access for ward rounds and reviews.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed that patients gave consent to treatment during the pre-assessment stage and this was reconfirmed on the day of surgery. We reviewed ten consent forms and found that all of these were completed in line with Department of Health Guidelines.
- All patients we spoke with told us they had been asked for their consent before surgery. They said the risks and benefits had been explained to them and they had received ample information about what to expect from their surgery.

Are surgery services caring?

Good



We observed patients being treated with compassion, dignity and respect. The Friends and Family Test (FFT) showed expected results which were similar to the England average, with the exception of ward 30 which was better. We saw evidence of patients being involved in their care, treatment and discharge.

As part of a local patient feedback survey of outpatients and the Treatment Centre (2014), patients had a very positive rating of care from the Treatment Centre. Staff showed they were able to emotionally support patients. We saw excellent reassurance for patients undergoing surgery; theatre and recovery staff were notably very compassionate with patients.

Compassionate care

- The Friends and Family Test (FFT) is a single question survey which asks patients whether they would

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recommend the NHS service they have received to friends and family who need similar treatment or care. The response rate for the surgical division was similar to the England average for the period December 2013 to August 2014. Ward 30 (general surgery) in particular stood out due to consistently high response rate and 99% of patients recommending the ward.

- As part of a local patient feedback survey of outpatients and the Treatment Centre (2014), (207 patients interviewed) patients had a 91% positive rating of care from the Treatment Centre. Staff found one patient gave very positive feedback however another patient discussed concerns over repeatedly cancelled ophthalmology appointments over 10 months. We saw 78% of patients said staff explained things in a way they could understand and 79% said staff listened to them.
- We observed patients being treated with compassion, dignity and respect. Patients were spoken to and listened to promptly. Patients made remarks such as “Excellent (service)”, “Couldn’t ask for better (care)” and “Staff are very attentive”. Patients told us that staff were very approachable and they were happy with their patient experience during their stay.
- Intentional rounding (checks to make sure patients were comfortable and had what they needed) took place dependent on the needs of the patient 1-2 hourly for dependent patient and 3-4 hourly if they were independent.
- Privacy screens were in use in the Treatment Centre and main recovery. All patients felt as though staff respected their privacy and dignity.

Understanding and involvement of patients and those close to them

- All surgical patients that we spoke with said they felt informed and involved in their care and treatment. A patient with learning disabilities gave us examples that they had been very involved with their care.
- Patients also had opportunities to discuss their procedure with the anaesthetist and surgeon when attending the elective admissions lounge on the morning of the surgery. We saw evidence of patients having choices over their treatment and were involved in the planning of their surgery and after care.
- The adult inpatients survey for 2014, asked patients who had an operation or procedure a series of questions about their care. For the question “did the anaesthetist or another member of staff explain how he or she would

put you to sleep or control your pain?” patients at the hospital answered positively and slightly better than the England average. Patients answered in line with the England average with regard to four further questions about staff explaining risks and benefits of the operation or procedure, explaining what would be done and answering questions. Survey results showed the hospital was worse than the England average for staff explaining how the operation had gone.

- Staff told us they felt that they did not adequately involve medical outlying patients and families with their care as they were often unsure of plans of the medical staff.

Emotional support

- Eight members of nursing staff on ward 19 (trauma and orthopaedics) had recently undertaken counselling training.
- We saw excellent reassurance for patients undergoing surgery, theatre and recovery staff were notably very compassionate with patients in the way they spoke with them and held their hand.
- Patients told us that staff had made them feel at ease and they were not worried about their pending surgery, expect for the one patient mentioned above that felt healthcare assistants on ward 20 (trauma and orthopaedic) were not sympathetic. We observed care on ward 20 which cared for several people with cognitive impairments such as dementia. During the inspection we saw nursing staff interactions were positive, caring and reassuring to those who were emotionally distressed by their confusion. We did not observe any healthcare assistant interactions.
- Psychological support services were available for patients with cancer, we noted staff had improved sign posting to this service for breast cancer patients.
- Clinical nurse specialists such as stoma and breast care were available to give support to patients.

Are surgery services responsive?

Good



The service was planned in a way that met the needs of the patients and there was good access to the service underpinned by clear pathways.

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The trust had consistently low rates of cancelled operations booked within 28 days of first cancellation.

Staff were responsive to patients' individual needs of people with cognitive impairments, communication difficulties and learning difficulties.

Service planning and delivery to meet the needs of local people

- From the 2015-2016 surgical business plan we saw plans were in place to increase the capacity of the ophthalmology service to meet demand of patients.
- We saw considerable work had been done to review the ophthalmology services and improve the referral to treatment times, clear action plans had been identified. The service had been reviewed and what treatment that could be moved to outpatients was moved, a business plan was developed for nurse led clinics and consultants had agreed to increase the amount of sessions they offered.
- Operational managers confirmed the trust had consistently low rates of cancelled operations which were not rebooked within 28 days of first cancellation, and the rate had been better than England average since 2013.
- The hospital had worked to improve pathways for patients who require admission from surgical, medical, ENT and fracture clinics, they aimed to make the service more streamlined and clearer for staff.
- Service level agreements were in place with Derby Hospital and University Hospital North Midlands covering vascular, dental and plastic surgery provision. Breast reconstruction services were being discontinued from University Hospital Birmingham and the trust was in the process of seeking a service level agreement with other neighbouring hospitals. Patients under this service were kept informed of the changes to this service and continued to be treated.

Access and flow

- Referral-to-treatment (RTT) 18-week performance was often below standard, but similar to England average. Between June 2014 and May 2015, the surgical services achieved the 90% target five out of twelve months. From the 2015-2016 surgical business plan we saw the 18 week RTT was identified as a risk.

- The service participated in "Choose & Book" allowing surgical patients to choose the most convenient appointment for them.
- The service monitored their theatre utilisation which was found to be 73% between April 2014 and March 2015 against a trust target of 80%. The bed occupancy levels were 91% against a target of 85%. We noted the mean length of stay was shorter than England average for the three main specialties at the hospital.
- Staff told us they wanted to expand on their number of beds which would aim to reduce the amount of medical outliers on the surgical wards. Consultants felt if they had more elective beds this would increase theatre utilisation. We saw hospital plans to review this however no plans were currently in place to open more beds.
- The division developed a performance dashboard which reviewed a range of indicators including bed moves, moves after 9pm, emergency readmissions, compliments, complaints and complaint response time.
- We found ward 30 (general surgery) was often used as a 'step down' ward for rehabilitation and preparing the patient to leave the hospital. We judged the moves to ward 30 to be an appropriate.
- Patients waiting to be discharged waited a varied amount of time for their take-home drugs. We spoke with one patient who had waited three hours and two others who told us their discharge was well co-ordinated and did not have to wait long for medication. The hospital had acknowledged this was an area for improvement.
- We saw the service completed discharge summaries for 85% of patients against a target of 100%. We were told by patients that the staff liaised with community staff and ensured a package of care that was appropriate for the patient.

Meeting people's individual needs

- Interpreters including access to British Sign Language could attend with patients at all points, pre and post-surgery including the anaesthetic room. Arrangements were also in place for those with dementia or other cognitive impairment to have a family member or carer with them in the anaesthetic room.
- We found a dementia champion on every ward they identified themselves by wearing a forget-me-not pin

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and attended monthly dementia champion meetings. On ward 20 (trauma and orthopaedics) staff told us how they played music and engaged in activities such as knitting. The ward also had a large orientation clock.

- Staff told us the trust had implemented a dementia strategy and the 'This is Me' communication tool which provided more holistic and detailed overview of the patient.
- A patient with learning disabilities explained to us how kind the staff had been and how well they involved them in their care. We saw staff understood how to meet the needs of people with a learning disability and promote their independence.
- We were told it was possible to for some information to be made available to patients in Urdu and Polish, this was aimed at meeting the needs of the local foreign community.
- Call bells on the wards were mostly answered promptly during the day and were in reach of patients who needed them. We did not monitor call bell response times at night but staff and patients confirmed they took much longer to assist patients throughout the night. The service did not audit call bell response times.

Learning from complaints and concerns

- We saw the service had 92 complaints between April 2014 and March 2015. Complaint response times could be improved, only 47% achieved the planned response time against a target of 90%. The service received 308 compliments during the same period.
- Patients were given details of how to make a complaint on information leaflets given to them prior to their surgery. Staff knew how to support a patient make a complaint and showed us the practical information they would hand out to patients on the ward about the patient liaison service.
- The hospital had delivered an annual complaint handling/awareness session as part of the Band 6 senior nurse development programme which staff from the service participated in.

Are surgery services well-led?

Good



There was a clear vision and strategy for the service supported by an up to date and thorough business plan. Managers had a vision of key areas for development and were aware of their strengths weaknesses.

We saw the culture throughout the division had developed recently and was very positive. The service had a good level of engagement with staff and staff confirmed this.

Sound governance and quality measures were in place after the support from external auditors. We saw strong leadership from the board to divisional managers to local managers. Much work had been done to review the sustainability of the service and much improvement had taken place since last year.

Vision and strategy for this service

- The surgical division developed a comprehensive business plan for 2015-2016. This covered key developments that aim to take place after additional investments had been made for example, increasing capacity of ophthalmology, additional provision for orthopaedics at another provider and increasing general surgery medical staff.
- The plan also included a performance overview of finances, quality indications, patient outcomes and staffing, risks, activity including utilisation/productivity of services and analysis of the strengths, weaknesses, opportunities and threats to the service. This outlined a clear vision and strategy for the service.
- The hospital outlined a five year plan with a number of challenges, one challenge was elective surgery cancellations due to medical outliers reducing the number of available surgical beds. The hospital board commented that this impacted on patient experience as well as income. Other challenges included ensuring theatres were operating at optimal efficiency and development of a colorectal network due to volume of activity.

Governance, risk management and quality measurement

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- The 2015-2016 surgical business plan provided details of the overall performance of the service there was a clear overview of compliance rates and targets rates.
- As a part of the business plan (2015-2016) managers analysed the teams strengths and weaknesses. We saw strengths were described as good patient outcomes, able to provide support to other specialities and have nurse lead assessment service seven days a week.
- Weaknesses were listed as covering on call, recruitment issues, difficulty recruiting consultants, short-term sickness rates, equipment needing replacing and lack of finance and vascular and colorectal pathways needed to be reviewed.
- The hospitals commissioned an external theatre governance review in December 2014 involving all staff, senior managers and the executive team. The review included observational visits to operating theatres.
- The report concluded there continued to be issues with theatre governance, due to concealment of serious incidents and responsibilities being deflected. These issues highlighted underlying problems. These related to culture, staff engagement, particularly in relation to medical staff.
- A number of recommendations were made including development of a multidisciplinary leadership programme, a review of training around incident reporting and improvements in engagement of staff.
- In 2015 the hospital commissioned a further facilitated theatre governance review. This review noted that significant work had taken place to address the issues identified in the 2014 report including the introduction of a new theatre management team and stronger monitoring of the WHO checklist. A quality meeting in theatres involving all staff had taken place which had covered communication, safety and use of the WHO Safer Surgery checklist. The review also looked at all the policies and procedures and provided recommendations on developments need.
- We saw quality assurance systems were in place for equipment management, cleanliness of theatres, preparation of clinical areas, spot checks of WHO checklist and a theatre performance dashboard.
- Staff had embedded the use of the WHO surgical safety checklist and had been compliant for the past three months and we saw evidence that the hospital were in the process of completing a scrub nurse competency assessment.

Leadership of service

- The trust-wide independent governance 2014 audit detailed that the surgical divisional board lacked leadership in escalating concerns and targets raised by staff. As a result the trust commissioned a programme of external support. The operational manager confirmed they were currently undertaking the leadership course as well as another member of their team.
- Ward managers felt particularly supported by the trust with their issues around booking agency staff, increasing the dependency of the ward. We were told HR would support managers on a monthly basis looking at any challenges and the staffing establishment. The manager on ward 20 (trauma and orthopaedics) gave us an example of where the dependency of patients had suddenly increased and managers supported them in finding a solution quickly and allowed them to book extra staff. Ward managers told us they felt listened to.
- Nursing staff felt as though their ward managers were all supportive and approachable.
- Medical staff told us they all felt well supported by the consultants who were readily available for advice and support.
- We saw several changes in practice based around recommendations from Keogh (2013) and the last CQC inspection (2014) and have seen the trust have led on implementing these changes. Staff had been well engaged and informed of all changes and appeared to have a passion for ensuring the trust was compliant with regulations. We saw strong leadership from the board to divisional managers to local managers.

Culture within the service

- The external theatre governance review in 2014 noted some serious issues amongst staff based upon a negative culture within theatres. The 2015 facilitated theatre governance review commented that managers were actively working to support the change in culture. Notice boards had been improved and were being well used for informing staff of progress.
- During the inspection we observed that staff felt comfortable in raising concerns, challenging senior members of staff and reporting incidents.
- We saw the culture on the wards was positive despite the lack of resources, this was not filtered through or observed by patients. We noted overall patients were very pleased with the way in which staff cared for them.

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Public and staff engagement

- The hospital had signed up to the charity “Breast Cancer Now” initiative to ensure services for local breast cancer patients were the best they can be. Through questionnaires and workshops with previous and current breast cancer patients a range of improvements at the hospital have been made.
- We saw evidence the urology staff had attended a number of different projects in the past year which were aimed at health promotion for the general public and increasing public engagement within the hospital.
- The matron and senior nurse on orthopaedics completed a monthly round to speak to the patients. The feedback from the patient experience was used to inform staff of areas of good practice and areas for improvement.
- We saw evidence from information submitted by the hospital that elective patients admitted for the enhanced recovery programme were involved in feedback to support the service and the information was collated by the physiotherapy team to better shape the service.

Innovation, improvement and sustainability

- The service had worked on reviewing and ensuring its sustainability and as a result had key developments

such as renewing endoscopy equipment, increasing the capacity of ophthalmology services, additional provision for orthopaedics and increasing general surgery medical staff. We saw a business case had been put forward for a clinical site practitioner and they had recently recruited 80 overseas nurses trust wide.

- We saw management had planned for the review of ophthalmology, ENT, maxillofacial and orthodontics in order to review the safety quality and progression of these three specialities. The service was currently reviewing outsourcing services such as general plastics, breast restorative and ophthalmology.
- We saw a project was being commenced in 2016 in order to increase theatre productivity, we saw they had measures and milestones in which managers aimed to review.
- We saw innovation in practice on ward 11(male surgical ward) where the infection control nurses had worked with staff to reduce infection control risks and increase hand hygiene. The team implemented technology which counted the use of alcohol sanitising gel and compared it against the target of how often it should be used. This was in response to hand hygiene audits which needed improvement.

Critical care

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

Information about the service

The critical care unit at the Queens Hospital, Burton upon Trent has ten beds. It consists of two geographically separate areas the intensive care unit (ICU) with six intensive care beds and a separate high dependency unit (HDU) with four high dependency care beds. Patients who have a potentially life-threatening illness can be admitted to an intensive care bed; they receive one-to-one nursing care, or those patients too ill to be cared for on a general ward can be admitted to a high dependency bed. The Intensive Care National Audit and Research Centre (ICNARC) data showed the unit had admitted around 470 patients in 2014.

The hospital had a combined critical care outreach and acute pain team who assisted with the management of critically ill patients on wards and departments and supported pain management across the hospital. The critical care outreach and acute pain team work between the hours of 8:30am and 7.00pm during the week. At the weekend, they provide cover between 8:30am and 4.00pm. Out of hours cover was provided by clinical site practitioners. A modified early warning system (MEWS) was used to manage the deteriorating patient, promoting early detection and intervention.

We spoke with four patients, three relatives and 35 staff including nurses, doctors, consultants, senior managers and support staff. During the inspection we looked at care and treatment and reviewed seven care records. Before and during our inspection we reviewed performance information about the critical care unit.

Summary of findings

There were effective processes in place to learn from incidents. The environment was clean and staff followed infection control procedures. Medicines, including controlled drugs, were safely and securely stored.

Patients received treatment and care according to national guidelines. Critical care was obtaining good quality outcomes as evidenced by its ICNARC data. We found there was good multidisciplinary team working across the unit.

Staff cared for patients in a kind, compassionate and professional manner. Patients spoke very highly of staff and said they were always treated with dignity and respect. Patients and relatives were kept fully informed and staff treated them with kindness and understanding. Staff were supportive and responsive to patients' individual needs.

Critical care was responsive to patient's needs. The overall capacity in the critical care unit meant that patients received timely care. The outreach team had developed and implemented a rehabilitation pathway which used a structured, team approach to monitoring events both during and following step down from critical care, to ward based care and through to follow up post discharge from hospital.

Critical care

There was a lack of clear overall strategy and vision for critical care. Staff felt well supported within an open, positive culture. There was a clear governance structure with on-going monitoring of the quality of care delivered.

Are critical care services safe?

Good



There were good systems for monitoring the NHS safety thermometer data and improving practice. There were effective processes in place to report and learn from incidents. The environment was clean and staff followed infection control procedures. Medicines, including controlled drugs were safely and securely stored.

The service was in the process of recruiting to 12 band 5 nursing vacancies. They used bank and agency staff to cover these vacancies and to safely manage peaks in activity. Staff reported on rare occasions they were required to look after more than one level 3 patient. These occasions were reported as incidents.

Incidents

- Staff we spoke with were aware of how to report incidents using the electronic reporting system.
- There had been no serious incidents or 'Never Events' (serious largely preventable safety incidents that should not occur if the available preventative measures have been implemented) reported between May 2014 and April 2015. 50 incidents resulting in no harm and one incident recorded as moderate harm had been reported.
- Incidents were reviewed at monthly directorate meetings and learning passed onto the nursing staff in their team meetings. We reviewed minutes of these meetings.
- Staff told us how they had changed the type of nasogastric tubes used in response to incidents of nasal pressure ulcers.
- Mortality and morbidity meetings were held monthly where all critical care deaths were reviewed. A new mortality electronic database and review system had recently been developed to ensure a standardised approach to mortality reviews across the trust. This database was accessible to personnel across the trust to assist with learning from reviews.
- We were shown an example of an incident that had been investigated and the family of the patient involved had been invited in to the hospital to have a meeting to discuss the incident. This demonstrated that staff were aware of their Duty of Candour responsibilities.

Critical care

Safety thermometer

- The ward assurance performance and Safety Thermometer, (for measuring, monitoring and analysing patient harms and 'harm free' care) results were displayed on a noticeboard outside ICU. This included data about the development of new pressure ulcers, catheter related urinary tract infections, venous thromboembolism (VTE) and falls. The information was accessible for relatives and members of the public to see.
- The trust target for performance against these standards was 95%. Critical care had achieved 95% and higher compliance in all areas for ten of the past twelve months. Where 95% compliance was not obtained action plans had been developed and implemented to address the deficits.

Cleanliness, infection control and hygiene

- Patients were cared for in a clean and hygienic environment.
- Staff followed the trust policy on infection control. The 'bare arms below the elbow' policy was also adhered to. There were hand washing facilities and protective personal equipment (PPE), such as gloves and aprons available. We observed staff using gloves and aprons and changing these between patients as per policy.
- Hand sanitising gel was available throughout the unit and signage reminded staff and visitors about hand hygiene. We observed that if necessary, staff also reminded people entering the unit to wash their hands.
- The results we saw for the hand hygiene audit demonstrated staff had achieved 100% compliance in ITU and 98% in HDU in May 2015 against trust standards.
- There had been no incidences of MRSA or Clostridium difficile (C difficile) in May 2015 and no incidences of C.difficile in the past 12 months. There were two cases of MRSA in the second quarter of 2014.
- 83% of medical and 97% of nursing staff had completed infection control training against a trust target of 90%.
- An audit of infection control standards conducted in May 2015 showed ITU had achieved 98% compliance and HDU 100% compliance against trust standards.
- The ITU and HDU did not have a side room facility to isolate patients with infections. This issue had been recorded on the critical care risk register and was being reviewed on an on-going basis.

- The local preferred solution was to redevelop ITU by building sideways into another area. Temporary side rooms had been considered and discounted because this would reduce overall capacity. This issue had been escalated and was now with divisional and executive level managers for consideration.
- The senior nurse told us that they had not spread any infections with adherence to good infection prevention practice and had a range of systems and processes in place to mitigate the risk.

Environment and equipment

- We found equipment was clean and fit for purpose.
- All equipment we checked was found to be in date for portable appliance testing (PAT) or external company servicing.
- The resuscitation equipment was checked daily and records were maintained of these checks.
- An intercom and buzzer system was used to gain entry to the critical care unit, to identify visitors and staff and ensure that patients were kept safe.
- We observed that the pedal bins were very loud on closure which could disturb patient's ability to rest. Following our visit, the trust immediately order new bins for the unit.

Medicines

- Medicines including controlled drugs were safely and securely stored. Records we looked at demonstrated that twice daily stock checks of controlled drugs were maintained.
- The medication records we looked at during our inspection were found to accurately reflect the prescribed and administered medicines to the patients concerned.
- Fridge temperatures were monitored daily; this ensured that medicines were maintained at the recommended temperature. We saw that the staff undertaking the checks signed on their completion.
- There were arrangements for the effective access to medicines out of hours. Critical care had its own dedicated pharmacist who visited the unit daily, Monday to Friday. The pharmacy was open until 12 o'clock on a Saturday and an on call pharmacist available Saturday afternoon and Sunday.

Records

Critical care

- There was standardised nursing documentation at the end of each bed. Observations were recorded clearly on a daily review chart and demonstrated that patients were being reviewed regularly. Risk assessments were incorporated including pressure ulcer risk, nutrition risk, coma scale and delirium assessments.
- All medical records were in paper form and followed the same format. This meant that information could be found easily.

Safeguarding

- Staff we spoke with demonstrated an understanding of safeguarding procedures and its reporting process. They were able to show us how they could access the safeguarding policies on the trust intranet.
- The trust safeguarding lead was available to staff for advice on safeguarding matters.
- Staff told us they had received training in adult and children's safeguarding. Data confirmed that 100% of medical and nursing staff had completed children's protection level 1 training. 89% of nursing staff had completed children's protection level 2. 100% of medical and nursing staff had completed adult safeguarding level 1 and 2. This was against a trust target of 90%.

Mandatory training

- Nursing and medical staff confirmed that they received their annual mandatory training in areas such as infection control, moving and handling, medicines management and information governance. Ninety-four percent of all individual statutory and mandatory courses had been completed within critical care.

Assessing and responding to patient risk

- The modified early warning system (MEWS) of acutely unwell adult patients was used to identify patients deteriorating. The trust had a single trigger point to escalate. If the score was greater than 4, then staff had to contact the doctor, outreach team or clinical site practitioner. There was an absence of a graded response strategy to the early warning score (as recommended by NICE guidelines). This would include different actions for the staff to take depending on the severity of the patient, for example, the more sick the patient, the greater the urgency and so the more senior the doctor who is contacted and

- The critical care outreach team consisted of a band 7 lead nurse and three band 6 sisters. Staff on the wards contacted the team when they were alerted to deteriorating patients using the modified early warning system (MEWS) The service was available from 8:30am to 7:00pm Monday to Friday, and 8:30am to 4:30pm Saturday, Sunday and bank holidays. Out of hours the clinical site practitioner team were responsible for the monitoring and assessment of acutely ill patients throughout the hospital.
- Patients in critical care were monitored using recognised observational tools and monitors. The frequency of observations was dependent on the acuity of the patient's illness. Alarms were set on monitoring equipment to alert staff to any changes in the patient's condition. This meant deteriorating patients would be identified and action or escalation to the appropriate team initiated without delay.

Nursing staffing

- Critical care currently had agreed funding to open two extra critical care beds taking them to a total of 10 beds. However, they had 12 nursing vacancies at Band 5 that they were in the process of recruiting to before these beds could be opened. The unit used bank and agency nurses to cover these vacancies and manage the peaks in activity.
- Nursing rosters indicated and staff confirmed that critical care did not use more than 20% of registered agency nurses on any one shift. We were informed by senior nurses that all agency nurses were provided with a structured induction to the unit prior to commencing work.
- The National Critical Care Alliance standards stipulate the minimum nursing ratios within critical care are: one nurse to one level 3 patient (intensive care) and one nurse to two level 2 (high dependency) patients. We observed an records showed these ratios were being achieved. All shifts in critical care had a supernumerary senior nurse (band 6 or 7).
- Staff we spoke with and nursing rosters indicated that on occasion staff had to care for two level 3 patients. This issue was also highlighted in a previous CQC inspection. Staff told us they report these occasions as incidents. Staff told us this had improved since the last inspection and only happened very occasionally. The

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issue only arose when it was unanticipated, for example, short notice sickness. We reviewed incident data provided by the trust and it showed this was reported on two shifts between January and June 2015.

- Nursing handovers occurred twice a day, during which staff communicated any changes to a patient's condition to ensure that actions were undertaken to minimise the risks.
- Staff told us that sometimes when the unit is not full they are required to help on other wards. However, there was reluctance from the site management team and matron to allow the nurse to return to critical care to manage new admissions. This posed a potential risk to the safety of patients on critical care.

Medical staffing

- The consultant work patterns delivered continuity of care. A consultant in intensive care medicine was present within critical care from 8:00am to 6:00pm seven days a week. Out of hours they were available on call and able to attend within 20 minutes. Staff said there were no problems contacting consultants or getting them to come into the unit out of hours.
- The consultant to patient ratio was 1 to 10 which met recommended national guidelines.
- The lead consultant for critical care told us that all patients were reviewed by a consultant within 12 hours of admission to ITU.
- We observed the medical handover from nightshift to day shift. This was an organised, structured handover with consideration of patient's pain control. There was appropriate consideration of nutritional support and involvement of dietetics. Physiotherapists were involved in discussions of weaning and rehabilitation.
- There was infrequent use of locums to cover sporadic absence, for example sickness. They used internal locums or a small pool of regular, external locums. There was only ever one medical locum per shift. They received the standard trust induction. The consultant stayed on-site until they felt confident that the locum could be left alone.

Major incident awareness and training

- The major incident policy was accessible within critical care and staff demonstrated how they could access the policy on the trust intranet.
- There were major incident drills held annually.

- Staff were aware of their roles and responsibilities in the event of a fire.

Are critical care services effective?

Good



Patients received treatment and care according to national guidelines. Critical care was obtaining good quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit and staff were well trained and felt supported.

At the time of the inspection, the proportion of nursing staff with the post registration award in critical care nursing was just below national core standards requirements but there were plans in place to address this. The trust told us that a further two staff were booked to attend this course.

A senior sister had 50% of her time allocated to the role of clinical nurse educator responsible for coordinating education. Senior management told us they were aware of the need for a full-time educator but told us the newly appointed matron would be reviewing this.

Evidence-based care and treatment

- The Intensive Care Society guidelines were implemented to determine the treatment provided.
- Care pathways and protocols were in use. For example, we observed that staff were following the unit's sedation break protocol.
- Critical care was meeting the requirements of the National Institute of Health and Clinical Excellence (NICE) (guidance 83) which identified a need for an individualised, structured rehabilitation programme.
- The critical care outreach team had developed an innovative pathway to holistically assess and use multi-professional working in order to meet the rehabilitation care needs of patients. Patients could attend a follow-up clinic post hospital discharge to further evaluate their on-going rehabilitation needs and if appropriate access a clinical psychologist.
- Critical care benchmarked itself against the General Provision of Intensive Care Standards (GPIC) via their local critical care network. They had obtained good results with an overall compliance of greater than 95%.

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- Local audits were carried out, for example, on re-feeding syndrome. This had resulted in improvements to treatment sheets.
- Critical care had not fully implemented evidence-based practice in relation to protective lung ventilation (PLV). Whilst not fully compliant with the PLV recommendations, we did not observe high airway pressures used.
- The trust has a draft policy in place on the management of delirium.
- ICNARC data demonstrated that mortality was higher than the England average but within statistically acceptable limits when compared to other similar sized units.
- Unplanned readmissions within 48 hours were better than the national average.
- However, much of the data contained in the ICNARC report was not being used in an effective way to improve care. For example, in-hospital cardiopulmonary resuscitation had increased to 9% which was well above the national average. The team were not aware of this and no investigation had been conducted to ascertain whether this was correct or the cause.

Pain relief

- We saw that pain scores were assessed and documented on an hourly basis in the seven records we reviewed. Numerical pain scores were used, 0 = mild pain, 1- mild, 2= moderate and 3=severe.
- Patients told us their pain had been well managed.
- Ward assurance data showed that pain management had been assessed as 96% compliant in April 2015 and at 100% in May and June.
- The trust has draft policy in place with regards to management of pain for critical care patients.

Nutrition and hydration

- We saw within the seven records we reviewed that staff on the unit used the Malnutrition Universal Screening Tool (MUST) to accurately assess the nutritional needs of patients.
- In the ITU, staff followed the unit's protocol for hydration and nutrition of ventilated patients and initiated enteral tube nutrition when necessary. We observed that patients were being treated according to this protocol.
- Ward assurance data showed that nutritional assessment compliance was at 100% in April 2015, 95% in May and 91% in June. Action plans were in place to improve compliance.
- Dietician support was available Monday to Friday.

Patient outcomes

- The unit contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. This is a national audit of critical care workload and outcomes. The ICNARC results between 1 July and 31 December 2014 were good. For the eight case mix programme indicators, the trust was better than the England average for six indicators and in line with the England average for the other two.

Competent staff

- All staff received one-to-one supervision and appraisals. These processes covered training and development needs and practices. In critical care 90% of staff had completed their appraisal. Staff we spoke with said that their appraisal had been well conducted and linked to training plans.
- All nursing staff new to the unit had a comprehensive six week induction during which they were supernumerary and supported by two mentors.
- National core standards require that at least 50% of nurse have a post registration qualification in critical care. At the time of the inspection, 45% of the nursing staff had the post registration award in critical care nursing. The trust told us that a further two staff were booked to attend this course.
- All staff were working towards ITU competences and were being assessed by a mentor.
- There was not a dedicated full-time clinical nurse educator responsible for coordinating education. A senior sister had 50% of her time allocated to this role. Senior management told us they were aware of the need for a full-time educator but had no immediate plans to address this. A new matron was starting soon and it would be the matron's decision to review education resources. Also, nursing roles at a senior level had recently changed and the newly appointed sisters were settling into their roles
- Trainee doctors told us they were well supervised and consultants were very accessible and supportive.

Multidisciplinary working

- There was a multidisciplinary team that supported patients and staff in the unit. For example, there was a

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dedicated critical care pharmacist who provided advice and support to clinical staff. The lead nurse, a member of the outreach team and physiotherapists attended the daily doctor's ward rounds. The pharmacist attended them when possible.

- There was adequate support and input from dietetics who obtained patient updates from the nurses caring for the patients. The support and input would reflect the patient's condition and the plans made on the ward round. Microbiology staff did not attend ward rounds but were available for advice on the phone.
- There was an outreach team that was fully integrated and provided valuable support in the care of critically ill patients. Members of the team obtained updates from the nursing staff on patient movements. They supported patients whose condition was identified as deteriorating.
- The outreach team also provided a 'follow up service' that monitored patient's physical and psychological needs after discharge from the unit. Staff held follow-up clinics post hospital discharge to enable patients to return to the unit and discuss their experiences.

Seven-day services

- There was consultant cover for patients in the unit during the day, 8am to 6pm, seven days a week and an on call service out of hours.
- There was a 24-hour consultant cover. The consultants carried out twice daily ward rounds and were available for advice and support at other times.
- Pharmacy, dietetics and microbiology staff were available Monday to Friday and physiotherapy staff seven days a week. Microbiology and pharmacy staff were available on call at weekends.
- There was an outreach team that provided support 8:30am to 7:00pm Monday to Friday and 8:30am to 4.30pm at weekends and bank holidays, for the management of critically ill patients.
- Out of hours the clinical site practitioner team were responsible for monitoring and assessment of acutely ill patients throughout the hospital.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust and access guides, policies and procedures to assist in their own role.

- Radiography and blood results were available electronically for staff to access.
- There was a standard handover on discharge of patients from critical care back to parent teams. This included a written discharge form with a verbal handover.

Consent and Mental Capacity Act

- Staff we spoke with were aware of the Mental Capacity Act 2005 and how this related to the patients they cared for.
- Patients were, whenever possible, asked for their consent procedures appropriately and correctly. Generic consent for critical care interventions was frequently recorded at the point of admission.
- Frequently within critical care, patients were unconscious or unable to communicate or lacked capacity to provide consent. We saw written examples of when doctors had acted in the patient's best interests when the patient did not have capacity to consent. The Mental Capacity Act 2005 was adhered to appropriately.

Are critical care services caring?

Good



Staff cared for patients in a kind, compassionate and professional manner. Patients spoke very highly of staff and said they were always treated with dignity and respect. Patients and relatives were kept fully informed and staff treated them with kindness and understanding. Staff were supportive and responsive to patients' individual needs.

Compassionate care

- We observed staff caring for patients in a kind and professional manner. Care was delivered in a compassionate manner. We saw patients were always treated with respect and dignity. Nurses were attentive and had a good rapport with patients.
- Both patients and relatives told us that staff treated them with dignity and respect.
- Patients and relatives spoke very highly of the staff. One patient said, "They are very patient and understanding." Another patient told us, "They are excellent, great."
- Critical care had conducted a patient questionnaire in 2014 to gain feedback about the quality of care they had received. The survey results had yet to be analysed. We

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reviewed individual responses which were all very positive. Comments included, “The staff always had time for you,” and, “We found staff very caring and friendly always.”

Understanding and involvement of patients and those close to them

- Relatives told us that they were kept fully informed and staff treated them with kindness. One relative said, “It has been excellent, the staff are very, very good. You can ask any question and they give you the answer.” Another relative said, “They are very professional and competent and explain everything to me.”
- One patient said, “Anything you need to know is explained, you can ask as many questions as you like.” Another patient told us, “They sit down and explain things.”
- The critical care team worked closely with the specialist nurses for organ donation. When ongoing treatment was considered to be futile, the relatives were made aware of this and the possibility of organ donation was discussed.

Emotional support

- We observed that staff were very supportive and responsive to patients’ individual needs. Even during an emergency situation we observed staff constantly reassuring the patient, trying to put them at ease.
- Staff told us they had good access to a psychiatric nurse, to provide additional emotional support and counselling for patients, who responded quickly to referrals.
- The follow up clinic post discharge provided emotional support to patients and their families.

Are critical care services responsive?

Good 

Critical care services were responsive to patient’s needs. The overall capacity in the critical care unit meant that patients received timely care. The outreach team had developed and implemented a rehabilitation pathway which used a structured, team approach to monitoring events both during and following step down from critical care, to ward based care and through to follow up post discharge from hospital.

Support for patients living with physical and learning disabilities or dementia was available, if needed within critical care. Translation services were available for patients whose first language was not English.

Service planning and delivery to meet the needs of local people

- Critical care currently had agreed funding to open two extra critical care beds taking them to a total of 10 beds. The trust told us they had planned this service development in response to the number of out of hours/early discharges they had experienced, although data we reviewed showed the hospital was in line with other trusts. Senior managers felt this would not only provide a more responsive critical care service but also impact on capacity and flow across the hospital.
- The critical care outreach team had developed and implemented a rehabilitation pathway for patients who had a stay in critical care, in line with NICE and Intensive Care Society (ICS) guidelines.
- This system used a structured, team approach to monitoring events both during and following step down from critical care to ward based care. The pathway had developed to holistically assess and use multi-professional working to meet the rehabilitation care needs of these patients.
- The service also provided a follow-up clinic post hospital discharge to further evaluate on-going rehabilitation needs and offer, if necessary, access to a clinical psychologist.

Meeting people’s individual needs

- Staff demonstrated they knew how to care for people with learning disabilities. Staff described how they had access to communication aids such as cards and an iPad. Staff also described how they would liaise closely with the patient’s carers/family to ensure the patient’s individual needs were met.
- Staff had access to a lead nurse for dementia that provided support and advice regarding caring for people living with dementia.
- The critical care outreach team was an integrated service for the management of critically ill patients across the hospital. The purpose of the service was to assess acutely ill or deteriorating patients on wards, and to provide advice to the managing teams on monitoring, investigations and management plans. The aim was

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either to stabilise patients at ward level and so avoid the need for escalation to critical care, or to facilitate timely referral on admission to critical care when a higher level of care was required.

- Staff had access to translators for patients whose first language was not English.
- A relative's room containing a bed and tea and coffee facilities was available to relatives who wished to stay overnight. This room had recently been refurbished and a new, comfier bed provided in response to feedback received by relatives at the follow-up clinic.

Access and flow

- Evidence provided by the trust showed that patients are able to access treatment in a timely way.
- Bed occupancy within critical care fluctuated between 60 - 100% per month which was similar to the England average.
- 100% of patients were admitted within four hours of referral within the last six months.
- ICNARC data showed that the number of delayed discharges in excess of 12 hours were lower (better) than the England average.
- The number of patients discharged out of hours (that is patients discharged between 10pm and 7am) was lower (better) than the England average.
- Non-clinical transfers out (that is, patients discharged to a level 3 bed in an adult ITU in another acute hospital) was in line with the England average.
- Two elective surgery operations were cancelled due to lack of critical care beds within the last six months.
- Unplanned readmission to critical care within 48 hours was in line with the England average.

Learning from complaints and concerns

- There had been no formal complaints made about the critical care services in the past 18 months. Complaints were handled in line with trust policy. If a patient or relative wanted to make informal complaints, they would be directed to the nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- Information on how to raise concerns or make a complaint was on posters displayed in critical care.
- Learning from complaints would be discussed at staff meetings.

Are critical care services well-led?

Requires improvement



There was a lack of clear overall strategy and vision for critical care, something that was highlighted at the last CQC inspection. Clinical and nursing leaders were keen to develop the service but this had not been drawn up into a strategy or plan. Leaders within the service were operationally focused on filling staff vacancies a priority.

There was a clear governance structure with on-going monitoring of the quality of care delivered but it was not clear how data and information collected was being used by the service to develop and improve services.

There was strong medical and nursing leadership within critical care. Staff felt well supported within an open, positive culture. Innovative practice within critical care included their rehabilitation pathway, a new system for monitoring mortality, and their organ donation system.

Vision and strategy for this service

- At the last CQC inspection, we highlighted there was no specific strategy for developing the critical care service. During this inspection, we noted that a strategy had not been developed.
- There was not an articulated, shared vision for the critical care service at the hospital. The clinical and nursing leaders were operationally focused and told us their top priority was recruiting to staff vacancies.
- Leaders expressed their plans to rebuild the unit to incorporate isolation rooms but we saw that these plans had not yet been advanced into a long term vision or strategy.

Governance, risk management and quality measurement

- Critical care services were an integral part of the surgical services directorate. There was a clear governance structure present. Monthly directorate meetings took place where incidents, complaints, audit results and the risk register were reviewed.
- There was alignment between the recorded risks on the risk register and what staff expressed was on their 'worry list'.

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- Learning from incidents and complaints was discussed at the daily ward rounds and staff meetings. Staff were sent minutes of these meetings via e-mail if they were unable to attend.
- The service took part in national and local audits. We saw that much of the data contained in the ICNARC report was not being used in an effective way to improve and develop care. For example, in-hospital cardiopulmonary resuscitation had increased to 9% which was well above the national average. The team were not aware of this and no investigation had been conducted to ascertain whether this was correct or the cause.

Leadership of service

- There was clearly identified nursing and medical leadership within critical care.
- All the staff we spoke with said they felt well supported and had good relationships with their managers.
- A senior sister told us there was good two-way communication between critical care and the board. We were told that the director of nursing was visible on the unit, was approachable and listened to their issues.

Culture within the service

- There was an open and supportive culture in which staff were encouraged to report incidents.
- Staff were passionate and committed to providing high quality care for patients and their relatives.
- Staff spoke of a friendly working environment where everyone got on well together. One member of staff said, "It is a united unit we support each other." Another told us, "Everyone works really well together."

Public and staff engagement

- Critical care conducted an annual patient survey to ascertain the quality of their service. The 2014 results had not yet been analysed but individual questionnaires reviewed contained very positive feedback.
- During our inspection, we saw a number of cards and letters from patients and their relatives expressing their thanks for the care they had received in critical care.
- Staff had refurbished the relative's room with a new bed in response to feedback from relatives at the follow-up clinic.
- Staff said they felt listened to and were engaged in improving practice. An example was given where a nurse had attended the intensive care course and proposed a new form of treatment to help resolve issues they had with haemofiltration. One nurse told us, "We all have a voice for improving patient experience and practice."

Innovation, improvement and sustainability

- Staff were proud of their innovative rehabilitation and follow up service which provided valuable psychological support to patients and their relatives.
- Two of the critical care consultants had developed a sepsis pathway for the trust. The plan involved development of a pathway bundle, design and delivery of a training programme, audit of current state and development of a feedback loop to medical staff.
- Critical care had developed an innovative electronic mortality review system. The aim of the mortality review system was to identify avoidable deaths and highlight any areas that need to be addressed.
- Innovative approaches to organ donation had been developed within critical care. An organ donation group had been developed. Consultants from critical care also spoke to local 6th form students to explain the principles of organ donation.

Maternity and gynaecology

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

Information about the service

Burton Hospitals NHS Foundation Trust provides maternity services across both acute and community settings including the Samuel Johnson Midwifery Led Unit (SJMLU), Litchfield and Queen's Hospital. Our last inspection (July 2014) reported on maternity and family planning, we now report on maternity and gynaecology services.

The maternity services at Queen's Hospital offer a consultant-led delivery suite which includes two low risk birth rooms; a maternity assessment unit which includes a triage area, induction of labour area and a hyperemesis room; an outpatient antenatal clinic and an antenatal and postnatal inpatient ward. Women can also choose to have a home birth supported by community midwives. Two teams of community midwives provided antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and in women's own homes

Between April 2014 and March 2015, 3,342 babies were born at the Burton Hospitals NHS Foundation Trust. Of these 3,226 were born at Queen's Hospital, 276 at SJMLU, Litchfield and 14 were born at home.

Some specialist maternity services are provided, for example, for women with diabetes. Women requiring more specialised care are referred to Birmingham Women's Hospital.

The gynaecology service offered inpatient services, day care and emergency assessment facilities. Outpatient services include colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment.

A team of gynaecologists are supported by specialist gynaecology nurses, general nurses and health care assistants. Women with gynaecological cancer are cared for by the team at Burton in collaboration with staff at Derby Hospital.

We visited all the wards and departments relevant to the service. We spoke with 11 maternity patients, 15 midwives and support workers individually and eight midwives in two focus groups. We spoke with ten women and three fathers on the maternity unit, and five gynaecological patients and one relative. We met and spoke with eight medical staff that worked across both the maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

The pathway for gynaecology patients was inefficient and we saw that the gynaecology ward was shared with other surgical patients and medical outliers. This sometimes prevented women with gynaecological conditions being admitted to the ward. We were told that women experiencing miscarriage could not always access a side room and this affected their privacy and dignity at a difficult time.

Two never events, both retained objects post procedure, were reported in October 2014. We saw that for each of the never events, an investigation had taken place, learning points had been identified and shared and an action plan had been developed.

There was a clear statement of vision and strategy, driven by quality and safety. However, staff we spoke with did not demonstrate awareness or understanding of the vision and strategy.

People received care and treatment that was planned in line with current evidence-based guidance, standards and best practice. For example, we observed that policies were carried out in accordance with The National Institute of Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.

Women told us they had a named midwife. The ratio of clinical midwives to births was 1 midwife to 29 women. We saw documentary evidence that 99% of women received one to one care in labour. Women told us that they felt well informed and were able to ask staff if they were not sure about something.

There was an active maternity services liaison committee (MSLC) which met quarterly and provided input into service developments

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

The maternity service was awarded the Excellence in Maternity Care award by CHKS in 2014. The quality of care at Burton Hospitals NHS Foundation Trust was judged to be the best out of 148 NHS maternity providers in England, Wales and Northern Ireland.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement



Two never events, both retained objects post procedure, were reported in October 2014. We saw that for each of the never events, an investigation had taken place, learning points had been identified and shared and an action plan had been developed but not yet put into practice and signed off by the trust.

Ten serious incidents were reported for maternity to the Strategic Executive Information System (STEIS) between May 2014 and April 2015. We saw documentary evidence that these were monitored and action plans reviewed and acted upon.

All areas of the maternity and gynaecology service we visited were visibly clean and well maintained.

Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was ready for use

In June 2015, the midwife to birth ratio was 1 midwife to 29 women. This is in line with the national average. The named midwife was model was in place and women told us they had a named midwife. Women received one to one care in labour and expressed their satisfaction with this.

The planned and actual staffing levels were displayed on all wards in the gynaecology and maternity units and were in accordance with national requirements.

- There were two never events in the maternity unit in October 2014, one retained surgical swab following caesarean section that required further surgery to remove it. The other was one retained vaginal swab. We saw the RCA reports for these incidents. A risk summit meeting was held to discuss the outcome of the investigations and action plans. Lessons learned were circulated through a trust wide process from the serious incident group and the directorates and trust wide by the medical director. Duty of candour had been applied; patients had been offered explanations, apologies and informed of the outcome of investigations.
- The reports were both completed in December 2014. Staff on the maternity unit told us of an immediate

change in practice that arose following an incident of a retained vaginal swab. However, at the time of our inspection the policy and standard operating procedure (SOP) for the use of swabs in maternity written as a result of these incidents had not been signed off and adopted by the trust clinical management committee.

- The never event was reported to the LSA as a serious incident. However, the LSA did not receive the RCA, a Supervisor of Midwives Decision Toolkit or an Instigation Form and there was no supervisory investigation in relation to this incident.
- Staff told us that they were able to raise concerns and were confident that their concerns were listened to. We saw that 153 maternity and seven gynaecology incidents were reported between January and April 2015.
- Escalation of risk was identified through a computer based incident reporting system. The Royal College of Obstetricians and Gynaecologists (RCOG) trigger list was used to guide reporting in maternity.
- All incidents were reviewed at a weekly risk meeting attended by the senior management team. The discussions at the meeting were not minuted. Lessons learned were however fed back to staff via a monthly clinical risk newsletter and shared learning files located in all ward areas.
- We saw evidence of a robust approach to safety incident investigations. Following every reported serious incident, a full investigation was undertaken and a report developed. Root Cause Analysis (RCA) was undertaken in line with national good practice. We were told by managers that when necessary women and those close to them were involved in reviews to ensure that requirements under the duty of candour were met.
- 10 serious incidents were reported to the NHS strategic executive information system (STEIS) by maternity services between May 2014 and April 2015. There were three unexpected admissions to the neonatal unit (NNU), two intrauterine deaths, one unexpected neonatal death, two unplanned maternal admissions to the intensive care unit (ITU), one surgical error and one unspecified incident.
- Perinatal case reviews were held to review intrauterine deaths, stillbirths and neonatal deaths. These meetings were attended by paediatricians as well as obstetric and midwifery staff to ensure a full review and make recommendations.

Maternity and gynaecology

Safety Thermometer

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- Each ward displayed quality data that complied with the safety thermometer. We saw that on the whole harm free care was provided across the maternity and gynaecology service.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained. We saw environmental audits for all areas. The maternity unit achieved between 95% and 98% compliance with the infection prevention and control policies and processes, and the gynaecology ward scored 95% compliance. We saw action plans in place to address any identified shortfalls.
- Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentae.
- We observed compliance with the trust infection prevention and control policy. We saw staff used hand gel and protective clothing, and adhered to the bare below the elbow policy. We saw that equipment was labelled with tags to indicate when it had been cleaned.

Environment and equipment

- We found most equipment was clean and fit for purpose. We noted one trolley on the delivery suite that was rusty and therefore difficult to clean. This meant that it could be an inflectional control risk as it could not be cleaned effectively.
- Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was ready for use.
- Resuscitation equipment was accessible and checked daily to ensure supplies were complete and within date. We saw completed records of the checks.
- An intercom and buzzer system was used to gain entry to the delivery suite and the maternity ward to identify visitors and staff and ensure that women and their babies were kept safe.

- Telemetry (remote) cardiotocography (CTG) machines were used for women whose babies needed monitoring in labour, but did not want to be restricted to the bed. CTG machines are used to monitor the baby's heart rate and the frequency of contractions when a woman is in labour. This involves two straps being applied across the woman's abdomen that are attached to the machine and does restrict movement. Telemetry CTG machines were operated by Wi-Fi and enabled women to be mobile.
- We looked at the birthing pool on the delivery suite and found it to be well maintained. Staff we spoke with knew the pool cleaning and evacuation procedures.
- We observed an effective outpatients clinic service. Privacy and dignity was maintained with quiet areas available for consultations.

Medicines

- Medicines including controlled drugs were safely and securely stored. Controlled drugs are medicines which require additional security. Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct.
- We saw that venous thromboembolism (VTE) scores were recorded in women records and monitored. VTE is the term given to blood clots. Treatment to prevent blood clots was prescribed and administered in accordance with the trust policy.
- We saw that the nurse or midwife administering medicines was identified by wearing a red tabard. This indicated that they were not to be disturbed during the medicine round to allow them to concentrate on the administration of medicines.
- Temperatures of refrigerators used to store medicines were monitored daily; this ensured that medicines were maintained at the recommended temperature. We saw that the staff undertaking the checks signed on their completion and that the temperature was within the required range.
- Midwives may supply and administer medicines under a system known as midwives' exemptions. We were told that sealed medicine packs were dispensed by the pharmacy for community midwives to supply and administer. This was good practice and ensured the medicines had been checked for safe administration.

Records

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- We saw that records were mostly stored securely and away from public view. Hand held maternity records were kept in a trolley adjacent to the midwives' station on the maternity assessment unit.
- On the maternity unit we saw the individual maternity records being reviewed as part of the women's care and the red books were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.
- We reviewed three sets of maternity records and seven sets of gynaecology records and noted that risk assessments were complete in all records.
- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and local policy.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- Safeguarding training compliance was recorded at 100% for both midwifery and medical staff for level 1, and 97% of midwives and 95% of medical staff had completed level 2. Safeguarding adults was generally well completed with 86% midwives and 91% of medical staff undertaking training.
- Staff reported good support from the safeguarding midwife who visited wards regularly to review safeguarding issues, and was available by telephone at other times.
- A flag showed on the maternity service information system for any woman who had a safeguarding concern. Any safeguarding plans were also uploaded to the information system.
- If a woman presented herself for treatment that was not known to the service, staff informed the local safeguarding board who then made enquiries with the social services department in the woman's home locality.
- Staffordshire Safeguarding Children Board (SSCB) is the key statutory organisation locally who agree how local organisations work together to safeguard and promote

the welfare of children and young people living in Staffordshire. The maternity services at Burton worked collaboratively with staff at Derby and Good Hope Hospitals to share information.

- There was a policy in place to safeguard people at risk of and treat those affected by female genital mutilation (FGM).
- We saw that all women are asked about domestic abuse in line with NICE guidelines [PH50] Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded. Staff knew how to make referrals to other agencies in cases of disclosure.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2010). A safeguarding case supervision policy was in date and community midwives undertook safeguarding supervision in line with trust policy.

Mandatory training

- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality and diversity, fire prevention, infection control, learning disability awareness, load handling, and positive mental health.
- Specific maternity mandatory training covered subjects including: maternal and neonatal resuscitation, electronic foetal monitoring, management of sepsis, perinatal mental health updates, safeguarding, normal birth, infant feeding and record keeping.
- Multidisciplinary 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse.
- Overall completion of mandatory training was high. As well as good compliance with safeguarding training, infection prevention and control was recorded at 93% for midwives and 91% of medical staff. 92% of midwives had attended training in the Mental Capacity Act.
- Cardiocotograph (CTG) machine was used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. Midwifery CTG training compliance for delivery suite in July 2015 was 91%.

Assessing and responding to patient risk

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- For women using the maternity services the booking visit took place before 12 weeks of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by community midwives at the booking visit. We saw that on-going risk assessment was carried out at subsequent antenatal visits and referral to the obstetric team made if risk factors were detected.
- Women that had problems in pregnancy were reviewed on the maternity assessment unit (MAU). From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised foetal growth charts were in use to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman.
- We were told that the critical outreach team support midwives with the care and management of critically ill women. We saw documentary evidence of a maternity sepsis screening flow chart which helped staff identify women at risk of sepsis and initiate required treatment.
- A high dependency policy was introduced along with a trolley containing equipment necessary to care for and monitor the ill woman. This trolley was designed to be mobile as there was not a designated high dependency room.
- There were arrangements in place to ensure checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery' guidelines. We observed that all the stages were completed correctly and that checklists showed that this was usual practice.
- The senior midwives on duty provided cardiotocograph (CTG) review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that it was within normal parameters.
- Handovers were carried out four times during each day on the labour ward. We observed the formal multi-disciplinary 8.30am handover which included discussion on all maternity and gynaecology inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate doctor.

Midwifery staffing

- The Centre for Workforce Intelligence and Health Education England made the Maternity Care Pathways Tool available to any maternity service provider in England on 29 January 2015. The trust had recently used the tool.
- The tool aims to enable service providers to analyse their whole maternity workforce aligned with their service's individual care pathways. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- The tool is to help decision making at a local level, and is not a replacement for other established tools. The trust has not used any of these established tools which demonstrate required versus actual staffing need to provide services.
- Nursing and midwifery staff were flexible and told us they worked hard to support each other. They all had a strong commitment to their jobs and displayed loyalty to senior staff.
- Midwifery staff rotated around the hospital based service on a daily basis. This was recorded on the duty rotas so that midwives knew in advance where they would be working. This model of providing care meant that all midwives could respond to times of full capacity because they could confidently and competently work across all areas of midwifery.
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. Midwives worked five, eight or 12 hour shifts. The delivery suite required six midwives per shift. We saw that the Band 7 delivery suite coordinator was supernumerary and we were told that in times of increased activity, they may have to look after women in labour. This could impact on the safety of women in labour as the co-ordinator needed to have an overview of activity at all times in order to manage

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the ward safely. The role of the delivery suite coordinator was to coordinate the activity on the ward. They required constant oversight of the ward so that decisions could be made regarding care and treatment.

- MAU, triage and the induction suite required three midwives on the early and late shifts, and two for the night shift. A maternity support worker supported the midwives on the day shifts.
- Staffing requirements for the postnatal wards was four midwives and two MSWs on the early shift, three midwives and one MSW on the late shift, and two midwives and one MSW on the night shift. This gave a ratio of 1:6 (one midwife to six women) on the early shift, 1:9 on the late shift and 1:14 on the night shift. Staff expressed concern that the number of midwives on night duty had been reduced from three to two and that this was impacting negatively on the quality of care they were able to provide.
- The Head of Midwifery produced a 'workforce information sheet' on a monthly basis that was distributed to the Band 7 midwives. We saw there was a 70/30 split of part time to full time staff and the minimum part time hours offered was 22.5 hours per week. The vacancy rate was 4.0 WTE and recruitment was in process; the sickness rate was 5.2% and maternity leave rate was 2.5%.
- The maternity wards did not use agency staff and had its own bank of temporary staff. This was made up of permanent staff who undertook extra work to cover shortfalls.
- The midwife-to-birth ratio is currently 1:29 (one midwife to 29 births). Midwives told us, and we saw, that they were able to provide one to one care in labour.
- Community midwives had caseloads of 100 for a full time midwife which was in line with recommendations by the Royal College of Midwives of 1:96.
- We saw that there was a lone worker policy. Midwives were provided with alert devices and satellite navigation systems.

Nursing staffing

- The gynaecology ward used agency (temporary) staff in times of staff shortage. We saw that two agency nurses were supporting the registered nurse on the first day of our visit.

- The ward was shared with ENT and nurses cared for a mix of surgical patients and outliers. We saw a safe staffing board that displayed planned and actual staff ratios for each shift on the ward.

Medical staffing

- The trust employed 20 whole time equivalent medical staff in the maternity services. The level of consultant cover was 35% which is similar to the national average of 34%. There were fewer registrars (45%) which is less than the national average of 51%. However, 15% of the doctors were middle grade which is more than the national average of 8%.
- The 'consultant of the week' covered all weekday emergencies from 17.00 Friday until 17.00 the following Friday. Consultant obstetric cover on the delivery suite was on average 60 resident hours per week at the time of the inspection. The required number for the size of the unit is 68 hours per week. The consultant staff stayed on the delivery suite every day from 08.30 until 17.00, Monday to Friday and 08.30 until 13.00 on Saturdays. The trust is in the process of recruiting more consultants. Once two more consultants are recruited, week day cover will increase to meet required standards and they will be present until 22.00 Monday to Friday. Out of hours cover was provided by the consultant on call. There was a formal consultant ward round at 08.30 and another one at 20.30.
- There was 24-hour senior anaesthetic cover for labour ward. A consultant anaesthetist was available from 08.00 to 18.00 weekdays on labour ward. Out of hours cover was provided by the anaesthetist on call.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- The gynaecology service was covered by a junior trainee and a registrar from 08.30 to 17.00 and by a junior trainee with support from the obstetric on call registrar out of hours. Emergencies were done on the CPOD list by consultants and/or middle grade staff.

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Are maternity and gynaecology services effective?

Good



Women received care and treatment that was planned and delivered in line with current evidence-based guidance, standards and best practice. Staff had access to and were using evidence-based guidelines to support the delivery of effective treatment and care.

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and outcomes were used to improve care. Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24 hour period.

Staff undertook appraisal and supervision. We saw good examples of multi-disciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women in the hospital and community settings.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home birth service.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by NICE and the royal colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.

- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Minor gynaecological surgery was undertaken in the treatment centre. The expectation was that the woman went home on the day of the procedure. Women we spoke with told us they had received good care and they had been informed about their discharge home.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4. We found that the completion of the documentation followed a robust process.

Audit

- The trust provided us with the audit plan and results for 2014 – 2015 which showed 13 obstetric audits, eight gynaecology audits and one joint obstetrics and gynaecology audit listed.
- Examples of presentations on audits included induction of labour, postpartum haemorrhage (bleeding within the first 24 hours following childbirth) and decision to

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delivery time for caesarean section. Gynaecology examples included cervical glandular neoplasia (abnormal cells in the cervix) and management of ectopic pregnancy. Each audit presentation made recommendations.

- The trust actively participated in national audits including the National Screening Committee antenatal and new born screening audit, the Midlands and North of England Stillbirth Study (MINOR) and the Diagnostic accuracy of pre-eclampsia using proteinuria (proteinuria is protein found in urine and is indicative of a pre-eclampsia, a complication of pregnancy) assessment study (DAPPA).
- The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the Trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw documentary evidence that the trust had monitored its performance against the recommendations of the report and that action plan was in place to address any shortfalls identified.

Pain relief

- Women we spoke with in maternity felt that their pain and administration of pain relieving medicines had been well managed.
- On the maternity ward we saw a variety of pain relief methods available including Tens machines and Entonox. Epidurals were available 24 hour a day.
- A birth pool was available on the delivery suite so women could use water immersion for pain relief in labour.

Nutrition and hydration

- A designated midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- The trust had been awarded and maintained UNICEF Baby Friendly Initiative stage three accreditation. This

meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.

- Women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 71% in June 2015 which was below the national average of 75%.
- In relation to meeting their nutritional needs women were able to choose from a varied menu, which also met their cultural requirements
- Women told us that food was available outside of set meal times if they did not feel like eating at set meal times.

Patient outcomes: Maternity

- The maternity dashboard was used for recording activity and outcomes for both QHB and SJMLU. The trust has revised the dashboard following the last CQC inspection to increase its thresholds and include targets. We noted that the revised dashboard did not include maternal admissions to intensive care and the number of babies readmitted following discharge, both of which are useful indicators of safety and quality of care
- We looked at the revised version for April – June 2015 and saw that in June, six indicators were rated red. These were the number of deliveries at SJMLU, the emergency caesarean section rate, the induction of labour rate, the number of third degree tears, the sickness rate and the compliance with VTE assessment. Four indicators were rated amber. These included the overall, elective and emergency caesarean section rates and postpartum haemorrhage over 1500mls at caesarean section.
- Information on the maternity dashboard demonstrated that in June 2015 the normal delivery rate was 67%, which is better than the RCOG recommendation of 60%. The caesarean section rate was 24%, which is better than the national average of 25%. Of these, 9.4% were elective, which was below the national average of 10.7% and 16.9% were emergency which was above the national average of 14.7%. The induction of labour rate was 29%, which was worse than the national average of 22%
- The Ventouse delivery rate was 10.9% and the forceps delivery rate was 3.38%.

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- There were 12 third degree tears recorded, which equated to 5% of patients. This is higher than the trust's target of 6%. There was one fourth degree tear which is above the trust's target of one.
- Six women experienced a postpartum haemorrhage of over 1500mls at caesarean section and one woman had a postpartum haemorrhage of over 1500mls following a vaginal delivery. The trust's target for this is five and three respectively.
- We saw that seven women were admitted to the intensive therapy unit following complications after the birth of their babies in 2014.
- There were 15 unexpected term admissions to the neonatal unit.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology assessment unit during the week. A team of professional staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours
- We saw that between three and six theatre sessions per week were carried out in the treatment centre, this averaged 17 major operations per month. The trust provided activity data for the year to date 2015/2016 showing there had been 668 day cases, 551 elective and 734 non-elective operations. 2,000 women attended the EPAU.

Competent staff

- Responsibility for mandatory training and other learning and development within the directorate was shared amongst the Band 7 midwives. An administrative assistant maintained the training database.
- The Head of Midwifery produced a 'workforce information sheet' on a monthly basis that was distributed to the Band 7 midwives. This contained the names of midwives whose training was not up to date. Midwives who have outstanding training for two concurrent months were escalated through management processes.
- Midwives had been trained in new born and Infant Physical Examination (NIPE) and carried out this examination within 72 hours of birth. This enabled women to be discharged home without waiting to see a paediatrician.

- All newly qualified midwives undertook a two year preceptorship period prior to obtaining Band 6. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- Band 6 midwives could participate in a development programme held by the Director of Nursing services.
- Appraisal rates for staff were provided for us and these demonstrated that 95% of midwives had been appraised.
- The function of statutory supervision of midwives to ensure that safe and high quality midwifery care is provided to women. The Nursing and Midwifery Council (NMC) sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:14 which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24-hours a day seven days a week and knew how to contact the on-call SoM.

Multidisciplinary working

- We saw good examples of multi-disciplinary team (MDT) working on the delivery suite.
- We observed staff and medical handovers where patient care was discussed and discharges planned. A multidisciplinary handover took place twice a day on the delivery suite and included an overview of all maternity and gynaecology patients wherever they were situated in the hospital. The handover was aided by a comprehensive list of patients that detailed diagnosis, plans for on-going care and the location of the patients. This included children who were on the paediatric wards with possible gynaecological conditions. The list was shredded after handover to protect patient confidentiality.
- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, Health Visitors, GPs and social services.

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Seven-day services

- Access to medical support was available seven days a week.
- There was a consultant on the delivery suite Monday to Friday between 08.30 and 17.00. At the weekend, a consultant was present between 08.30 and 13.00. A consultant was on call out of hours to cover obstetrics and gynaecology.
- The lead anaesthetic consultant for obstetrics was available between 8am and 6pm during weekdays, with on call cover out of hours. There was other senior anaesthetic cover for labour ward 24-hours a day.
- The early pregnancy service ran weekday mornings but if necessary early pregnancy scans could be done at weekends by the on call consultant or a radiologist could be called in by the on call consultant.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- All local policies and guidelines could be accessed electronically on the trust's intranet. Local policies were written in line with national guidelines. Staff demonstrated they knew how to access this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- MCA and DoLS training had been delivered to 562 staff across the trust since March 2014. The trust was unable to provide data for training attendance for the maternity and gynaecology services.
- We also saw evidence that 92 staff in the surgical division had undertaken consent and DoLS training. The percentage figure was not available as this training was not recorded as a competency.
- We reviewed 10 sets of notes and saw that the process for obtaining consent was effective.
- We saw that the procedure of consent was reviewed prior to surgical procedures which were good practice.

Are maternity and gynaecology services caring?

Good



Feedback from people who used the service and those who were close to them was positive. They told us that they felt safe. People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.

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

Staff responded compassionately when people needed help and supported them and their babies to meet their personal needs. Staff helped people and those close to them to cope emotionally with their care and treatment.

Compassionate care

- Maternity services were added to the Friends and Family Test (FFT) in October 2013. The data was collected on a prepaid postcard or by text message. In November 2014, 100% of patients would recommend the delivery suite which is better than above the national average of 97%.
- The CQC maternity survey of December 2013 surveyed women who gave birth in February 2013. A total of 155 women returned a completed questionnaire, giving a response rate of 56% compared with the national response rate of 46%. It showed that most outcomes were similar to the national average. The trust scored better than the national average in two areas; regarding not being left alone at a time when they were worried and being spoken to in a way they could understand.
- We observed caring and compassionate interactions between staff and women.
- Women experienced good care from the Early Pregnancy Assessment Unit. We were told that one woman experienced an 'exceptional response' from the team and that 'highly personalised care made a difficult situation much better'.

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- We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. Partners of pregnant women told us that they felt included and well informed.

Emotional support

- Women reported continuous one to one support during labour.
- Midwives observed women for anxiety and depression levels. There was a community midwife with specific responsibility for women with postnatal depression.
- A specialist mental health midwife and obstetrician offered support to women. The team had links with the mental health team for on-going support and continuity. This meant that women with mental health conditions were seen in a 'one stop shop' style clinic where their needs were assessed and treatment plans developed and acted upon.
- A dedicated bereavement midwife provided support to women who had suffered a loss.
- Staff on EPAU offered counselling to women experiencing pregnancy loss. On-going support was provided by the bereavement midwife who offered to women.

Are maternity and gynaecology services responsive?

Requires improvement 

There was no clear emergency gynaecology pathway. Although women with miscarriages received good care, the EPAU was only open during weekday mornings and on occasions there was a lack of suitable accommodation for women on the ward due to medical outliers. Miscarriage was managed on an outpatient basis. The EPAU was small and cramped and did not enable privacy for women suffering pregnancy loss.

The gynaecology ward had many outliers that impacted on the care provided to women with gynaecological conditions.

There was a shortage of scanning facilities. This impacted negatively upon maternity and gynaecology patients because they could not access scans in a timely manner which could impact negatively on their care and treatment.

People's individual needs and preferences were considered when planning and delivering services. The maternity service was flexible and provided choice and continuity of care.

The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs. Community midwives carried caseloads for women with specific needs such as teenagers and women with post-natal depression.

Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The Red Book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.

Access and flow: Maternity

- The trust reported that the maternity unit had no closures between July 2013 and December 2014.
- Women could access the maternity service via their GP or by direct referral. We saw that 92% of women were seen by a midwife by 12 weeks and six days of pregnancy. This is better than the trust target of 90%.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place to give birth. This decision was made when they were 34 weeks pregnant and information was provided to assist in making their

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choice. We saw that specific risk factors were taken into account, which needed to be considered and would lead midwives to advise a hospital birth, rather than home or the SJMLU.

- A Maternity Assessment Unit (MAU) provided a 24-hour assessment service to women. Women could be referred to the MAU by community midwives, GPs, or they could self-refer. Day care was available for women with concerns such as reduced foetal movements and hyperemesis gravidarum (severe morning sickness). The MAU included the designated triage area where women with urgent complaints could be reviewed and assessed. The unit also managed the care of women having their labour induced. The MAU was run by three midwives. Medical cover was provided by obstetricians from the on call team.
- A designated room where women with hyperemesis gravidarum could be treated as day cases was located on the unit. This service was frequently accessed by women from outside the trust as there were only two such units in the area. We saw that this room was equipped with a comfortable chair and items such as hand wipes and toothbrushes were provided to help keep women comfortable.
- Midwives were competent in examination of the new born. Support workers held talks where women could learn about care for the baby after discharge. Both these activities meant that women were transferred home and to the care of community midwives in a timely manner.
- Bed occupancy for maternity for Q2 (July to September) 2014/15 was 35.6% compared to the England average of 59.9%. This indicated that women were having shorter stays in hospital in comparison to the other trusts.
- We saw documentary evidence that a lack of scan capacity could lead to missed screening which could cause patient harm. A scan is part of the nuchal screening test for foetal abnormalities between 11+6 and 13+6 weeks of pregnancy. This test is only reliable in this time frame.
- The Early Pregnancy Assessment Unit (EPAU) offered appointments each weekday morning. Women were normally seen within 24 hours. This nurse led service was managed by staff from ward 14 and an ultra-sonographer. (An ultra-sonographer performs ultrasound scans) Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs, nurse practitioners and A&E.
- Staff told us that the accommodation in the EPU was too small for the number of women that were seen and that women who may have received bad news had to walk across the waiting room from the scan room to the office for discussions about next steps. This meant that women were not afforded privacy and dignity at a difficult time.
- Managers told us that the side room on ward 14 had been protected for several years and that it was only used by gynaecological patients, usually women experiencing miscarriage. However, staff told us that on occasions women experiencing pregnancy loss had to be placed in a bay with other patients due to the lack of bed capacity.
- We saw evidence that 325 outliers (patients who are not being nursed in a specialist area for their particular condition) had been placed on Ward 14 between January 2015 and June 2015. Staff told us that this could affect care provided to women with gynaecological conditions.
- We saw that pre-operative assessment took place in a separate unit. This was additional to the outpatients department visit although consent to operation took place at the initial outpatient visit. An anaesthetist was only available for three afternoons per week which meant a further attendance was often necessary for the patient if they were seen at another time. There was no coordination between the outpatient and pre-operative services to pre-empt this. It led to a disjointed approach to planning care.
- A treatment centre provided three to six gynaecology operation lists per week. This centre offered 23 hour care and a nurse led discharge policy was in place which meant that women were able to go home without delays. Any women who became unwell were transferred to ward 14 and we were told that transfer was arranged by calling the emergency services.
- The treatment centre had undertaken 920 gynaecological operations in 2014. There were 549

Access and flow: Gynaecology

- There was no clear gynaecology pathway. The existing pathway was focussed on the capacity of the service. We saw that the ability to admit women onto Ward 14 for specialist care was considered a weakness in the divisional business plan. We asked about future plans and were told this was to 'keep a bed on ward 14 for gynaec patients'.

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elective in patient episodes and 910 non elective episodes in the same time period. The trust were unable to provide us with information regarding delayed or cancelled surgery.

- Women with suspected gynaecological cancers were cared for in collaboration with the gynaecology service at Derby Teaching Hospitals NHS Foundation Trust. Weekly management team meetings were held by video link to discuss and plan care.

Meeting people's individual needs

- Women with complex requests or needs, for example requesting home birth when risk factors were present, were discussed with the supervisor of the midwife and a plan was then developed.
- We saw that women made birth plans and that, on the whole, these were adhered to. One woman told us that she felt listened to and was able to adapt her plan so that she could walk around the building 'to get her contractions going'.
- The trust ran a specific clinic to support women with diabetes through their pregnancy. A woman told us that the staff had been 'very helpful' and that she was 'well informed'.
- A number of midwives had chosen to specialise in a specific area of practice. Many of the midwives worked with specialists to provide a link between community maternity services. Having successfully completed additional training they gave advice and support to midwives and parents in areas such as antenatal and newborn screening, bereavement support, infant feeding and child protection.
- Partners could visit between 10am and 10pm. Other people could visit at fixed times. This enabled new parents to spend private time with their babies. Managers told us that they were working with a London trust that won a national award to develop a system that enabled partners to stay overnight.
- We saw information leaflets and posters in use across the maternity service. Posters displayed on the MAU were translated into the most commonly used local languages.
- Information leaflets were available for women suffering pregnancy loss outlining the choice of expectant (awaiting events) or surgical management. Staff on the EPAU told us that although doctors would undertake surgical management of miscarriage if the woman requested it; this option was not offered routinely due to the difficulty in arranging beds. We were told that this decision had not resulted in any negative impact or complaints.
- Scanning facilities were not always available for women at weekends. We were told that they had to wait until Monday to be scanned. On further investigation, we were told that consultants would scan over the weekends if required.
- We saw that there was an available face to face or telephone interpreter service.
- Two designated low risk birth rooms offered a 'home from home' experience for low risk women. Specialist equipment such as bean bags, mattresses, and birthing balls were provided to promote the comfort of women in labour. There was a birth pool for women who wished to use water immersion for pain relief in labour.
- Privacy and dignity was enabled by the use of privacy screens at the entrance to the rooms.
- We found that women who had experienced stillbirth were cared for in the Snowdrop Suite that was situated away from the main delivery suite so they and their partners could remain private and avoid areas where women had just given birth. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents.
- There was an after birth listening service run by Band 7 midwives that women could access via PALS to discuss their concerns about labour following the birth of their babies.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was an on-site Neonatal Unit (NNU).
- Supervisors of midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- There was a policy not to offer caesarean section upon request. Patients were referred to surrounding hospitals for an opinion and, if necessary treatment, if they made this request.

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- We saw that there were effective processes for screening for foetal abnormality. High risk women were invited into the clinic for counselling and referred to Birmingham Women's Hospital for on-going treatment.
- We spoke with a carer who supported a patient with learning difficulties. They told us all appointments were well structured and tailored towards the person's needs.

Learning from complaints and concerns

- Complaints were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. Patients would be advised to make a formal complaint if their concerns were not resolved.
- We saw a PALS information leaflet for patients and those close to them informing them of how to raise concerns or make complaints.
- We discussed learning from complaints with the management team who told us that, where possible, complaints were resolved locally and at the time of the complaint. We asked about identifying and recording themes arising from complaints. Locally resolved complaints were not logged and therefore themes not identified. Having such information could improve patient experience.
- Trust data showed that there had been two formal complaints between April and June 2015.

Are maternity and gynaecology services well-led?

Requires improvement



There was a clear statement of vision and strategy, driven by quality and safety. However, staff we spoke with did not demonstrate awareness or understanding of it. We heard little about a strategy to develop or introduce a pathway for women with gynaecological conditions

There were good governance structures in place. However, we found evidence that some incidents were not shared fully with the Local Supervising Authority (LSA). This could impact upon the quality of midwifery care provided to women and babies.

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

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

Vision and strategy for this service

- We saw in the surgery business plan for 2015 – 2016 that the vision for the surgery division was 'Clinical Excellence, Innovative Practice, Safe and Effective Care'. This was linked to the trust vision. It included maintaining excellence in maternity services and the expansion or relocation of the midwifery led service.
- The action plan identified an obstetrics and gynaecology strategic service review as part of the division's sustainable cost improvement programme (CIPs).
- We asked staff about the vision and strategy and we were told the maternity strategy was to develop an alongside midwifery led unit (an alongside midwifery led unit is a unit located on the same site as the consultant unit) on the Queen's site. Staff also told us that they wanted to maintain the excellence in the maternity services.
- We heard little about a strategy to develop or introduce a pathway for women with gynaecological conditions. We saw in the business plan that one of the service developments was to promote the uro-gynaecology service as one of only 30 nationally. We were told that the trust would like to expand its ambulatory gynaecology hysteroscopy service but without a recovery area that had capacity for this activity, the local Clinical Commissioning Group was reluctant to agree to it.

Governance and risk management

- We saw that robust clinical governance and risk management arrangements were in place. A risk midwife/manager was in post, who prepared and submitted a monthly report to the Women's & Children's risk group. The minutes of the Women's & Children's risk group were submitted to the Women's and Children's Directorate Board meeting. The minutes of the monthly directorate board meeting were submitted to the surgery division board meeting which then go to the trust board.

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- We reviewed the minutes of the women and children directorate meeting for January 2015 to May 2015 and saw that governance, finance and human resources reports were reviewed. The head of midwifery submitted a report on maternity activity and outcomes.
- We reviewed the maternity dashboard and saw that this had been developed following the recommendations of the last CQC report.
- The maternity and gynaecology risk register contained seven risks related to maternity; there were no risk related to gynaecology. We saw that progress was noted and that the risk register was discussed at the monthly women and children directorate meeting.
- Staff told us that they received feedback in various ways. Performance issues were taken up with the individual staff member. A quality and risk newsletter was available electronically and in hardcopy.
- The risk manager maintained the guideline database. Guidelines due for review were flagged up three months in advance of their review date. This enabled review and updating. We were told by the risk manager that clinical staff led on the review of guidelines and, following circulation to all staff for contributions, they were ratified by directorate board, which is chaired by clinical director.
- The gynaecology accommodation appeared to have been a long standing problem with no serious attempt to rectify it. The impact of the lack of gynaecology beds was that women were not routinely offered choice of management in that evacuation of products was not offered at all unless there was a specific request. It was then sometimes difficult to get these patients admitted.
- New hysteroscopes were needed for the hysteroscopy service. The staff trialled scopes and reported back on the scopes they considered best. We were told that the order was changed by management for a cheaper, untested hysteroscope and that when they arrived they were found to be inferior.

Leadership of service

- Senior midwifery leaders in the service were capable and effective however a top down and directive and management style was observed throughout our inspection.
- There was a strong approach to accountability and responsibility which meant that, although some staff said they felt actively engaged, we observed an attitude of resigned resilience.

- We observed a punitive attitude towards 'naming and shaming' midwives who had not attended mandatory training. Line managers were informed when midwives had missed booked mandatory training. If they did not attend the second time, they could be managed through the capability system although the trust told us this had not happened to date.
- We noted a record-keeping audit tool for use by Band 7 SoMs and Band 7's midwives. Supervisors of midwives are peer nominated, the role is not band specific and all SoMs regardless of grade attend the same training and undertake the same role. Supervision of midwives is not hierarchical and is separate from management. We would therefore not have expected to see reference to grade in relation to SOM activity. The trust informed us they have changed the title of the audit to ensure it reflects the inclusivity of the audit.
- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership at ward level. For example, the maternity ward staff were enthusiastic, motivated and spoke highly of the ward manager.
- We were told that the Head of Midwifery had access to the trust board. We saw the annual report she submitted to the Board that included an overview of clinical activity and developments over the year. The report contained information on clinical statistics, midwifery staffing, achievements and development, governance and external reports relevant to maternity services.
- Staff said that senior managers were visible and that an 'open door' policy was in operation. However, members of the trust board were not visible

Culture within the service

- The trust promoted a positive safety culture and encouraged incident reporting.
- From our observations and discussion with staff we saw a strong commitment to meeting the needs and experiences of people using the service. In particular midwives were keen to normalise the birth experience and to ensure that appropriate support was available following the delivery.
- There was a very low turnover of staff. Staff told us that they felt valued and enjoyed working at the trust.

Public and staff engagement

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- We saw minutes of the MSLC meetings held in May 2015. A standing agenda was followed and members had the opportunity to provide input and ask questions. It was noted that only one lay member attended the meetings, who is the chair of the meeting.
- The MSLC was instrumental in setting up a Twitter account for the maternity services.
- Other work streams included delivery of maternity services to vulnerable women within the community, and better support for breast feeding including awareness within primary care and the provision of parent education.
- Regular open days are held so that women and their partners can tour the maternity unit and were well attended.

Innovation, improvement and sustainability

- The maternity service was awarded the Excellence in Maternity Care award by CHKS in 2014. The quality of care at Burton Hospitals NHS Foundation Trust was judged to be the best out of 148 NHS maternity providers in England, Wales and Northern Ireland.
- A designated room where women with hyperemesis gravidarum could be treated as day cases was located on the unit. This services was frequently accessed by women from outside the trust as there were only two such units in the area. We saw that this room was equipped with a comfortable chair and items such as hand wipes and toothbrushes were provided to help keep women comfortable.

Services for children and young people

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

Information about the service

Children's services were part of the surgical division at the hospital. The service employed seven consultants and 60 staff including nursing and non-nursing staff. Services were provided at Queen's Hospital which has two children's wards. Ward one for acute admissions; ward two for planned surgery, day cases and young people. The children's outpatient clinic was adjacent to the wards. Children with fractures, orthopaedic needs or with conditions affecting the ear, nose and throat were seen in specialist clinics in the main out patients departments.

The neonatal unit is part of the Midlands Central New-born Network. This trust provided neonatal care at level 1. Level 1 care is for those babies requiring continuous monitoring of their breathing or heart rate, additional oxygen, tube feeding and phototherapy (neonatal jaundice). The unit had facilities to care for a baby requiring intensive care for a short period of time until they were transferred to a specialist unit. There were facilities to accommodate parents overnight.

We spoke with seven patients and 10 relatives. We spoke to 26 staff including consultants, doctors, nurses, domestic and support staff. We observed care and looked at seven sets of nursing and medical records. We reviewed other documentation including performance information provided by the trust. We received comments from people who contacted us to tell us about their experiences.

Summary of findings

Incidents were reported and investigated appropriately with learning from incidents shared with staff. Staff were open and honest with patients when things went wrong and when errors were made. Staff had appropriate paediatric life support training relevant to their role and there was equipment and facilities available to respond to patients who became seriously unwell.

The service conducted local and national audits to measure performance against national and local guidance. There was learning and action taken to improve services. Transitional arrangements were in place for young people moving into adult services. Staff were caring.

There were clear discharge pathways and procedures to ensure patients received the appropriate care and treatment after their stay in hospital.

The service was responsive to patient's needs. There were resources in place to communicate with patients and their families. There was a clear vision and strategy for the service with both staff and managers aware of key priorities. Staff felt engaged and involved in improving and developing services.

Services for children and young people

Are services for children and young people safe?

Good



Incidents were reported and investigated appropriately with learning shared at management and ward level. Staff were open and honest with patients and their relatives when mistakes and errors were made. The environment was clean and staff cared for patients in accordance with the trust infection control policy.

Staff had received paediatric life support training relevant to their role and there was facilities and equipment available to care for seriously unwell patients.

There were policies and procedures in place to safeguard children and young people from harm. Staff were aware of the child protection leads for the service and the majority staff had received appropriate training for their role. Mandatory training for the service was better than the trust target. There were safe levels of staffing for both medical and nursing staff with national guidelines of staffing ratios adhered to.

Incidents

- Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. The service recorded zero never events in the last 12 months.
- Between May 2014 and April 2015 the service recorded one serious incident. We saw that incidents were investigated appropriately using Root Cause Analysis (RCA), with actions and learning identified. There was a section on the RCA that identified when and how the patient and their family were informed of the incident.
- We saw from directorate meeting minutes between October 2014 and February 2015 that incidents were discussed at a senior level. Actions were agreed and added to serious incident action plans to prevent future risks to patients. The action plans were monitored by the clinical risk manager who ensured that actions identified were followed up and implemented. Following completion of an action it was reviewed by the risk manager three months later to ensure that it had worked or changes were embedded.

- Staff told us that learning from incidents took place at ward meetings which were held every month. We saw minutes of ward meetings where discussions had taken place about incidents. Staff received feedback from incidents via the electronic incident reporting system and through one to one meetings. Newsletters were also used to highlight learning or changes in practice as a result of incidents.
- The admission onto the ward of all children and young people receiving child and adolescent mental health services (CAMHS) was automatically recorded as a serious incident by staff. We were told by the staff that this was because management wanted a way of recording how many patients were being admitted. Due to this process, numbers of incidents were higher than expected. For example in June, 26 incidents were reported by the paediatric wards and 11 of those were the arrival of CAMHS patients.
- Mortality and morbidity meetings were conducted on a case by case basis and were minuted. Neonatal deaths were recorded on an electronic recording system, which was a national database. There were systems and processes in place to review neonatal deaths, including complex cases with multi-disciplinary input. Perinatal (the period immediately before and after birth) deaths were discussed at a regional palliative care network where learning was shared and cases discussed.
- Knowledge of the requirements of the duty of candour regulation was mixed. This regulation requires providers of healthcare to be open and transparent with people using services when things go wrong with care and treatment. Senior staff, including senior sisters and matrons, were able to describe the duty of candour and explain how it was used within the trust. Other staff were not as aware but described a culture of openness and transparency with patients and their families. They gave examples of when things had gone wrong and immediately informing patients of families of this.

Cleanliness, infection control and hygiene

- Trust data showed that the neonatal unit and children's wards recorded no cases of methicillin-resistant staphylococcus aureus (MRSA) or clostridium difficile between April 2014 and March 2015.
- We observed staff were bare below the elbows, used hand gels and soap. Staff washed their hands in between treating patients. Staff we spoke with were able to describe how they met the trust's infection

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prevention and control policy. The trust policy on infection control was available on the wards and on the trust's intranet system. Staff showed us where the policy was kept if and when they needed to refer to it.

- The trust conducted infection control audits to assure cleanliness and adherence to trust policies. The neonatal unit was 100% compliant between April 2014 and March 2015 and the children's wards were between 95% and 100% compliant over the same period.
- We saw staff wearing different coloured gloves and aprons which were used when performing different duties. For example red for administering medications, white for nursing procedures and blue for serving lunch. This was in accordance with the trust policy.
- All wards and equipment were clean. We saw that there were cleaning schedules and procedures in place for equipment. Once clean a green tag would be attached signed, dated and the time of the clean. There was a cleaning rota for domestics who explained that there was a plan for each day. In addition domestic staff would deep clean areas that were required by wards. Ward assurance data for May and June showed that the ward environment was checked and was above the trust standard.

Environment and equipment

- The children's wards had a room equipped for the treatment of acutely ill patients. Equipment was age appropriate and was organised and easy to access.
- All equipment we checked had been tested checked and were all in date meaning that equipment was safe and ready to use. We checked four resuscitation trolleys which were easily accessible and were checked daily to ensure they were ready for use. The equipment was suitable for all ages of children treated on the ward.
- Staff competency was assessed for using equipment on the ward to ensure that it was safely used with children. Competency was reviewed yearly and training refreshed between one and three years depending on the equipment.
- The environment on all the wards we visited was safe for patients. The entrance to wards had lockable gates so that small children were unable to leave the ward without staff or parents. At the entrance to the wards doors were locked and accessible only by pressing a buzzer and being let in.
- There were concerns expressed by staff and managers about the layout out of the neonatal unit. The unit was

split into four nurseries containing three beds each and a central room for high dependency patients. The layout of the unit did not make it easy for staff to move around the unit and to make observations. We were told by a senior nurse and managers that work was on-going to find a new layout. The issue was on the service risk register and business plan as a priority.

Medicines

- Audit controls were in place with regards to controlled drugs. We saw that for May and June 2015 that the wards were 100% compliant with regards to the storage and checking of controlled drugs.
- We looked at five medicines storage rooms. Medicines were kept in locked rooms and were only able to be accessed by smart cards meaning that storage was secure. The door to the drug room had a flashing light and an alarm to indicate it had been left open. We saw this demonstrated by staff.
- Medicines were all in date, sealed and stored in locked fridges and cupboards. Fridge temperatures were monitored and we saw checklists situated in the storage room. Staff were able to describe the escalation procedure if the temperature was not within the defined limits and would also record this as an incident.

Records

- We reviewed seven sets of nursing records. Electronic and paper records were in use. Care plans were comprehensive, personalised and covered all aspect of the child's care. This included detailed information regarding social assessments and key individuals in the child's life. We saw that notes had been added after every shift and were up to date. Observation charts were kept next to the patient's bed and they were clear and child specific.
- The assessment documents were held electronically and paediatric early warning scores were being used and accurately calculated based on observations. We saw on the electronic notes that the same file was used for multi-disciplinary input. This meant that staff could see entries and comments from other staff groups such as physiotherapists or dieticians.
- Medical records were all stored in lockable cupboards or trolleys. We saw that most of the trolleys were stored safely next to or behind the nursing stations, ensuring confidentiality.

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- We looked at seven sets of medical records. Medical records were clear, legible, signed and dated in line with General Medical Council standards. Doctors used structured forms to record examinations and we saw that these were filled in dated and signed after every examination.

Safeguarding

- All staff were trained in child protection levels one and two for the service. ninety-four percent of nursing staff and 95% of medical staff had undertaken level three child protection training. All nursing staff had undertaken level one safeguarding vulnerable adults training with 94% having completed level two. 87% of medical staff had completed level one and two safeguarding vulnerable adults training.
- Staff received appropriate safeguarding training. Level two and level three training in safeguarding children was delivered by the safeguarding team. This was delivered in line with the guidance 'Safeguarding Children and Young People: Roles and competencies for Health Care Staff' published in March 2014.
- All staff we spoke to were aware of the trust child safeguarding policy. Staff could describe and demonstrate where to find the policy on the ward and electronically. Staff were able to tell us what they would do if they had a concern in the line with the trust policy and guidance.
- There were nursing and medical leads in place for child protection in line with safeguarding guidance. All staff we asked knew who the nursing and medical child protection leads were. Most of the staff we spoke to said that they had spoken to the leads about a safeguarding issue.
- Ward assurance data for paediatrics and the neonatal unit in June showed that 100% of staff were aware of the safeguarding lead consultant and nurse and how to contact them.
- Alerts to local authorities and other agencies were carried out by the safeguarding team. All potential sexual abuse referrals were sent to the Sexual Abuse Referral Centre in line with local guidance from the Staffordshire safeguarding children board. Arrangements were also in place to protect children at risk of female genital mutilation with advice and support available from the safeguarding leads. This demonstrated clear lines of communication and clear referral protocols in place for children at risk.

- The children's ward frequently cared for children and young people with mental health conditions. There were policies and procedures in place when patients absconded from the ward. The ward had a description sheet which staff filled in and passed to the police if patients absconded. We saw this sheet had been filled out in two sets of nursing notes. The process enabled staff and police to be better informed and find absconded patients from hospital quicker.
- There was safeguarding supervision for nurses in place. For doctors, cases were discussed in a teaching session but there was no formal peer review session. This meant that doctors potentially were not receiving appropriate support and learning. Royal College of Paediatrics and Child Health recommends that all safeguarding cases should be discussed formally in a safeguarding peer review meeting and discussions should be minuted.

Mandatory training

- All staff we spoke to said that they were up to date with their mandatory training. Mandatory training included records, mental capacity act and incident reporting. As of March 2015, 96% of nursing staff and 93% of medical staff had completed their mandatory training; this was above the target set by the trust.
- We saw that senior nursing staff kept a log of mandatory training and the dates for review ensuring that staff kept their training up to date.

Assessing and responding to patient risk

- At the last CQC inspection, concerns were raised regarding the number of staff training in paediatric life support. Data from the trust showed 100% of medical staff and 83% of nursing staff had received advanced paediatric life support training (APLS). One hundred percent of medical staff had completed basic paediatric life support training (PBLs) and immediate life support (PILS) training. All nursing staff had completed PBLs and 95% had completed PILS training. This showed a significant improvement.
- To ensure staff were competent in life support training there was a rolling programme every three months so that new staff were trained quickly and existing staff were able to have regular refresher training.
- Children and young people services used paediatric early warning scores to assess and respond to risk. Staff we spoke to were aware and knew how to use the scoring system and paperwork. We checked seven

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nursing notes and saw that in each file scores were used and where appropriate acted upon. Audits of the use of early warning scores were reported at ward level so that issues could be easily identified.

- The paediatric ward had facilities for staff to treat deteriorating or seriously ill patients. The room had a resuscitation trolley and an incubator for young children. All equipment was well organised and easy to reach with speed. We saw there was guidance for staff on drug dosages for different weights of children on the wall. This meant that patients were able to receive urgent and important care quickly when required.
- Transfer equipment was being used when children were taken to theatre and for scans. This meant that patients could be stabilised or remain stable whilst going for other elements of treatment and care. The equipment was appropriate for purpose and was regularly checked by staff.
- Children's services had access to the regional Kids Intensive Care and Decision Support (KIDS) team. Teams caring for a seriously ill child could call the KIDS team for specialist advice, finding paediatric intensive care beds, and transporting patients to other hospitals. Staff told us that the service was well used and valuable to them when looking after seriously ill patients.
- There were regular audits looking at the use of paediatric early warning scores (PEWS) with regards to accuracy and completeness. Between September 2014 and July 2015 improvements had been made in recording patient details and observations. Improvements had been made as a result of training and increased communication to staff.

Nursing staffing

- Senior nursing staff used an electronic acuity tool to determine staffing levels which took into account staff ratios and the needs of patients, ensuring extra staff could be brought in when required.
- We saw from staffing rotas that there were four trained nurses on during the day and three trained nurses on at night which was better than the RCN standard of a minimum of two trained nurses on at all times. In addition we saw the staffing ratios met RCN standards with regards to the number of nurses to children under two (1:3) and over two (1:4).

- Actual staffing levels met the desired establishment. We looked at staffing rotas since May 2015 and saw that wards had met their establishment on the majority of occasions.
- We observed a nursing handover. Each patient was discussed in turn with the needs of patients discussed and identified. Roles and responsibilities were identified against any actions generated from the discussion.
- There was at least one European life support trained nurse on each shift as per Royal College of Nursing (RCN) standards. This ensured that there was always someone qualified on shift to recognise and prevent respiratory or circulatory failure, begin treatment and escalate concerns in children.
- The children's wards and neonatal unit had their own bank staff meaning that any bank staff required were already appropriately trained. Substantive staff and students also volunteered for extra shifts if required. Agency and bank use for children's services was lower than most other departments. Since June 2014 agency/bank usage was below 5% for most months for all wards.
- Staff turnover for paediatric and neonatal wards was an average of 7% between July 2014 and March 2015. This meant that there was stable staffing and continuity of care for patients.
- We saw that the staffing ratio for the neonatal unit met the British Association of Perinatal Medicine (BAPM) guidance. There were two high dependency patients cared for by one nurse and there was one nurse caring for four special care babies. However at the time of our inspection senior nurses were filling in for a nurse due to sickness covering the shift and supervising a student nurse. This took the senior nurses away from other duties. Senior nurses on the unit said that at times they did struggle for staff.

Medical staffing

- We observed a medical staff handover. Each patient was discussed in turn by name, there were clear actions discussed and clear communication between medical staff. All staff knew their roles and responsibilities.
- There were seven whole time equivalent paediatric consultants employed by the trust. The consultants covered the two children's wards, neonatal unit and the children's clinics. We saw the skill mix of medical and

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junior medical staff was appropriate. The consultants were supported in children's clinics by three consultants from Birmingham Children's Hospital who ran specialist clinics for patients.

- The vacancy rate for medical staff was 6% of the total staffing hours required. This meant that there was a low vacancy rate for the service. We were told that one consultant was leaving the service at the end of the year. Recruitment was in place so that a replacement could be recruited quickly before the end of the year.
- There were two locum doctors working across the service and there were no gaps in the rota for medical staffing. Locum use had dropped from 15% to 3% since October meaning that the majority of medical cover was by permanent staff. Therefore patients had continuous care and were able to build relationships with their doctors.
- Medical staffing met the minimum BAPM standard for the neonatal unit of a junior trainee doctor and an appropriately trained specialty doctor. This meant that there were the appropriately trained medical staffing on hand to ensure patient care was safe.

Major incident awareness and training

- There was a major incident policy. Staff were aware of the major incident and business continuity policy, and understood their roles and responsibilities in the event of a major incident. Staff were informed when the level of need at the trust was high and major incident drills were held annually.
- There was an identifiable responsible person to lead on ensuring staff followed the procedures and protocols for a major incident.

Are services for children and young people effective?

Good



Patients received treatment and care according to national guidelines and this was monitored. There was learning and actions generated to improve how the service was delivered as a result. The service also conducted local audits and used them to improve care. Outcomes of patients care was routinely collected and monitored.

The majority of staff had received appraisals and all staffing roles had their own competency framework to ensure they were working to the required standard.

The service had some formal transitional arrangements with other departments and hospitals in the region for young people. There was multi-disciplinary team working internally and externally with regional networks to ensure effective care and treatment for patients.

Consultants were available out of hours and play therapists, physiotherapists, dieticians and speech and language therapists were available seven days a week.

Staff were able to describe their responsibilities and approach to gaining consent from patients.

Evidence-based care and treatment

- The service worked to a range of national guidance such as National Institute for Health and Care Excellence (NICE) guidelines and local policies. We saw a planned approach to monitoring compliance against guidance and standards in the form of regular audits and evaluations. We saw learning had been identified through audit plans. Discussions took place in directorate meetings on risk and assurance against national standards.
- The neonatal unit operated in accordance to the Central New born Network (CNN) standards. The network was one of 22 that were developed nationally as a result of recommendations from the Department of Health's "National Strategy for Improvement 2003". The network provided advice to NHS trusts and commissioners on all aspects of neonatal care with a particular focus on the delivery of high quality services.
- We saw that staffing levels, patient flow, guidelines and policies were developed in line with the CNN and Department of Health guidance. However, the layout of the neonatal unit did not meet the CNN standards due to the difficulties in clearly observing patients.

Pain relief

- Audit data showed that compliance against pain management standards in April 2015 was 88% against the trust standard of 95%. Senior staff told us that this was being addressed through team meetings, training and reviewing documentation. The data for June 2015 demonstrated an improvement to 97%.

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- The approach to pain management for children was multi-disciplinary involving the pain team, doctors, and anaesthetists. Two patients told us they had been offered pain relief when it was required.
- The trust had an acute pain team. This was not a paediatric specific team; however, patients had a specific care plan with regards to pain. This was identified through pain scores filled out as part of the paediatric early warning score documentation.

Nutrition and hydration

- In all the nursing notes we looked at there was detailed information regarding nutrition and hydration. Assessments were filled out correctly and we saw that children were getting their required nutrition and hydration needs.
- We saw staff feeding babies on the neonatal unit in accordance with their care plans.
- The neonatal unit used La Leche League International (a worldwide organisation providing advice and support on breastfeeding) guidelines for storing breast milk. Information included where and how the milk should be stored including fridge temperature and the number of days for storage.
- Data from the trust showed that 97% of patients in June had received nutritional assessments. This was an improvement from May (92%) which was below the trust standard of 95%.

Patient outcomes

- Outcomes of patients' care and treatment were routinely collected and monitored. For example, data was collected on outcomes for pre-term babies and for patients that had pneumonia. We saw evidence that standards were being met and conclusions and recommendations identified. We saw positive outcomes for example the appropriate prescription of antibiotics for pneumonia which increased the patient's chance of recovery.
- The NICE Quality Standard QS6 states "People with diabetes agree with their healthcare professional a documented personalised target." The hospital recorded that almost 14% of patients had control of their diabetes which was worse than the England average of 18%. This showed that the service was not meeting the requirements for the standard of care with patients who had diabetes.

- Work was on-going to improve patient outcomes regarding controlled diabetes. We were told by senior managers that a consultant was due to retire and instead of a direct replacement two consultants with interests in diabetes would be employed. The service had also appointed two paediatric diabetes nurse specialists, improved dietetic support and offered patients full psychological support in order to support patients gain control of their diabetes. The service was also meeting with commissioners to improve data collection on retinopathy (a disease that can cause impairment or blindness) screening.
- There were no emergency readmissions following planned admissions among patients in the under one age group between December 2013 and November 2014. Readmission rates following unplanned care admissions for this age group were in line with the England average for the same period.
- There were emergency readmissions after planned admissions among patients in the one to 17 age group between December 2013 and November 2014. However, no treatment speciality reported six or more readmissions. Readmission rates following unplanned care admissions for this age group were in line with the England average for the same period.

Competent staff

- The appraisal rate for all staff across paediatrics was 97% in April 2015 and 96% for neonatal staff between in March 2015. All staff we spoke to said that they had had an appraisal in the last 12 months.
- Staff had their own job specific competency frameworks including student nurses. These were reviewed and signed off by managers. We saw staff competencies stored in files on the wards. We saw that they had been updated and reviewed regularly. This ensured that staff were able to work to the desired standard required for the ward.
- Nurses and nursing assistants told us that they were encouraged to attend training courses in addition to their mandatory training. Student nurses we spoke to told us that they had learning opportunities and they were supported by their mentors to learn new skills.

Multidisciplinary working

- There were two ward sisters responsible for patients making the transition from children's to adult care. Once the linked adult ward was identified a meeting would be

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held with the ward team regarding the patient. The sisters showed us a detailed document that covered medical and social aspects of a patient's condition. There would also be a summary document placed in the front of the patient's notes for staff on the adult ward to refer to.

- There were formal transitional arrangements and joint clinics for example with adult cardiologists or gastroenterologists. Patients were transferred to another trust for cardiology services. There were no formal transitional meetings for complex epilepsy patients. We were told by consultants that if the epilepsy was managed then the patient would be seen by their GP.
- The service was a member of a number of networks including the palliative care network, the oncology network and the Central New born Network (CNN). The networks looked at training, clinical best practice, and continuous improvement with regards to neonatal and paediatric care.
- The service worked with other organisations to ensure that patients received safe care and treatment. We saw from medical notes that there was regular communication with the police and social services regarding the care and welfare of children. The service also worked with mental health service provider who provided drop in sessions on the ward. The matron for the service attended a Mental Health Operations Group which was a multi-agency group to discuss services and supporting children with mental health conditions.

Seven-day services

- Consultants were available out of hours. Consultants were on call and if they did not live locally they would stay at the hospital to ensure that they could be available quickly if emergencies should arise. Nursing staff told us that consultants were available straight away.
- There was access to physiotherapists, dieticians, and speech and language therapists seven days a week. These roles were not specifically allocated to paediatrics due to fluctuating demand; however senior staff told us that they were available when requested. We saw from patient notes that physiotherapists were available and working with patients seven days a week.

- Play therapists were available and working seven days a week on the children's wards. This means that there were activities and support for patients and their families through play every day.

Access to information

- Patient records were kept on an electronic system. This meant patient records could be accessed from multiple locations including clinics that were held in other areas. Consultants were able to access the information they needed in order to treat a patient across a wider area.
- Handovers were used to ensure that medical and nursing staff had access to information about patients in a timely way. There were two nursing handovers every day, three medical handovers and a post ward round update handover by a senior nurse to nursing and non-nursing staff.
- When patients were transferred to other hospitals and services where the electronic copies of their notes were unable to be seen, a paper version of the notes would be escorted with the patient. For x-rays and other digital imaging services if the receiving service did not have picture archiving and communication system (PACS), images would be sent on a CD. Staff also had secure emails so that information could be shared confidentially and securely.
- Personal child health records (also known as red books) were given to parents on the neonatal unit. We saw nursing staff filling out information in the books such as growth charts.

Consent

- The service sought the consent of children and young people when providing care and treatment. The 'Gillick Competency Assessment' helps clinicians to identify children aged 16 or under who have the legal capacity to consent to medical examination and treatment. Gillick competency assessment was used and we saw evidence of this through observing staff and in medical notes. All staff we spoke to understood their roles and the need to gain consent.
- We observed staff seeking consent from children. If a staff member was not sure a patient was able to seek consent the member of staff talked to the patient first to ensure that the patient understood them. We saw in medical notes that consent form had space for the child to sign as well as their parent or carer. We saw that these were used appropriately and signed by children.

Services for children and young people

Are services for children and young people caring?

Good



There were positive interactions between staff and patients. Staff were always visible and on hand to speak to patients and their families. Patients were positive about staff and the care that they received. Privacy and dignity of patients and their relatives was respected by staff across all areas.

Staff involved patients and their relatives in their care and there were numerous examples of staff understanding the needs of patients. There was emotional support available for patients and their families in a variety of ways including specific rooms and the availability of support services. Staff knew how to access these services and what to do in the case of a child or neonatal death.

Compassionate care

- There were positive and caring interactions between staff and patients of all ages in all areas. Staff were visible, friendly and addressed patients directly before speaking to parents.
- Patient's privacy and dignity was respected. Staff asked permission to approach the patient's bed before entering their bed space. Older children and teenagers were talked to and given respect with freedom to walk around the ward if they desired.
- The children inpatient survey between April and June 2015 showed that 100% patients felt that staff were kind, friendly and could help make patients feel better.
- We spoke to seven patients and 10 relatives. Patients told us that staff were friendly and that they helped the patients. Relatives told us that care was very good and staff were calm, caring and professional. Parents described staff as making stressful situations much better.
- The service used the Friends and Family Test (FFT). This was a single question survey which asked patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Data for April to June 2015, for both the neonatal unit and paediatric wards showed that 100% of patients or their families would recommend the service between.

Understanding and involvement of patients and those close to them

- We observed staff involve patients and those close to them in their care and treatment. Staff talked to patients and describe what they were going to do. Staff also checked with the patient that they understood what they'd been told and where they were.
- Patients told us that they were involved in their care. Relatives described staff as very good and communicative." One patient said that they were able to ask questions and that the answers from the nurses made sense. Another patient said that they were told what was happening to them and understood what was going to happen in the future.
- The parent's survey between April and June 2015 showed that 100% of parents for April and May and 97% for June felt that staff involve and inform them in the care of their children. In the same period the patient survey highlighted between 94% and 100% of patients felt that they were involved in their care.
- The nursing staff responsible for transitional care of patients described how they helped patients overcome anxiety before and during the move to an adult ward. Meetings were held with parents and the patient leading up to the change of care and six months after to evaluate the transition. .

Emotional support

- There was no dedicated space for families to be given bad news in the children's clinic area. The consultant room, sisters' office or a private meeting room were utilised or they could use the Snowdrop Suite on the labour ward which was used for patients that had suffered a still birth or neonatal death.
- Staff were able to tell us about the other support services that were available for patients and their families. These included chaplaincy support, referral to health visitors and multi-faith room. There was information on wards about pastoral and spiritual care.
- There was a bereavement link nurse for patients who had suffered a death of a child. The link nurse worked with the trust bereavement team and staff to support patients. Families were given information about the post mortem process and help with completing necessary forms.
- The neonatal unit had a quiet room which was used for counselling parents when babies passed away.

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- The neonatal unit had an off-site support group for new parents called 'Queens Early Starters.' This group provided advice on issues or parenting, for example breastfeeding. It provided a safe environment for parents to receive emotional support and encouragement in the early stages of being a new parent.

Are services for children and young people responsive?

Good



The service was responsive to patient's needs. There were resources in place to communicate with patients and their families. The environment met the needs of children and young people. There were activities to occupy patients and the wards were colourful and interesting to patients and families.

The service worked with other NHS trusts so that patients could access specialist care. There were arrangements in place to follow up and improve patients who did not attend clinics. There were clear discharge pathways and procedures to ensure patients received the appropriate care and treatment after their stay in hospital.

Complaints and concerns were dealt with locally at ward level and staff tried to resolve patient issues before they became a complaint. There was learning from complaints and concerns and the number of complaints about the service had reduced over that last three years.

Service planning and delivery to meet the needs of local people

- The service worked with other NHS trusts to ensure that patients could access specialist care and treatment. For example, a paediatric surgeon had recently retired and so the service were working with another trust to provide paediatric surgery. Another example included transferring acutely ill patients to specialist hospitals able to provide the care required. Consultants from a nearby NHS trust came to the hospital to deliver specialist services and outpatient clinics.
- Outreach clinics were provided at Samuel Johnson Hospital on alternate weeks and at Sir Robert Peel Hospital once a week to ensure that the local

population had access to the service. All clinic letters, emergency attendances and inpatient nursing records were electronic which meant that records were available to consultants delivering the clinics.

Access and flow

- Overall the hospital had 3,825 attendances of children and young people between January and December 2014. The majority of these, (95%), were emergency admissions; 3% were day case patients and 2% planned admissions. While the overall admissions were less than the England average there were more emergency admissions than the England average of 68%.
- The NHS Constitution provides patients with the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. We saw that between March 2015 and May 2015 all patients (with one exception) accessed treatment within this period.
- Length of stay for planned and unplanned admissions were better than or in line with the England average.
- Patients arriving at the emergency department were signposted to the triage service at the paediatric ward unless they were in urgent need of care and treatment. GP's and midwives would also refer patients to the triage service and the triage nurse was usually notified of patients that had been referred. Triage staff or consultants went to see patients in the emergency department to ensure that patients did not wait a long time to be seen.
- The triage room was linked to a large playroom where children were able to play and wait comfortably to be seen. The triage room was managed by a triage nurse and a nursing assistant. There was also a recovery room with a bed where a patient who needed a short recovery period could rest. There was a clear process and flow for patients who would either be sent home from triage or admitted onto the ward.
- There was a two hour stay limit in triage, unless a patient was admitted to the ward. Staff told us that there were some patients who needed a longer than two hours but did not need to be admitted this would either impact on bed space in triage or the ward in the short term. Work was under way creating a business case for a paediatric assessment unit which would be a short stay ward area.

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- Patients using the children's clinic were referred by their GP or consultant after being a patient on the children's ward. There was an electronic booking system for new and follow up appointments.
- A discharge letter was sent to the patients GP after being discharged from a ward or outpatient clinic. The patient and their family would also be sent the same letter. An audit of discharge reviews and summary showed that all notes had discharge planning notes for patients. We saw from looking at medical records that appropriate discharge information was contained in medical notes. This meant that patients were more likely to be discharged with the right support or appointments in place to help with ongoing treatment.
- There was a discharge pathway for patients on the neonatal unit. Discharge planning was started as soon as a patient entered the unit. A checklist was used to track key actions up to the point of discharge, for example ensuring parents had a copy of the personal child health record and the Bliss (a charity that supported premature and sick babies and their families) booklet which contained information and guidance for parents. An audit of the pathway document showed that it was a necessary and valuable document.
- There were clear processes in place for patients who did not attend (DNA) children's clinics. The doctor decided whether a patient should be discharged or offered another appointment. Attempts would be made by staff to contact the patient by letter or by liaising with a health visitor. If the patient did not attend at the third appointment this would trigger a referral to safeguarding procedures. The nursing staff working in the clinic gave examples when this had happened and knew the procedure.
- The service conducted an audit on DNA for children's clinics. The audit showed that nearly 14% of patients did not attend clinics if they were just sent a letter compared to just over 3% of patients who were spoken to over the phone. As a result a text reminder service and phoning patients prior to their appointment was introduced the DNA rate for June had reduced to 8%.
- There were occasions when children under 16 had to be treated on adult wards due to the nature of their condition. We spoke to staff and saw that there was no formal process or guidance for this.
- The paediatric wards used different tools of communication for children of varying disabilities. For example they had British Sign Language cards so that they were able to communicate with patients who had speech and language impairments. There was also a communications book at the nurse's station which was used to communicate with children and young people with a learning disability.
- Interpreter and translation services were available to the service. Staff were able to use a telephone interpreter service. Staff told us they were able to get written translations when the patient and their family needed specific information or a copy of a letter and they gave us examples of when this had happened. We also saw that some leaflets had been translated into other languages, for example a leaflet about asthma had been translated into Urdu.
- The ward had many regular patients with long term conditions and disabilities. Ward staff understood that hospital life could be more structured than at home meaning it could be difficult for some patients to adjust. Ward staff gave us examples of where they tried to fit in with home life, for example administering medication.
- There were special beds for patients with disabilities and mobility issues. These cots kept patients safe and prevented them from falling or hurting limbs on metal beds. The paediatric wards had 'pod chairs' which came in different sizes, were mobile and provided pressure relief so that disabled patients were able to move about the ward and go for walks.
- There was no system to make staff aware of a patient with a learning disability. Staff said that they had to rely on the parents or carers informing them on arrival to clinics and wards. If a patient had more complex needs staff may get an email from the referring body or individual.
- One member of staff gave an example of supporting a young person with learning disabilities. The patient had become agitated because they were in the hospital environment and therefore instead of trying to keep the young person in the ward they were allowed some space to walk the corridors. Staff worked with the family and the patient to ensure that the young person was supported and felt comfortable within the environment.
- The paediatric ward had play leaders working seven days a week. The play leader would play games, ensure children had activities or games to play with as well as monitor the play areas. They had resources for example

Meeting people's individual needs

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books that would explain to a child what would happen in hospital. The play leaders also supported parents who had stayed the night by entertaining or playing with a child while the parent had a break.

- There was appropriate equipment for children of most ages. There were books, games and activities for young children in the play room and outdoor play area. There were TV's, DVD's and game consoles for older children. One patient told us that they had not been bored during their stay in hospital because there was plenty to do.
- There were facilities for parents on the neonatal unit and the paediatric wards. Facilities were basic, however, parents were able to make drink and have hot food. In the parents' room there was an honesty box where parents could make financial contributions for using the food that was made available by the ward. There were sofas in the parents' room and in a lounge room on the neonatal unit so parents could relax and feel comfortable when taking breaks.
- The neonatal unit used parent passports which were cards that communicated the extent of parent involvement achieved during a baby's care pathway. This was particularly useful when babies were transferred between hospitals and units because staff were aware of what parents had achieved and where they still required support. We saw an example of the passport but we did not see any that were currently in use by parents.
- All staff we spoke to on the paediatric wards told us they were working with increased numbers of children and young people with mental health conditions. Four members of staff expressed concerns that they were able to provide little more than a 'babysitting service' to patients while they waited for specialist beds. No audit or research had taken place as to why there was an increase. This issue was identified as a risk by staff and the trust.
- Young people aged between 16 and 18 years of age who presented with self-harm, were admitted to adult wards. However these young people were still seen by child and adolescent mental health services team (CAMHS) and the crisis team. The safeguarding team provided guidance to adult services to ensure that the patient was treated and managed correctly. Immediately following our visit, the trust drafted a pathway for staff to follow.
- Staff had received training on child and adolescent mental health services. Senior nursing staff were able to

recruit registered mental health nurses when required to support patients and reduce the risk of patients harming themselves. Patients who did not require one-to-one support were cared for in bays so that they could be observed at all times.

Learning from complaints and concerns

- Data from the trust shows that complaints about the service had reduced over the last three years. There were 15 complaints about the service in 2012/13 and this had reduced to nine in 2014/15. So far this year since April 2015 there had only been one complaint about the service.
- All staff we spoke to said that they try and deal with complaints at a local level. Staff said that it was important to deal with issues at ward level and ensure the patient and their family leave the ward happy. Staff knew they could escalate issues to the senior sisters or to Patient Advice and Liaison Service (PALS). Staff could provide examples where this had happened. There was information available on the wards about how to make a complaint and to contact the PALS service.
- The numbers of patient contact with PALS about the service had reduced in the last three years. In 2012/13 there were 22 contacts with PALS. This was the same in 2013/14. In 2014/15 this had been reduced by more than half to 10. There had been two contacts with PALS since April 2015. Staff said that the reduction in complaints and contacts with PALS had been due to staff dealing with issues at a ward level.
- There was no formal departmental process to review and learn from complaints. Half the staff we spoke to said that they had received no feedback or learning from complaints. The other half said that learning took place through meetings, newsletters and through the ward assurance dashboards. A small number of staff were able to provide examples of learning from complaints.

Are services for children and young people well-led?

Good



There was a clear vision and strategy for the service; staff at all levels were able to refer to it. The strategy was reviewed at directorate meetings where action plans to deliver it

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were discussed. There were systems in place to manage and monitor risks. Risks were communicated through the service and ward level staff were able to identify key risks to the service. Ward assurance took place monthly and was communicated to staff. There was a clear process for escalating issues through the governance structure. Leaders were visible and staff said they were approachable.

There was a supportive culture within the service which also centred on the needs of patients. Staff felt supported by each other and by managers. The service had systems and processes in place to be able to engage patients and their relatives. There were positive examples where engaging patients and their relatives had changed services. Staff felt engaged and said that they could influence the ways services were run.

Vision and strategy for this service

- Services for children and young people were in the women and children directorate which was situated within the surgery division. Managers at divisional level and those at directorate/service level shared the same vision and strategy for the service. For example, addressing key service issues and risks such as addressing the layout of the neonatal unit and the development of a PAU. All ward-based staff we spoke to were aware and could identify the key priorities for the service meaning that there was a common focus on the vision and strategy for the service.
- The paediatric management team had developed a vision document in 2014. Staff understood and could refer to the vision. We saw that the vision for the service was visible on the walls of staffrooms and treatment rooms.
- The strategy for the service was reviewed at directorate meetings who reviewed progress and discussed actions plans. We saw in minutes of meetings that the strategy was reviewed and actions plans put in place to ensure areas of the strategy were met.

Governance, risk management and quality measurement

- There were monthly directorate meetings attended by the clinical director, senior managers within the directorate as well as other representatives from other specialities such as surgery and gynaecology. The directorate meeting would monitor performance against key performance indicators, governance

strategies and deliver short-term action plans for problems arising within the directorate. The representation from other specialities meant problems could be solved holistically in a joined up way.

- Ward assurance was discussed at the directorate meetings as well as key risks to the directorate. If ward assurance went below the trust standard of 95%, an action plan was implemented. Ward assurance was discussed at all levels and feedback given to staff through team meetings and newsletters.
- Discussion took place regarding the escalation of issues onto the risk register, such as the availability of patient transport to transfer children for further care at other hospitals. We saw that actions were followed up with patient transport partners and improvements reported back to the meeting.
- The directorate meeting provided quarterly updates to the divisional board providing a clear line of accountability and communication. Minutes of the meetings showed that accountabilities and responsibilities were discussed, for example department leads had been set up for the management of patient information.
- There was clear communication through the service regarding risks. Ward staff were able to identify the key risks for the service as they appeared on the risk register. Senior staff were also able to tell us what their key risks were. Risks and key issues for the service were communicated through newsletters and ward meetings. The largest risk identified by the service was the number of children and young people who had mental health conditions accessing hospital services.

Leadership of service

- All paediatric consultants had up to date job plans implemented. Job plans are an annual agreement between the employer and the doctor setting out: what work is done for the trust, when and where it is done, how much time consultants are expected to be available for work and what resources are required.
- When CQC previously inspected the service in 2014, staff told us they felt disconnected from the rest of the trust. Senior nursing staff told us that they felt much more included and part of the hospital. Senior staff felt that this had made a positive impact on patient care. For example, senior nursing staff felt that because they knew all the sisters on the adult wards communication was better around transitional care arrangements.

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- Nursing staff told us that managers from senior sisters, matrons to senior managers were accessible and visible. All staff we spoke to felt comfortable raising issues with managers and senior managers. We were told by the majority of staff that members of the senior management team visited the wards and talked to staff.
- The directorate managers told us that they had lots of support from divisional managers and the board. One manager told us, "They really do listen." Senior staff in the directorate said that they could access the executive team at any time and that there were no blockages or barriers to decision making.

Culture within the service

- There was a supportive culture in the service. All staff we spoke to said that they felt supported by their managers and they had no issues in escalating issues if they needed to. All staff said that if their own manager was not available they were happy to approach a more senior manager.
- Staff described morale as positive. We observed positive interactions between nursing staff, non-nursing staff and medical staff. All staff we spoke to described good relationships between nursing and medical staff. We saw staff communicating and supporting each other to achieve tasks and duties on the ward. A nursing assistant told us that she felt part of the team and, "I don't feel I'm just the nursing assistant." A relative of a patient said that the atmosphere on the ward was, "Really good. You can tell staff are happy to work here."
- The culture centred on the needs of people who used the service. All staff we spoke to told us that they enjoyed working with and the interaction with patients. Staff were passionate about patient care and we observed staff dedicating time to talk to patients or deal with their issues. We saw genuine concern for patient welfare and observed discussions with other agencies to ensure that a patient was safe and receiving appropriate support upon leaving the hospital.
- There was a culture of openness, honesty and candour. Staff at ward level described the importance of being open and honest with patients and their families. Staff were able to provide us with examples of when they had been open and honest with patients and their families.

Public engagement

- We saw evidence of engagement of parents leading to changes and improvements on the wards, especially

through social media. The children's and neonatal wards used social media to engage parents and get feedback on services. The parents' forum used a social media site moderated by the nurses. This led to increased support amongst parents for each other. It also led to fundraising for improvements to the parents' room. Parent packs (toothbrush, deodorant and so on) were also provided for parents of admitted children. Nursing staff were proud to tell us that they had presented their work using social media at regional conferences with other trusts.

- Children's and young people services had a young person's forum. The forum moved to a local school from a local college which led to better attendance. The forum influenced practice by purchasing books for teenagers attending the unit.
- There were comments boards outside the wards where patients and their families were invited to write comments about what they liked best and what could be improved. Patients coloured in stickers and if able could write on the stickers themselves. We saw patients sticking comments on the board during our inspection. There was information for parents on the parent forum and how they could get involved.
- Staff told us of changes to the ways meals are delivered to wards as a result of patient feedback. Meals were defrosted and reheated on plates meaning that food had to be transferred to cold plates to be eaten. This affected the appearance and quality of the food. A new system was introduced where meals arrived on the ward hot meaning the food was fresher and looked better.

Staff engagement

- There were monthly ward and departmental meetings meaning that communication with staff was regular with information being passed up and down the department. We saw ward meeting minutes where staff were asked about their opinions as well as key messages from the trust being passed down to staff. Staff we spoke to said that they felt engaged by managers and that they could make difference within the service.
- All consultants we spoke to said that there was good clinical engagement. Divisional leads for the service met consultants directly and regularly. There was also consultant representation at the clinical board and

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decisions were made with clinical colleagues as well as operations managers and service representatives. Consultants told us that they felt they were able to influence their own services.

Innovation, improvement and sustainability

- Staff described improvements in policies and procedures since the last inspection. One example a nurse gave was a pilot to expand the number of conditions checked through the neonatal blood spot. This was a blood test that all new babies have to find out whether they have any rare or serious conditions. The number of conditions screened for had increased to include metabolic disorders which were abnormal chemical reactions in the body
- There was a culture of innovation on the wards. Staff told us they were given opportunities to implement ward level changes without going through the senior management structure. Staff told us that they felt that they could contribute and generate ideas for improvement and sustainability.

End of life care

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

Information about the service

End of life care at the trust encompasses all care given to patients who are approaching the end of their lives and following death, and may be delivered on any ward or within any service of the trust. It includes aspects of basic nursing care and specialist palliative care.

It was the responsibility of all staff to care for and support patients who were palliative (in the last year of life) and those who were at the end of their lives (the last few days or hours).

Patients and staff were supported by the specialist palliative care team (SPCT) who saw both palliative and end of life patients who were referred to them. End of life care was a significant part of the service provided by the trust's SPCT, supported by the chaplaincy and bereavement support services and mortuary services. Ward staff refer patients to the SPCT who required specialist input such as symptom control.

These services were based at Burton Queen's Hospital and visited Sir Robert Peel and Samuel Johnson Community Hospitals weekly.

An end of life steering group, made up of senior staff from the trust's executive board, heads of medical divisions, the lead nurse for oncology, the head of therapies, a senior nurse for older people, a consultant paediatrician and a nurse practitioner from the child death overview panel met quarterly. This group addressed issues raised regarding end

of life care and recommended and supported the dissemination of best practice throughout the trust. The end of life provision at the trust was supported by staff at St Giles Hospice in Lichfield.

During our inspection we spoke to seven patients, three patients' relatives and 45 staff. We visited twenty wards, three specialist teams and the hospital mortuary.

End of life care

Summary of findings

Patients and relatives were treated with dignity, respect and compassion in the time leading up to the end of patients' lives and after their death.

The service was supported by proactive, dedicated and passionate members of the specialist palliative care team who were working to improve the structure of end of life care services and to embed the key areas of end of life care into the hospitals' culture.

Medical and nursing staff on hospital wards told us they were well supported in decisions about the care of dying patients and that they knew when and where to find specialist advice.

Partnership arrangements with local hospices were well-managed and effective.

Managers of the service were aware that work was needed to further develop the quality of end of life care and plans were in place to progress further.

Are end of life care services safe?

Good



We found that patients, relatives and staff were protected from abuse and avoidable harm and that safety was important to all staff. Staff were aware of their responsibilities to ensure the safety of patients approaching the end of their lives and of their role in reporting incidents to make sure improvements were made when things went wrong. Reported incidents were investigated thoroughly and outcomes were communicated both to staff and to patients and relatives who were involved.

Staff were trained in and understood the process for safeguarding vulnerable adults and knew when to raise a concern. Staffing levels in the specialist team were sufficient

Staff were well versed in procedures to prevent the transmission of infections and these were followed to keep patients, colleagues and visitors safe.

Patient records, including DNACPR forms were comprehensively completed and stored safely.

Incidents

- From January to April 2015 seven incidents relating to end of life care patients were reported within the hospital. Of these, four related to potential pressure ulcers; two of these were assessed as relating to end of life skin changes rather than pressure damage. Of the remaining incidents two were concerns raised by GPs about issues with equipment and medicines for patients discharged from hospital and one was about an inappropriate transfer between wards in the hospital.
- Within the investigation notes for these incidents we saw evidence that patients' families had been informed about them and that appropriate action had been taken to minimise harm to the patients involved and to decrease the chance that similar incidents would recur.
- From April 2014 to March 2015 no never events were reported that were directly connected to end of life care within the trust.

Cleanliness, infection control and hygiene

End of life care

- We saw evidence of comprehensive infection control procedures to keep nursing, portering and mortuary staff protected from infection when moving and handling the bodies of deceased patients.
- Nurses we spoke with on general wards were able to explain the steps they would take when preparing a patient's body for transfer to the mortuary or funeral directors and how this helped to reduce the risk of infection.
- There was a process in place which ensured those handling the deceased were aware of any infection risks. This meant that all staff from the hospital and from outside organisations were protected from the risk of infection.
- We saw staff observing good hand cleaning practice on all the wards we visited, and patients told us that staff regularly cleaned their hands before and after providing care for them. We saw that staff used personal protective equipment such as gloves and aprons when required.

Environment and equipment

- Porters told us that the trolley used to move patients who had died was not suitable as it needed a lot of space to lower its sides and that could not be done in side rooms as they were too small. The porters told us that this problem had been raised with managers on several occasions over the preceding year but had not been resolved. We did not see this recorded on the trust's risk register.
- There was a policy and guidelines for the use of syringe drivers (a device to administer medication slowly over a long period of time) in place. The guidelines were written to comply with safety directions published in a National Patient Safety Agency Rapid Response Report and covered indications such as, criteria and preparation for use, details of compatible medicines and actions to be taken in the event of any problems. This meant that patients were protected from avoidable harm while receiving treatment via a syringe driver.
- Nursing staff told us that syringe drivers were available from the medical equipment library and that they had never had any difficulty obtaining them. The trust had been using McKinley T34 syringes since May 2014.
- Mortuary arrangements were in place such as fridges, trolleys and a protocol for bariatric patients. We saw that a cot was available for families to see infants who had died.

- Specialist pressure relieving and bariatric mattresses were available from the medical equipment library.

Medicines

- We saw evidence of anticipatory prescribing of pain relief medicine in six sets of patient notes. Anticipatory medicines are emergency medicines which can be provided to patients who may otherwise suffer unnecessary pain and discomfort in the last stages of their passing. Prior to the use of anticipatory prescribing patients might have suffered unnecessarily waiting for doctors to be called.
- The specialist Macmillan palliative care team (SPCT) did not hold any medicines outside of normal ward storage systems.
- End of life medicines were held by the wards caring for those patients in accordance with their normal storage policies and systems.
- One middle grade doctor told us that guidelines on anticipatory prescribing were easy to find on the trust intranet and was able to demonstrate this to us.

Records

- We looked at 17 sets of patient notes. These related to patients who were receiving end of life care palliative care. We saw detailed entries from the SPCT in both the medical and nursing notes. The nursing notes demonstrated good communication with patients and relatives and an individualised approach to care.
- In medical notes for patients approaching the end of their lives we saw clear descriptions of their conditions and of the rationale behind the decisions to stop active treatment whilst still supporting the patient and their families.
- We looked at 17 'do not attempt cardiopulmonary resuscitation' forms and found them to be accurately completed. Forms showed patient details, discussions with patients and relatives and the rationale behind making the decision. They were signed and dated by the clinician who completed the form. All but one of the forms had been countersigned by a consultant within 72 hours of completion, in line with the hospital's policy.
- The trust's DNACPR forms included a section stating that they were valid for a period of seven days following the patient's discharge from hospital, which was designed to allow enough time for the patient's GP to visit them at home and arrange for a community DNACPR order to be made.

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- We were shown the record keeping system in the hospital mortuary. The system ensured that details of patients who had died and of their property were accurately recorded and promptly made available to the county Coroner's Officer if required. Records were kept secure in a locked filing cabinet.
- The bereavement services coordinator told us and we saw that a photocopy of all death certificates was held in their office. This meant that accurate information was available in the event of any queries or if information was needed by families or other organisations such as funeral directors.
- We saw examples of properly completed and coded post-mortem examination forms.

Safeguarding

- We saw records which showed that 100% of end of life care administration staff and 100% of palliative care nursing and medical staff had completed level one child protection training and level one safeguarding adults training. 100% of end of life care medical staff and 95% of nursing staff had completed level two safeguarding adults training.
- All of the staff we spoke with demonstrated an understanding of when to raise a safeguarding concern and were able to explain how they would go about doing so. Staff understood the different types of abuse and how to recognise them.

Mandatory training

- The SPCT was made up of a small number of staff, comprising three nurses and two consultants. With the exception of one course which showed that one nurse and one doctor still had to complete it, nursing staff had completed between 82% and 100% of their training and medical staff had completed 100%. We saw that the remaining training courses were scheduled for completion before the year end.

Assessing and responding to patient risk

- Use of the Medical Early Warning Score (MEWS) was well established on all the wards we visited and staff we spoke with told us they used that as part of the process of deciding when patients were approaching the end of their lives.
- Any patient suffering from or with a history of cancer was automatically flagged for the attention of the SPCT on admission. This happened as a result of the answer

given to a mandatory question in every patient's electronic nursing notes. This ensured that all patients who may at some point require end of life support were identified at an early stage in their care.

Nursing staffing

- The SPCT was made up of one full time and two part time nurses, totalling an equivalent of 2.4 whole time equivalent staff. This allowed the team to provide cover six days a week.
- We were told that when the SPCT had started working on Saturdays they had conducted an audit to show how often their services were used, and that the results of this audit were used to justify Saturday working being made permanent. We were shown the data from this audit, which included the number of referrals made to the team, the number of patients seen, medicines prescribed as a result of the referrals and the reason for referral.
- The lead nurse for cancer services was aware that one of the SPCT nurses was going to be released to study for a degree and plans were being made to fill the temporary shortfall.
- On every ward or unit we visited there was an identified end of life care link nurse. This helped to ensure that patients who were at the end of their life had early and on-going access to appropriate care and treatment. End of life link nurses had received additional training which helped them identify patients who required end of life interventions. They acted as a first point of contact for advice to other nursing staff in the area.
- Staff on all the wards we visited told us the SPCT were easy to contact and would always attend wards quickly to assess patients, and we saw the SPCT nurses and consultants on several wards during our visit to the hospital.
- On ward seven we were told that there were two palliative care link nurses who attended discussion groups and meetings with the palliative care team every two or three months to keep them up to date with current practice.

Medical staffing

- Two part-time consultants, which equated to 1.2 whole time equivalent staff, worked with the SPCT. Both consultants had a background in end of life care and had previously worked in local hospices, and one

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consultant still formed part of the on-call rota for St Giles Hospice. This meant that they had the specialist knowledge necessary to support the care of patients who were at the end of their lives.

Mortuary Staffing

- The hospital mortuary was staffed by two full time anatomical pathology technicians who also provided an on-call service if access to the mortuary was required out of hours.
- If the mortuary staff were required out of hours and had to attend the premises alone they carried an on-call mobile phone and a process was in place for them to book in and out of the building with the porters. This meant that the risks of lone working were kept to a minimum.
- Short term unexpected mortuary staff shortfalls were covered by locum mortuary technicians. We were shown the mortuary's standard operating procedures and told that locum technicians could reasonably be expected to run the mortuary unassisted by making reference to these, as processes in mortuaries throughout the country were very similar so that they complied with Coroner's rules.

Major incident awareness and training

- The mortuary staff demonstrated a good understanding of their role in a major incident and showed us their major incident plan and action cards which were kept ready for use in a grab box.
- The mortuary staff told us that they were involved in exercises designed to test the hospital's response to a major incident.
- We were provided with a copy of the trust's major incident policy and shown the section detailing what actions the mortuary staff may need to take to support a major incident. The section was clearly written and easy for staff to understand their roles.

Are end of life care services effective?

Good



Care and treatment provided for patients at the end of their life followed national guidance, legislation and used evidence-based practice. Patients were provided with care that promoted a good quality of life and minimised their pain and discomfort.

Audits were regularly used to assess how effective care provided was for patients, and practice was changed in response to lessons learned.

End of life care was supported by a dedicated and passionate team of clinical nurse specialists and consultants who made up the specialist Macmillan palliative care team (SPCT). This team worked proactively to improve end of life care throughout the trust and provided regular training opportunities for staff at all levels.

Multidisciplinary working was well embedded within end of life care, with meetings taking place weekly, monthly and quarterly at ward, operational management and strategic levels. Working arrangements were maintained with local authorities and with charitable hospices.

Staff demonstrated a good understanding of the Mental Health and Mental Capacity Acts. The trust paperwork for mental capacity assessments was not completed, although from speaking with nursing and medical staff we were confident that assessments had been carried out properly.

Evidence-based care and treatment

- The specialist Macmillan palliative care team (SPCT) used the West Midlands Palliative Care Guidelines, to ensure that they were providing effective care for their patients.
- The NHS Leadership Alliance for the Care of Dying People identified five priorities for care of the dying patient, these were: recognise; communicate; involve; support; and plan and do. The SPCT had produced pocket-sized laminated cards with these priorities listed on one side and explained in more depth on the reverse. The cards had been distributed to wards and to staff attending end of life care training sessions.
- At the time of CQC's inspection in 2014, the trust was trialling the AMBER care bundle on three wards. All the

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staff we spoke with were familiar with the AMBER Care Bundle and had received training in it. All of the doctors and all but one of the ward nurses we spoke with demonstrated a good understanding of the AMBER Care Bundle and how it was triggered.

- The palliative care lead nurse told us that AMBER Care was in use on all wards at the hospital except maternity, paediatrics and the intensive care unit (ITU).
- We were shown a copy of the quarter four report on the implementation of the AMBER care bundle at the hospital, dated March 2015. The report showed progress being made with implementation of and training on AMBER care but confirmed that more work was needed before the care bundle was used consistently and appropriately throughout the hospital. The report identified the number of patients identified for the AMBER care bundle and how many had had the paperwork completed.
- A paper written by a palliative care consultant from the SPCT had been submitted to the trust board for consideration. The areas highlighted for implementation were advanced care planning and the use of an electronic patient coordination system.
- The trust did not have a specific care plan for patients on end of life care. General care plans that we looked at included end of life planning, however these were held electronically so patients' families were not able to access them. The SPCT lead nurse and consultants told us that as a result of the recommendations of the NHS Leadership Alliance for the Care of Dying People they were developing a paper care plan. This would be used to design individualised care for patients at the end of their lives and would be accessible for families and carers.
- The spiritual care service worked to NHS England's 'NHS Chaplaincy Guidelines 2015' which ensured that they followed the latest guidance.

Pain relief

- We saw that audits were completed of anticipatory prescribing to ensure that it was appropriate in each case. We reviewed the audits for May 2015 and saw that 65% of patients on end of life care had been correctly prescribed all four of the medicines included in the audit. This was an improvement from 50% in the August 2014 audit.
- Patients described how staff responded when they were in pain or discomfort and told us staff were attentive

and enabled them to remain pain free. One patient described their pain relief as "proactive" and told us that his medicines and doses were changed during his treatment to achieve the best result.

- We saw evidence of the Abbey pain score being used to assess and reassess the pain some end of life patients were experiencing and to manage the pain relief they were given. The Abbey pain score is designed to measure pain in patients who are unable to verbalise, and is endorsed by the Royal College of Nursing for patients with dementia or other issues affecting their ability to communicate.

Facilities

- A chapel and multi-faith prayer room with space for up to 15 people was provided by spiritual services. Facilities for ablutions were also provided.
- The mortuary provided a private viewing room for bereaved families, and when this room was in use signs reading "Quiet – please show respect" were automatically illuminated in nearby corridors.
- The emergency department had one private room which was used for bereaved families when available. There was no viewing room in the department and we were told that staff tried to use side rooms to allow viewing by relatives of patients who had died but that this was not always possible and families sometimes had to view their relatives in the resuscitation department. This meant that on occasions other patients were being treated in adjacent bays with only a curtain to screen the grieving family.

Nutrition and hydration

- End of life patients' nutrition and hydration needs were assessed using the malnutrition universal screening tool (MUST). MUST is an evidence-based assessment system developed by the British Association for Parenteral and Enteral Nutrition. Based on the outcome of that assessment patients could be referred to a dietician if required.
- Patients' food intake and fluid balance were recorded on a chart in their nursing notes. We looked at nutrition and fluid balance charts in 12 sets of patient notes and saw that they were properly completed.

Patient outcomes

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- In the 2013/14 National Care of the Dying Audit the trust had achieved only three out of the seven organisational key performance indicators and were below average on seven out of the ten clinical key performance indicators.
- As a result of this the trust had rewritten its end of life care guidelines and promoted them both on the intranet and through inclusion in the palliative care team folders which were present on every ward and unit we visited. It had also increased staffing numbers in the palliative care team to a level where there were six times as many staff as there had been when the audit results were published.
- Staff in the SPCT were aware of the trust's previous performance in the audit and were working to improve the results through improvements to the care of patients and relatives. We saw that improvements had been made in all of the areas where the trust had previously failed to achieve standards.
- The trust planned to submit data to the 2015 audit.

Competent staff

- Education on palliative and more general end of life care was provided across the trust by clinical nurse specialists from the SPCT, both in the form of structured lessons in the trust's education centre and drop-in sessions to wards at the three hospitals.
- Palliative care link nurses met for a discussion group every three months to update their knowledge and understanding of new practice.
- One nurse told us that she had been supported by her ward manager to complete a degree module in palliative care and to undertake a secondment to St Giles Hospice as part of her studies.
- We were shown details of three study days which were facilitated by the SPCT three times a year. The subjects covered were 'Care of the Dying for nurses', 'Care of the Dying for nursing assistants' and 'Answering Difficult Questions'. These study days were open to staff from any of the trust's three hospitals.
- End of life care course did not form part of the trust's mandatory training; however staff we spoke with on all wards were aware of the training opportunities that were available. Many staff had taken these up although formal figures were not available.
- End of life care was included in induction training for all new staff and was delivered by members of the SPCT.

- The clinical nurse specialists on the SPCT told us that they had monthly one-to-one meetings and team meetings with their manager.
- The technicians working in the hospital mortuary were both members of the Association of Anatomical Pathology Technicians and had completed the society's diploma course. They told us they had monthly one-to-one meetings with their manager.
- Mortuary staff provided training for porters on the safe use of mortuary trolleys and equipment, and this was evidenced by a competency document held on the porters' personal files. Annual refresher training was provided for equipment infrequently used by the porters. We were given a copy of the porters' training protocol for mortuary procedures which detailed the equipment on which they were trained, and spoke with two porters who confirmed that they had received training on mortuary equipment and procedures.
- A 'listening into action' event was planned for autumn 2015 to obtain views of staff on end of life care training.
- Two doctors told us that they had received training from the SPCT team about how to recognise when patients were at the end of their lives and how to refer patients to the team; they described how this had been valuable to them in their work.
- Eight of the band five and six nurses on the gynaecology ward had received training in counselling and could be called upon to support relatives and patients on any ward if needed.

Multidisciplinary working

- Five doctors told us that they were well supported by the SPCT in general and the palliative care consultants in particular.
- Weekly multidisciplinary meetings were held, involving palliative care doctors and nurses, Macmillan therapists, spiritual care staff, pharmacists and oncology staff. We were given attendance records for these meetings which showed between 90% and 100% attendance from each of the groups of staff.
- A multidisciplinary end of life operational group met monthly to discuss and improve care for patients at the end of their lives. The group was made up of representatives from palliative care, cancer care, surgery, medicine, allied health professionals, discharge services, St Giles Hospice, chaplaincy, bereavement services, the clinical commissioning group, a dementia lead and a patient representative.

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- An end of life steering group, made up of senior staff from the trust's executive board, heads of medical divisions, the lead nurse for oncology, the head of therapies, a senior nurse for older people, a consultant paediatrician and a nurse practitioner from the child death overview panel met quarterly to address issues raised regarding end of life care and recommend and support the dissemination of best practice throughout the trust.
- Palliative care nurses carried out joint ward visits with acute oncology and lung nurses to coordinate care.
- We saw evidence of speech and language therapists' assessments of patients' swallowing ability and documented rationales when assessments were not able to be carried out due to the patient's condition. These were evidenced in five sets of patient notes.
- We were told about and saw records of medically-led multidisciplinary team meetings that were held to discuss 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions.

Seven-day services

- The SPCT provided cover six days a week. Three clinical nurse specialists from the team told us that a business case was being written to support them moving to seven day working. The team had previously only worked on weekdays. As a result of improvements to the service leading to increased referrals the team had successfully moved to six day working.
- Out of hours support was provided to the trust by on-call consultants from St Giles Hospice in Lichfield, and details of how to contact them was given on the outgoing message used at weekends on the SPCT's office answering machine, in the SPCT team folders and on the posters kept or displayed on every ward
- The hospital pharmacy was not open on Sundays however a small stock of commonly used medicines, including those planned in anticipatory prescribing, were made available in an out-of-hours stock cupboard. Pharmacy staff were available on-call on Sundays if additional medicines were required.
- Ward staff had out-of-hours telephone access to advice about end of life care from clinicians at St Giles Hospice. Several of the nurses we spoke with told us they had used this service and found it effective.

- Mortuary staff worked Monday to Friday, but were available on call if needed, for example, where an unexpected death had occurred and families needed to see their relatives.

Access to information

- On every ward we visited staff of all levels were familiar with and quickly able to find the SPCT information folder. Staff told us that they found the information it contained useful when deciding whether patients should be referred to the team, and having all the details they needed in one easily identifiable place on every ward in the trust helped to improve consistency.
- Two junior doctors told us that the SPCT consultants were accessible and approachable, were happy to give advice.
- Guidance on end of life care was also available to all staff on the trust's intranet. Staff we spoke with were aware of this and were able to navigate to the relevant section of the intranet.
- End of life care guidelines and criteria for patients to be referred to the SPCT were also provided on the palliative care pages of the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at 17 DNACPR forms. Decisions about whether patients had mental capacity to make decisions about treatment were recorded on those forms, however where patients had been assessed not to have capacity the rationale behind those decisions was not recorded in the patient's notes.
- The trust's 'Do Not Attempt Resuscitation' policy states that when adult patients lack capacity and decisions are being made about resuscitation the 'Burton Hospitals NHS Trust Consent Form 4 "Form for Adults who are unable to consent to investigation or treatment" must be completed' however these forms were not present in the notes we looked at for patients who had been deemed to lack capacity and had DNACPR orders. We asked nursing staff on five wards about this form but none of them were familiar with it or knew where to find it.
- Nurses and junior doctors told us that consultants assessed patients' mental capacity and informed them

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verbally of the decision. All of the nursing and medical staff we spoke with knew how a patient's capacity to consent should be assessed and demonstrated a sound understanding of the Mental Capacity Act 2005.

- Evidence of the assessments was not being recorded in line with the trust's policy. When we informed the trust, they asked their safeguarding team to immediately review all patient DNACPR documentation to review MCA status and ensure appropriate actions were taken.
- Information given to us by the trust indicated that managers were concerned that the surgical division were only 66.7% compliant with proper completion of DNACPR forms. This appeared on the trust's 2015 risk register. We reviewed the action plan which included advertising the proper completion of DNACPR forms on the hospital's computers' screensavers and on posters. Information about the DNACPR policy and proper completion of forms had been distributed to all healthcare professionals on their mandatory resuscitation courses. The compliance rate had not been reassessed since the changes had been made due to the short timescale, however the 17 DNACPR forms we looked at during our inspection showed almost 100% compliance.

Are end of life care services caring?

Good 

Patients and relatives spoke positively about the care provided by staff, and told us that they were treated with dignity and respect and did everything possible to minimise discomfort and pain for patients.

With one exception patients and patients' families told us that they were involved in decisions about their relatives' care and treatment and they felt that the hospital staff took their wishes into consideration.

Patients and relatives told us that staff really cared about them as individuals and that care and compassion was extended to families as well as patients.

Compassionate care

- A patient's relative told us that they "couldn't fault the nursing care" on ward 11 and described the nurses as very supportive, open and caring and said they had done everything they could to keep the patient comfortable.
- Two patients on the coronary care unit told us that the nursing care was "excellent" and that the nurses always made sure they were comfortable and free from pain.
- Staff from the bereavement service told us that they met with recently bereaved families in a separate room to return patients' belongings, give them the death certificate, discuss concerns, explain any medical terms used in reports and answer any questions they may have.
- A patient on ward 11 told us that the general nurses and the clinical nurse specialists from the specialist palliative care team (SPCT) had great passion and that their work was not just a job for them, they genuinely wanted to make patients' lives better and were very caring. They told us the nurses were always aware when the patient felt down and were "as good at listening as giving advice".
- We spoke with a relative of a patient on ward 20 who described the care provided as "absolutely first class", told us they "honestly couldn't have asked for better care", that the ward provided an "outstanding service" and "really cared about" the patient.
- A relative of a patient on ward seven described the nursing staff as "absolutely wonderful" and told us that they cared deeply about the individual patient and treated them with compassion and kindness. They told us that the hospital was a very friendly place overall and told us that care was shown by staff from all departments and services.
- We were given the results of the bereavement services survey carried out between January and May 2015. Eight families whose relatives had died in the hospital had replied. Seven of them said that they had been encouraged to spend time with their relative privately, before and after they died, and all eight said that staff respected their relative's privacy and dignity at all times.
- Seven out of the eight families said that they were satisfied with the way their relative's personal property and valuables had been handled. On the eighth survey no answer was provided for this question.
- A nursing assistant on ward four explained the practice that staff followed whenever a patient died on the ward.

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They told us that treating the patient with dignity and involving the family are two of the most important parts of the process and that many families compliment the staff on their compassion.

- The mortuary staff told us that porters always treated the bodies of patients who had died with the utmost respect in all their dealings with them.
- The family of a patient who had died on ward 12 made a financial donation to the ward after the funeral because of the quality of care the patient had received while there.

Understanding and involvement of patients and those close to them

- We saw evidence in patients' notes of discussions between nurses, doctors and relatives about preferred places for care to take place when patients were at the end of their lives.
- We also saw evidence in patients' notes of relatives being involved in discussions about food and drink for the patients, how these needs may change over time and the options available when the patient could no longer take food and drink orally.
- We saw records of patients and families being involved in discussions about end of life care and DNACPR decisions.
- We spoke with a patient on ward 11 who told us that they felt very involved in plans about their on-going care and about plans for moving them to a hospice. They told us that staff made them feel secure.
- A relative of a patient on ward 20 told us that the patient's situation had been explained to them and both the patient's and relative's wishes had had been acknowledged throughout their time on the ward. The relative said that all the staff team were approachable, friendly and helpful and happy to answer questions and that they had explained the care throughout and involved the relative in every decision.
- A patient on ward 14 told us that they felt that the doctors were not good at explaining things in layman's terms but that the oncology nurses explained their treatment clearly.

Emotional support

- Chaplains were available to speak with patients and relatives 24 hours a day, seven days a week, in any ward or unit in all three of the trust's hospitals.

- A relative of a patient on ward 11 told us that the nursing staff had supported them as well as the patient through distressing times.
- The head of the bereavement service told us they gave pastoral and spiritual support to patients' families while patients were still being cared for on wards and prepare them for the approaching death of their relative.
- After an unexpected death the bereavement services staff worked with the Coroner's officer to provide support for patients' families.
- Support for patients and families was also provided by the trust's support officer.
- The mortuary staff told us they felt able to help bereaved relatives who were upset by answering any questions they had and helping them with the grieving process.

Are end of life care services responsive?

Requires improvement 

The trust did not have a formal rapid discharge pathway to enable patients to go home in a timely manner. Work to rectify this was in process.

The trust and its staff were aware of the needs of different communities in the area it served and provided services to cater for different cultures and faiths. The specialist Macmillan palliative care team (SPCT) was able to attend patients quickly when they were referred by ward staff and out of hours provision was well structured and reliable.

End of life care leads were made aware of any complaints relating to their service and ensured that learning from complaints was fed back to staff so that improvements were made for patients and their relatives.

Service planning and delivery to meet the needs of local people

- Nursing notes we saw demonstrated that the individual needs of each patient had been taken into consideration and that care plans were written from a patient-centred point of view
- Comfort packs containing snacks and toiletries were available to be given to patients' family members who found themselves staying at the hospital unexpectedly due to deterioration in their relative's condition.

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- A discounted weekly parking ticket was available for patients' families and friends who had to make repeated or extended visits to the hospital. We were given a copy of the leaflet explaining this scheme however three families told us that this needed to be more widely publicised as they had not been told about it until they had been attending for several days or weeks.
- Palliative care consultants were able to transfer patients to specialist palliative care beds in a hospice directly, using a process which allowed for speedy admissions.
- We were shown a copy of the trust's 'because we care' booklet, which was given to families after their relative had died. The booklet opened with a message of sympathy and details of how to contact the bereavement co-ordinator, and gave information about how to register the death, which agencies the bereavement service could notify on the family's behalf as part of their 'tell us once' service and explained processes involving the Coroner and post-mortem examinations. It also provided information about tissue donation, arranging a funeral, the grieving process and where families could get further help and counselling if required. The bereavement services survey was included in the booklet as a tear-out page.
- In order to facilitate people's wishes local authorities or community services are often involved to provide suitable equipment for the needs of the patient, if they prefer to die at home. The hospital staff had to liaise with community based services from three different counties. There was limited expert clinical advisory group input on end of life care in any of the three clinical commissioning groups the trust dealt with but senior managers were aware of the issues staff faced and were working on building professional relationships.
- The trust had not properly audited the percentage of patients dying in their preferred location, however preliminary data had been collected between April and September 2014 to use as a benchmark against which future audits would be compared. Data collection for the first formal audit was in process at the time of our inspection but results were not available at that time.
- The SPCT ran two outpatients clinics to provide treatment for patients being cared for by the team who were not inpatients at any of the trust's hospitals.
- Staff were able to provide 'comfort packs' for families of patients if they had to stay in hospital unexpectedly to be with relatives who were approaching the end of their lives.
- A relative of a patient on ward seven told us that open visiting was actively encouraged when patients were approaching the end of their lives.
- The bereavement service had 34 volunteers from a range of different faiths including Christianity, Islam, Buddhism, Humanism and atheism, and had access to a Rabbi for Jewish families.
- Bereavement services staff told us that they offered a 'tell us once' service for families. Through this service, the staff and volunteers took care of official matters such as patients' passports, state benefits and council tenancies and dealt with funeral directors to remove the burden from recently bereaved families.
- The bereavement support service had established a bereavement 'help point' in Burton upon Trent town centre to allow bereaved families to talk to bereavement counsellors in an informal, non-clinical environment.
- Clinical nurse specialists from the SPCT sent sympathy cards to bereaved relatives of patients for whom they had cared and made follow up telephone calls to families to offer any further support that they could.
- The mortuary staff told us that they were able to facilitate the early release of bodies out of normal working hours to comply with the wishes of families whose faiths demanded quick funerals. We were given a copy of the mortuary's 'release of bodies' policy document which included a section detailing the procedure for this to take place.
- We were told that the last time trust staff had received learning disability awareness training was in 2011. All staff received training on dementia awareness as part of their induction on joining the trust.

Access and flow

- On every ward we visited a poster explaining how to refer patients to the SPCT was prominently displayed near to staff areas. We saw appropriate referrals to the SPCT in four patients' medical notes. Staff told us that all end of life patients were referred for assessment by the SPCT even if they did not have complex needs.

Meeting people's individual needs

- Information leaflets about end of life services were available in a number of different languages and staff had access to translation services.

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- The SPCT aimed to see patients within 24 hours of them being referred; we saw that they were achieving this for 96% of referrals.
- Twelve nurses told us that they received good support from the SPCT and that doctors were happy to prescribe medicines for end of life care due to the support received from the team, but that they would prefer to have the team available seven days a week.
- A staff nurse on ward seven told us that they sometimes experienced difficulty in arranging end of life care packages in patients' homes to allow them to be discharged, and that the palliative clinical nurse specialists completed 'fast track' paperwork but that discharges were not always as fast as families would like.
- The palliative care lead staff told us that the trust did not have a formal rapid discharge pathway, and work on this project was in progress. They told us that at present clinical nurse specialists worked closely with discharge coordinators to try to facilitate same day or next day discharges but that the procedure was not yet formalised and work was in progress to improve the process.
- We were given a copy of the mortuary's 'release of bodies' policy document which included sections detailing the procedures to be followed to release bodies out of hours if needed on religious grounds.

Learning from complaints and concerns

- We were given minutes from the end of life care operational and steering group meetings, which included details of any complaints received by the trust that were related to end of life care. The complaints detailed had generated learning needs for general ward staff and these had been addressed by the SPCT clinical nurse specialists as education opportunities.
- The trust's patient advice and liaison team brought any complaints with a bearing on end of life care to the attention of the lead nurse for cancer services for investigation, who then fed back into the divisions concerned within the hospital to improve services.
- Only two complaints had been made about end of life care during the preceding year. One of these had been partially upheld.

- The SPCT nurses had links with palliative care teams from hospitals in neighbouring areas and were starting a local interest group to share good practice and learning from complaints between colleagues in other NHS trusts.

Are end of life care services well-led?

Good



Senior managers in end of life care demonstrated an understanding that whilst the service had improved further progress was needed. They had put in place a strategy to achieve improvement which was being regularly reviewed. Plans for the service took into account national standards and guidelines.

Staff from different teams worked well together and felt respected, valued and supported and that their views were listened to by managers and acted upon. Managers were described as open, approachable and responsive to their suggestions and concerns.

Managers had a good understanding of the risks faced by the service and plans were in place to address and mitigate these.

Vision and strategy for this service

- The palliative care team lead staff told us that an end of life care strategy had been put in place in summer 2014. An action plan was in place and the strategy was due to be reviewed in autumn 2015.
- We were given a copy of the strategy document for end of life care at the trust. This document acknowledged that while a number of elements of the service provided had a bearing on end of life care there had not previously been a clear strategy. It set out plans to improve coordination of end of life care at a strategic level in the trust and we saw several of its recommendations in practice during our inspection. Examples of recommendations that we saw being implemented were increased medical and nursing staffing numbers in the SPCT, the use of the AMBER care bundle, promotion of the 'five priorities of care of the dying patient' and of anticipatory prescribing guidelines.
- The palliative care lead staff told us that they were aware of their areas of risk. These included: delivering

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performance against the NHS Improving Quality 'TRANSFORM' programme (a programme of measures to improve the quality of end of life care in acute hospitals across England), rapid discharges, advanced care planning, embedding the five priorities of care of the dying patient into the trust and development of individualised care plans.

- We were given a copy of an update paper written by a palliative care consultant in January 2015. This paper acknowledged that while progress had been made with implementation of the AMBER care bundle and development of a rapid discharge home to die pathway there were two other areas of the TRANSFORM programme that would need to be considered by the trust. These areas were advanced care planning and an electronic patient coordination system. The paper had been submitted to the board for consideration.
- The strategy document laid out plans to develop end of life care pathways in line with guidance and recommendations from the National Gold Standards Framework in End of Life Care. Also to coordinate the work being done on long term conditions, frail elderly care, patients with dementia and palliative care into a structured end of life care service.
- A non-executive director and the chief nurse had responsibility for end of life care at trust board level. Nurses in the SPCT, members of the bereavement and spiritual care teams thought they fulfilled their responsibility in this role and supported the work of the team.

Governance, risk management and quality measurement

- The end of life care steering group had an oversight of the work that was required to implement a structured end of life care service in the trust. The group was chaired by the head nurse and fed into the trust's quality assurance group and ultimately to the trust board.
- The end of life operational group met regularly to review issues and developments affecting the provision of end of life care in the trust.
- The trust had a well-developed system of partnership working with local hospices to provide support for patients at the end of their lives and advice for the trust's staff out of hours. Representatives from local hospices took part in the end of life care steering group meetings.

- Audits had been carried out into use of the AMBER care bundle and anticipatory prescribing to assess how well they were embedded into the staff culture on wards and to identify where further training may have been necessary.
- We spoke with a Coroner's officer who told us that the Coroner's office had an excellent working relationship with the trust's mortuary department.
- Issues which impacted on the trusts ability to provide a good end of life service were escalated to and carried forward by senior managers in support of the service, an example of this was when an ambulance had been requested at midday to take a patient home to their preferred place of death but had not arrived until midnight. This problem had been escalated to the Clinical Commissioning Group by the head nurse and the contract with the providers was being discussed.

Leadership of service

- The clinical nurse specialists from the SPCT told us that they felt very well supported by the lead nurse for cancer services, who managed their team, and described them as approachable and operating an 'open door' policy. They told us that they would feel comfortable approaching the chief nurse if they had to but that they had had no need to do so as any issues brought to their manager's attention had been resolved without needing to be escalated further.
- We saw one member of ward staff who had become upset at the deterioration of a patient being comforted and taken off the ward for a break by a senior member of staff.
- The mortuary staff spoke very positively about the general manager who was responsible for their department. They told us that the manager had a great deal of input into the department, was accessible and kept them informed about plans for the department.
- The palliative care team leads told us that the trust board were engaging positively with the end of life care steering group and working with them to improve the service.

Culture within the service

- Staff in every ward we visited spoke positively about the SPCT nurses and consultants and described them as proactive and willing to respond quickly to patient referrals and requests for advice.

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- Porters who were moving bodies from a ward to the mortuary for the first time were always accompanied by a more experienced colleague to offer support and guidance.

Public engagement

- Patient representatives took part in the end of life care steering group meetings, which allowed senior staff to hear first-hand feedback on the experiences of patients and relatives.
- All families whose relatives had died in the hospital were given a bereavement services questionnaire in the trust's 'because we care' booklet and results of returned questionnaires were collated quarterly. The results from the January to May 2015 surveys showed that 100% of respondents found the 'because we care' booklet useful, said that staff respected their relative's privacy and dignity at all times, were advised how to contact the bereavement office and what to do after the patient had died, were offered an appointment with the Registrar to follow their visit to the bereavement office and found it convenient for the registration to be made within the hospital. 88% were encouraged to spend time with their loved one privately, before and after they died, were given the opportunity to discuss the circumstances of the death with a Doctor, were able to visit when they wanted as a family and were satisfied with the handling of all personal property and valuables.
- Only one out of the eight respondents to the survey said they were offered the support of the hospital chaplaincy or a minister/priest of their choice, however three comments about this question were: "but this wasn't something the family wanted", "but not required" and "my father had only been admitted to A & E on the day he passed away". Four of the eight respondents said that they had been offered the support of the SPCT, one replied that they had not that the remaining three stated that it had not been appropriate for them.

- 38% of respondents to the survey said that staff did not update them on a regular basis as to what to expect.
- All of the families who had responded to the bereavement services survey said that they were advised how to contact the bereavement office and what to do after their relative had died.
- Comments on the bereavement services survey included "I was very pleased with the care and medical treatment my sister received. Many thanks to all staff who cared for her", "your services are excellent" and "we cannot fault the treatment and care my father received at the hospital. It was of a high standard at all times."

Staff engagement

- A 'listening into action' event was held in September 2014 to discuss how to make end of life care better for staff, patients and families.
- Nurses in the SPCT told us that they were actively involved in improving end of life care in the trust and that their managers and the trust board listened to and acted upon their advice.

Innovation, improvement and sustainability

- Information from the bereavement services questionnaire was discussed during end of life steering and operational group meetings and used to reinforce positive action and improve services.
- Palliative care staff took part in mortality and morbidity reviews to offer advice on whether better care could have been provided for patients who had died in the hospital.
- In April 2015 the trust had introduced an electronic system to review deaths in the hospital, which offered better information management and allowed information to be shared where appropriate.

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

Information about the service

Outpatient and diagnostic imaging services are provided at all three hospital sites at the trust. Each hospital was visited as part of the inspection process and each is reported upon separately. However; services on all three hospital sites were run by one management team. As such they were regarded within and reported upon by the trust as one service, with some of the staff working at all sites. All the data provided by regarding out patients services was at trust level.

Between July 2013 and June 2014 Queens's hospital had 145,929 planned outpatient appointments of which 108,030 actually took place. Between April 2014 and March 2015, the trust reported an increase of actual attendances at Queens's hospital to 181,440. Diagnostic services were available 24/7 for inpatient and emergency services. During 2014/2015, the department carried out over 233,000 examinations across all services, across the three sites. The department carried out on average over 11,000 x-rays each month.

As part of our inspection we visited a range of clinics and units at the hospital including the main x ray department, outpatient A, the burton clinic, medical outpatients, surgical outpatients, ENT clinic, ophthalmology and audiology clinics, reception areas A and B, oncology clinic, endoscopy unit and the belvedere urology unit. We spoke with 24 members of staff and 42 patients and relatives.

Summary of findings

Patients, visitors and staff were kept safe as systems were in place to reduce and monitor risk. Services followed recognised pathways of care and were completed by trained and skilled staff. Patient outcomes were audited and benchmarked against national standards. Staff were caring and involved patients, their carers and family members in decisions about their care.

Whilst we found that the service was responsive to the local community we identified issues with the appointments system. Overbooking of appointments had become common practice which led to clinics over running and frustration for patients who experienced long waits. Five percent of patients failed to attend appointments. The hospital cancelled 10% of appointments and patients cancelled 11% of appointments.

Formal complaints processes were embedded however we did not see evidence that informal complaints were being recorded in line with the trust complaints policy.

Local leadership was good. Managers understood their staff and provided an environment where they could develop.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good 

We found that services in outpatients and diagnostic imaging services were safe. Systems were in place to record, assess and share learning from incidents. Infection prevention and control measures were effective. Staffing levels met national standards although this was achieved through the use of bank and agency staffing. Equipment was maintained well, provision had been made for the replacement of major pieces of equipment as they aged or became less reliable.

Incidents

- The trust used an electronic reporting system to record, escalate and respond to incidents. We saw that there was a culture of learning from incidents. This was evidenced as staff in the outpatients department were able to describe incidents which had occurred elsewhere in the trust which had not directly involved their own department.
- All staff we spoke with understood the incident reporting process and described how they would report an incident. Feedback from incidents was discussed at team meetings and we saw evidence of this on meeting agendas and minutes.
- We saw the trust briefing sheet 'Sharing for Caring, lessons learnt' which had been circulated to all staff through team meetings.
- Staff told us that they reported incidents such as overbooking, excessive waiting periods and cancelled clinics through the incident reporting system. We saw evidence of this on the outpatient incident log.
- Between January and June 2015, 182 incidents were reported by Queen's hospital outpatient department. None were categorised as causing serious harm. Five were categorised as moderate harm. From 1 May to 30 June 2015, 26 incidents were reports by the radiology department. . None were categorised as causing serious harm. Three were categorised as moderate harm.
- One member of staff described learning and new practice resulting for the investigation of a never event in another area of the hospital indicating that learning was shared across the trust.

- We saw evidence in the minutes of meetings within the diagnostic imaging service to show how information was shared and lessons learnt from incident investigation.

Cleanliness, infection control and hygiene

- We found the outpatient departments, treatment rooms; consultation rooms and sluices we visited were clean and tidy.
- Personal protective equipment such as gloves and aprons were readily available. We witnessed staff using these and washing their hands where appropriate.
- Hand sanitising gel was available throughout the department and we witnessed both staff and patients using the gel.
- Audits were completed to ensure that infection control measures were implemented, for example the hand hygiene audit for December 2014 to March 2015 showed that staff in the Belvedere Centre had achieved 100% compliance, Oncology Outpatients 100%, and Fracture clinic 84%. We saw that diagnostic imaging completed regular hand hygiene audits but the results were not made available.
- Cleaning schedules were in place and we saw they were followed by housekeeping staff.

Environment and equipment

- The main reception area was well lit and was decorated with art work which enhanced the patient experience. We saw that there was ample seating for patients and their relatives or carers. A water dispenser and cold drinks machine were available. However we noted that there were no disabled toilet facilities in the area.
- The consultation areas in fracture clinic included some areas where beds/trolleys had only curtains separating them from adjacent beds. This meant that confidentiality could not be guaranteed.
- The waiting area in clinic/outpatient A was very cramped. At the time of our inspection the lights in the area were switched off. We were advised that there was a fault causing the lights to flicker. They had been switched off for patient comfort and patients were advised of this when they attended. The fault had been reported and we noted that they were fixed later the same day.

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- The information board in this area was very small and not very visible. Staff and volunteers were present and vigilant to ensure patients were in the right place for their appointment.
- The therapy department gym was well equipped with treadmills, trainers, static bikes and parallel bars. All the equipment was clean and well maintained.
- There was an ice machine in the therapy department; we were told this had been broken since March and staff had to collect ice from the orthopaedic ward.
- Plans were in place for a new CT scanner within diagnostic imaging. The current CT scanner was nine years old and nearing the end of its useful working life.
- We saw two health and safety notice boards in the imaging department one specifically for radiation related safety guidance.
- A quality assurance programme was in place for the replacement of equipment as it aged or became obsolete. We saw the latest meeting minutes.
- Data provided by the trust showed that between July 2014 and June 2015, on average less than 1% of patients notes were not available on request for the clinic. The trust has a policy and procedure in place for clinic staff to follow if records are unavailable.
- We saw that documentation was clear and accurate. Staff explained that a new e-record system was being phased in. They described how this had led to patient records being more accessible, information easier to find and easier to read.
- We reviewed two sets of electronic patient records and two sets of paper records. We did this as we wanted to see that information we had been told was correct and that records included accurate information. We saw that records were completed thoroughly and reflected the needs of the patients.
- The trust told us they do not conduct any audits on outpatients notes.
- We examined the maintenance records for digital imaging equipment and saw that equipment was serviced regularly and in accordance with the manufacturer's recommendations.

Medicines

- The trust had systems in place to ensure the correct management, storage and administration of medicines.
- We checked drug cupboards and fridges in the outpatient department and therapy department. Records were up to date and drugs stored safely in accordance with regulations.
- We saw a patient group directive for the administration of sodium hyaluronate in the therapy department.
- Pharmacy support was available for advice and guidance. Members of the pharmacy team completed regular audits. The medicines management audit carried out May 2015 in the Belvedere Unit, Outpatient Department and ENT outpatients showed them to be fully compliant.
- Radiology dose audits were undertaken in all diagnostic imaging treatment rooms every three years. Local diagnostic reference levels were reviewed for all rooms and lowered when possible.
- Delivery of Isotopes to the nuclear science department were conducted under recognised security arrangements which had been reviewed and monitored by police special branch.

Records

Safeguarding

- The trust had a safeguarding lead and team. Policies and procedures were clear and available to staff.
- All the staff we spoke with were able to describe the different forms which abuse might take. Nursing staff told us they understood the process for raising a safeguarding concern. Fracture clinic staff told us about a patient who regularly attends the clinic for self-harm issues. The Fracture clinic staff followed safeguarding procedures and referred the patient to the local safeguarding team and GP.
- We saw the reporting flow chart for safeguarding issues and the names of safeguarding leads were clearly displayed on the staff notice boards.
- All (100%) of radiology, administration, nursing and medical staff had completed safeguarding adults level 1 training. Eighty-nine percent of nursing staff had completed level 2 safeguarding adults training along with 93% of medical staff and 95% of radiology staff.
- All (100%) of radiology, administration, nursing and medical staff had completed child protection level 1 training. Sixty-seven percent of administration staff had

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undertaken level 2, along with 89% of radiology staff, 91% of nursing staff and 100% of medical staff. All (100%) of nursing staff had completed child protection training to level 3.

- PREVENT training was provided and compliance with completion was 93% of above for all staff groups.

Mandatory training

- We reviewed training logs across the outpatient and diagnostics departments. We saw that training was taken seriously and staff were encouraged to complete their training. Email alerts were sent to staff to remind them when their training was due.
- Mandatory training compliance for the physiotherapy department was at 98%. We viewed various training logs which showed that compliance with mandatory and statutory training was good. For example, 100% of radiology staff had completed equality and diversity training, 92% of administration staff had completed manual handling training, 100% of medical staff had completed blood handling training and 92% of nursing staff had completed information governance training.

Assessing and responding to patient risk

- Systems were in place to provide safe care for deteriorating patients in clinic areas. Staff described the process for admitting patients who had attended an outpatient appointment but had either been taken ill or whose condition had deteriorated. The decisions to admit depended on the immediate clinical need of the patient. They would either be admitted to the emergency department or in some circumstances direct to the ward managing their speciality/illness. If a ward bed was not immediately available the patient could be accommodated in the discharge lounge temporarily.
- Resuscitation trolleys were located at various locations throughout the department. We checked these and saw that they were regularly checked and endorsed to show that they were in order and ready for use.
- Records provided showed that 100% of medical and nursing staff had completed advance life support training, 100% of administration staff had completed basic life support training, as had 92% of radiology staff. Additionally, 90% of nursing staff had completed paediatric basic life support training.
- Principles of the World Health Organisation (WHO) surgical safety checklist were utilised in radiology. A

Pause and Check identification procedure was in place. The identification of the patient and details identifying the procedure about to be done were both checked before staff pressed the radiation button.

Nursing staffing

- We were shown the template used for planning staff rotas in the outpatient clinics. The template recorded on a daily basis the number of clinics running, whether there was a consultant or a consultant plus a registrar and the nursing skill mix required depending on the type of procedures carried out in the clinic.
- We were informed that the department had only been recorded as short staffed once in the past three months and that this had been documented as an incident. The impact on patients of staffing shortages can be slight delays in the appointment times, and waiting longer for chaperone availability.
- We were told by several members of nursing staff that nursing staff vacancy was high in the department in response the trust utilised a pool of bank staff who were mainly retired nurses, well known to the department, a highly skilled and flexible workforce. Data provided by the trust showed that for the three months April to June 2015, outpatients services used 1553 nursing bank hours and no agency nurse time.
- The physiotherapist department reviewed the theatre list to plan staffing levels. We observed a team meeting of nine occupational therapists. We saw how they systematically reviewed the organisation of their workload.

Medical staffing

- Consultants and registrars attended clinics to see patients with appointments. We saw that there were sufficient medical staff to enable all appointments to be met.
- The trust had two Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holders a part time radiologist consultant and a consultant physician.
- At the time of our inspection, the department had one radiologist vacancy. The vacancy had been advertised and locum staff were being used. The agency staff tended to be the same personnel who were familiar with the systems and working practices at the trust.

Major incident awareness and training

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- The trust had a major incident and business continuity plan. The plans were available to all staff on the electronic shared drive. Major incident action cards were available for individual staff.
- Radiology services formed part of the major incident planning. We saw evidence of major incident planning being discussed in diagnostic imaging safety meetings.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Both outpatients and imaging services provided effective care and treatment, based on recognised pathways.

Radiology had been understaffed and to relieve pressure they outsourced report writing in order to maintain service levels to the public.

Radiology had ensured that all relevant staff were trained in CT head scan, in order to provide 'Golden Hour' service for stroke patients.

Multidisciplinary working was evident throughout the departments with excellent interaction from therapies staff.

Staff training and re-validation were effective, as were supervision and appraisal systems.

Evidence-based care and treatment

- We saw effective interaction between different staff groups and departments. This was evidenced in the fracture clinic where staff had developed specific treatment pathways such as an Achilles tendon pathway. Patients could be scanned, diagnosed and start treatment on the same day.
- Physiotherapy staff told us they had set protocols in place for the more common treatments, this in combined with in house training had enabled more junior staff to progress and reach high levels of competence. We saw the protocol for the post-operative physiotherapy treatment of shoulder replacement and saw that this was based on recognised good practice and guidance.
- A falls prevention policy was in place. This outlined the requirement for falls referral, provision of home equipment, falls prevention plan, home assessment and

on-going therapy. We also reviewed a patient's record where the falls policy had been applied. The patient was at risk of a fall but after a course of therapy had improved.

- Clinical audit was evident in the physiotherapy department. A back and neck audit had been completed and the results presented to the CCG.
- Two patient surveys in relation to catheters and oncology had been completed within the Belvedere urology unit. We requested the outcome of these from the trust.
- We saw that Administration of Radioactive Substances Advisory Committee (ARSAC) guidance was followed in line with the Medicines (Administration of Radioactive Substances) Regulations 1978.
- In 2013, the Royal College of Radiologist's undertook a review of the service at Burton Hospitals. Thirty-one recommendations were made, of which 95% have since been implemented. Radiologists told us that they welcomed the reviews findings as at the time they felt that executive level support could have been improved as could the IT system. As a result of the review, there had been an improvement in conditions and better team working. Staff stated that they now felt part of the hospital team.
- The trust is part of the east midlands radiology group which encourages exchange of best practice and benchmarking.

Pain relief

- Patients we spoke with whose condition involved pain or discomfort, described how they had been able to discuss these symptoms and they had been prescribed drugs or recommended over the counter remedies which enabled them to control their pain.
- Pain assessments were completed at each appointment to enable clinicians to monitor effectiveness of treatment.

Patient outcomes

- The physiotherapy department hold 'Bees Knees' classes where patients attended two sessions pre operatively and were then seen post operatively by the same physiotherapist on the ward. Staff collate and use outcome measures from these classes to measure progress and develop the service.

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- We saw the endoscopy unit programme for clinical audit which we validated by seeing the reports of the audits. The unit had full Joint Advisory Group accreditation.
- Radiation protection advisor (RPA) meetings took place on a quarterly basis and included radiation protection supervisors. We saw minutes of the last meeting. The minutes were also available electronically to staff on the trusts shared drive.
- We visited the MDT tracking team responsible for organising the multidisciplinary meetings relating to the cancer referral to treatment targets. We saw the most recent information which showed that all targets had been met for May 2015.

Competent staff

- All staff we spoke with informed us they had a current annual appraisal in place. Data showed 100% of outpatient staff had received an appraisal during the current year. However, one member of staff told us that the appraisal process was poor and their appraisal had been completed in 10 minutes with no planning or advance notice.
- Staff were actively encouraged to develop within their roles; one member of staff in the physiotherapy department was commencing the enhanced master's degree in physiotherapy.
- We saw evidence of staff development documented in supervision notes. We reviewed three supervision records; all showed recent supervision meetings with clear developmental objectives.
- Supervision meetings were also used as a tool to assess competency; for example one record showed discussion regarding an emergency department competency assessment which had been completed by a band five staff member.
- We spoke with one physiotherapist who was a clinical expert in muscular-skeletal health. They explained how they supported the rest of the team with complex cases by attending treatment sessions and offering advice and support.
- Information on notice boards sign-posted staff to additional sources of information and support. Department managers confirmed information regarding a network of link nurses covering a variety of subjects such as, infection control and safeguarding.
- Senior members of staff told us they were proud of the number of nurse led clinics in place. For example nurse

- practitioners for urology, ophthalmology, bowel cancer follow up and a colorectal nurse specialist, all of whom had undertaken additional training to increase their knowledge and skills.
- Comprehensive induction programmes were in place for all new staff. We saw examples of the induction process within diagnostic imaging.
- Staff were encouraged to complete continual personal development evidence and to revalidate their registration where appropriate.
- We saw the radiology induction process in place and witnessed an induction pack being given to a new member of staff on their first day. The induction pack is a six week programme which is signed off at end of period by line manager.
- Junior radiology staff rotate to the community hospitals to experience different working environment and increase their skills and experience.
- Radiology services for the trust were working towards membership of the Imaging Services Accreditation Scheme (ISAS) which is jointly run by The Royal College of Radiologists (RCR) and the Society and College of Radiographers (SCoR). This involves peer review and assessment of services. The department had been assessed as 86% compliant with the scheme. The trust aims to have achieved accreditation by 2017.
- Diagnostic imaging staff had all completed training in The Ionising Radiations Regulations 1999 (IRR'99).
- Radiology staff; including junior staff had all been trained to enable the department to provide immediate access to CT head scan for stroke patients to achieve the Golden hour for stroke patients.
- As a result of staffing issues the trust had outsourced some reporting of MRI and CT scans. We were told that they anticipate they will be in position to complete all CT scan reporting in-house by September 2015.

Multidisciplinary working

- Multidisciplinary working was evident throughout the outpatients department. In particular the fracture clinic displayed excellent interaction between consultants, nurses, physiotherapists and occupational therapists.
- Specific hand splint clinics had been developed which were run by physiotherapist and occupational therapists.
- We saw that the trust had good administrative support for consultants on average one secretary per two consultants. Secretaries understood their role in

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achieving targets for letters and appointments to patients and worked closely with the patient Access Centre to enable outpatient appointments to be made on time.

- We saw evidence of meetings between the hospital therapy department and the community therapists to reduce duplication of assessments and goal setting. Working towards Trusted Assessor, earlier discharge date for stroke patients and awareness sessions for community therapists on the patient pathway.

Seven-day services

- We saw staff rotas in the therapy department that showed seven day working, 7am to 7pm Monday to Friday and 8am to 7pm Saturday and Sunday.
- Diagnostic imaging services were available on a 24/7 basis, this was due to their work with the emergency department and inpatient wards. However it also meant that the service was available at all times when outpatient clinics took place.
- Outpatient clinics ran on weekdays between 8am and 7pm.

Access to information

- All department protocols for diagnostic imaging were in view in the magnetic resonance imaging (MRI) and computed tomography (CT) rooms. Staff could also access information on the trust computer shared drive.
- Outpatient staff had access to patient records electronically and from their written notes. We were assured that if patients written notes were not available at the time of their appointment, patients were still able to be seen as medical staff could access the required information by reviewing the electronic system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a good knowledge of the mental capacity act. They understood how to support patients and their carers or family when they attended appointments.
- There was clear guidance available for staff to follow if a patient did not have capacity to make important decisions about their health care. Documentation was available in the department which enabled staff to follow the guidance and ensured correct procedures would be followed.

- We did not encounter any patients in the outpatients or diagnostic imaging services who did not have capacity. Staff described how capacity issues occasionally arose in relation to elderly patients with dementia or other memory problems, and with people with a learning disability.

Are outpatient and diagnostic imaging services caring?

Good



Feedback from patients and relatives was positive about the way staff treated people. Interactions between staff and patients were kind and friendly.

Patients and their carers were involved and informed and complimentary about their experiences with staff at all levels. They felt staff took time to explain complex information in a way they could understand.

Compassionate care

- All the patients we spoke with were positive about the care and treatment they received from the staff. We observed interactions between staff and patients and saw that they were friendly and professional. Staff smiled as they spoke and patients appeared comfortable in the presence of staff. We observed an exercise class for patients with arthritic knees. Staff spoke in a calm and reassuring manner.
- A patient told us that over the past two years their hospital experience had improved. Staff were more caring, seem more relaxed and talk to the patients more. Other patient quotes included “From a medical point of view I couldn’t fault the care, the consultant is very open and honest”, and, “Brilliant staff, always polite”.
- Patient surveys were undertaken. Nuclear medicine received good reviews the results were posted in the waiting area for patients to see. Radiology also carried out annual patient surveys. This identified a problem with patient gowns and dignity issues which resulted in alternative gowns being used.
- Friends and family tests were only introduced for outpatient services in May 2015 and national comparisons have yet to be published.

Understanding and involvement of patients and those close to them

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- All the patients we spoke with felt fully informed about their care and treatment.
- We spoke with a patient who was waiting to have a minor surgical procedure. They told us staff had been lovely and put them at ease. They also described how the doctor had tried to explain everything to them. They had been confused and hadn't understood, and then the doctor had taken time to explain again in terms they could understand.
- A patient was very complimentary as they described how a consultant had drawn a picture to help explain a procedure which they were proposing.
- Patients told us how they both went into the consulting room and how they were both able to ask questions and discuss the care and treatment. They commented 'they always look after me' and, 'I am very happy with the care my wife gets'.
- Another patient said, "I have nothing but praise for how I have been treated, staff were always brilliant with me. I have always been fully involved and informed of my treatment, so was my husband, even down to an explanation of my medication".

Emotional support

- If patients needed to be given bad news about their condition or general health this was generally done by the doctor in charge of the case.
- Where specialist clinical nurse specialists were involved such as in cancer care, they would use their additional training and knowledge to provide support and signpost patients and their carers or family to external organisations.
- Diagnostic imaging had an identification assistant who would assist patients if they were in distress or just provide comfort and making a cup of tea.
- Chaplaincy services were available if required, staff could be called to the department or patients, carers or family could be directed to multid denominational facilities if they preferred.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Appointment systems did not always meet the needs of the community. Overbooking was common place resulting in clinics overrunning and long delays in clinic resulting in poor patient experiences.

Outpatients had high numbers of cancelled appointments. Did not attend, hospital cancellations and patient cancellations were all higher than average.

For almost all conditions, referral to treatment times were better than national targets.

Staff had received training and understood how to support vulnerable patients and their carers. Volunteers were used effectively to assist patients in finding clinics, or with mobility issues.

Service planning and delivery to meet the needs of local people.

- The trust had positive working relationships with community services and local GP's. If the patient access team wanted to communicate any changes or developments in the referral process they could place an article in the GP Newsletter. This process was also used for reminders such as indicating that an interpreter is required for the consultation.
- We visited the patient Access Centre. Staff told us a weekly waiting list meeting was held. The meetings included a "confirm and challenge" waiting list initiative which had been implemented in April 2015.
- One consultant told us that the number of audiograms had been restricted to 10 per day in the past few months which meant that patients at the end of the clinic did not get the audiogram they required and had to return at a later date for it.

Access and flow

- Referral to treatment times were consistently better than the England average. The NHS target is that 95% of patients should be seen within 18 weeks of referral. Statistics were collated at trust level which showed that they had achieved 98% to 99% throughout the whole of 2014 and into 2015.

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- The latest published statistics for outpatient attendances from the Health and Care Services Information Centre were published in April 2015. The statistics relate to performance between July 2013 and June 2014. The figures show that whilst the Queens hospital planned 145,929 outpatient appointments; the actual number of attendances was only 108,040.
- Five percent of patients did not attend (DNA) their appointment, 10% of appointments were cancelled by the hospital and 11% of appointments were cancelled by patients. We asked the trust for details of analysis of hospital cancelled appointments. They were unable to provide any details but assured us that this analysis was 'a work in progress'.
- During the last twelve months the trust had attempted to reduce cancellations in all areas. Initiatives included sending text messages reminders to reduce DNA's. Therapy department staff told us they used text messaging to remind patients about appointments and that this had reduced DNA's by 17% from May 2014 to May 2015. Patients told us the text reminders were welcomed and very helpful.
- Patients who DNA are given alternative appointments. If they continue to not attend, after the third failed appointment they would be removed from the list and advised that they need to re-visit their GP.
- Hospital cancellations had reduced due to better advanced planning of consultant leave. Consultants were required to give six weeks' notice of annual leave to assist with planning.
- Diagnostic services rarely cancelled appointments at Queens Hospital, when they did this was due to equipment breakdown.
- We found that the signage to the various outpatient departments was unclear in places. The geographical layout of the departments was not easy to follow; clear outpatient signs that stood out from other trust signs would have assisted.
- We observed that queues did form at the reception desk, at one point there was only one person on reception and 12 people in the queue.
- During one day of the inspection we found the afternoon clinic had overbooked appointments. Ten appointments had been booked over the capacity of the department to deal with within the normal clinic times. Staff told us this was a regular occurrence. Overbooking led to delays up to an hour and half on occasions.
- Patients were mostly kept informed when appointments were running late and the reason why (for example why some patients had been seen before others) and we saw this in action on a wipe boards. However, some patients were not kept well informed.
- An ENT patient arrived for their appointment at 2.40pm and did not get called in until 3.10pm. They were not informed about the delay and there was no information on the message board to suggest there would be a delay or reasons for it. We also observed that the message board faces the doorway and not the waiting area. Staff in the area were not proactive in letting people know there were delays.
- We spoke with two patients who informed us they had experienced long waiting times in the last two months. One lady in the rheumatology clinic stated that she always expected to have to wait well beyond her appointment time in order to see the consultant.
- We asked the trust for their analysis of waiting times, they advised that this information was not yet captured in the main outpatients department but systems were being developed which would enable the analysis to be done in future.
- We observed that the fracture clinic was very busy, we were told that some clinics were overbooked but that this was sometimes compensated by some patients not attending their appointments. Staff told us that the fracture clinic had reached its capacity, patient numbers regularly overstretched the planned capacity which resulted in patients not always having a seat and long queues. We saw that there 120 patients booked into the following days clinic.
- Diagnostic services had target referral time of six weeks. The actual waiting times for routine paediatrics was up to one week, this included booking a bed, sedation and a nurse escort. Actual waiting times for a CT scan were up to 4 weeks and 5 weeks for an MRI scan.
- Reporting turnaround times were five days for GP's requests, in-patients reports were completed within 24hrs and emergency department reports were turned around on the same day.
- Interventional radiology, radio pharmacy collected patient lists, the day before treatment is due. Individual doses of radiopharmaceuticals were prepared for the examinations (technetium and iodine therapies – isotopes). This means that individual vials of isotope were available for each patient when they attend their appointment.

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Meeting people's individual needs

- Volunteers were available to assist patients to different areas of the hospital. They visited the reception area several times a day with a snack trolley including hot drinks and helped patients and relatives navigate their way around the hospital clinics.
- Some patients said it could be difficult to know when they were being called into clinic. They couldn't always hear staff clearly. We witnessed staff calling patients into clinic from the reception area but they stood in the doorway and could not always be heard clearly. One patient who used a wheelchair explained that they could not react as quickly as able bodied patients. When they were called they would start to make their way but staff would call again because they had not realised they were on their way. They said it did not seem appropriate to shout back to the staff and believed more thought should go into how patients were called.
- The therapy department had adjusted clinic times and appointment availability following a patient survey which showed that patients did not want appointments on Friday afternoon or at the weekend but did want extended hours mid-week.
- One patient described how their physiotherapy appointment had been arranged to suit their holiday plans. They were pleased that in addition to finding a suitable date they had also managed to arrange for the same therapist who had provided treatment during their initial emergency admission.
- Dementia champions worked across all the outpatient and diagnostic departments. Their role included assisting other staff to support patients and carers and to raise understanding.
- Staff were trained in mental health awareness to help them identify and support patients appropriately. Advocacy services could be arranged for vulnerable patients.
- Fracture clinic staff told us that whenever possible they would fast track vulnerable patients through the system to reduce anxiety and distress.
- A learning disability pack was available to staff which included pictures and flash cards. A full communication toolkit was available from the Medical Library which was aimed at patients with visual and hearing impairments and for those with learning disabilities.
- Therapy staff explained that patients with dementia or those who required close support from their carers,

were able to have their carer present during the sessions. They described a patient with dementia who attended the exercise class for arthritic knees. The patient's carer also attended the class. This had the double benefit of reducing anxiety for the patient but also increased understanding of the carer.

- Interpretation services were available, initially through a telephone service, but face to face services could be arranged if advance notice were given. The most commonly used services were for Urdu and Polish.
- Patient information sheets were available and can be translated into other languages if required. Urdu and Polish were always available and other languages could be provided within 24 hours.
- British Sign Language (BSL) interpreters were also available and could be booked for consultations between patients and clinical staff.
- Diagnostic imaging had distraction toys in the x-ray rooms and immobilising appliances were also available which helped small children remain still during procedures. There were play areas for children to keep them entertained whilst waiting for their procedure.
- Radiology patients who were known to have diabetes were given early appointments to reduce their waiting.

Learning from complaints and concerns

- All staff we spoke with were able to describe the process they would follow if a patient wished to complain. One nursing member of staff told us there were frequent complaints from patients in the waiting room relating to waiting times. These were often diffused by face to face explanation and referral to PALS if necessary.
- There were 22 formal complaints made in regard to outpatient services in the previous 12 months. There were two complaints made about radiology services in the same period.
- Information was available to assist people if they wished to make a formal complaint, including references to the system on the trust website. We saw the PALS flowchart and information displayed on the notice board.
- Trust policy required that all complaint including those which were resolved informally should be fully documented. We did not see evidence that this was being done. Staff did not volunteer that they recorded details of informally resolved complaints.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement 

The overall strategy and vision for outpatients was not clear, the trust had recently established a project to look at outpatient efficiency issues but this was in its infancy.

There were systems and processes in place to manage risks and monitor quality but managers had not addressed a number of issues which affected the services ability to respond to patients.

Staff spoke well of local leaders and said they felt supported by the organisation.

Culture within the organisation had changed over the last 18 months. Staff now felt more engaged and able to challenge. There was an open culture of learning and progression.

Vision and strategy for this service

- There was not an articulated, shared vision for outpatient services at the hospital. Staff we spoke to were aware of the trusts vision statement and understood their role within the organisation and how they contributed to the trusts vision and strategy. Staff at all levels were keen to show and explain their work.
- The service had established an outpatient efficiency project in June 2015, to address a number of strategic issues facing outpatients such as clinic utilisation, DNAs and booking processes.

Governance, risk management and quality measurement

- Outpatients are part of the surgical specialities directorate. Diagnostics are part of the community and clinical support services directorate. Both directorates held monthly meetings where quality and risk issues were discussed.
- There were systems in place to enable department managers to identify and respond to issues affecting the service. Regular team meetings took place where staff were able to raise concerns or receive feedback or updates.

- Local audits were completed in relation to working practices, such as the availability of patient records in clinics; these were reviewed within departments and overseen by directorate heads.
- During our inspection we noted a number of issues which limited the out-patients service ability to respond effectively to patients. For example, overbooking of clinics, clinics running late and high number of patients not attending or cancelling appointments. Managers told us they had recognised some of these issues and had recently implemented some strategies but we noted that these issues were not on the risk register and we did not see any specific plans or strategies to address these issues.

Leadership of service

- Staff told us that local managers were supportive of their work, understood their issues and represented their needs.
- The fracture clinic staff demonstrated organised, effective team working and good morale.
- Therapy department staff told us they felt well supported by line managers and always knew who was available if there was a problem. They described regular team meetings and an annual look back meeting to review what had been achieved over the past year, discuss forward planning, review referral rates, waiting lists and the patient satisfaction survey. We saw minutes of these meetings and plans for future meetings in the diary.
- We spoke with the senior nurse at the urology unit. She described clear staff management procedures and expressed her pride in the team working and positive patient feedback.
- Radiology described a visit to the department from the chief executive. They believed the department is now recognised for its contribution to the trust; this had not been the case eighteen months ago when they felt isolated and unsupported.
- We met with several senior staff they were enthusiastic and proud of what their staff had achieved, they displayed understanding and appeared competent in their role.
- One member of staff expressed some negative views of team working to us but we did not receive negative feedback from any other members of staff all of whom suggested that support from managers was good.

Outpatients and diagnostic imaging

- Many of the staff we spoke with were able to name members of the hospital board. Staff told us that board members made periodic visits to their area. Staff were familiar with the chief executive as she had been involved in their induction process.

Culture within the service

- Staff in outpatients regularly worked overtime or additional hours to cover clinics which had over-run. Time back was always given but this way of working had become the norm for some areas of the department.
- There was an open culture where staff were happy to raise issues and challenge practice. We were told that this had changed over the last twelve to eighteen months with improved relationships between nursing staff and doctors. Staff told us that they felt empowered to learn and do better.
- Staff of all disciplines were proud of their work and keen to explain how they worked and how this affected their patients. There was an air of ownership in what staff did and a belief that it not only helped the patients but also that it contributed to the trust.

Public and staff engagement

- Senior managers told us about engagement events called 'Listening into Action'. They described simple

changes made as a result of these consultation events. For example painting doors a different colour to distinguish which door patient were being directed to and revising outpatient letters to make them clearer.

- Staff engagement was through team meetings and by directed learning through avenues such as dementia champions and link nurses. All nursing and medical staff had individual email accounts and these were used to circulate messages and alerts. Radiology disseminate the minutes from clinical governance meetings to all staff via email.

Innovation, improvement and sustainability

- One manager we spoke with described how they had inspired and engaged staff in new and different ways of working and embedding new ideas into practice. They described how they had involved staff; asking for opinions and suggestions.
- Innovations and improvements that had been introduced so far included a one stop cystoscopy and haematuria clinic, helpful to working patients or people with families; nurse led plastics clinic; Saturday clinics planned for neurology and audiology and developing a "Forced Booking" policy.

Outstanding practice and areas for improvement

Outstanding practice

- Critical care had developed an organ donation group to improve and promote organ donation within the hospital and the local community. There was representation from spiritual services, donor recipients, donor families, consultants and critical care theatre and emergency department staff. Consultants from critical care also spoke to local 6th form students to explain the principles of organ donation.
- The maternity service was awarded the Excellence in Maternity Care award by CHKS in 2014. The quality of care at Burton Hospitals NHS Foundation Trust was judged to be the best out of 148 NHS maternity providers in England, Wales and Northern Ireland.
- The trust had been awarded and maintained UNICEF Baby Friendly Initiative stage three accreditation. This meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Children's services had used a variety of methods to ensure that patients and their relatives were able to feedback. Methods included questionnaires, comments boards, and social media. There were numerous examples of where this had led to service improvements or changes such as the development of the parent's room on the children's ward.
- Patients arriving in the emergency department by ambulance were automatically weighed as they crossed the threshold. This meant that nutritional assessments and medication dosage would be accurate.
- We saw innovation in practice on ward 11 (male surgical ward) where the infection control nurses had worked with staff to reduce infection control risks and increase hand hygiene. The team implemented technology which counted the use of alcohol sanitising gel and compared it against the target of how often it should be used. This was in response to hand hygiene audits which needed improvement.

Areas for improvement

Action the hospital MUST take to improve

- The trust must develop a clear plan to address the risk it had identified concerning no accommodation appropriate to support patients with mental ill health while they waited for assessment.
- The trust must ensure that ward assurance targets, such as hand hygiene practice and recording of patient observations, is achieved at a consistent level in the emergency department.
- The trust must improve the uptake of statutory and mandatory training among emergency department staff to a consistently level.
- The trust must take steps to minimise the number of medical outliers across the hospital to ensure patients are care for in an appropriate environment by staff with the right skills to meet their needs.
- The trust must review the number of bed moves made by patients, especially at night to minimise disruption and improve patient experience.
- The trust must review the use of agency staff on surgical wards to ensure staffing levels and skills mix are maintain and all staff have access to the relevant records.
- The trust must develop a clear vision and strategy for critical care services which is shared with staff and clinical leaders and demonstrates how the service will develop in the medium and long term.
- The trust must ensure that all identified learning points from the investigations into recent Never Events are fully implemented and signed off to ensure that learning and changes to practice have been put in place.
- The trust must develop a strategy and long term vision for gynaecology services at the trust to ensure that patient services can improve and develop.
- The trust must develop a clear pathway for gynaecology patients to ensure their care is delivered safely and responds to their needs.

Outstanding practice and areas for improvement

- The trust must ensure that a rapid discharge pathway for end of life patients is formalised to ensure that people can leave hospital in an effective way that meets their wishes.
- The trust must review policies and procedures for planning and booking outpatient clinics to ensure that waiting times for appointments are minimised and patients are not subject to long delays in waiting for appointments. Waiting times in outpatient clinics should be routinely monitored.
- The trust must ensure managers are sighted on issues affecting the responsiveness of outpatient services and risks are identified and actioned.
- The trust should ensure all staff are aware of their responsibilities under Duty of Candour regulations in order to meet with legal requirements.
- The trust must review the service arrangements and leadership of ward 44 to ensure that services are provided in a timely and consistent manner and patients are able to access rehabilitation services effectively.
- The trust should review the staffing on ward 44 considering the acuity of the patients.
- The trust should review arrangements for young people and children who require CAMHS services to ensure their needs are met and they are cared for in a safe environment.
- The trust should ensure that consent documentation for adults who are unable to consent to investigation or treatment is completed, in line with the 'Do Not Attempt Resuscitation' policy, for every patient who has been assessed as lacking the mental capacity to give consent.

Action the hospital SHOULD take to improve

- The trust should carry out an interim assessment of control measures needed while the work was scheduled to remove the ligature point in the crutches store room in the emergency department.
- The trust should address the risk of the Middle East respiratory syndrome coronavirus (MERS) being brought into the ED.