Care Quality Commission

Sherwood Forest Hospitals NHS Foundation Trust

King's Mill Hospital

Quality Report

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Date of inspection visit: April 2014
Date of publication: 22 July 2014

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
Accident and emergency	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Good
Maternity and family planning	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

In 2013, the trust was identified nationally as having high mortality rates and it was one of 14 hospital trusts to be investigated by Sir Bruce Keogh (the Medical Director for NHS England) as part of the Keogh Mortality Review in July that year. After that review, the trust entered special measures.

We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Sherwood Forest Hospitals Foundation Trust was considered to be a high risk trust.

We carried out an announced visit on 24 and 25 April 2014 and unannounced, out-of-hours visits on 29 April and 9 May 2014.

Our key findings were as follows:

- We saw poor record keeping in some areas, particularly relating to patients care.
- We found that staffing in some areas was below the levels that would be expected.
- Care plans should be improved to reflect patients needs.,
- Discharge planning should be improved.
- The WHO surgical checklist should be embedded in all practice.

We saw several areas of outstanding practice including:

- The Rotherham model for reducing smoking in teenage pregnancy has reduced smoking rates.
- Pillow cards were left in Gynaecology during comfort rounds when a patient was asleep or not in their bed so they knew when the next round would be.
- There was good multidisciplinary working across the trust.

Importantly, the trust must:

- ensure that accurate record keeping is maintained with regard to people's observations and hydration.
- ensure that accurate record keeping is maintained on drug administration charts so people receive the appropriate care and treatment for their needs.
- ensure that all staff have the competence to recognise when a person is deteriorating so appropriate care is provided.
- ensure that there are secure systems for storing medicines and that people are given medicines according to their prescription.
- ensure that all people have an effective and current care plan that meets their individual needs and provides appropriate guidance for staff to be able to meet their needs.
- ensure there is full medical support for all surgical specialties, in particular vascular services.
- ensure mandatory training and appraisals take place to ensure all staff are appropriately trained and have up-to-date knowledge.
- ensure actions taken and lessons learned are shared with staff at all levels
- ensure that staff mandatory training and appraisals are completed to meet trust targets

In addition the trust should:

- Equipment should all be portable appliance tested and serviced to ensure they are fit-for-purpose
- Midwifery staffing could be improved by completion of the directorate's on-going recruitment programme
- The trust should ensure that team briefings are completed before and after surgery, including fully embedding WHO surgical safety checklists

Summary of findings

- Introduction and implementation of children and young people services specific pain management guidance and protocols.
- Nurse presence and inclusion at all 'Team Around the Child' ward rounds on paediatric ward, ward 25.
- Confirm and establish longer term nurse management structures on paediatric ward, ward 25, to provide staff with increased, visible managerial support.
- Increased receptionist staffing on paediatric ward, ward 25, including weekends.
- The trust should ensure that people with a dementia have an accurate and current care plan to provide staff with clear guidance to meet their needs.
- The trust should ensure there is an appropriate skill mix of nursing staff on duty so that people's needs are recognised and met.
- The trust should plan to provide seven day a week and effective out of hours cover by doctors and consultants for all specialties.
- The trust should ensure that effective discharge planning occurs across all specialties for all people who are fit for discharge.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Accident and emergency	Requires improvement 	The emergency department at King's Mill Hospital was clean and staff followed hand hygiene procedures. The environment was generally safe, with a 24-hour security presence, but there was not a safe and effective system in place for the identification of equipment for repair. Staff had a good understanding of the incident reporting system. However, some incidents had not been reported and improvement opportunities missed. Not all medicines were secured appropriately, and some equipment was out of date or not fit-for-purpose. The department did not have appropriate care pathways available for staff to use. The majority of patients we spoke with were complimentary about the care they received. We saw that people were treated with dignity and respect. Staff were responsive to the needs of patients. Information was available, along with translation services for patients for whom English was not their first language. Plans for leaving hospital were begun early and specialist teams were available to support early discharge. Complaints were responded to in line with trust policy. However, the trust's performance with regard to the four hour waiting time was inconsistent and below the 95% national target. There were some examples of good leadership within the department, especially for supported learning and training materials developed within the department. However, there was a lack of shared strategy or vision, and a lack of coordinated risk-based improvement planning.
Medical care	Requires improvement 	Hospital Standardised Mortality Ratio (HSMR) was high, but is has now fallen within the expected range. There were no reliable systems in place to ensure that all people were monitored effectively, and some documentation was poor.

Summary of findings

Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet their assessed needs. People may not have been receiving the appropriate care and treatment for their needs, as their records were not always clear and current.
We also found specific concerns about the staff's ability to recognise when a person was deteriorating, and the quality of recording for people's observations.
Staffing levels were variable. Medical care service were addressing some of the concerns regarding staffing levels, staff skill mix and monitoring the condition of deteriorating people. Staff recruitment was in progress to fill staff vacancies.
All wards had introduced clearer systems for sharing information about the ward's performance with staff and visitors.
People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received.
Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Surgery **Requires improvement** 

Surgery services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. Staff have a good understanding of the incident reporting process, but did not always receive feedback as to what action was taken and what lessons were learnt.
Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training was not always carried out to ensure staff were competent, and had best practice knowledge to effectively care for and treat patients.
Monthly audits were carried out regarding patient safety, patient experience and the environment.
Patients and relatives we spoke with told us that they felt that they received good quality care and were informed of any treatment required. Patients told us that they felt their privacy and dignity were respected.
We found that staff were responsive to people's individual needs; however, we found that there were

Summary of findings

often delays in discharge, which impacted on patients needing to be cared for in recovery after their operation. We also found that the trust was not always meeting the 18 week deadline for treatment. However, there were waiting list initiatives which were helping to meet some of the demand.
There was some good leadership at local levels within the surgery services, and staff felt well supported by their managers. The trust had plans in place to stabilise the senior management team, and a clinical governance framework was also in place, which at the time of our inspection, was being strengthened. Staff were not always supported and developed through the appraisal system. A new strategy had been implemented for the values and behaviours of employees.

Critical care

Good

The critical care service provided safe care. There were effective systems in place to report incidents and staff were aware of what to report and how to do this. Incidents were monitored and reviewed, and appropriate action taken to reduce the risks to patients. Staffing levels were appropriate for the needs of patients. There were appropriate procedures to prevent and control infections, and to safely manage medicines.
The critical care service provided effective care. Care and treatment was delivered in line with current standards and nationally-recognised evidence-based guidance. The staffing and operation of the unit was in line with 'Core Standards for Intensive Care Units' published by The Faculty of Intensive Care Medicine and The Intensive Care Society.
Patients and their families were satisfied with the care and treatment provided, and reported good outcomes. The multidisciplinary team effectively collaborated and communicated to support the planning and delivery of patient care.
Patients were treated with compassion, dignity and empathy. Patients and their relatives were involved in decisions about their care and treatment. Patients were offered appropriate emotional support during their stay in the intensive therapy unit and afterwards.
The critical care service responded to meet patient's needs. Staffing ratios in the intensive therapy unit

Summary of findings

were in line with national guidance, and staffing was flexible to meet changing demands. Staffing in the CCOT had been increased in response to a rise in the use of the team. Discharges from the intensive therapy unit were appropriately managed, though there were recognised delays.
The critical care service was well-led. There were clear management and governance structures in place. Key risks were identified and managed by staff and managers. Risks were regularly monitored and reviewed, and effective action was taken to reduce or resolve risks.
Patients were encouraged to comment on their care and treatment in the intensive therapy unit, and their comments were acted on. Staff spoke positively about working in critical care. They were aware of the trust's vision and values, and they told us they had confidence in senior management to continue to make improvements.

Maternity and family planning

Good

The maternity service provided safe care. Midwifery and medical staffing levels were appropriate for the numbers of births at the unit. Staff reported incidents, which were monitored and regularly reviewed. The service had appropriate procedures in place to prevent and control infections, and to manage medications. Wards and departments were spacious and well maintained.
We found that appropriate equipment was available to ensure safe care. Sealed resuscitation equipment boxes were supplied to individual wards and clinics by the trust resuscitation team, but these boxes were not checked by maternity service staff. This meant the maternity service, along with other trust services, could not ensure that resuscitation equipment boxes were routinely checked to ensure that all equipment worked safely.
The maternity service provided effective care. The percentage of normal deliveries within the maternity service was significantly higher than the national percentage. Rates for elective (planned) and emergency caesarean sections were lower than national figures, particularly the trust's emergency caesarean section rate. Good rates of smoking reduction had been consistently maintained by women throughout their pregnancies. The Sherwood Birthing Unit was jointly-led by midwives

and consultants, which provided effective, managed care. Most staff were positive about the multidisciplinary team approach to the provision of care. There was mutual respect between staff in different roles and teams throughout maternity services.

Most women were complimentary about the care they had received from maternity services. Throughout our inspection we observed that staff treated women with compassion, dignity and respect. The CQC maternity service survey 2013 reported that the trust's maternity service was rated at 8.9 out of 10 by women for their experience of care during labour and birth, which was similar to results from other trusts.

The maternity service responded to meet people's care needs, and planned the allocation of midwifery staff according to the requirements of the service. Staff used translators and translation services to meet the needs of women whose first language was not English. Complaints were responded to in line with the trust complaints policy.

Maternity services had clear management and governance structures in place within obstetrics and gynaecology. Key risks were identified and managed by maternity services staff and senior managers. These were regularly monitored and reviewed at local, directorate and divisional levels. Staff spoke positively about their work, and were aware of the trust's overarching vision. Staff told us that they felt part of the drive to ensure the strategy and plans for improved patient care were delivered.

Services for children and young people

Good

The children and young people services provided safe care. Staffing levels were adequate and the directorate was in the process of recruiting additional nursing and medical staff. Incidents were reported and investigated, and learning was shared with directorate staff. The service had appropriate procedures in place to prevent and control infections, and to manage medications. Wards and departments were spacious, well equipped for patients, and were mostly well maintained.

Sealed resuscitation equipment boxes, including adult resuscitation boxes, had been supplied to individual children and young people services wards

and clinics by the trust resuscitation team. These boxes were not checked by staff in children and young people services. This issue was highlighted in other trust areas.
Effective care was provided in children and young people services. The majority of staff were positive about the provision of care. There was a multidisciplinary approach to care, and staff respected colleagues in different roles and disciplines. However; staff mandatory training and appraisal rates had not met the trust target percentages.
We saw professional and compassionate care delivered to patients. Parents we spoke with were very complimentary about the service provided. Feedback received by the services from patients and families had been mostly positive.
Dedicated services for children and young people were provided, including a nursing outreach team for community-based care, and a children's diabetes nurse specialist. Links with local and regional children and young people services were excellent and worked well. The services had received numbers of complaints which were in line with other trust specialties.
There were management and governance structures in place for children and young people services. However, some staff told us they felt the services sometimes lacked trust-wide visibility. Key risks were identified, reviewed and managed by staff and senior managers. Staff were proud to work for the children and young people services within the trust. We found children and young people services provided good care.

End of life care — **Requires improvement**

Care and comfort rounds were carried out regularly to ensure patients were well cared for. We found that most of the patients we reviewed had chosen to stay at King's Mill Hospital for their care. Communication with relatives about their relative's care was not always clear and there was no specific provision made for relatives staying at the hospital for long periods of time.
Staff had 24 hour access to a hospice by telephone for symptom control and advice. There were systems in place to refer patients to the Specialist Palliative Care team; however, some staff referred patients to

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the pain team, which had delayed patients receiving the appropriate care. There were systems in place to provide planned discharges, but there were no systems in place for a rapid discharge at end of life. There was no named executive or non-executive director with a responsibility for end of life care which meant that end of life care was not represented at board level or in the Trust's vision or strategy. Staff no longer used the Liverpool Care pathway, yet the Trust had not implemented guidelines or documentation to all wards that provided end of life care. The Trust had recently started to pilot end of life care protocols on four wards.

There was no system in place for Trust wide learning from complaints or incidents about end of life care as there was no specific governance or communication channels for end of life care. There was no co-ordinated plan for audit to monitor the quality of end of life care, and there was no representation of the end of life care team at the mortality meetings. There was no Trust-wide co-ordinated multidisciplinary training in end of life care.

Records of patients' preferences, decisions and discussions with the medical teams were not always recorded and in some cases there was no evidence that these had taken place. The decision not to resuscitate a patient was recorded on Allow Natural Death (AND) forms which were not always complete, legible or the recorded reason to allow a natural death was not always appropriate.

Outpatients

Requires improvement

Outpatients departments were clean and staff washed their hands before attending to patients. There were staff shortages which had led to cancelled clinics or lack of chaperones at King's Mill Hospital. The trust had identified shortfalls in radiology and outsourced work to maintain service levels. Patient records were primarily paper files, which sometimes caused a problem when Newark patients received treatment at King's Mill Hospital. Not all staff had received their mandatory training; however, most staff had received their training in

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safeguarding adults and children. Staff knew how to report incidents, and were encouraged to do so. There was evidence that changes in practice had been implemented following incidents.

There were a wide range of clinics, with most patients receiving their appointments within target times. Staff were competent. Multidisciplinary working was especially evident and effective at Mansfield Community Hospital.

Patients were treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink, and transport arrangements. Emotional support was available in specific clinics when needed.

Most patients had access to outpatient services within national guidelines. However, some patients found difficulty getting follow-up appointments, as the demand for some clinics could not be met by the service. Telephone reminder systems were only available to those patients who had mobile phones. There had been long waiting times for people attending their appointments in some clinics; the trust had responded by reviewing the delays and capacity in the clinics.

Staff aimed to deal with complaints as they occurred to prevent them being escalated to a formal complaint. Where formal complaints had been made, the trust had not always responded within their own policy guidelines.

Staff perception of the leadership was positive; they thought that directors were approachable and listened to their concerns. The vision for the trust had recently been introduced and had not been embedded.

Staff at Mansfield Community Hospital had high regard for their colleagues, and this was demonstrated by the effective multidisciplinary team working, and the delivery of their services. However, the influence of the Mansfield Community Hospital team in policy and governance decisions was not evident.

Requires improvement

King's Mill Hospital

Detailed findings

Services we looked at:
Accident and emergency; Medical care (including older people's care); Surgery; Critical care; Maternity and family planning; Services for children and young people; End of life care; Outpatients

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Detailed findings

Background to King's Mill Hospital

Sherwood Forest Hospitals NHS Foundation Trust provides healthcare services for a population of 418,000 people across Nottinghamshire (Mansfield, Ashfield, Newark and Sherwood), and parts of Derbyshire and Lincolnshire. The trust provides comprehensive district general and acute hospital services across two sites.

King's Mill Hospital, in Sutton-in-Ashfield, consists of 623 beds and 13 operating theatres.

The King's Mill Hospital is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

Staffing

The trust employs around 3,800 whole time equivalent (WTE) staff. Its annual sickness absence rate of 4.9% is the highest of the eight acute trusts in the East Midlands.

The trust provides services for a population of 418,000 across Nottinghamshire (Mansfield, Ashfield, Newark and Sherwood), as well as parts of Derbyshire and Lincolnshire. It is a medium sized trust for inpatient and outpatient services, relative to the rest of England. General medicine and gynaecology are the largest inpatient specialties, while trauma and orthopaedics (T&O), and ophthalmology are the largest for outpatients. In Nottinghamshire, 4.5% of the population belong to non-white ethnic minorities; smoking in pregnancy is the single largest health-related concern in the trust's local area.

Approximately 90% of the activity of the trust is on the King's Mill hospital site

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality and Commissioning (Medical and Dental), Health Education England

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission

The team had 34 members, including CQC inspectors, managers and analysts, experts by experience who have personal experience of using or caring for someone who uses the type of service we were inspecting, and medical and nursing clinical specialists.

How we carried out this inspection

We visited King's Mill, Newark and Mansfield Community Hospitals during our inspection. We have included the Mansfield Community activity as part of the King's Mill Hospital report, identifying, where appropriate, the site to which our findings refer.

We inspected this hospital as part of our in-depth hospital inspection programme. The trust was placed in special measures following an investigation in June 2013 led by Sir Bruce Keogh for NHS England into the quality of care and treatment provided by trusts that were persistent outliers on mortality indicators. A follow-up visit was carried out in December 2013.

We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance

Detailed findings

information and the views of the public and local partner organisations. Using this model, Sherwood Forest Hospital NHS Foundation Trust was considered to be a high risk trust.

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

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

The inspection team always inspects the following core services at each inspection:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before visiting, we reviewed a range of information we hold about the hospital and asked other organisations to share what they knew about the hospital. We carried out an announced visit on 24 and 25 April 2014, and unannounced, out-of-hours visits on 29 April and 9 May 2014.

During our visit, we held focus groups with a range of staff, including health care assistants, nurses, allied health professionals, non-executive directors, senior staff, junior doctors, trust governors, non-clinical staff and consultants. We talked with patients and staff at the three hospitals from a range of wards, theatres, outpatient departments, minor injuries and the A&E department. We observed how people were being cared for, and talked with carers and/or family members. We reviewed personal care or treatment records of patients. We held two listening events in Mansfield and Newark, where members of the public shared their views and experiences of the hospitals.

Facts and data about King's Mill Hospital

King's Mill Hospital, in Sutton-in-Ashfield, consists of 623 beds and 13 operating theatres. Over half of the beds are in single-occupancy en-suite rooms.

King's Mill Hospital includes a 24 hour emergency department. The facility undertakes assessment and treatment of accident and emergency patients and has a designated children's area with the King's Treatment Centre offering outpatient appointments in clinics with a contemporary environment.

King's Mill Hospital has been inspected nine times by CQC on the following dates:

- 04/08/2010 (fully compliant);
- 01/09/2010 (fully compliant);
- 02/03/2011 (compliant on 10/16 outcomes);
- 31/10/2011 (compliant on 5/7 outcomes);
- 27/04/2012 (fully compliant); 28/05/2012 (fully compliant);
- 10/01/2013 (compliant on 1/2 outcomes);
- 25/06/2013 (compliant on 3/8 outcomes)
- 21/11/2013 (compliant on 0/1 outcomes)

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Accident and emergency	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good	Good	Good	Good	Good
Maternity and family planning	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Accident and emergency

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

Information about the service

King's Mill Hospital 24-hour emergency department undertook assessment and treatment of accident and emergency patients, and had a designated children's area. The department was attended by an average of approximately 90,000 patients per year; approximately 25% of these were children.

Adults were treated in one of three areas: minors, majors, or resuscitation. Children up to and including those aged 16 were treated in the children's emergency department between the hours of 9am and 8pm, and thereafter in the adult areas.

The minors area (where patients with minor injuries or illnesses were treated) had a waiting area, one streaming room (initial assessment, previously known as triage), five assessment rooms, five treatment cubicles and one eye, plaster or suture room.

The majors area (where patients with more significant injuries or illnesses were treated) had ten cubicles, three isolation cubicles, seven beds in an open observation area, and a 12-seated ambulatory area with two curtained bays for treatment purposes. An ambulatory area is where some medical conditions can be treated without the need for an overnight stay in hospital.

The resuscitation room (where seriously ill patients were treated) had seven beds (including one specifically designed for children).

The children's emergency area had a dedicated children's waiting area, four treatment cubicles, one monitoring cubicle, and one plaster and dressing room.

Within the emergency department, there was also a clinical decisions unit, with 12 reclining chairs with footrests. This unit was open from 8am to 9pm.

We visited all of these areas. We talked with 17 patients and 31 staff, including nurses, healthcare assistants, consultants, doctors, support staff and senior managers. We observed care and treatment, and looked at treatment records. We also observed care and treatment within the department using a short observational framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. Before and during our visit we received comments from people who used the service, and we reviewed performance information from and about the trust.

Accident and emergency

Summary of findings

The emergency department at King's Mill Hospital was clean and staff followed hand hygiene procedures. The environment was generally safe, with a 24-hour security presence, but there was not a safe and effective system in place for the identification of equipment for repair.

Staff had a good understanding of the incident reporting system. However, some incidents had not been reported and improvement opportunities missed.

Not all medicines were secured appropriately, and some equipment was out of date or not fit-for-purpose.

The department did not have appropriate care pathways available for staff to use.

The majority of patients we spoke with were complimentary about the care they received. We saw that people were treated with dignity and respect.

Staff were responsive to the needs of patients. Information was available, along with translation services for patients for whom English was not their first language. Plans for leaving hospital were begun early and specialist teams were available to support early discharge. Complaints were responded to in line with trust policy. However, the trust's performance with regard to the four hour waiting time was inconsistent and below the 95% national target.

There were some examples of good leadership within the department, especially for supported learning and training materials developed within the department. However, there was a lack of shared strategy or vision, and a lack of coordinated risk-based improvement planning.

Are accident and emergency services safe?

Requires improvement

Incidents

- Staff were aware of the trust's incident reporting procedure but some were unable to explain the system for capturing and sharing learning across the team or the wider organisation.
- All staff in the emergency department told us they knew how to report incidents. Staff showed us that they had access to the trust reporting system, Datix. They told us that where actual harm to patients took place, they always reported it. However, some staff told us that they did not always report other incidents because they did not receive feedback. They also told us that they did not always have time, as they prioritised patient care when staffing levels were low.
- A senior nurse told us about the process for investigating incidents, and was able to discuss how the outcomes were fed back to the team and individuals. We saw information about incidents displayed on a staff noticeboard. However, the information had not been updated since December 2013. A manager told us that this information was updated ad hoc, when there was more information, and that there was no regular system of update.
- There was a handover (huddle) board in the department which displayed some 'learning from' incidents. This information was discussed at the morning meeting of staff on duty, led by the consultant. This system was the primary focus for sharing learning with staff. Information remained for 2 weeks to ensure staff on differing shifts had chance to read it. Important information was then emailed out to all staff.
- Security staff told us that they completed paper incident report forms, which were passed to the contractor's security supervisor. We saw examples of incidents recorded on this paperwork. The supervisor passed the records on to the trust security management team. However, staff were unable to tell us how the incidents were then recorded on the electronic system used by

the trust. On the day of our visit the security staff had recorded five incidents. However, the total number of incidents recorded for the department for the previous month was one.

- The emergency department's had a system of streaming introduced self-presenting patients. The aim of this system was to increase the number of patients seen for initial assessment within 15 minutes of arriving in the department. The percentage of patients seen within 15 minutes of arrival was rising as a result of this initiative. A senior manager had recently introduced the use of different coloured chairs in the department, so that staff were aware which patients were waiting for assessment and which for treatment.

Cleanliness, infection control and hygiene

- The emergency department at King's Mill Hospital was clean and staff followed hand hygiene procedures
- Staff washed their hands and use hand gel between patients. Hand gel was available at the point of care and at the entrance to the department.
- The department had achieved 93.8% compliance with the hand hygiene audit in January 2014. Staff adhered to the 'bare below the elbow' policy.
- However, we saw one nurse disposing of a needle and blood stained swabs without wearing gloves.
- Near the nurses' station we saw that a large sharps bin (a container for the safe disposal of needles, sharps and contaminated items) had a blood stained swab partially hanging out.

Environment and equipment

- There was not a safe and effective system in place for identifying faulty equipment for repair and maintenance.
- The environment was generally safe, with a 24-hour security presence
- The children's emergency area had a large, bright, welcoming area, appropriate for children and young people. It was accessed via two sets of double doors from the area outside the adult majors department. The first set of doors remained open between the hours of 9am and 8pm. The second set of doors opened automatically when approached. The rear double door entrance to the department connecting with the adult department also remained unlocked between the hours of 9am and 8pm.
- The process for identifying faulty equipment was not clear. In the department we saw a monitor with a paper towel attached stating that it was faulty. The paper towel also stated 'no fault found'. The practice of attaching paper towels to equipment was mentioned as unacceptable in the notes of an internal assurance team audit of the department on 6 February 2014.
- We saw a pump in a clean utility area with a paper towel attached. The note on the towel said 'do not use – software error'. The note was not signed or dated. We asked the nurse in charge about the process for reporting faulty equipment. They told us that they did not understand the process of receiving feedback from a medical equipment technician about equipment. However the trust has a clear documents process managed by its medical equipment management department. We asked staff to confirm that the pump had been reported as faulty. A staff member called the help desk, but they were told that faulty equipment could only be reported to the medical equipment management department (MEMD) helpline during the daytime. The call was made during our out-of-hours inspection.
- Another nurse in charge told us that each piece of equipment had a sticker listing the asset number and the phone number for the MEMD, the department that repairs or replaces the equipment. They told us that MEMD visited the department daily and returned repaired equipment, repaired some in situ and took anything requiring repair away with them. The department did not have a documented audit trail for this process as this was held by MEMD.
- A member of staff told us that a communication handover and equipment log book previously used had been discontinued. They said that information was passed by word of mouth or using the co-ordinator's white board. Staff were unable to explain how recurrent issues were followed-up longer term. This meant that there was not an effective system in place for the maintenance and repair of equipment.
- We saw in the children's emergency area that a drawer for the storage of local anaesthetic drugs was broken. A suitable alternative storage location was being used. However, the sign on the drawer indicated that it had been broken since 1 May 2012. This means that there was not an effective system in place for the maintenance and repair of the environment.
- In the paediatric resuscitation area we found three items of single use equipment that had been opened but not used. This equipment could be dirty or

damaged when needed for life saving treatment. We found that resuscitation equipment in the paediatric high dependency room was out of date. The department took immediate action to replace this equipment during our inspection.

- The Security team were based next to the ambulance entrance to the Emergency Department and were staffed 24 hours per day, seven days per week. We saw the Service level agreement which confirmed this. Staff told us that security team members were responsive to requests for help and that they regularly patrolled the area, especially at night. Staff told us that they felt safe working in the department.

Medicines

- Some medicines were not stored safely.
- Medicines in the emergency department were stored correctly in locked cupboards. However, six out of the nine cupboards we saw did not have labels listing their contents, which is usual practice.
- Medicines in the children's A&E area were kept in the clean utility. Although this door was kept unlocked, staff told us that the medicines were kept in locked cupboards. On entering the room we found that the analgesia cupboard was unlocked. Unlocked drugs cupboards in the children's area were identified as a risk in the internal assurance team audit of 6 February 2014. The team's findings stated that "the security of medicines … is a major issue that needs immediate action". All other drugs cupboards were locked.
- We found a folder containing nurse drug dispensing protocols in the children's emergency area, which were past their review dates of January 2014.
- Staff in the emergency department told us that they used patient group directions (PGDs) for analgesia. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s), such as painkillers, to a pre-defined group of patients, without them having to see a doctor. The trust had recognised that they were not following best practice in updating these PGDs, and only having the minimum number necessary. An emergency department staff member was working on a trust-wide task and finish group, led by the clinical pharmacy manager, to reduce the use of obsolete or inappropriate PGDs, and make those that remained more robust. This meant that the department was working on some improvements for patient care.

Records

- After 8pm the children's A&E area was closed, and children had to use the main adults' waiting and treatment areas. During our visit on 29 April 2014 three patients were transferred to the adult area for continued treatment. At 9.15pm there were an additional three children and their families waiting in the main waiting area.
- There were no facilities specifically for children in this area, and they had to wait alongside adults.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy around capacity to consent, and that staff had received training in this area. In addition, staff in the department were given prompt cards to support them to follow the law. The Mental Capacity Act (2005) sets out the basic principles for dealing with patients who lack capacity to make decisions for themselves.
- We reviewed patient records and we saw one which had an appropriate mental capacity assessment recorded

Safeguarding

- The majority of staff had completed emergency department-specific safeguarding training.
- Nursing and medical staff told us they knew what to do if they had a safeguarding concern about a patient. We saw from training records that the majority of staff had completed emergency department-specific safeguarding training, including additional topics, such as domestic violence and substance abuse.
- We reviewed ten children's patient records. The front of the form states "always complete Pg5 and if concerns Pg6". These pages referred to safeguarding information. None of the ten records we reviewed had been fully completed.
- Staff showed us the documentation they used to make referrals. However, the department only had the paperwork for a referral within Nottinghamshire, despite providing services to patients from parts of Derbyshire and Lincolnshire. Staff did however have phone numbers for local safeguarding teams if required.

Mandatory training

- The department had suitable plans in place for foreseeable emergencies and staff had received relevant training

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Management of deteriorating patients

- The department used the recognised National Early Warning System (NEWS), to show when a patient's condition was serious or deteriorating. At the Keogh Review in July 2013 concerns were raised that the system had been rolled out without an updated policy, and an action plan was put in place by the trust. At the time of our visit, staff we spoke with were aware of the tool and the policy, which was being consistently used.
- We saw an example of a patient chart filled out and scored correctly. The staff member we spoke with had a good understanding of the NEWS purpose and rationale. We reviewed 20 patient records. We saw that observations were recorded accurately and in full in these records.

Nursing staffing

- The trust had a review of Emergency Care by ECIST (Emergency and Urgent Care Intensive Support Team) in 2013. This review had suggested a demand modelling process. Whilst the staff did not see this as a recognised staffing tool (to calculate the number of staff required for duty), it was being used for this purpose. The trust was staffing the service to meet the demand model.
- A nurse told us that there should be 11 emergency nurse practioners, but that there were only ten employed at the time of our visit. However, recruitment was taking place to fill the vacant position. Nursing staff told us that they were concerned about staffing levels at night.
- A nurse told us that staffing overnight was "a bit of a stretch". They felt that this "could compromise patient safety". We note that the trust does not run a day/night shift system in the ED. All staffing is staggered to match the likely profile of patients in the department with staggered start times through the 24 hour period (based on ECIST demand model). The lowest staffing is between 1am and 7am at 64% of peak day staffing when there are 7 nurses compared to 11. Patient numbers are significantly lower at this time We saw from the rotas that staffing levels at night were approximately 50% lower than during the day. We saw that nursing staffing levels had been adjusted as far as possible within the budget, to allow for increased cover overnight. However, according to data provided by the hospital, patient numbers at night were similar, and on some occasions higher, than during the day; this meant that there may not be enough qualified, skilled and experienced staff to meet people's needs at night.
- Staff in the children's area told us that if all staff were occupied with patients, and additional staff were required, members of the team from the department would assist. They told us that if no staff were available from the department, the request would be escalated to the site manager, and staff from the children's or adults' inpatient wards in the trust would attend to offer support. A staff member also told us that there was a reciprocal agreement with the neonatal department. However, we were not able to find any written policy or agreed standard operating procedure for these actions.
- The Royal College of Nursing recommends that there is a registered children's nurse in all facilities that provide emergency care for children. However, the college acknowledges that there are insufficient registered children's nurses to staff emergency departments. They recommend that emergency departments use the skills within their nursing team, but also invest in additional training for children's emergency nursing. They recommend a set of competencies for this training. Whilst the children's area at King's Mill had a lead nurse, the department had not identified competencies for registered nurses working in that department. A manager told us that they had looked at the competencies required at other hospitals in the area with a view to mirroring them. However, we saw a combined foundation and skills pack, which all nursing staff recruited to the department completed.
- A paediatric nurse told us that new paediatric nursing posts were rotational between paediatrics, neonatal and the paediatric emergency area. They told us that they were unsure who would support and deliver training for these rotational posts in the children's emergency area.

Medical staffing

- The trust risk register dated 06 January 2014 stated that the Department had the largest number of vacancies in on-call shifts it had ever experienced.
- There were not sufficient permanently employed middle grade doctors to cover night shifts in the department. The required staffing level for this grade was 12 doctors and the Department currently employed three. Shifts were covered by agency staff which the hospital's risk register stated meant "significant financial and patient harm/experience implications". Recruitment in this area is a national problem.

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- A consultant told us that the department was funded for 11 consultants, but at the time of our visit there were only seven employed. Staff told us that there were often more people in the resuscitation area at night, which meant that middle grade doctors were busy in this area, and were not available to see patients in the majors area. We saw during our announced and unannounced out-of-hours visit that this was the case. We also saw that this meant that patients with less urgent conditions waited longer than should be expected to see a doctor.
- A junior doctor told us that when working in the children's emergency area they had little contact with the paediatric inpatient staff teams.

Major incident awareness and training

- The department had suitable major incident plans in place, and staff had recently completed relevant training. There was a nominated lead nurse for major incident planning.
- Staff were aware of trust-wide plans for emergencies. For example, we spoke to the staff member leading specifically on chemical, biological, radiological and nuclear (CBRN) protocols, which are one category of emergency planning. They were able to explain the trust protocols and show us the relevant documentation and personal, protective clothing. They were also able to explain decontamination procedures for the trust, in line with accepted current guidelines and practice.

Are accident and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The emergency department at King's Mill Hospital did not have appropriate care pathways available for staff to use.

There was sufficient equipment available in the department. The majority of staff working with children had completed a European paediatric life support course.

There was some evidence of effective and innovative working between teams within the department.

Evidence-based care and treatment

- The emergency department at King's Mill Hospital did not have appropriate care pathways available for staff to use. The documents shown to us, and described as care pathways were, in fact, guidance. National Institute for Clinical Excellence (NICE) guidance documents set standards for high quality healthcare. NICE Care Pathways are a visual representation of NICE's recommendation on a topic, with accompanying tools to support implementation of their guidance.
- Folders labelled as clinical pathway documents were empty at the time of our visit.
- The pathway for diabetic ketoacidosis (DKA) was a flow sheet with insufficient space to complete the information required. When we asked to see the pathway this folder was also empty. We asked the trust for evidence that they had recently carried out audits of care pathways, but we did not receive any evidence of this.
- The emergency department ambulatory protocols displayed in this area were marked draft v1 and dated 14/11/11. A nurse told us that these were out of date, and this included the pathway for deep vein thrombosis (DVT).

Patient outcomes

- NICE guidance for a fractured neck of femur (hip fracture) states that the patient pathway should “from admission, offer patients a formal, acute orthogeriatric or orthopaedic ward-based Hip Fracture Programme." Data from the British Orthopaedic Association, the British Geriatrics Society and the National Hip Fracture Database to suggest that if this does not happen there is an increased risk of poor outcomes to the patient. King's Mill Hospital has been flagged by Dr Foster Intelligence as having “an elevated risk” in hospital-standardised mortality ratios. We saw evidence that patients at King's Mill Hospital emergency department were admitted to a bed on the emergency assessment unit which is not in line with evidence-based guidance. Staff were unaware of the fractured neck of femur database, which monitors performance against nation guidance. The lead nurse for the children’s emergency area was not aware of any care pathways for paediatric patients.

Nutrition and hydration

- We saw staff checking on the welfare of patients and providing drinks.

Competent staff

- A senior nurse told us that there was always a nurse working in the children’s area who had completed the

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European paediatric life support course. Staff we spoke with who worked in the department had completed the required training, and records showed that 60% of all staff had completed it.

Multidisciplinary working

- During our visit there was a junior grade medical doctor working in the emergency department. This doctor was there for six months, to help avoid unnecessary admissions. Staff told us that doctors from the medical division took a rotation in this team. This meant that there was evidence of some effective and innovative working between these two teams.

Are accident and emergency services caring?

Good

The majority of patients we talked with were positive about the care they had received. We heard staff introduce themselves and explain the purpose of their actions. We saw that staff responded rapidly to the needs of patients and relatives, and information leaflets were available in the department.

Compassionate care

- The A&E department scored above the England average in the Friends and Family test, with a score of 4.5 for March 2014.
- The majority of patients we talked with were positive about the service. Comments included:
- “it’s been brilliant here”;
- “I’m happy with what they’ve done”;
- “my experience has been very positive; I have been treated with kindness and respect”.
- During our inspection we observed care and treatment within the department, using a short observational framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We saw that interactions between staff and patients were all positive. We saw that privacy curtains were used appropriately for every patient we observed. We heard staff introduce themselves and explain the purpose of their actions. We saw a porter gently wake a patient to explain that they were taking them for an X-ray. We saw that staff responded rapidly to the needs of patients and relatives. For example, we saw staff checking on the welfare of patients and providing drinks and extra blankets.

Patient understanding and involvement

- We saw that nurses greeted patient’s relatives with a smile, and supported them to find their loved ones in the department. We saw information leaflets on a number of conditions were available within the department for patients and relatives.
- However, on one occasion in the children’s area we overheard staff discuss a patient with their parents, in an open area where two other patients and their parents were waiting to be treated.

Emotional support

- We observed staff talking to patients respectfully and offering them reassurance.
- One patient was seen wandering around the department confused, and a nurse immediately helped them back to a treatment area and explained what would happen next. We saw another nurse take a distressed relative to a private area to reassure them about the treatment of the patient.

Are accident and emergency services responsive to people’s needs?

(for example, to feedback?)

Requires improvement

The trust’s performance, with regards to the four hour waiting time target for accident and emergency departments, has been inconsistent. In January 2014, 93.9% of patients spent less than four hours in the department, just under the target of 95%.

Patients arriving at the department by ambulance should be received by staff within 15 minutes of arrival according to targets. In January 2014, the average time for patient handover at King's Mill Hospital emergency department was 16.4 minutes.

Staff were aware of how to manage complaints and how to support patients who wished to complain. However, the system may not be effective at night.

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Service planning and delivery to meet the needs of local people

- The trust's performance, with regards to the four hour waiting time target for accident and emergency departments, has been inconsistent. Trusts within England are set a government target of admitting, transferring or discharging 95% of patients within four hours of their arrival in the accident and emergency department. Since May 2013, performance at the trust has improved. In January 2014, 93.9% of patients spent less than four hours in the department, just under the target of 95%.
- A doctor told us that the main issue with meeting the four hour target was patient flow within the hospital. Between October 2013 and December 2013, the trust's bed occupancy was 91%. It is generally accepted that bed occupancy rates above 85% have an impact on the quality of care provided, and the orderly running of the hospital.
- During our visit we saw that it was sometimes not possible to admit patients onto a ward from the emergency department, because there were no beds available. The meant that the patient stayed in the department longer than four hours.
- Staff told us that the trust had started a project to look at this challenge. A consultant from the department had joined the project group. We saw a copy of the 'Emergency Flow Transformation Project'. However, this was in draft form, and the project had not begun at the time of our visit.
- Patients arriving at the department by ambulance should be received by staff within 15 minutes of arrival according to targets. In January 2014, the average time for patient handover at King's Mill Hospital emergency department was 16.4 minutes.
- We saw posters in the department for an interpreter service for patients whose first language was not English. Staff told us that there was an interpreter available by telephone. A staff member told us that some of the health information leaflets, such as head injury advice, were available translated into languages appropriate to the local community. We saw that these leaflets were available in a waiting area.

Access and flow

- During our inspection, staff told us about the emergency discharge assessment team (EDAT). We saw this team getting involved with a patient very soon after they arrived in the emergency department. This meant that plans for the patient to leave hospital and go home were begun when they arrived.
- The nurse in charge told us about the medical assessment and discharge support service (MADS), which had been set up during 2013 to support patients to be discharged from the emergency department, when they were medically fit, but requiring an interim care package. The trust provided us with the service specification document for this team.
- We saw that during the months April to December 2013, the service supported 329 patients to be discharged from the emergency department, avoiding unnecessary admissions. These teams worked to ensure that patients left hospital as soon as possible, with the right support to go home. This meant that patients did not stay in hospital when they had a social, rather than a clinical, need for support.

Meeting people's individual needs

- Staff showed us four relatives' rooms which were available for use. These rooms contained information leaflets for relatives.
- Staff told us that in the case of bereavement relatives were able to use these rooms. We also saw a bereavement centre leaflet which staff told us they gave to relatives to support them with the practicalities of the death of a loved one.

Learning from complaints and concerns

- We saw posters displayed around the department which explained to patients how they could make complaints and give feedback. We saw a complaints board in the department. Staff told us that this would be updated monthly in future, to show what patients and relatives had said about services, and what the department had done. However, staff told us that this board had only been put up within the past week, so this information was not yet on display.
- Staff were aware of how to manage complaints and how to support patients who wished to complain. We talked with nursing staff who told us that they would put patients in contact with the Patient Advice and Liaison Service (PALS). Information about this service was displayed in the department for patients. However, this service was not open at night.
- We talked with housekeeping staff, who told us that they would escalate complaints about housekeeping to their

line manager. Where the complaint was about patient care, they would direct the complainant to a nurse. We talked with a senior manager who showed us how they managed complaints in line with trust policy, and we saw that a nurse supported a relative to make a complaint during our visit.

Are accident and emergency services well-led?

Requires improvement

Although the trust had recently introduced a 'Quality for All' programme, focusing on shared values and behaviours, none of the staff we spoke with were aware of this initiative.

Staff were not aware of a strategic plan for the emergency department,

Some identified risks had not been appropriately responded to.

All the staff we spoke with told us they felt well supported by their colleagues and line managers. Staff told us very clearly that this was a strong team working very hard to meet the needs of patients.

Vision and strategy for this service

- The trust had recently introduced a 'Quality for All' programme, focusing on shared values and behaviours. The intention of the programme was to support staff to provide the best patient experience and outcomes. This was launched in March 2014; none of the staff members we spoke with in the emergency department were aware of this initiative.
- Staff were not aware of a strategic plan for the emergency department. Individual staff members had views about how improvements could be made, and were focused on improving patient care.

Governance, risk management and quality measurement

- We were not able to see a single overall action plan for the department which also took account of risks. For example, the internal audit team had noted in February 2014 that "the security of medicines … is a major issue that needs immediate action". Nevertheless, at our visit in April we found an unlocked drugs cupboard in the children's emergency area. This audit visit had also identified the inappropriate use of paper towels attached to faulty equipment. This practice was still being used two months later during our visit. These risks had not been effectively responded to.
- Staff told us that there was a monthly governance meeting held between consultants and senior nurses. However, although we saw agendas for this meeting, staff were unable to show us copies of minutes taken or actions recorded.

Leadership of service

- All the staff we spoke with told us they felt well supported by their colleagues and line managers. One staff member told us that the chief executive officer had visited the department recently on two occasions. The first time he had walked through a patient journey, and the second time he had presented an award to a nurse. They told us that this was "an enormous morale boost to the team".
- They also said that the trust chair had visited the department, and taken time to speak with the team on a personal level, which they appreciated.

Public and staff engagement

- Staff told us very clearly that this was a strong team working very hard to meet the needs of patients. We saw that consultants worked effectively and supportively with other doctor grades. We also saw doctors working effectively with nurses. Communication was clear and encouraging, and senior doctors repeated important information where necessary to ensure junior staff understood. We spoke with a porter and a housekeeper who told us that they felt part of the team and enjoyed their job. However, the porter did question why the emergency department board did not feature photographs of porters along with the rest of the team.

Innovation, improvement and sustainability

- Several staff explained how they were taking a lead in making improvements, such as learning basic phrases in another language, or developing training to ensure that trauma skills were maintained by all staff.

Medical care (including older people's care)

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

Information about the service

King's Mill Hospital's Medical Care service has 15 wards, including cardiology, haematology, gastroenterology, stroke care, respiratory care, care of the elderly, a short stay ward and a discharge ward. The cardiac ward, including the coronary care unit, has 23 beds in total. The three respiratory wards each have 24 beds. There are three wards for the care of the elderly, each having 24 beds. The stroke care ward has 23 beds and the stroke rehabilitation ward has 15 beds. Linked to the hospital's Accident and Emergency service in the Emergency Department (ED) is the emergency admission unit (EAU) ward, with 47 beds provided. Overall, the hospital's Medical Care service has 352 beds, with up to 47 beds in the EAU for medical care patients. The bed occupancy for general and acute departments (including the medical care service) for the period October to December 2013 was 91% across the 505 beds available in the hospital. This is above the England average of 85.9%, indicating a higher than average demand on the beds available.

During our inspection, we visited 15 wards, and the EAU, and spoke with 56 patients, 82 staff, and 10 people visiting relatives. We also looked at the care plans and associated records of 43 people. We carried out an unannounced inspection in the early morning and visited three wards.

Summary of findings

Hospital Standardised Mortality Ratio (HSMR) was previously high, but is now falling within the expected range.

There were no reliable systems in place to ensure that all people were monitored effectively, and some documentation was poor.

Some people's care plans were not effective in providing guidance to staff as to how to safely provide the care and treatment to meet their assessed needs. People may not have been receiving the appropriate care and treatment for their needs, as their records were not always clear and current.

We also found specific concerns about the staff's ability to recognise when a person was deteriorating, and the quality of recording for people's observations.

Staffing levels were variable. Medical care service were addressing some of the concerns regarding staffing levels, staff skill mix and monitoring the condition of deteriorating people. Staff recruitment was in progress to fill staff vacancies.

All wards had introduced clearer systems for sharing information about the ward's performance with staff and visitors.

People we spoke to were, in the majority of cases, very complimentary about the staff and the care they received.

Medical care (including older people's care)

Staff felt well supported at a ward level, but not all staff had a clear understanding of the board's vision and strategy.

Are medical care services safe?

Inadequate

Although we found the medical care wards to be clean and well maintained, we found that the numbers of nursing staff was variable. Incidents were reported, but staff teams were not consistently aware of what preventative actions could reduce the risk of harm to people.

People may not have been receiving the appropriate care and treatment for their needs, as their records were not always clear and current. We also found specific concerns about the staff's ability to recognise when a person was deteriorating, and the quality of recording for people's observations.

Staff training was variable across the wards in meeting the trust's targets, and we found poor record keeping with regard to people's observations and also on some drug administration charts The introduction of the performance boards across the wards was seen as a positive by staff, but not all staff were fully aware of the significance of the issues reported on them.

Regular audits were being carried out on the main risk areas, and the medical care wards had a number of areas of concern.

People were not always given medicines according to their prescription.

Incidents

- A serious incident known as a 'never event' is classified as such because they are so serious they should never happen. ('Never events' are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.) The trust have reported that one such incident occurred in the past year on a care of the elderly ward, whereby a patient received a medicine daily when it should have been weekly.
- There were 157 patients safety incidents between March 2013 and February 2014, which represented 41% of the trust's total incidents. Most of these incidents related to pressure ulcers and falls in line with the requirement placed on the Trust to report all Grade 3 pressure ulcers

Medical care (including older people's care)

- In those incidents where patients suffered severe harm, 60% of the whole trust's incidents occurred on medical wards. These incidents mostly related to people having pressure ulcers or falls.
- From March 2013 to February 2014, the trust reported three incidents where patients died in medical care wards, out of a trust total of eight for this period. The trust investigated one incident when a patient died as the monitoring score for recognising when people deteriorate (NEWS) had not been calculated correctly, and was therefore not reviewed by a doctor, as was the standard hospital's practice. One person was not given intravenous medication (IV) as they did not receive IV access. The outcome of third incident was not available at the time of our visit.
- Some staff were able to tell us of how people's falls were investigated, and what plans were in place to reduce the risk of further falls. However, not all staff across the medical care service had an understanding of falls prevention, other than to refer to the trust's falls advisory nurse.
- Staff told us how incidents were recorded and reported via the trust's computerised Datix system. Most staff told us they had feedback about the incidents, but some staff told us they did not know what happened to the reported information.
- For February 2014, a total of 277 incidents were reported across the medical wards on the trust's Datix reporting system.

Safety thermometer

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing harm to people and 'harm free' care. Monthly data was collected on pressure ulcers, falls and urinary tract infections (for people with catheters), and blood clots (VTE).
- For April 2013 to March 2014, the trust had seven out of 12 months where the reported 'harms' rate was less than the national reported rate. Falls reported in the last quarter of this period showed the trust reported 0.3% against a national average of 0.8%. When reviewing new harms (hospital-acquired harms) for 11 out of 12 months, the trust reported fewer 'harms' to people when compared to the national results.
- The trust had reported an incidence of 0.61% for new pressure ulcers, against a national average of 1.06%.
- The incidence and timing of falls was being monitored on all wards, and some wards had extended visiting times so that visitors would be able to spend more time with their relatives in the afternoons, which was a peak time for falls on these wards.
- The number of falls in February 2014 showed as not meeting the trust's ambition of zero falls on all medical wards. In February 2014, there was a reduction in falls across all wards except two. Seven wards reported more than 10 falls for the month. However, only two falls out of the total of 130 resulted in severe harm, and only one was reported as a serious incident.
- Some staff were able to explain the trust's pressure ulcer prevention plan (PUPP), in line with standards set out by National and European Tissue Viability Standards, but some staff were not able to explain clearly what actions were being taken to prevent pressure ulcer development.
- One grade two hospital-acquired pressure ulcer was reported across the medical care wards for February 2014.
- For February 2014, ten medical wards achieved an average of 88% against a trust target of a 90% for the tissue viability nursing metrics

Cleanliness, infection control and hygiene

- Wards and communal areas were visibly clean and odour free. Personal protective equipment was available in all areas for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display.
- All wards that we visited had facilities for isolating patients with an infectious disease, and we saw appropriate signage on people's doors to indicate barrier nursing was in place.
- Generally, cleaning schedules had been completed as required, but on one care of the elderly ward, we found they had not always been completed in March.
- Staff followed universal infection control procedures. However, we saw one staff member attend to five separate patients without washing their hands in-between, in breach of the trust's policy on universal infection control.
- One incident of hospital-acquired C. difficile was reported in February 2014 for the medical care wards, and no new cases of MRSA were reported in the same month.

Medical care (including older people's care)

- Three norovirus cases were reported for February 2014.
- For February 2014, ten medical wards achieved an average of 88% against a trust target of a 90% for the infection control nursing metrics.

Environment and equipment

- The environment was clean and tidy, and the décor was to a high standard. Side rooms and communal areas were spacious and well lit, and overall the environment was well maintained.
- There were systems to maintain and service equipment as required. Firefighting equipment had been checked regularly. On one ward, we saw that two hoists did not have the date of the last check on them, but staff were able to confirm they had been serviced recently.
- The care of the elderly wards were not specifically designed to provide an appropriate environment for people with dementia. Staff told us of plans for ward 52 to become a dementia-friendly ward with appropriate décor, flooring and a larger lounge for activities.
- There were gaps in the required daily check records of resuscitation equipment on five wards. One ward had eight occasions in March when the record had not been signed. Staff in one ward told us they had identified this issue, and addressed it by putting in place systems to ensure this check was completed and audits carried out regularly.

Medicines

- All wards had appropriate storage facilities for medicines and had lockable drawers in people's bedside cabinets to keep medicines in.
- On most occasions we saw that medicines were stored safely. However, when we asked a junior staff member on one ward where the medicines were stored, we were given the key to the medicines store. The senior staff nurse that we informed of this concern did not recognise this as a concern about the key holding arrangements for medicines.
- We looked at the medicine records for six people, and found gaps in the signing for prescribed medications in each case. We brought these to the attention of senior staff.
- We were told that regular medication audits were carried out and that at each shift handover, nurses checked the drugs record to be able to identify and action any such discrepancies. Reconciliations of controlled drugs were also carried out at staff handovers.
- We looked at the records for one person who was having pain relief via a syringe driver, and we found that the driver had not been checked every four hours, as was required, but at five hourly intervals.
- We found that one person had had their antibiotic medicine given late for five doses out of thirteen. Staff said it was due to difficulties in inserting a cannula to give this medicine intravenously.
- We found one person had refused all medication apart from pain relief for a period of five days without this being reviewed by a doctor. Senior staff confirmed this was not in accordance with hospital procedure, and said they would arrange for the person to be seen by a doctor.
- For February 2014, four medical wards did not meet the trust target of 90% compliance with the trust's quality audit for medicines.
- Medicines reconciliations were carried out on peoples' admission. Audit data for the National Institute of Excellence (NICE) and National Patient Safety Agency (NPSA) joint recommendation in 2008 shows over 95% of reconciliations completed, with 75%-85% done in 24 hours of admission (the target is 95% completed, with 90% in 24 hours). The trust was therefore meeting its target for reconciliations completion, but not meeting the target for completion within 24 hours. We found that fridge temperatures were not being monitored daily, with the one date completed for April in the Emergency Admission Unit (EAU).
- A total of 27 medication incidents were reported for February 2014, with one incident reported as causing moderate or severe harm.
- There was a trust-wide policy for self-medication. Staff were aware of it and it was used at King's Mill, though not widely. There was no facility to support self-medication at Mansfield Hospital, even though they have rehabilitation wards there.

Records

- We looked at the documentation kept to record peoples' vital signs observations, fluid balance charts, food intake and repositioning charts. We found inconsistent recording on most wards that we visited.
  - On one ward, out of nine people's records, we found gaps in recording for all nine people regarding their fluid intake.

- In other cases, we found there was no recorded repositioning for one person for 14 hours, yet their care plan said to reposition two hourly.
- On another person's repositioning chart, there was a gap in recording of seven hours, which meant there was not sufficient evidence that the person had received appropriate care to prevent the development of pressure ulcers.
- We also found that staff had not always calculated the National Early Warning Score (NEWS) when required. Observations of vital signs had been taken, but the total score had not always been recorded. For example, on one person's chart, the total NEWS score was not recorded on three occasions in 24 hours.
- On one ward, we found that people's documentation for their cannula checks was not always completed.
- For most people's fluid balance charts, the daily total had not been calculated to give an indication of how much fluid they had had that day.

- On one ward, we looked at the hydration records for nine people, and found that the recording of what they had to drink was not clear for all nine people. Some charts did not have daily totals calculated, others had gaps, and others did not specify the amount of fluids taken.
- On most wards, people's confidential records were stored securely, but we found one ward did not have secure lockable facilities for people's records. On another ward, we found a serious complaint document was clearly visible, on an unlocked computer screen, with no staff present, that any visitor could have read, breaching confidentiality procedures.
- People's risk assessments were generally reflective of their needs, but on two occasions, we found that safer moving and handling plans had not been updated regularly, and were not reflective of people's current needs.
- We noted that not all updates and amendments to nursing risk assessments and care plans had been dated or signed, so it may have been difficult to check who had made the entry if required.
- We found that daily checks on pressure relieving equipment had not been recorded every day for four of the records that we viewed. Ward leaders confirmed it should be recorded daily.
- From the most recent data provided, five medical wards did not meet the trust target of 90% compliance with the trust's quality audit for infection control in February 2014. Seven medical wards did not meet the trust target of 90% compliance with the trust's quality audit for recording of observations.
- We saw from one person's records that they had had minimal food intake for four days, less than half the daily recommended fluid intake for four days, had refused all their medication for seven days (apart from pain relief), and had refused to have their observations taken 11 times in five days. They had not been reviewed by a doctor for over seven days, which was not in accordance with hospital procedure, so a senior staff member said they would arrange for the person to be reviewed by a doctor that day.
- We found that there had been a delay of over six hours in one person having their insulin administered due to staff not being able to locate the person's insulin record chart. This person's blood sugar level was checked and, as it was high, a single dose of insulin was administered.
- We found that one person, with a grade three pressure ulcer, had not been repositioned two hourly as per their care plan.
- At a staff handover we observed, staff did not mention people's pressure area risk or whether they needed repositioning.
- We observed one person being assisted to move from bed to chair by one staff member, but when we checked the person's moving and handling plan, it said the person needed the support from two staff to move safely.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found that staff understanding and awareness of assessing people's capacity to make decisions about their care and treatment was variable. Some assessments correctly recorded specific decisions and the reasons for the judgement made, whilst others did not. The involvement of family members or people's representatives was only recorded in a minority of cases.
- In one case, we saw that a Deprivation of Liberty Safeguards (DoLS) assessment had been authorised six weeks previously on a different ward; yet the rationale for this authorisation was not clear. The staff on the patient's current ward had identified this as an area of concern, and arranged for the DOLs authorisation to be reviewed during our inspection.

Medical care (including older people's care)

- We found that whilst 93% of staff had had Mental Capacity Act (MCA) awareness training as part of the mandatory staff training programme, this training was only for half an hour, and staff told us it was not comprehensive. Additional MCA training was provided by the trust, but only 50% of staff had attended this training.

Safeguarding

- The trust had a safeguarding lead for the hospital, who was supported by a part time colleague. We found that there was effective multidisciplinary communication with safeguarding leads in other organisations, and all referrals and concerns were triaged by the Nottinghamshire Multi Agency Safeguarding Hub (MASH). Staff told us this worked quickly and efficiently to safeguard people from harm.
- We found that all safeguarding investigations were carried out within the target timescale of 28 days and we saw evidence of effective protection planning to keep people safe.
- The commonest themes for safeguarding referrals about the hospital was poor communication by hospital staff, especially regarding discharge planning.
- Staff told us the trust's target for staff safeguarding training was 100%, and that 90% of staff had had safeguarding training. We were told that some staff had not had this essential training due to staff turnover, and that further work was being undertaken to explore reasons as to why the training target had not been met.
- For February 2014, five medical wards did not meet the trust target of 95% compliance with safeguarding adults' training.
- For February 2014, 11 medical wards did not meet the trust target of 95% compliance with safeguarding children's training.
- No advanced safeguarding training was offered to staff, apart from the trust's safeguarding leads.
- The staff we spoke to demonstrated an understanding of the signs of abuse, and how to raise concerns. Staff were able to tell us about the trust's whistleblowing policy, but not all staff said they would be confident of using it.

Mandatory training

- Staff told us they had had mandatory training events annually, which included infection control, moving and handling, and health and safety.
- Dementia awareness was included in the mandatory training days, and some staff had also completed the managing conflict training offered by the trust. The hospital reported that 83% of staff had had dementia awareness training against the target of 90%.
- We found on some wards that only 50% of staff had completed the managing conflict training, and we were told that some staff had been booked onto forthcoming sessions.
- Half the staff had completed the additional training event for mental capacity act awareness and DoIS awareness.
- For February 2014, 12 medical wards did not meet the trust target of 95% compliance with infection control and hand hygiene training, and 11 medical wards did not meet the trust target of 95% compliance with the management of medicines training.

Management of deteriorating patients

- The trust reported that the national early warning score system (NEWS) was implemented in February 2013. The use of this risk assessment tool had resulted in a significant increase in calls to the critical care outreach team (CCOT) so that people's condition could be reviewed by a doctor.
- The trust reported that data from the nursing care metrics (Focus IT) monthly audits indicated that compliance with recording all six vital signs (respiratory rate, oxygen levels, blood pressure, pulse, temperature and level of consciousness) was 97-100%, and compliance with documentation of the NEWS score was 96-99% Additional training in the use of a simplified colour-coded observation chart had been provided, together with further involvement of the Healthcare Support Workers, who had all been trained to calculate the NEWS score. The trust has noted a 50% reduction in the number of cardiac arrests. It is unclear if this is related.
- However, when we looked at the observation charts for 16 people, we noted that whilst most had been completed, there were gaps in one person's records, which may indicate that this person's observations had not been completed at the time frequency specified, and that the NEWS score had not been completed.
- Another person had last had their NEWS score done nine hours previously when it should have been done every four hours.

Medical care (including older people's care)

- This NEWS assessment was based on accuracy of observations being taken by the staff. We saw one occasion when junior staff had not taken accurate respiratory observations, and this meant the NEWS score was not accurate. Their rate of breathing observations had not been taken correctly and junior staff had not recognised this person was deteriorating. We brought this to the attention of senior staff so that appropriate care could be delivered.
- Some healthcare support workers (HCAs) told us they had been instructed to do people's observations, and some did not feel confident or competent to take them.
- Two ward leaders told us that not all HCAs fully understood the importance of accurate recording for people's observations, and also that gaps in recording occurred when staff were "under pressure" and very busy.
- The trust was piloting an electronic system for monitoring and recording patient's observations. This 'VitalPAC' system was being piloted in four wards, and staff told us that it was very easy to use. VitalPAC is an electronic, wireless point of care system, which enables staff to record people's observations using hand held devices, which trigger earlier reviews by doctors. The system made it clear for staff to see when a patient was due to have their next observations taken via the handheld device, and staff could change the frequency of observations if they considered someone's condition was changing. Future plans included a full roll-out of the system across the hospital including doctors, so an electronic escalation procedure would be implemented when someone was deteriorating and needed a medical review.
- Not all staff we spoke to were able to tell us about the hospital's pressure ulcer prevention protocols.
- We looked at ten people's weight charts and found that three people had not been weighed since admission, which meant there was not an accurate body mass index (BMI) which was used to monitor weight loss or weight gain. Also, the skin damage risk assessment for this person may not have been accurate as weight loss was used to calculate the overall risk.
- We found sepsis boxes (boxes of antibiotics for rapid treatment of infection) were available on wards to facilitate timely treatment of those people whose observations indicated an infection was contributing to their deterioration.

Nursing staffing

- Data from the Association of UK University Hospitals (AUKUH) acuity and dependency audit, collected daily across the trust, showed that the proportion of acutely ill adults (those people needing Level 1a care) had increased gradually from below 1,000 people in January 2012 to over 1,500 people March 2014. The increase in patient acuity had led to an increased number of calls to the outreach team (CCOT) for assistance.
- On five wards we visited, we noted that some call bells were not answered within five minutes, which staff told us was the trust's policy. We saw that one bell was not answered for 18 minutes and another for over 10 minutes. Whilst the majority of people said they did not have to wait for staff assistance, two people told us that staff didn't answer call bells quickly, and one person said it can take the staff up to 15 minutes to answer the bell at busy times.
- We were told no wards have ward sisters on duty at the weekend, and senior nurses, usually a Band 6 registered nurse, act as shift leaders.
- We observed a morning handover between staff on one ward, and we saw that printed handover sheets were used which listed people's conditions and treatment. Some staff gave detailed handovers, included the person's co-morbidities, but other staff gave a perfunctory verbal handover that did not give all the required information.
- The handover we observed included non-qualified staff, but one senior staff member on one ward told us that these junior staff did not always attend the handovers.
- Wards had seen an increase in staffing levels following our last inspection.
- The staff to patient ratio ranged from 1:6 to 1:8 on different wards. Some staff told us there was enough time to attend to people and to sit with them when needed, whilst other staff said there was not enough time and they were "always busy".
- The staffing skill mix for qualified nurses to healthcare support workers (HCA) varied from ward to ward. Over half the wards had a skill mix of 50:50 with a patient to qualified nurse ratio of 1:8. Staff told us of the trust's aim to move to 70:30 skill mix: this was dependent on an ongoing recruitment drive. Some wards had a higher ratio of qualified nurses to HCAs. For example, the skill mix was 77:23 on the stroke wards, with a patient to qualified nurse ratio of 1:5.

Medical care (including older people's care)

- Some wards reported higher than average staff vacancies and sickness, and were reliant on bank staff and agency staff to maintain staffing levels. We saw that an induction checklist was used for agency staff, to support them in familiarization with the ward. Staff told us that they tried to use the same staff so there was consistency in the level of care for people.
- From the monthly nursing care metrics report for February 2014, five medical care wards had more than three whole time equivalent (WTE) vacancies for qualified nurses.
- For February 2014, only two medical wards had more than three whole time equivalent vacancies for unqualified nursing staff.
- Some people told us there were more agency nurses on duty at night than during the day.
- The newly employed staff we spoke with told us they had had a good induction and that there was effective support in this process.
- The hospital used a 'reducing harm' additional staffing service, whereby wards could request additional staff, from a central bank or agency, to provide a one-to-one care service for those people with high needs. This was used, for example, for people with dementia who were agitated or displaying disruptive behaviours.
- One person on a care of the elderly ward told us they did not feel safe, as during the previous night, another person tried to remove a cannula from their arm, and no staff were around.
- One ward leader was able to explain there was a monthly nursing care metrics based on the electronic staff rota that showed whether each ward was over or under staffed. However, most senior staff we spoke to were not able to tell how the trust was monitoring actual staffing levels against the planned staff rota, other than the performance boards on display in the wards.

Medical staffing

- There was no dedicated specialist consultant cover at the weekends. For the healthcare of the elderly wards, out-of-hours cover was provided by the hospital's on-call rota of doctors, who were from all different medical specialisms.
- Staff told us that not all wards had doctors working on them out of hours, and would therefore be reliant on the doctor's' on-call system.
- Staff told us that on a recent Bank Holiday, there was insufficient medical cover, which led to three people who were deteriorating not being medically reviewed for two hours.
- Some staff on the care of the elderly wards told us there were usually more doctors on the other wards, and their ward only had two doctors.
- Staff told us that consultant cover was good during the working day in the week, but that consultant cover for out of hours and weekends was variable. For example, staff told us that the respiratory wards had an effective weekend consultant cover rota in place that worked well.
- Some wards reported that the doctor's cover rota was reliant on the use of locums.
- The medical handover that we observed was efficient and there was effective communication displayed about people's conditions.
- A doctor we spoke to said that their induction was the "best they had had" and there was excellent support from senior doctors.
- One person told us that they had had an X-ray after a fall at home, and had been waiting over seven hours to be told by doctors whether they had broken a bone or not.
- Doctors told us of lack of consultant cover at nights for some specialties (for example, cardiology and care of the elderly), and some said there was variable quality in locum doctors used.

Major incident awareness and training

- Senior staff told us the trust had business continuity plans in place, and had systems and processes in place to be able to respond to major incidents.
- One ward had been used as a 'winter pressures' ward, but staff told us there was not always sufficient cover by doctors.
- This was, at the time of the inspection, being used as a short stay ward for people who needed short length stays in the hospital.

Are medical care services effective?

Requires improvement

Care was provided in line with national best practice guidelines, the trust participated in most of the national clinical audits they were eligible for (except for diabetes).

Medical care (including older people's care)

Due to inconsistent record keeping, particularly about people's fluid intake, effective care was not provided, because accurate records were not kept to ensure staff were able to monitor people's condition.

The trust had responded to higher than average deaths from infection and stroke, to reduce the level of risk to people. There was evidence of progress to providing seven day a week services, but this had not been consistently achieved across the medical care service.

Not all staff said they were supported effectively, and there were limited opportunites for regular supervisions with managers.

Evidence-based care and treatment

- Both the stroke and cardiology wards administered care in line with national (NICE) guidelines.
- We saw one person was trying to climb out of a low bed, which had bed rails up on both sides. Staff attended to this person, who had a cognitive impairment, quickly and appropriately. Staff told us that the bed rails should not have been up, and they did not know if the person was to have crash mats on the floor next to the bed to reduce risk harm of falls.
- This person's falls risk assessment and mobility assessment had not been updated to fully reflect the current risk of falls, and what equipment should have been used. We revisited this person later in the inspection, and found that crash mats were then in place. However, the falls risk assessment and mobility care plan had not been updated to reflect the level of risk and the equipment that had been put in place.
- We were told by staff that audits on documentation for mental capacity assessments, and DoLS assessments, were "only just starting". The trust confirmed that this had begun in September 2013.
- We found that the medical care service was participating in and reporting on the national clinical audits, apart from the audit of adults with diabetes.
- For February 2014, the medical service carried out 12 local audits, including falls, medicines and tissue viability, and reported the findings using the nursing care metrics system. Two wards did not report any data for this month.
- Five medical wards and three surgical wards, who had dementia patients present on the ward met the trust's target for 90% compliance with dementia care for February 2014. Five medical wards and three surgical wards had no dementia patients during the audit. Only 2 wards didn't submit data.
- The cardiology department contributed to the Myocardial Ischaemia National Audit Project annually.
- However, the hospital performed worse than expected against the national average for those people with nSTEMI who were admitted to a cardiac ward. The quicker a person is admitted to a cardiac ward, the better their prognosis would be. No data was available for those people with a diagnosis of STEMI (a type of heart attack) being seen within 90 minutes by a cardiologist.
- The stroke department also contributed to the Sentinel Stroke National Audit Programme (SSNP).

Pain relief

- Not all people's pain relief assessments and care plans that we saw had been reviewed on a daily basis, as was required. One person's pain assessment chart had not been reviewed for 11 days.
- One patient told us that they had asked the nurses for pain relief, but they had been unable to give any, as they had to follow the doctor's prescription, and the person said they had to wait for a doctor to be informed.
- On one of the stroke wards, we found that a person's pain relief was being managed via a syringe driver. The documentation for the medicines showed that an incorrect amount had been made up at the commencement of the treatment, with 1.5mls less than the required 17mls. Also, the driver was running slowly by two hours, but there was no recorded explanation of why it was running slow.
- For February 2014, eight medical wards did not meet the trust target of 90% compliance for the pain management audit.

Nutrition and hydration

- The trust reported that the 'Making Mealtimes Matter' initiative was developed to support the national 'protected mealtime's initiative' and drive up standards, with clear expectations for all staff. The hospital has a specialist nutrition nurse, and a nutrition steering group to promote staff awareness.
- Monthly audits were carried out to assess wards' compliance with the documentation, and staff understanding of promoting nutrition and hydration.

Medical care (including older people's care)

- For February 2014, four medical wards did not meet the trust target 90% compliance with nutrition based on their nursing metrics, but all wards achieved above 80%.
- We saw that for those people at risk of dehydration, a red lidded water jug was used to indicate to staff their status of being at risk. The trust had a clear, written policy for staff to follow.
- At one handover we observed, there was no mention of people's risks of dehydration.
- We saw that one person, who was at risk of dehydration, had only ½ cup of drink recorded as taken in 20 hours. This was not followed up by staff.
- Staff told us there was not always effective measurement of people's urine output; for example, if they used continence aids, there was no system for assessing the urine contained in the used aid.
- Due to inconsistent record keeping, particularly regarding people's fluid intake, effective care was not provided, because accurate records were not kept to ensure staff were able to monitor people's condition.

Patient outcomes

- The trust was meeting its targets to reduce the number of cardiac arrests, with 1.8 arrests per 1,000 admissions against a year-end target of 2.21 (data as of 12 March 2014). This represented a reduction in inpatient cardiac arrest rates by 53% since 2010.
- Sepsis is a life-threatening illness caused by the body overreacting to an infection. It is often referred to as either blood poisoning or septicaemia. The trust had introduced the sepsis care bundle, which is a collection of clinical interventions for a person with an overwhelming infection which, when delivered promptly within the first hour of diagnosis, can significantly improve chances of recovery. Sepsis boxes were introduced on all wards, so that people could receive effective antibiotic therapy once septicaemia was indicated.
- The trust reported an overall annual 70% compliance with the sepsis care bundle at end of March 2014, against a target of 75%, and that there had been a downward trend in sepsis-related mortality.
- The trust's aim was to reduce the falls resulting in harm rate to less that 1.79% by the end of March 2014, and this target was met overall with a falls rate of 1.50% by the end of this month.
- The trust told us that the introduction of the reducing harm team had contributed to reduction in falls, by providing one-to-one's in an environment where there were 50% side rooms. Staff told us the reducing falls strategy was to be reviewed again shortly.
- The trust reported that to eliminate unnecessary deaths due to venous thromboembolism (VTE) the hospital would ensure the percentage of people receiving a VTE risk assessment within 24 hours of admission to hospital would be at least 95%. This target was met for the year 2013/2014, and in addition, 95% of patients who were identified as being at risk of VTE also received appropriate preventative treatment.
- In terms of infection control, the trust reported that they did not meet their targets. For C. difficile rates there were 36 cases against a target of 25; for MRSA there were three cases against a target of zero; and for catheter-associated infections, there were 14 cases against an internal target of two.
- In September 2012, there were two alerts received from the Dr Foster Intelligence 2012 Hospital Guide regarding in-hospital deaths due to septicaemia (not maternity-related) and from cerebro- vascular accidents (strokes). The hospital put in place action plans to reduce the level of risks for people. Sepsis boxes were introduced on all wards, so that people could receive effective antibiotic therapy once septicaemia was indicated.
- More recent information received for the period 1 April 2012 to 29 January 2014, showed that there was no longer an elevated risk for these two conditions when compared to similar hospitals.

Competent staff

- Most staff told us there were no formal systems in place for regular supervision sessions with their line managers, but that any issues were addressed via informal support from managers.
- Senior staff told us they had regular supervision sessions, which did include reviews of their training and development needs.
- Only a small proportional of qualified staff we spoke to said they had opportunities for clinical supervision. However, there were supervision arrangements in place for newly qualified nurses, and new non-qualified staff (HCAs) had a 'buddy' system.

Medical care (including older people's care)

- Most staff told us they had had an annual appraisal, and their training needs were discussed, and individual development plans completed.
- Two ward leaders told us that not all of the HCAs fully understood the importance of accurate recording of people's observations. Further training was being arrangements and monthly audits being undertaken.
- For February 2014, 12 medical wards did not meet the trust target of 90% compliance for having an annual appraisal; however, many staff told us that their appraisal had been booked.
- Doctors told us there was an effective system for assessment and revalidation.

Multidisciplinary working

- A daily meeting about bed availability was held three times a day to determine priorities, capacity and demand for all specialties. We observed one such meeting, and it was well organised, and clear actions for the attendees were determined.
- A daily meeting was held to review discharge planning, and to confirm actions for those people who had complex factors affecting their discharge.
- Staff told us that there was robust multidisciplinary working at ward level, but sometimes links with other departments was not always effective. Staff told us there was effective liaison between nurses and doctors. Doctors told us that nurses knew people's condition, and would report any changes, so as to deliver best outcomes for people.
- Some HCAs told us they were not always kept informed of clinician's assessments and the outcomes from them.
- Staff told us that there was a specialist respiratory nurse, a falls advisory nurse and a dementia care practice development nurse available to support people, and also advise staff on appropriate treatment options.

Seven-day services

- Staff told us that the process for having X-rays taken and getting the results for people could be slow at times, particularly in the evenings and weekends, due to the out-of-hours cover rota. The trust have audited this and shown no delays.
- Staff told us that the level of cover by doctors in the evenings and weekends varied from ward to ward, however, Junior doctor rotas have increased the medical input at weekends across all medical wards, there is a junior doctor based on each floor of the hospital from 9am – 5pm.
- Staff told us that the hospital discharge team had worked over the recent bank holiday weekend, and it had proven very effective. The hospital discharge team did not normally work over weekends.
- Access to therapists was variable in the evenings and weekends.

Are medical care services caring?

Good

Patients told us that the staff were caring and respected their wishes. We saw that staff's interactions with people were person-centred and unhurried. Staff were kind and caring to people, and treated them with respect and dignity. Most people we spoke to during the inspection were complimentary and full of praise for the staff looking after them. The data from the hospital's patients' satisfaction survey, Friends and Family Test, showed that the medical care wards performed above average for the hospital.

Compassionate care

- We saw that interactions between staff and people were positive, respectful and caring.
- Most people we observed were well presented, and appeared comfortable in their surroundings.
- People's dignity was respected whilst they were being supported with personal care tasks.
- Staff knew people's names and spoke in an appropriate tone of voice when supporting people. A doctor told us that the nurses "know their patients and their needs". The majority of people were very complimentary about the staff and the care they had received. One person said "this is the best hospital I have been in". Another said "I would recommend this hospital". The majority of people told us that nurses checked upon them regularly, and were polite and respectful. The relatives we spoke with were complimentary about the care and attention their relatives had received from staff. Some wards had extended visiting times to allow people to see their relatives for longer and more easily.
- Most people told us that staff answered their call bells in a timely fashion, but two people told us they had waited at times for up to 15 minutes.
- The trust carried out a monthly survey into people's experiences of call bell response times, and in March

Medical care (including older people's care)

2014, from 144 responses across the 15 medical care wards, 33% of people said their call bells were responded to within two minutes, and 9% of people said it took over five minutes to answer their call bell.
- Staff were able to tell us how the needs of people from culturally-diverse backgrounds were met.
- People told us that there was a good choice of meals available, and that generally the meals were very good.
- Friends and Family Test (FFT) results for the medical service in March 2014 showed a response rate from 19.4% to 50% of eligible adult discharged patients. The trust average score in March 2014 was 63, with 11 out of the 16 medical care wards performing higher than this average. The average score for the 16 medical care wards (including EAU) was 73%. One of the respiratory wards scored 100% from a response rate of 23.3% in March 2014.
- The trust carried out an inpatient survey of 565 patients in January to March 2014, and 100% of respondents found the staff courteous and helpful, and 531 people said they would be extremely likely or likely to recommend the hospital to family and friends.
- The trust's cancer patient experience survey results for inpatient stay for 2013 showed that the trust was in the bottom 20% of all trusts nationally for 28 out of the 69 questions people were asked. In the survey, some people said that there was a lack of communication from staff about treatment options, side effects of medicines, and types of support groups available.
- One person told us that "70% of the staff are nice but 30% are rude".

Patient understanding and involvement

- Most people we spoke with said they had been informed of their conditions and treatment plans. Staff kept people informed of any changes.
- All wards had appropriate signs in place, so that people would know who their named nurse was.
- One person told us that staff did not encourage people to self-medicate, as it takes too long for the nurses, and it is easier for them to administer medicines to people.
- The care plans that we looked at were not personalised to the individual, and most did not reflect their involvement in agreeing the plan of care.
- Some people had the trust's care for people with dementia document 'This is me' completed and available for staff to read; however, some did not. People's life stories and likes/dislikes, which were included in the document, had not been effectively transferred into the main care plan, especially regarding people's behaviours, and known 'triggers' for aggressive behaviours.
- Most care plans and risk assessments we looked at had not been signed by the person or their representative.
- Some patients told us they had not read their care plans, and did not know their treatment plans.
- Staff told us that the translation service worked well when needed.
- Responses from CQC's adult inpatient survey in 2012 showed the medical care service was performing the same as other trusts, with one area of concern, that of people being kept waiting for discharge.

Emotional support

- For those wards that had increased staffing levels, the majority of staff told us that they could spend more time with people to offer reassurance when required.
- Most staff said the use of additional staff to provide specific one-to-one support for people with higher needs had allowed them to spend more time with the other people.
- One of the care of the elderly wards had appointed a mental health nurse, and another was about to start employment. This was to facilitate enhanced support and treatment for those people with dementia and mental health conditions.
- People spoke highly of the hospital's chaplaincy service, and found it easy to access support.
- Staff told us that timely assessment and support was available for patients, from mental health practitioners.

Are medical care services responsive?

Requires improvement

Problems with the effective discharge of people were highlighted across the medical care department, from both staff and other people we spoke to. Whilst the trust had implemented a dementia care strategy, there was more work to do in terms of effective care planning and staff competency to provide person-centred dementia care.

Service planning and delivery to meet the needs of local people

- The trust's strategy plan for 2013/14 said the trust was aiming to reduce the average length of stay for patients

to six days, and to reduce the number of readmissions. It was also looking to work closer with commissioners, to provide care closer to people's homes, with effective relationships with GP practices.

- The trust had reported that improving dementia care required a sustained improvement in screening and diagnosing dementias, and during 2013/14 this continued to be a main focus. The trust wanted to ensure more staff had received dementia training, leading to improved care, delivered by competent and compassionate staff. The enhanced support of carers and family of people living with dementia was also a key area.
- During the last quarter of 2013/14, the trust reported that they had achieved the 95% rate of screening, assessing, investigating and referring patients aged over 75, admitted as an emergency. The trust were continuing to deliver dementia awareness training to all clinical staff, and remained on course to achieve their target of 90%.
- The trust told us they had a dementia link strategy, and a 70-strong team of dementia link staff met quarterly and were key in the roll-out and embedding of service improvements, in all clinical areas of the trust. These dementia link staff represented all specialties and clinical areas, ensuring that dementia care was improved in all areas.
- The trust had introduced a life history profiling document, 'This is me', but we found that it had not been completed for all people with dementia. We also found instances where a person's detailed life history had been received from family members, but was not available for staff to read.
- One stroke ward had a research nurse for thrombolysis working on the ward, to enhance the service delivered.
- At busy times, the medical care service had a process for placing people in other wards and to monitor their condition. At times of peak demand for beds, some wards had the facility to open up a specially designed lounge area into a bay to provide additional beds.

Access and flow

- The trust's average length of stay for people in February 2014 was 6.8.days across all wards.
- The trust reported that delayed discharges of care had increased over the past three months. This meant people fit for discharge were not able to leave the hospital, and these beds were not available for new patients. These were medically fit patients ready for discharge, but were waiting for either NHS or adult social care reasons. The number of days delayed within the month for all patients delayed throughout the month for February 2014 was over 600 bed days for NHS reasons (twice the bed days lost in September 2013), and over 100 bed days for non NHS reasons (down by two thirds from September 2013). The reasons included delays in completing assessments, lack of beds in further non acute NHS care (including intermediate care, rehabilitation being required), waiting for places in care homes, and respecting family choices.
- The hospital discharge team were focusing on managing those people; however, there had been particular problems with a small number of patients being made homeless while in hospital. Due to some people's person circumstances, their length of stay was dependent on effective liaison with social services and housing departments.
- Staff views on the discharge process were mixed: some staff thought it had improved, with better co-ordination, whilst others said "it is difficult and time consuming to make the arrangements".
- Some wards had implemented their own discharge co-ordinator process, which we were told was working effectively. For example, the respiratory ward had an early discharge team, whereby two nurses would go to the Emergency Admission Unit (EAU) on a daily basis to identify those people who could be discharged home, following their consultant's review.
- One of the care of the elderly wards had recently appointed a discharge co-ordinator and they told us that it had helped facilitate quicker discharges, and also allowed more time for other staff to spend with the people on the ward.
- The hospital's target for people transferring from the EAU was 48 hours, but staff told us that sometimes it can take up to 10 days to transfer people to the specialist ward.
- One person told us that there had been a two week delay in getting the results of a scan which would determine the appropriate course of treatment, yet they had not been told why there had been a delay.
- Staff told us that there were delays regarding people's discharges, with transport being the main factor, and it happened on a daily basis. The hospital had two transport providers, and staff told us there were significant problems with one provider, which the trust

was discussing with the clinical care group, who commissioned the service. For example, the wrong type of vehicle would arrive and be unable to take the person home, or ambulances would fail to turn up for hours when people were ready to be discharged, with no communication as to the delay.

- Some staff told us the hospital's integrated discharge team only did "fast track" discharges, and the ward staff had to do the majority of discharges, which took them "ages to do". Staff reported difficulties in arranging home care support packages with colleagues from social services, and also in delays for people who needed to move to a care home.
- Staff told us that the hospital social work team was significantly understaffed, and this had impacted on the discharge planning process.
- The hospital had a discharge ward, which took people from other wards, provided they were medically fit for discharge. Some staff told us that it can take up to two days to obtain a bed in the discharge ward due to capacity and demand for places in this ward.
- One person said they had been told they were going home that day, but they did not know at what time, or whether it would definitely happen.
- In times of peak demand for beds, some wards had an 'overspill' facility, whereby the day lounge (which was designed as a ward bay) could be converted back into a bay area for people, with the appropriate equipment and facilities to care for them. This meant day rooms were not available for people to use in these busy times.
- The trust told us the hospital aimed to improve its medicines to take out (TTO) error rates, and medicines reconciliation rates, and ensure appropriate prescribing of anti-microbial medicines. The aim of medicines reconciliation was to ensure that medicines prescribed on admission correspond to those that the person was taking before admission. The TTO rate for the emergency care and medicine department was 25%, above the trust-wide error rate of 24%. For reconciling medicines when a person is admitted, the trust ensured that over 90% of people had their medicines reconciled; however, this was done within 24 hours for 80% of patients (against a target of 95%). The trust reported this was an area for improvement. Prescribing of appropriate anti-microbial medicines did meet the annual targets.
- On the first day of the inspection, the medical care service had 11 people outlying in non-medical wards. This represented 3% of people who were medical care inpatients. Staff told us that ensuring those people outlying in a different ward were monitored effectively was quite difficult at times. The hospital policy stated that a decision tool would be completed by the ward receiving the person and that there would be no transfers after 11pm at night. Staff we spoke to said this had much improved, and people were not transferred between wards after 11pm unless there was a bed emergency.

Meeting people's individual needs

- Most people we spoke with knew who their consultant was, but some did not and said they did not know what their treatment plans were, and when they may be able to go home. Another person, who had a complex medical condition, told us they had been seen by 20 different doctors and "they still didn't know what to do".
- One person told us that they were due to be discharged home, but it had been delayed for 15 days, but they had not been told why.
- The trust had achieved all of the acute Commissioning for Quality and Innovation (CQUIN) quality targets during 2013/14, including assessing people over 75 for dementia on admission. The trust endorsed staff to become a dementia friend. The hospital had a dementia care practice development nurse, who supported wards to care for people with dementia.
- Care for people with dementia, particularly those that became agitated and displayed challenging behaviours, was an area that the trust was looking to enhance. We found that the trust did not have "core care plans" for dementia, cognition, or managing difficult behaviours, but a working group had been set up to devise standard templates for staff to use. Staff were not able to tell us when this project would be completed.
- Staff told us that they give people's relatives the 'This is me' document to complete, but they did not necessarily get many completed documents back. This meant care and treatment was not always delivered to meet people's needs, as staff did not have appropriate guidance to follow.
- Staff told us that there were activities equipment available for people with dementia, but there was not sufficient time to be able to sit with people to engage them in meaningful stimulation.

Medical care (including older people's care)

- The hospital has no activity co-ordinators employed, but we were told that a business plan has been submitted to the board for a care of the elderly ward to have dedicated activity co-ordinators.
- Staff on the care of the elderly wards told us that there was a lack of chiropody services provided from Mansfield Community Hospital.
- The hospital had access to a translation service, which staff told us was effective and met people's needs.
- During January to March 2014, the trust reported that there were 78 referrals to the learning disabilities nurse for support with complex patients. We were told that the hospital's learning disability steering group was planning to review the learning disability risk assessment and care plan.
- Following a concern, the hospital had now introduced a specific discharge checklist for people with a learning disability to ensure all discharges were planned and carried out effectively.
- The majority of people we spoke with said they saw a doctor when they needed to quickly.

Learning from complaints and concerns

- People's views of the way the hospital dealt with complaints was mixed. One person told us that a concern had been dealt with "on the spot" and they were happy with the resolution. Another person said "all the complaints' policy does is get you an apology and nothing ever changes. It protects the staff, not the patients".
- For February 2014, the medical care service received eight complaints and staff told us that the trust had a target date for investigation and resolution of complaints within 40 days.
- Ward leaders told us how they were now working to achieve "on the spot" resolutions to concerns where possible, and would hold meetings with people and their families to seek to resolve the concern.
- Staff told us that learning from complaints was disseminated via informal staff meetings.
- We saw that all wards displayed the compliments they received.
- The trust reported that the number of complaints received by the Emergency Department and medicine division had reduced for the previous quarter from 100 to December 2013, to 51 in the quarter ending March 2014.

Are medical care services well-led?

Requires improvement

We had some concerns regarding leadership of medical care in this hospital; although the medical care service was well-led on some wards, with some evidence of effective communication within staff teams, and the implementation of information boards to highlight each ward's performance. We saw a number of good examples of this, especially on ward 51.

The visibility and relationship with the board was less clear for junior staff, not all of whom had been made aware of recent trust-wide initiatives.

Vision and strategy for this service

- Most ward leaders spoke positively about the vision and strategy the board had for the ongoing development of the medical care service.
- Ward leaders were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward. We noted that the planned and actual staffing levels displayed on these boards were only done for the daytime, and not for the night shifts. Staff we spoke to did not think they were done for nights.
- Some ward leaders felt that the pace of change in recent months was "overwhelming" and the staff team needed time to ensure recent changes were fully embedded in the service.
- One ward leader told us how some new documentation was piloted, and feedback sought from staff to ensure it was fit-for-purpose; for example, the PUPP documentation. However, other changes to documentation were brought in with no staff consultation; for example, the new discharge planning checklist.
- Whilst the trust reported its plans to develop the dementia care service, the majority of staff were not able to tell us about the dementia link staff initiative. Staff told us there were dementia friends on each ward, but did not tell us these staff were the dementia link 'champions'.

Medical care (including older people's care)

- The trust's 'Quality for All' initiative had been recently introduced, and whilst senior staff were able to demonstrate a good understanding, not all junior staff had been made aware of it.

Governance, risk management and quality measurement

- We were told by senior staff that CQC standards were incorporated into the quality assurance programme for the trust.
- Ward leaders were able to tell us about the ward's performance against the trust's targets and objectives, and were aware of the current risks on the risk register. However, junior staff were not always able to tell us how the ward was performing, or what actions were being introduced to mitigate risks to people.
- The trust had in place quarterly governance meetings and incidents, where audits and complaints were discussed.
- Each ward had a quality assurance plan, which included findings from audits, complaints and areas of risk from the nursing metrics system, which ward leaders maintained and in which they recorded any actions taken.
- On ward 51 we saw good learning from incidents reported.

Leadership of service

- Most staff told us that leadership at ward level has improved with clearer communication. For example, communication boards that highlighted key issues and messages, and also recognised staff achievements, were available for staff to read. A few staff felt there was a lack of consistency in ward leadership.
- Some ward leaders told us that leadership courses were much more accessible for them.
- Ward leaders and staff told us about most wards having weekly informal staff meetings that were held for staff to share their issues, and also to get feedback from senior managers. Staff told us that generally they were well supported by their managers.
- Not all staff were aware of the concerns found on previous inspections, and thought that the trust's financial situation was the major area of concern.
- All wards had visible performance boards on display for patients and their visitors, which showed performance against key risks areas, current staffing levels and other information, such as how individual wards were performing on the Friends and Family Test (FFT) surveys. For example, one cardiology ward displayed information to show people that there had been no new pressure ulcers on the ward for the past five months.
- Some staff told us that the board members and executive team were more visible and accessible to staff, whilst others said there had been little improvement.
- Some HCAs told us they did not know what the ward performance and staff communication boards were for, and the majority of HCAs were not aware of the trusts' 'Quality for All' initiative.
- On ward 51 we saw strong leadership.

Culture within the service

- Senior staff reported an improvement in staff morale over the last few months, with the increase in some wards' staffing levels being pivotal. However, some staff reported feeling pressurised, and said keeping morale up was "a struggle".
- Most staff reported an improvement in effective communication to and from the trust's board.
- Some support staff felt work pressure had increased, as their hours of work had been reduced, but the workload was increasing.
- Some wards reported a higher than average sickness absence rate; this was usually down to the impact of having staff off on long-term sick leave. Ward leaders told us of the trust's more robust approach to supporting staff with attendance issues.
- The majority of ward leaders were very positive and spoke well of colleagues, but this was not universal, with one ward leader openly expressing criticism of some staff.

Public and staff engagement

- Regarding stroke care, we were told by staff that there have been problems with the integration of community and acute stroke services, with community staff having to work on the acute hospital wards. Some staff expressed concern about the integration process.
- Some people told us that having the board meeting minutes available to the public online helped them to understand more about the hospital and how it was performing.
- Some HCAs told us that they were not well informed of the trust's plans to recruit more nurses to improve the skill mix on wards. Some HCAs expressed concern that their jobs would be at risk and that as a consequence, they would focus on people's care, as opposed to record

keeping for their observations. Some HCAs told us that the quality of care for people will decline when less HCAs are on the wards, and some were critical of the personal care given by qualified nurses.

Innovation, improvement and sustainability

- Innovation was encouraged, but not all staff told us they were able to recommend changes due to time pressures.
- Some staff were aware of the rationale behind recent changes to processes and documentation, but some junior staff had not been made aware.
- Ward leaders felt confident about managing the pace of change if it were carried out in a planned fashion.

Surgery

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

Information about the service

The surgical division at King's Mill Hospital consisted of five surgical wards, a day case unit, a surgical assessment unit (SAU) and 14 operating theatres. The hospital provided a range of surgery including trauma, orthopaedic, ophthalmology, urology and general surgery. The emergency theatres provided a 24-hour service.

We visited all wards, the SAU and operating theatres within the surgical division. We talked with 20 patients, eight relatives and 44 staff, including nurses, healthcare assistants, consultants, doctors, allied healthcare professionals, support staff and senior managers. We observed care and treatment. Before our inspection, we reviewed performance information from, and about, the trust.

National clinical audits were completed, such as the fractured neck of femur audit (from April 2012 to March 2013) and the national bowel cancer audit.

Summary of findings

Surgery services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. Staff have a good understanding of the incident reporting process, but did not always receive feedback as to what action was taken and what lessons were learnt.

Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training was not always carried out to ensure staff were competent, and had best practice knowledge to effectively care for and treat patients. Monthly audits were carried out regarding patient safety, patient experience and the environment.

Patients and relatives we spoke with told us that they felt that they received good quality care and were informed of any treatment required. Patients told us that they felt their privacy and dignity were respected.

We found that staff were responsive to people's individual needs; however, we found that there were often delays in discharge, which impacted on patients needing to be cared for in recovery after their operation. We also found that the trust was not always meeting the 18 week deadline for treatment. However, there were waiting list initiatives which were helping to meet some of the demand.

There was some good leadership at local levels within the surgery services, and staff felt well supported by

their managers. The trust had plans in place to stabilise the senior management team, and a clinical governance framework was also in place, which at the time of our inspection, was being strengthened. Staff were not always supported and developed through the appraisal system. A new strategy had been implemented for the values and behaviours of employees.

Are surgery services safe?

Requires improvement

Surgery services were provided in a clean and hygienic environment in line with recognised guidance, which helped protect patients from the risk of infection, including hospital-acquired infections. Staff have a good understanding of the incident reporting process, but did not always receive feedback as to what action was taken, and what lessons were learnt.

Incidents

- Nursing and medical staff in the wards and theatres were knowledgeable about the reporting process for incidents using Datix (the trusts incident reporting system). However, they told us that they did not receive feedback from incidents. This meant that although incidents were being reported, staff were unsure what action was taken as a result, or if any changes were made to improve practice.
- Senior staff informed us that serious incidents were investigated and discussed at the planned care and surgery division clinical governance group meeting; written notes of the meetings confirmed this. This meant that learning from incidents was taking place at a senior level. For example, sharing the results of an investigation for a patient who was under the care of both vascular surgery and ophthalmology.
- We observed the paper-based system of surgical safety checklists in place in the operating theatres. This included the use of the World Health Organization (WHO) surgical safety checklist, which is designed to prevent avoidable errors. However, we noted that the checklist was not completely embedded, and briefings before and after surgery were not yet mandatory in the trust. It was confirmed that in the near future briefings would be mandatory, and that a few theatre teams were already completing team briefs before and after surgery. We noted that compliance here was improving.

Safety thermometer

- Patient safety boards displayed in the various surgical wards showed the figures for the previous month on specific areas, such as the number of pressure ulcers, the number of falls and the number of medication incidents. This data was comparative of previous

months, and demonstrated to all patients the safety of the ward. Actions included accurate completion of documentation in patient records, and to ensure that buzzers were in reach of patients so they could call for assistance when required.

- We noted that the trust had five serious incidents between September 2013 and February 2014 for surgery services. These incidents related to a fall, a medication incident and a hospital-acquired pressure ulcer.

Cleanliness, infection control and hygiene

- Infection rates (September 2013–January 2014) for surgery services demonstrated that there had been no incidents of MRSA. There had been four incidents of hospital-acquired C. difficile, but these were within an acceptable range.
- All elective patients who attended the pre-operative assessment area before their operation were screened for MRSA. This meant that a patient could be given appropriate treatment if their MRSA screening was found to be positive. Information leaflets were also available for patients.
- The trust carried out various nursing metrics which included infection control. The results since September 2013 demonstrated that the ward areas within the surgery services had achieved above the 90% target consistently. There were two wards that had not achieved this target, one in November 2013 when they achieved 76% and another in February 2014 when they achieved 89%.
- Our observations through the inspection visit confirmed that staff wore appropriate personal protective equipment (PPE) when required, and that staff adhered to 'bare below the elbow' guidance in line with national good hygiene practice. The premises were visibly clean.
- Patients and relatives told us that the environment was always clean. One patient went onto say that staff always washed their hands or used hand gel.

Environment and equipment

- We saw that most equipment available in the departments had 'I am clean' stickers on them, which were easily visible and documented the last date and time they had been cleaned. This meant staff could be assured that equipment they used was available and clean.
- We checked the emergency equipment, including for resuscitation in all the departments within surgery services, and noted that equipment was checked on a regular basis. However, emergency resuscitation equipment was kept in a sealed box, which was often stored on a shelf above shoulder height. This meant there was a potential safety issue accessing the equipment. Other equipment was also stored in front, limiting the access to the equipment in an emergency situation.
- In the operating theatres, there was a pre-planned maintenance programme (on-going maintenance checks at regular intervals to prevent the failure of equipment before it actually occurred). We checked a random sample of equipment within the anaesthetic areas, operating theatres and recovery areas, and found that the majority of equipment could be easily identified as having a recent service and an electrical portable appliance test. About 10% of equipment showed that the service or portable appliance test due date had passed and the equipment was still in use. This meant that we could not be assured that all equipment used was maintained and fit-for-purpose.

Medicines

- There was a lack of pharmacy cover for the day case unit.
- Cost improvement plans were in place for the financial year. We saw that these included plans to improve the efficiency of theatre scheduling, and a review of drug expenditure.

Records

- An audit of compliance with the surgical safety checklist was carried out in February 2014. This identified a vast improvement in the completion of forms compared to previous years. Where non-compliance had been identified, staff had been spoken with to ensure compliance was met. This included a surgeon washing their hands during the start of the checklist and potentially not taking an active part in the team brief. We were also shown an additional monthly audit to check a sample of 10 surgical safety checklists for completeness, which was carried out within the nursing metrics for theatres.
- Sub-specialty clinical governance minutes demonstrated that common incidents were discussed; however, it was not clear how this information then filtered down to staff on the ward and in theatres, including junior doctors
- We reviewed 14 patient records and found that for one patient a fluid balance chart had not been completed,

and for two patients the fluid balance totals had not been completed for one of the days the patient had been in hospital. This meant that for three out of the 14 patients, the fluid intake and output for a patient was not appropriately monitored at all times, and could potentially cause further harm to the patient, for example dehydration.

- Appropriate care plans, including for falls, were in place for patients. For one patient we noted that the time of their cannula insertion had not been recorded, although all after care and monitoring had been documented. This was raised with a nurse who took action immediately.
- During out unannounced visit, we saw that one patient had had surgery since their admission. However, there were no operation notes within the patients' medical records. This meant that staff were unaware of what surgery the patient had had, and if there were any complications of which they needed to be aware.
- Appropriate risk assessments and management plans were in place for patients. However, staff did not always complete the records correctly to ensure the correct care and treatment was provided, and some documentation was missing.

Safeguarding

- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and had an awareness of the trust's safeguarding systems and processes.
- Training data from January 2014 showed that 94% of staff received safeguarding adults training and 95% of staff received safeguarding children level 2 and level 3 training in the last year. This meant that the trust was meeting its target.

Mandatory training

- Medical and nursing staff told us they had received mandatory training and were able to take time from the ward to complete training. Attendance rates for the planned care and surgery division (this includes all of theatre, children services and maternity services) showed that as of 31 January 2014, compliance with all mandatory training was 79%. The lowest attendance rates for training that was required to be renewed were within escort training (56%), conflict resolution (66%), alcohol and drugs (68%) and information governance (69%). Whereas the highest attendance rates were within mental capacity act (92%) and safeguarding children level 2 (90%).
- We also noted that for doctors that were required to attend MRSA and C. difficile training, the attendance rates were 24% and 35% respectively. This meant that not all staff required to attend appropriate training had done so to ensure they had the most up-to-date knowledge to provide effective care and treatment for patients.

Nursing staffing

- We reviewed the staffing establishment of the different areas we visited, and noted that staffing levels were consistent with the needs of the patients, to ensure patient care was delivered safely.
- Some staff members informed us that they were concerned about proposed changes to staffing figures at night time, as this would result in one less healthcare assistant. The matron for surgery and trauma and orthopaedics informed us that the plan was to increase registered nursing numbers at night time, which would mean the numbers of staffing would remain the same. However, the matron assured us that depending on the needs of the patients, additional healthcare assistants could be rostered for a given night shift.
- Patients told us that staff were very busy. For example, one person told us "there are not enough, buzzers are going constantly".
- Nursing staff informed us that they used their own staff to cover any shifts due to vacancies or sickness, and agency staff were rarely used. This ensured the care patients received was consistent.
- On each ward, the number of staff at different levels, working for that specific shift, was displayed. If the staffing levels were lower than planned, actions taken were also displayed for patients and visitors to see. For example, a healthcare assistant had reported as sick and another healthcare assistant had been requested to cover.

Medical staffing

- Medical and nursing staff informed us of their concerns around the medical support for some surgical specialties, including vascular surgery. It was confirmed

that patients requiring vascular surgery have this done at the Nottingham University Hospital, and would then be transferred back to King's Mill Hospital 48 hours after surgery.

Major incident awareness and training

- The surgery services had various business continuity plans in place. Staff were aware of trust-wide plans; for example, if there was no water supply, if the electricity failed, and what action to take in the case of a heat wave. Within the operating theatres, we were also informed of action taken in a decommissioned theatre, which involved carrying out a deep clean in line with their business continuity plans.

Are surgery services effective?

Good

Clinical management guidelines were reviewed and acted upon to ensure patients' needs were met. However, staff training was not always carried out to ensure staff were competent and had best practice knowledge to effectively care for and treat patients. Monthly audits were carried out regarding patient safety, patient experience and the environment. National clinical audits were completed, such as the fractured neck of femur audit (from April 2012 to March 2013) and the national bowel cancer audit.

Evidence-based care and treatment

- We noted that a pathway was in place for patients admitted with a fractured neck of femur, in line with the British Orthopaedic Association and British Geriatrics Society. Weekday support was available from an orthogeriatrician (a doctor who works in close co-operation with orthopaedics and has a focus on care of the elderly and rehabilitation). Medical staff informed us that all patients admitted with a fractured neck of femur would be seen by an orthogeriatrician within 24 hours, except for those admitted over the weekend.
- Staff on the trauma ward were unaware of the fractured neck of femur database, which monitors performance against national guidance.
- Staff told us that a medical ward was previously half medical patients and half trauma patients, which facilitated shared care for complex medical orthopaedic patients. However, since the ward had become solely medical, there had been an increase in falls and an increase in the number of trauma patients admitted to the elective orthopaedic ward.
- Trust data demonstrated that there had been three surgical site infections within the past year, which was within an expected range. Ward performance data also demonstrated that for the two trauma and orthopaedic wards there had been 69 falls between September 2013 and February 2014, one of which resulted in moderate or severe harm. The monthly data demonstrated that for one ward, there had been an increase in the number of falls since December 2013.
- The surgical division senior managers informed us that mortality rates were reviewed on a regular basis by sub-specialty teams. Records we reviewed confirmed this. We were also informed that although the surgical mortality rate was in line with national figures, a new sepsis pathway (management of patients who had inflammation of the body caused by severe infection) had been implemented across the trust.

Patient outcomes

- We saw that a nursing metric audit was carried out on a monthly basis for each ward area, and for operating theatres. The audits on the wards covered 12 areas, such as nutrition, privacy and dignity, and falls. The audit results demonstrated from September 2013 to February 2014 that the majority achieved the required standards each month; this included compliance with falls management, medicines management and nutrition. The main areas for improvement were pain management and tissue viability management (the prevention of pressure ulcers).
- Performance data in the operating theatres included information around the number of cancellations, delays in theatre starts and average operating times. Staff told us this data was collated by an external consultancy reviewing the performance and efficient of the operating theatres. This information was also newly displayed. Staff went on to tell us that there were discrepancies in the data, such as measuring operating times, and there were plans in place to improve it.

Multidisciplinary working

- Nursing staff informed us that a new accountability handover had been introduced for the beginning of each shift, which involved trained and untrained staff. Staff were also encouraged to complete these

handovers by the patient's bedside. This meant that staff had to sign to acknowledge that they had received the handover for the patients they were responsible for. This had been received well by staff and implemented successfully. It ensured that patient care and treatment was consistent.

- One staff member told us that where multidisciplinary input was required for a patient's discharge, at times patients were discharged against the advice of some members of the team, resulting in unsafe discharges.
- Staff informed us that if they believed a patient was discharged unsafely, they completed an incident form. The trauma and orthopaedics (T&O) readmissions (from April 2013 to January 2014) were a total of 41 for elective patients readmitted within 30 days and 125 for non-elective patients readmitted within 30 days. We were told that additional information had been requested so that the trust could complete an audit of those readmissions, to identify areas for development, and an action plan would be implemented.

Are surgery services caring?

Good

Patients and relatives we spoke with told us that they felt that they received good quality care and were informed of any treatment required. Patients told us that they felt their privacy and dignity were respected.

Compassionate care

- We spoke with 20 patients and eight relatives during our inspection. The majority of patients told us that they were very happy with the service they had received from the surgery services.
- One patient told us that staff "pop in and talk, they don't seem in a rush". They also told us that they had to remove their shorts temporarily to have a catheter fitted, and staff treated them with respect throughout.
- In ward areas we saw displays of thank you cards to staff members for the care and support shown to patients and their relatives.
- We saw that patients were cared for in accordance with national same sex accommodation guidelines. We reviewed the trust's data from September 2013 to February 2014 for surgery services, and noted that during this time there had been no incidences of same sex accommodation breaches.
- Patients we spoke with told us that staff respected their privacy and dignity, by the use of privacy curtains and side room doors as appropriate.

Patient understanding and involvement

- Most patients we spoke with told us that they were involved in their care. One patient told us that they were moved from a six-bedded bay to a single room, and although they were happy to be in the single room, they said "I wasn't asked to move, I was told". Another patient told us that a doctor discussed their condition, what the plan was to treat the patient and if they had any questions.
- A healthcare assistant explained the use of a 'This is me' document for patients living with dementia. The document was given to relatives or carers to complete, to ensure staff on the ward could communicate with the patient effectively and understand their individual needs. A member of the domestic staff went on to explain that one patient was refusing hot drinks and was unable to communicate why. When the patient's carer came in to visit they explained the patient did not like milk, which emphasised the importance to staff of using the 'This is me' document.

Emotional support

- Patients we spoke with told us that they were unaware of the chaplaincy services, as they had not been discussed with them. One patient went on to say that a member of the chaplaincy service visited them; however, this was unexpected as they were unaware that this service was available.
- Visiting times had recently changed to 11am to 7pm, which encouraged relatives to visit their relatives. However, staff explained that at times this had a negative impact on the protected meal times and other support that patients may need during the day, including physiotherapy.

Surgery

Are surgery services responsive?

Requires improvement

We found that staff were responsive to people's individual needs; however, we found that there were often delays in discharge which impacted on patients needing to be cared for in recovery after their operation. We also found that the trust was not always meeting the 18 week deadline for treatment. However, there were waiting list initiatives which were helping to meet some of the demand.

Service planning and delivery to meet the needs of local people

- During our tour of the wards, we saw information displayed for staff to access an emergency multilingual phrasebook in the short term until a trained interpreter had arrived. We saw that this information was displayed near the ward reception area.
- During our visit we met a patient who chose to use a relative to explain and translate for them, although they were aware that an interpreter service was available.

Access and flow

- The trust was not meeting the national 18-week maximum waiting time for eight out of 13 surgical specialties for patients to have planned surgery. During 2013, the trust did not meet its own targets for the proportion of elective patients cancelled for non-clinical reasons on the day of surgery in six out of nine specialties. This was specifically for elective surgery in trauma and orthopaedics (T&O) and ENT.
- The trust met its target for patients to receive an operation within 28 days following cancellation.
- Staff within the operating theatres informed us that waiting list initiatives started in March 2014; this was to ensure that those patients who were nearing their 18 week deadline received treatment. This was specific to T&O and general surgery, and we were informed that patients receiving maxillofacial treatment were referred to the Nottingham University Hospital. This meant that patients did not have to wait longer than expected for their surgery.
- One staff member informed us that surgical outliers were often admitted to the day case unit to allow for medical outliers to be admitted to surgical wards. Staff in the day case unit explained that this added additional pressures, including the need for additional staff members to meet the needs of patients. Staff informed us that sometimes patients would have to wait in recovery before a bed was available. One staff member informed us that on occasions, a patient could be discharged from recovery.
- We were informed that the discharge team attended each ward every morning to review all potential discharges. A staff member informed us that if a patient was discharged when a ward receptionist was not working, the system would often not be updated. This meant that staff did not always have accurate information about patients and if they were still in hospital.
- Patients we spoke with were unsure of the plans for their discharge or approximately when this would be.

Meeting people's individual needs

- We were informed by the planned care and surgery division senior management team that for certain surgical specialties, the trust liaised with other surrounding hospitals to ensure patients received the appropriate care and support. This included vascular services, maxillofacial services, and ears, nose and throat (ENT) services. This was to ensure that patients local to King's Mill Hospital were able to receive the services they required, although some services had to be accessed at different hospitals, for example, for vascular surgery.
- Staff on the main surgical wards and in operating theatres also explained that for some elective patients, there would be a delay in transferring them back to the ward from recovery due to the availability of a bed. We were told this was commonly caused by a delay in discharge for the previous patient.
- We saw the effective use of the 'This is me' document for patients living with dementia. Although staff were reliant on relatives or carers to complete the document, once completed, staff were able to respond appropriately to people's body language, and communicate with the person effectively.
- Staff we spoke with were very knowledgeable about the individual needs of those patients on the ward living with dementia.
- Ward areas had storage areas for relevant equipment and that wards had a high number of side rooms which promoted privacy and dignity.

Surgery

Learning from complaints and concerns

- Parents we spoke with told us that they had seen leaflets and posters on the ward areas to contact the Patient Advice and Liaison Service (PALS) if they wanted to raise a concern or make a formal complaint. However, this information had not been clearly communicated to them by staff members.
- The number of complaints from the previous month was displayed on the ward, including any actions taken. Staff informed us that they were encouraged to resolve concerns and complaints at a local level.
- The senior management team for the planned care and surgery division also told us that as part of a new process, they were encouraging staff to meet with complainants, and if appropriate, visit the complainants' home to discuss their concerns.
- Written notes from sub-specialty governance meetings demonstrated to us that complaints were discussed between consultants, doctors and senior nurses. However, it was not evident how this was then communicated with all staff at ward level.
- Information displayed on wards were generated by a central team, and any actions were added by the ward leader; this was not always evident. Staff informed us that they received limited information about the lessons learnt from complaints.

Are surgery services well-led?

Requires improvement

There was some good leadership at local levels within the surgery services, and staff felt well supported by their managers. The trust had plans in place to stabilise the senior management team and a clinical governance framework was also in place, which at the time of our inspection, was being strengthened. Staff were not always supported and developed through the appraisal system. A new strategy had been implemented for the values and behaviours of employees.

Vision and strategy for this service

- The trust had recently implemented a new 'Quality for All' strategy, which included new behaviours and values to ensure staff deliver quality care at all times. Staff we spoke with were able to vaguely describe the strategy once they were prompted.
- The planned care and surgery division senior management team informed us that to improve quality care for their patients, specifically in the surgical specialties, they needed to improve their governance structure, and to focus on and improve communication.
- The senior management team told us that improvements had been made in their governance process, and communication from the ward to board, board to ward and across sub-specialties still required some improvements. As part of this strategy, the division was also going to make team briefs and de-briefings, before and after surgery, mandatory, as few areas were currently carrying this out.

Governance, risk management and quality measurement

- The surgery services were within the planned care and surgery division, and we were shown the reporting structure for quality and performance issues within the division. This included monthly sub-specialty governance meetings led by a Service Director, monthly mortality and morbidity meetings, and a monthly divisional clinical governance meeting. Any risks or lessons learnt were escalated through the reporting structure and to trust board level. We saw evidence of this in the written notes of the meetings, and noted where agreed risks would be added to the risk register to monitor.
- We were also informed that performance and financial management were discussed, but the corporate governance structure within the division was not as strong as the clinical governance structure. The team were developing plans to improve this.

Leadership of service

- Most nursing and medical staff we spoke with told us that they felt well supported by their line managers. We were informed that the division was clinically-led, and that the senior management team had been unsettled, as a permanent divisional general manager had not been in place for some time.
- At the time of our inspection, there was an interim divisional general manager in place, and we were informed that a new permanent divisional general manager was to start in the near future. This meant that the senior management team would have stability, and could review and improve pathways more effectively and efficiently, as well as give stability to those working within the division.

- Staff also informed us that they believed the chief executive officer wanted to listen and improve quality care in the trust. A few staff informed us that they knew who members of the trust board were, including the director of nursing; however, most staff informed us that they had not seen members of the trust board visit ward areas.

Public and staff engagement

- We saw that medical and nursing staff were encouraged to participate in locally-led clinical governance meetings, to improve the safety of patients and quality of care, by sharing lessons learnt. This included learning from patient experiences. However, we did not see how this was collected at ward level, other than in the form of concerns, complaints, and the Friends and Family Test.

Innovation, improvement and sustainability

- Nursing and medical staff told us that they received clinical supervision and appraisals, and thought that the process was, "okay". The trust appraisal rate for planned care and surgery was 76% as of December 2013. The specialty groups with the lowest appraisal rates were anaesthetics (53%) and head and neck (72%) against a target of 80%. This meant that staff were not always receiving appropriate support and development through the use of the appraisal system.

Critical care

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

Information about the service

The critical care service at King's Mill Hospital was provided by the Intensive Therapy Unit (ITU), the critical care outreach team (CCOT) and the acute response team (ART). The ITU had 13 bed spaces, although it was usually staffed for eight patients. The CCOT and ART teams were made up of staff from the ITU. During our inspection, we visited the ITU and spoke with patients and staff. We observed care and treatment, and looked at records. We reviewed information received from the trust and from commissioners.

Summary of findings

The critical care service provided safe care. There were effective systems in place to report incidents and staff were aware of what to report and how to do this. Incidents were monitored and reviewed, and appropriate action taken to reduce the risks to patients. Staffing levels were appropriate for the needs of patients. There were appropriate procedures to prevent and control infections, and to safely manage medicines.

The critical care service provided effective care. Care and treatment was delivered in line with current standards and nationally-recognised evidence-based guidance. The staffing and operation of the unit was in line with 'Core Standards for Intensive Care Units' published by The Faculty of Intensive Care Medicine and The Intensive Care Society.

Patients and their families were satisfied with the care and treatment provided, and reported good outcomes. The multidisciplinary team effectively collaborated and communicated to support the planning and delivery of patient care.

Patients were treated with compassion, dignity and empathy. Patients and their relatives were involved in decisions about their care and treatment. Patients were offered appropriate emotional support during their stay in the intensive therapy unit and afterwards.

The critical care service responded to meet patient's needs. Staffing ratios in the intensive therapy unit were in line with national guidance, and staffing was flexible

Critical care

to meet changing demands. Staffing in the CCOT had been increased in response to a rise in the use of the team. Discharges from the intensive therapy unit were appropriately managed, though there were recognised delays.

The critical care service was well-led. There were clear management and governance structures in place. Key risks were identified and managed by staff and managers. Risks were regularly monitored and reviewed, and effective action was taken to reduce or resolve risks.

Patients were encouraged to comment on their care and treatment in the intensive therapy unit, and their comments were acted on. Staff spoke positively about working in critical care. They were aware of the trust's vision and values, and they told us they had confidence in senior management to continue to make improvements.

Are critical care services safe?

Good

The critical care service provided safe care. There were effective systems in place to report incidents and staff were aware of what to report and how to do this. Incidents were monitored and reviewed, and appropriate action taken to reduce the risks to patients. Staffing levels were appropriate for the needs of patients. There were appropriate procedures to prevent and control infections, and to safely manage medicines.

Incidents

- Staff we spoke with knew how to report incidents and could describe a range of incidents they would consider reporting. We saw that incidents reported were investigated within the critical care department, and the findings were passed on to staff within the department. Incidents were also discussed at meetings of senior managers, and at board level.
- Staff told us that they were encouraged to report incidents and near misses. Staff knew of action taken in response to incidents to reduce the risk of recurrence. An example was a near miss where a member of staff saw the wrong patient name on a bag of blood for infusion (before it was given to the patient). The investigation of this had resulted in discussion of ideas for improving the identification of patients, and for ensuring that existing procedures were correctly followed.

Safety thermometer

- The trust performed below (better than), the England average for the percentage of patients who acquired a pressure ulcer after their admission to hospital, from November 2012 to November 2013. This trend was reflected in the intensive therapy unit. We saw that any new pressure ulcer was reported as an incident and a root cause analysis investigation was carried out. The results of the investigation were discussed with staff, and action was taken to reduce the risk of recurrence. One example was a patient who had developed a pressure ulcer around the site of a nasogastric feeding tube. As a result of the investigation, the method of securing this type of tube was changed

Critical care

- The trust's infection rates for C. difficile and MRSA were within an acceptable range, taking into account the trust's size and the national level of infections. C. difficile and MRSA are bacteria responsible for infections that may be picked up by patients in hospitals, and can be difficult to treat. In the intensive therapy unit, there had been no patients with C. difficile or MRSA infections since September 2013. Most staff were up to date with training in infection prevention and control
- Monthly monitoring was carried out on a range of issues that impacted on patient safety, such as pressure ulcers, medicines management, patient falls, and infection control. The results and action planned were displayed for staff to see, and were also discussed at staff meetings. Brief key action points were prominently displayed to remind staff.

Cleanliness, infection control and hygiene

- There was an infection prevention and control team within the trust, who carried out regular audits of the unit. Any issues raised were reported back to the unit staff for action.
- We observed good practice during our inspection, such as:
- Staff washing their hands prior to providing care, and following 'bare below the elbow' guidance
- Adequate hand washing facilities on the unit
- Access to and use of personal protective equipment, for example, gloves and aprons
- Arrangements for storage and disposal of clinical waste.
- Medicines were securely stored, handled and administered. Most staff who required it, were up to date with training in medicines management.
- Nearly all staff were up to date with training in safeguarding vulnerable adults. Staff told us they knew how to report any suspicions or allegations of abuse.

Environment and equipment

- The intensive care unit had 13 bed spaces, although it was usually staffed for eight patients. The layout of the unit was a little disjointed because of changes in the service over time. This meant that some beds were not within sight of the main nurses' station. However, staffing allowed for a minimum of one nurse to each patient, and we observed that nurses spent most of their time at the patient's bedside.
- Entry to the intensive therapy unit by visitors was controlled by staff, to ensure safety and security. The unit appeared clean throughout, and we saw that there were systems in place for cleaning the environment and the equipment in use.

Records

- The trust's risk register identified a lack of storage space in the intensive therapy unit. Unused bed spaces were being used for storage of equipment and this was considered to be a minor infection control risk. Staff told us about the plans currently being discussed to address the lack of storage space.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The MCA provides the legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves.
- Staff had attended training about the Mental Capacity Act 2005 (MCA), and staff we spoke with understood the requirements of the MCA when delivering care.
- We saw that consent to care and treatment had been obtained from patients or from the relatives where necessary. This included consent to decisions not to resuscitate the patient.

Mandatory training

- Staff told us that training was positively encouraged by their line managers. Most staff were up to date with the trust's mandatory training programme. Staff said that training specific to critical care was provided in addition to the mandatory training. There was a clinical educator attached to the unit to provide specialist training, such as the use of new equipment.
- There were arrangements in place for new staff to work supernumerary for at least a month with experienced staff. This gave new staff the opportunity to gain experience and confidence in their role. This arrangement also applied to staff returning from long-term leave.
- The nurses and care assistants in the intensive therapy unit had regular supervision and an annual appraisal. Staff told us that learning from incidents was followed up-in supervision. Annual appraisals included

discussion of personal development and training needs. One member of staff said, "We talked about my aspirations and what training I wanted to do. I've got a plan for the year."

Management of deteriorating patients

- Staffing in the intensive therapy unit and the outreach teams enabled the effective delivery of care and treatment. The intensive therapy unit was staffed by nurses with specific training in critical care. The nurses were supported by care assistants working on each shift. The care assistants had received additional training to carry out tasks to help with the nurses' workload; for example, inserting urinary catheters and taking out arterial lines.
- The provision of medical and nursing staff in the intensive therapy unit was in line with 'Core Standards for Intensive Care Units' published by the Faculty of Intensive Care Medicine and the Intensive Care Society. This meant, for example, that there was a supernumerary clinical co-ordinator on duty at all times, and the clinical co-ordinators were band 6 nurses - senior, experienced nurses.
- The staffing for the CCOT had been increased in response to the increase in the use of the team after the implementation of NEWS.

Nursing staffing

- Staff told us that staffing levels were responsive to changes in patients' needs. Staffing could be increased up to 12 nurses if necessary. This was normally arranged through the trust's in-house agency. Occasionally, nurses from an outside agency were used, but we were told this was rare. The preference was for the in-house agency, as this would provide nurses with relevant skills and experience who had previously worked in the unit.

Medical staffing

- There was specialist consultant cover provided seven days per week. Staff told us there was close working with other consultants within the trust. This meant that changes in patients' needs could be responded to quickly if necessary.

Are critical care services effective?

Good

The critical care service provided effective care. Care and treatment was delivered in line with current standards and nationally-recognised evidence-based guidance. The staffing and operation of the unit was in line with 'Core Standards for Intensive Care Units' published by the Faculty of Intensive Care Medicine and the Intensive Care Society.

Evidence-based care and treatment

- Care and treatment was delivered in line with current standards and nationally-recognised evidence-based guidance. The staffing and operation of the unit was in line with 'Core Standards for Intensive Care Units' published by the Faculty of Intensive Care Medicine and the Intensive Care Society. This meant, for example, that care was led by a consultant in intensive care medicine, and consultant support was available to staff at all times.
- These standards also include a hospital-wide standardised approach to the detection of the deteriorating patient, and a clearly documented escalation response. The trust implemented the National Early Warning Score (NEWS) in February 2013. This tool is used to assess inpatients using physical observations and monitoring, to detect signs of deterioration in their health as early as possible. The tool indicates when an urgent response is needed, and this was provided by the critical care outreach team (CCOT), or the acute response team (ART). Both teams were made up of staff from the intensive therapy unit.
- The intensive therapy unit provided care and treatment for patients assessed as requiring level two (high dependency) or level three (intensive care), as defined by the Intensive Care Society document 'Levels of Critical Care for Adult Patients' (2009). There was a clear pathway for escalation of patients from level two to level three care.

Patient outcomes

- The care and treatment of patients achieved good outcomes. Outcomes for patients in the intensive therapy unit were discussed at a monthly clinical governance meeting. Action to improve outcomes was

planned, monitored and reviewed. This included action taken to reduce the risk of accidental extubation of patients, and how to ensure patients were properly supported when being weaned off intensive therapy.

- Patients, and their relatives, were encouraged to comment to staff about their care and treatment during their stay and afterwards. We saw positive comments from patients and relatives including, “we are very pleased with all the care from everyone. Staff are very informative, calming and caring”, and, “the nursing care is excellent in here.”
- The use of NEWS had resulted in a significant increase in calls for assistance from the CCOT. This was seen as a positive result, because it meant that deteriorating patients were identified sooner in the course of their decline, and were supported by staff with specialist critical care skills and expertise.
- In February 2014, data was gathered about the outcomes for patients supported by CCOT in the 24 hours following the call for CCOT assistance. The analysis of the data, although currently at an early stage, indicated a positive outcome for patients at King's Mill Hospital. The data is to be used as part of an international multicentre research study.

Competent staff

- There was a shift co-ordinator who was not allocated to a patient, so they could monitor patients’ needs and staffing levels. The shift co-ordinator worked closely with the department lead and the matron, to plan for new patients coming into the unit, patients being transferred to other wards, and anticipated changes in the needs of patients in the unit.

Multidisciplinary working

- The multidisciplinary team in critical care included nurses, doctors, physiotherapists, and speech and language therapists. We saw physiotherapists actively involved in the care and treatment of patients in the intensive therapy unit during our visit.
- We saw that multidisciplinary working was discussed at the monthly clinical governance meetings. Ideas for new ways of working were discussed and action agreed.

Are critical care services caring?

Good

Patients were treated with compassion, dignity and empathy. Patients and their relatives were involved in decisions about their care and treatment. Patients were offered appropriate emotional support during their stay in the intensive therapy unit and afterwards.

Compassionate care

- Patients in the intensive therapy unit were treated with compassion, dignity and empathy. We observed that patients’ privacy and dignity were upheld by staff caring for them.
- Male and female patients were not always in separate areas, but privacy screens were used, in addition to curtains between beds, where male and female patients were next to each other.
- We saw that patients in the unit were generally treated with compassion and respect. An example of this was one patient, who was visibly distressed, being calmed and reassured by a nurse. We saw comments from patients and relatives, such as “everyone is so kind” and “when we call on the telephone at night staff are polite and helpful.”
- However, we saw one patient who saw a newly admitted patient. This existing patient was awake on the unit and was clearly anxious about the noise and discussion surrounding the new admission in the adjacent bed. Staff did not provide reassurance or explanations to the existing patient during our observation.
- However, we saw one patient newly admitted who was clearly anxious about coming into the unit. Staff did not provide reassurance or explanations to the patient during our observation.
- Staff told us that if an ‘allow natural death’ decision had been made, and the patient would benefit from moving to a more private environment, then a transfer to a side room on a ward could be arranged. If a patient’s death was expected within a short time, staff said they would not move the patient from the unit, as this may cause unnecessary distress to the patient and relatives.

Patient understanding and involvement

- Patients and their relatives were involved in making decisions about their care and treatment.

Critical care

- Patients told us they were consulted about their care and treatment. We saw that discussions with patients, or their relatives, were noted in their records. This included discussion of 'do not resuscitate' and 'allow natural death' decisions.
- Staff told us that relatives could be involved in the care of patients if they wanted to be.

Emotional support

- Patients and their relatives received the support they needed to cope emotionally with their treatment and their stay in the intensive therapy unit.
- Staff told us that open visiting had been tried on the unit, but feedback from patients and visitors led to this being revised. Visitors were asked to visit between 11am and 2pm and then after 4pm. Staff told us that visiting was flexible to allow for the needs of patients and relatives.
- Visitors could stay overnight if they wanted to, as there were two quiet rooms with reclining chairs. There was no bedroom for visitors to use on the unit, though staff told us a bedroom was available elsewhere in the hospital.

Are critical care services responsive?

Good

The critical care service responded to meet patient's needs. Staffing ratios in the intensive therapy unit were in line with national guidance, and staffing was flexible to meet changing demands. Staffing in the CCOT had been increased in response to a rise in the use of the team. Discharges from the intensive therapy unit were appropriately managed, though there were recognised delays.

We saw that patient diaries were used, where staff recorded what had happened to the patient each day. This was useful for patients who may not remember everything that happened in the unit, and also for their visiting relatives.

Service planning and delivery to meet the needs of local people

- The minimum ratios of medical and nursing staff to patients in the intensive therapy unit were in line with 'Core Standards for Intensive Care Units' published by the Faculty of Intensive Care Medicine and the Intensive Care Society. Staffing was flexible to allow for changes in patient's needs or unexpected admissions to the unit.
- Unexpected, unplanned admissions to the intensive therapy unit had reduced between November 2013 and February 2014. This was believed in part to be due to the increased staffing, and use of the CCOT team from October 2013.

Access and flow

- Nearly all admissions to the intensive therapy unit were from within King's Mill Hospital, from the emergency department, theatres / recovery, and surgical and medical wards.
- The unit was always able to accommodate planned admissions, such as admissions of patients following certain types of surgery. Staff from the unit went to the theatre recovery area to be with patients waiting to be transferred to the unit. There was direct access to the theatre area from the unit.
- Staff told us that the physiotherapy service covered seven days a week to respond to patient needs.
- Most patients leaving the unit were transferred to wards within King's Mill Hospital. The handover of the patient to the ward included a summary of their critical care stay and a plan for their ongoing treatment.
- Staff told us they avoided discharging patients from the unit after 10pm. This was in line with the 'Core Standards for Intensive Care Units'. Discharges overnight have been historically associated with an excess mortality and patients perceive it as an unpleasant experience being moved from intensive care to a general ward outside of normal working hours.
- There were some delays in discharging patients from the unit. Discharge should occur within four hours of the decision that the patient is ready for transferring to a more suitable environment. On the day of our visit there was one patient who was ready for discharge to a ward, but was delayed by one day as there was no bed available. Information from the trust showed that between January and March 2013 more than 50% of discharges from the unit were delayed. Most of these were delayed by less than a day, and none were delayed for more than two days.
- Patients were invited to attend a follow-up clinic after their stay in the intensive therapy unit. Critically ill patients have been shown to have complex physical

and psychological problems that can last for a long time after discharge from hospital. The clinic offered support and practical help, such as physiotherapy and exploring psychological issues. Patients attending the clinic were asked for their feedback about the care and treatment received in the unit.

Meeting people's individual needs

- We saw that patient diaries were used, where staff recorded what had happened to the patient each day. This was useful for patients who may not remember everything that happened in the unit, and also for their visiting relatives.

Learning from complaints and concerns

- Information was available for patients and their relatives, about how to make a complaint or raise concerns. There had been no formal complaints from patients in the unit in the last 12 months. Patient experience was discussed at the monthly clinical governance meeting and action planned to make improvements. An example of this was a relative who felt that they were spoken to using too many medical terms, and that staff were a little negative. The action planned included being more sensitive to patients and relatives, and updating the information leaflet about the intensive therapy unit.

Are critical care services well-led?

Good

The critical care service was well-led. There were clear management and governance structures in place. Key risks were identified, and managed by staff and managers. Risks were regularly monitored and reviewed, and effective action was taken to reduce or resolve risks.

Patients were encouraged to comment on their care and treatment in the intensive therapy unit, and their comments were acted on. Staff spoke positively about working in critical care. They were aware of the trust's vision and values, and they told us they had confidence in senior management to continue to make improvements.

Vision and strategy for this service

- The trust had recently introduced their 'Quality for All' initiative that focused on shared values and behaviours. The intention was to support staff to provide the best patient experience and outcomes. Most staff we spoke with were aware of the trust's vision and values.

Governance, risk management and quality measurement

- There was a system in place to record, monitor, manage and review key indicators of clinical performance within the intensive therapy unit. The indicators included patient falls, pressure ulcers, and reported incidents. Monthly monitoring of the indicators was displayed for staff, along with action to be taken to improve performance.
- Key risks within the critical care service were identified, and discussed at team meetings and the monthly clinical governance meetings. Risks were escalated by reporting to the divisional clinical governance steering group. Action was taken to address risks. This was evident from risks that had been resolved, such as insufficient staffing and issues with equipment.

Leadership of service

- Staff we spoke with said they felt well supported by their colleagues in critical care, and by their line managers. Staff told us "I'm very proud to work here", "it's a well-run unit" and "I absolutely love my job. I have a lot of respect for my colleagues and I feel they respect me".
- Most staff we spoke with were aware of the basic structure of the trust, and knew the name of the chief executive. They told us that the chief executive and senior managers had visited the intensive therapy unit, which was appreciated by staff.

Culture within the service

- Staff felt that the senior management team were visible and approachable. They described 'drop-in' sessions with the chief executive, although they said they were not easily able to attend these.
- One member of staff said "I would have no qualms in contacting a senior manager if I needed to raise any concerns".
- Another member of staff said "there's confidence in the board and senior management now. There have been lots of changes and that's been unsettling for staff, but now we feel listened to. Things have really settled down and they are improving".

Critical care

Public and staff engagement

- Patients and their relatives were encouraged to provide feedback about their experience of the intensive therapy unit using comment cards and through informal discussion. Their comments were discussed and used to make improvements.

Innovation, improvement and sustainability

- Staff told us they could bring ideas to their managers and felt they were listened to. One member of staff told us about ideas they had that had been put into action. This included a system to cut down the wastage of disposable equipment

Maternity and family planning

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

Information about the service

The trust's maternity and family planning services at King's Mill Hospital provided antenatal, intrapartum and postnatal care to patients. The service also included a delivery theatre and provided community-based midwifery services. The maternity service included a neonatal unit, and we have reported on this area in the children and young people section of this report. There were more than 3,000 deliveries every year at the unit. A separate ward provided gynaecological care to patients on ward 14.

During our inspection we visited the Sherwood Birthing Unit, the maternity ward, the antenatal clinics and the gynaecology ward. We spoke with patients, relatives and staff within the service. We observed care and treatment, and looked at care records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust's maternity service.

Summary of findings

The maternity service provided safe care. Midwifery and medical staffing levels were appropriate for the numbers of births at the unit. Staff reported incidents, which were monitored and regularly reviewed. The service had appropriate procedures in place to prevent and control infections, and to manage medications. Wards and departments were spacious and well maintained.

We found that appropriate equipment was available to ensure safe care.

The maternity service provided effective care. The percentage of normal deliveries within the maternity service was significantly higher than the national percentage. Rates for elective (planned) and emergency caesarean sections were lower than national figures, particularly the trust's emergency caesarean section rate. Good rates of smoking reduction had been consistently maintained by women throughout their pregnancies. The Sherwood Birthing Unit was jointly-led by midwives and consultants, which provided effective, managed care. Most staff were positive about the multidisciplinary team approach to the provision of care. There was mutual respect between staff in different roles and teams throughout maternity services.

Most women were complimentary about the care they had received from maternity services. Throughout our inspection we observed that staff treated women with compassion, dignity and respect. The CQC maternity

Maternity and family planning

service survey 2013 reported that the trust's maternity service was rated at 8.9 out of 10 by women for their experience of care during labour and birth, which was similar to results from other trusts.

The maternity service responded to meet people's care needs, and planned the allocation of midwifery staff according to the requirements of the service. Staff used translators and translation services to meet the needs of women whose first language was not English. Complaints were responded to in line with the trust complaints policy.

Maternity services had clear management and governance structures in place within obstetrics and gynaecology. Key risks were identified and managed by maternity services staff and senior managers. These were regularly monitored and reviewed at local, directorate and divisional levels. Staff spoke positively about their work, and were aware of the trust's overarching vision. Staff told us that they felt part of the drive to ensure the strategy and plans for improved patient care were delivered.

Are maternity and family planning services safe?

Good

The maternity service provided safe care. Midwifery and medical staffing levels were appropriate for the numbers of births at the unit. Staff reported incidents, which were monitored and regularly reviewed. The service had appropriate procedures in place to prevent and control infections, and to manage medications. Wards and departments were spacious and well maintained.

Incidents

- The trust incident reporting system, Datix, was used by maternity service. Staff reported incidents which were monitored and reviewed on a quarterly basis.
- Posters with information on incidents reported by specific wards or clinics had recently been displayed in each of these areas.
- There were no recent 'never events' reported by the service. A never event is a serious incident which is so serious that it should never happen. The maternity service reported incidents related to patient safety, which were in line with expected numbers for the size of the trust. Serious incidents were reported externally to the trust, in line with nationally-required reporting protocols.
- Staff we spoke with were fully aware of the incident reporting system and how to report incidents. They told us they were encouraged to report incidents; this meant there was a transparent reporting culture within the service.
- We saw incidents had been discussed at maternity service clinical governance and team meetings. Actions had been implemented to improve practice and to learn from incidents. Staff also told us they received feedback about reported incidents, which meant learning and actions following incidents were shared

Safety thermometer

- Safety information posters had recently been displayed at the entrance to each ward. They included information about staffing levels and incidents reported by the ward or clinic, including medication-related incidents and falls. The service was performing within expectations.

- Where required, risk assessments were being completed appropriately on admission, and patient care plans were updated with relevant information.

Cleanliness, infection control and hygiene

- We checked ward and clinic areas within the maternity service for cleanliness. We found that patients' bays, beds and equipment were clean. We found hand gel dispensers were situated in clinical and public areas of the women and children's unit, including the entrances to wards and clinics. This meant patients, staff and visitors were able to access and use hand gel without restriction.
- There were no recently reported cases of MRSA and C. difficile between September 2013 and February 2014. This meant infection control rates were well controlled, and rates for the maternity services were within expected limits. We saw that information on infection control rates was displayed on posters within wards, and was clearly visible to patients and visitors.

Environment and equipment

- The environment in the women and children's unit was safe. The unit had an access control system in operation which managed access to wards and clinics during the day and night. Local ward or clinic managers liaised with the trust's security management team to control access to their individual areas. This ensured that access to maternity service clinical areas was available to staff, patients and visitors, but was managed safely, in line with local and trust-wide security requirements.
- The antenatal clinic waiting area had subdued lighting and music playing while patients waited for their appointments. Staff confirmed that the lighting and music in the antenatal clinic helped to ensure a calmer environment for waiting patients.
- We noted that maternity service wards and clinics were spacious. Some staff and patients told us that the layout of wards and distances between rooms meant that there was sometimes a delay in midwifery staff attending patients. We checked reported incidents and found no significant issues reported in relation to ward layouts.
- There was adequate equipment on the wards to ensure safe delivery of care. Sealed resuscitation equipment boxes were supplied to individual wards and clinics within the maternity unit by the trust resuscitation team, in line with trust policy. We asked staff if the resuscitation equipment boxes were checked or audited for content and expiry dates of individual items of equipment. They told us resuscitation boxes were not opened unless equipment was required to deal with an emergency incident. Staff told us they were not fully aware of the contents of each resuscitation equipment box. They also said they did not check the contents of boxes and they had limited access to resuscitation equipment in clinical areas for training purposes.

Medicines

- Medicines were stored correctly in locked cupboards or fridges, where necessary, and controlled drugs were stored in separate, locked cupboards. This meant that access to medicines, including controlled drugs, was controlled and medicines were stored securely.
- However, we noted there were some gaps in the checking of medicines, including twice daily checks for controlled drugs and weekly checks for non-controlled drugs.

Records

- All records were in paper format. Health care professionals documented and updated patients' information using the same records. We found records were generally well maintained. We looked at four care plans during our inspection, and found that staff had assessed patients' individual needs and documented information relevant to their care.
- We saw a noticeboard on the maternity ward which contained patients' names. The board was displayed in a public area and was clearly visible to visitors and the public. The maternity ward noticeboard contained only patient names, no clinical information was displayed We discussed the noticeboard with the ward manager. They acknowledged that patient confidentiality might be breached and amended the format of patient information displayed on the board.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Safeguarding

- We spoke with the trust safeguarding lead about safeguarding within the maternity service. We found safeguarding procedures were in place and were effective. Midwifery staff told us they were encouraged to raise and report any actual or potential safeguarding concerns.

Maternity and family planning

Mandatory training

- We looked at staff mandatory training records, including training for infection control, information governance, and safeguarding of adults and children. The trust had a target of each directorate achieving 95% compliance. Records confirmed that most staff were up to date with their mandatory training; however, the maternity service had not achieved the target compliance rate for staff training.

Management of deteriorating patients

- We observed both medical and nursing handovers on the Sherwood Birthing Unit (labour ward) and the maternity ward. Handovers occurred twice a day, at the start and end of each day or night shift. We observed information related to individual women and the effective running of the ward was discussed. Women at higher risk, potential issues and staffing for the shift were also discussed, and clearly communicated. Handovers were structured and gave staff relevant information about women and their care requirements.

Midwifery staffing

- The maternity service used a dashboard to monitor and review key performance indicators on a quarterly basis, this included staffing levels and midwife to birth ratios. The national standard ratio for midwives to births is 1:28. The dashboard showed that the maternity service had a ratio of midwives to births which was 1:27, which meant that the ratio was slightly better for the maternity service compared to the national standard ratio.
- We saw that the ratio of supervisors of midwives to births was 1:15.5. This was slightly worse than the national standard which was 1:15 supervisors of midwives to births.
- Senior directorate managers for maternity services told us that the ratio of midwives to births had previously been worse than the national standard, and additional recruitment had been instigated for midwives and Band 3 carers within the service. This meant that the team had recognised the requirement for additional staff to achieve the national standard ratio of midwives to births. Recruitment processes to address the issue had been implemented, which remained on-going, in order to provide adequate and safe levels of staffing in the maternity service.
- The maternity service maintained adequate staffing levels; however, we were told that the service was sometimes short staffed. Measures were in place to maintain adequate staffing levels. These included midwives from the trust's midwifery team working overtime shifts, and the use of bank staff to fill vacancies.

Medical staffing

- The clinical performance and governance scorecard for maternity services showed there was 60 hours a week of dedicated consultant cover on the Sherwood Birthing Unit (labour ward). This was in line with national recommendations for the number of babies delivered on the unit per annum.
- Senior directorate managers confirmed that consultants provided on-call cover on a weekly basis. Medical staff told us that the weekly on-call system worked well, and provided good continuity of care to patients. We spoke with registrars and junior doctors, who told us there were adequate numbers of doctors on the wards out of hours, and that consultants were contactable if they needed any support.

Are maternity and family planning services effective?

Good

The maternity service provided effective care. The percentage of normal deliveries within the maternity service was significantly higher than the national percentage. Rates for elective (planned) and emergency caesarean sections were lower than national figures, particularly the trust's emergency caesarean section rate. Good rates of smoking reduction had been consistently maintained by women throughout their pregnancies. The Sherwood Birthing Unit was jointly led by midwives and consultants, which provided effective, managed care. Most staff were positive about the multidisciplinary team approach to the provision of care. There was mutual respect between staff in different roles and teams throughout maternity services.

Evidence-based care and treatment

- The maternity service used a combination of National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines, to determine the treatment and care

provided. We saw guidelines were dated and review dates were clearly stipulated, which meant that maternity service staff were assured they were following up-to-date national guidelines.

- Staff and managers monitored, reviewed and regularly reported on key guideline performance indicators. These included midwifery and obstetrician staffing levels, complaints, and readmissions following elective and non-elective admissions. This meant that there was an on-going assessment of the maternity service's performance in relation to key indicators of clinical care.
- During the period October 2012 to November 2013, there had been 3,861 births at the trust. Of these, 67.3% of all births were delivered normally; this figure was substantially higher than expected. The percentage of normal deliveries was almost 7% higher than the national percentage. Higher rates of birth by normal delivery indicate effective delivery practices. The births performed by elective (planned) caesarean section were lower than the national average.
- The trust's rate of emergency caesarean sections for the same time period was significantly lower than expected compared to the national figure. Lower rates of births, performed by both elective and emergency caesarean sections, are desirable because these indicate good practice within the maternity service.
- Sherwood Birthing Unit staff said elective caesarean sections were prioritised each morning, and women were scheduled for inductions of labour in the afternoons. Staff said the aim was to lower waiting times for women for both elective caesarean sections and inductions of labour. Staff told us these procedures were now better organised to deliver care and support to women. The new procedures were being audited to evaluate their effectiveness.
- Staffing levels within obstetrics theatres had recently been reviewed and changes made. Dedicated nursing staff now worked in obstetric theatres, which enabled midwives to provide increased time to deliver effective care.

Patient outcomes

- Staff and managers used a local dashboard to regularly monitor key performance indicators. Senior managers discussed these at regular directorate and divisional meetings. This meant staff and managers monitored the use of best practice. The performance indicators were within expected levels and the local dashboard showed good patient outcomes.
- Staff and managers held ward and department team meetings. These included discussion of national guidelines, updates to guidelines, and specific issues related to maternity service performance indicators. This meant staff were aware of their performance, and areas in which they needed to improve.
- The Care Quality Commission (CQC) routinely monitors patient outlier information for the trust, including maternity outlier alerts. The CQC maternity outlier surveillance programme reviews indicators for effectiveness, which include maternal readmissions, perinatal mortality, emergency caesarean sections and elective caesarean sections. At the time of our inspection, there were no outstanding maternity outlier alerts reported for the trust's maternity service and no evidence of risk.

Competent staff

- Staff attended regular learning and development days which focused on specific areas related to the maternity service. However, some areas related to clinical care had not been included for midwifery staff within planned learning days. These included the management of post-partum haemorrhage and eclampsia. We discussed this with maternity service managers, who adjusted planned learning and development days to include these areas. This meant staff attended learning and development days, but these had not included all training relevant to the delivery of effective maternity care.

Multidisciplinary working

- We spoke with staff in clinical and non-clinical roles from various wards and departments within the maternity service. We found there was mutual respect between maternity services staff in different roles and teams. Most staff were positive about the multidisciplinary team approach to patient care. They told us they were able to deliver effective care in their individual roles, and as a part of the maternity services.
- We noted there were good working relationships between different professional groups and wards. One example of this approach was the Sherwood Birthing

Unit, which was jointly-led by midwives and consultants. Staff told us that the unit was extremely effective because of the integrated management of care from midwifery and medical teams.
- One consultant told us "we [midwifery and medical teams] work as a family and support each other very well. I've not seen this on any other unit".

Are maternity and family planning services caring?

Good

Most women were complimentary about the care they had received from maternity services. Throughout our inspection we observed that staff treated women with compassion, dignity and respect. The CQC maternity service survey 2013 reported the trust's maternity service was rated at 8.9 out of 10 by women for their experience of care during labour and birth, which was similar to results from other trusts.

Compassionate care

- Throughout our inspection we observed women being treated with compassion, dignity and respect in all areas of the trust's maternity service. We found that staff welcomed women, and remained respectful and professional during the delivery of care.
- We saw that staff completed regular 'care and comfort rounds' to check on mothers and their babies, and provided information to women on postnatal routines. Care and comfort rounds were also undertaken on the gynaecology ward, to ensure women were well cared for and monitored. Staff and patients told us that if patients were not in their rooms when staff completed care and comfort rounds, 'pillow cards' were for these patients in their rooms. This meant patients knew staff had come to check on them.
- Most women were complimentary about the care they had received within the maternity services. Women and their families told us they felt welcomed and supported by friendly staff. One person provided feedback about the care they had received on ward 14, the gynaecology ward. They said, "I cannot praise the nurses, health care assistants and other staff enough. They answered call bells promptly and regularly came to ask me if I was ok or needed anything. What I want to emphasise was the atmosphere on the ward. All the staff presented as happy and cheerful and the atmosphere was lovely. They really did see me as a person not just a patient".
- However, we also received some information and comments from women whose experience of care had not been as positive. One mother told us, "I'm here for my second baby and it's been much better this time compared to my last visit". Another mother commented that some maternity service staff had been less caring and sensitive. One staff member echoed these comments and told us, "the focus and direction for the ward depends on who's in charge. It's ok most times but it can vary".
- In the CQC maternity service survey 2013, 134 women responded about their experience of the maternity service and care at this hospital. The trust performed the same as other trusts for all aspects of maternity care, including antenatal, during labour and birth, and in the first few weeks after birth. The average response from women for their experience of care during labour and birth was 8.9 out of 10; the average score for treatment by staff was 8.3 out of 10, and care after birth was scored at 8.1 out of 10.

Patient understanding and involvement

- The trust website provided women and their families with a wide range of information about maternity services, including details about the different wards and departments, and a 'virtual' tour of wards. This meant people with access to the internet were easily able to view relevant information prior to admission, during their pregnancy and in order to prepare for the birth of their baby.
- Partners were encouraged to visit and were given information about care during and after the birth of their baby. The Sherwood Birthing Unit arranged visiting times for mothers in labour on an individual basis. This meant mothers and their partners were supported by maternity staff throughout the delivery of their baby.
- Information leaflets on a variety of topics were widely available for women and their families. These included information on ward visiting times, and information leaflets on breastfeeding in obstetrics wards. Feedback forms, information on how to contact the Patient Advice and Liaison Service (PALS), and how to make complaints

to the trust, were readily available in all maternity service areas. Most of the information we saw was printed in English, but leaflets were available for people whose first language was not English.

Emotional support

- There was a specific room in the Sherwood Birthing Unit which was allocated for use in the event of a stillbirth or unexpected death. Staff provided support to mothers and parents in the event of an unexpected death or traumatic event. Chaplains were also available to provide support. This meant staff support and facilities were in place to provide emotional support to women and their families in an appropriate environment.

Are maternity and family planning services responsive?

Good

The Maternity service responded to meet people's care needs, and planned the allocation of midwifery staff according to the requirements of the service. Staff used translators and translation services to meet the needs of women whose first language was not English. Complaints were responded to in line with the trust complaints policy.

Service planning and delivery to meet the needs of local people

- Staff told us there was an on-going liaison between the trust maternity and paediatric services. Maternity service senior managers confirmed they had good working relationships with local GPs and clinical commissioning groups. This meant the maternity service was able to work with these stakeholders in the provision of obstetric and gynaecological care to women.
- Maternity service senior managers confirmed there were robust measures and procedures, should the service need to divert women or close the unit due to lack of capacity. There were good reciprocal arrangements in place with maternity services located in other regional trusts if women needed to be diverted due to lack of capacity. Staff told us local and regional maternity services networks worked very well.

Access and flow

- Managers on the Sherwood Birthing Unit and the maternity ward confirmed the running of obstetrics wards was reviewed to ensure patients were cared for in a way which responded to their needs. We were told that women booked for induction of labour on the Sherwood Birthing Unit were now admitted in the afternoon in order to provide a better flow of patient care. This change in the routine operation of the unit was being monitored, and staff felt that patient flow was working well.
- We also discussed the allocation of midwives and healthcare assistants between the Sherwood Birthing Unit and the maternity ward. Staff told us they were allocated based on the requirements of the service, and worked on wards depending on the numbers of women and their needs, especially at busier times. Maternity service senior managers confirmed that midwives based in the community worked shifts within the trust's acute, inpatient maternity wards, and were contacted if additional staff were needed. This meant that the maternity service allocated staff appropriately, dependent on the clinical needs and numbers of women.

Outlying patients on the gynaecology ward

- The gynaecology ward, ward 14, was often used to provide care for outlying patients from other specialties within the trust. This occurred when beds were unavailable for these patients on wards related to their specific care requirements. The manager of ward 14 confirmed that any outlying patients placed on the ward were monitored and reviewed by specialty-specific consultants, to ensure that they received appropriate and responsive care.
- There were clear guidelines and patient pathways which were followed by staff. Staff were knowledgeable about individual patient pathways, and delivery of care to patients on the ward.

Meeting people's individual needs

- Staff told us that translation services or translators were readily available, and easily accessible for women whose first language was not English. We saw posters displayed in maternity services areas for translation service contact numbers. This meant staff had access to translators or a telephone translation service in order to communicate with women whose first language was not English.

Maternity and family planning

- In addition to scheduled appointments, women were able to access a maternity helpline which was staffed by community-based midwives. This meant people had the means to communicate with maternity service staff should they need advice or guidance, and were assured that appropriate staff would be able to respond to their queries.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Staff were encouraged to resolve issues, concerns and complaints reported by people at a local level. If this action did not adequately resolve the person's concerns, they were reported to managers at local and directorate levels for further resolution.
- Leaflets containing information about Patient Advice and Liaison Service (PALS) and the trust complaints process were readily available in maternity service areas. People were also able to access information via the trust website and from individual staff. This meant that the service provided relevant information and access to PALS and complaints teams, in order to address, resolve and respond to people's concerns.
- We received comments from a woman who had received care and treatment on ward 14, the gynaecology ward. She told us, "A senior nurse asked me what my care had been like at the end of my stay and if I had any suggestions for improvement. Actively seeking such feedback I see as a real positive". We saw comments from women and families were displayed on information posters on maternity service wards. This meant people were asked for their feedback in order that maternity service staff could respond to received comments or concerns.

Are maternity and family planning services well-led?

Good

Maternity services had clear management and governance structures in place within obstetrics and gynaecology. Key risks were identified and managed by maternity services staff and senior managers. These were regularly monitored and reviewed at local, directorate and divisional levels.

Staff spoke positively about their work and were aware of the trust's overarching vision. Staff told us they felt part of the drive to ensure the strategy and plans for improved patient care were delivered.

Vision and strategy for this service

- The trust vision was visible throughout the maternity services. The maternity service-specific strategy and staff appraisals were clearly linked to the trust's corporate strategy. Staff were aware of the trust's overarching vision, and felt part of the drive to ensure the strategy and plans for improved patient care were delivered.

Governance, risk management and quality measurement

- The maternity service used a quality dashboard to record, monitor, manage and review key indicators of clinical performance. Indicators included reported incidents, audits undertaken and complaints received by the service. This meant there was an on-going review and assessment of key performance indicators for the directorate and its specialties.
- Maternity service senior managers had identified key risks, which included staffing and community-based midwifery services. These were echoed by staff who worked in the clinical areas of both obstetrics and gynaecology specialties. This showed that frontline staff and senior management were aware of the same key risks within the directorates. These risks were reported to the trust's clinical risk committee. They were monitored and managed by staff and managers at local, directorate and divisional levels. This meant staff in the maternity services had processes in place to identify and manage risks specific to the delivery of care in obstetrics and gynaecology.
- The maternity services held monthly clinical governance meetings, and key staff attended trust committee meetings on behalf of the maternity services. We looked at minutes of maternity services clinical governance meetings. Information was provided at local and directorate levels for incidents reported within the service. The service had completed investigations and action plans to address issues raised from reported incidents or key risks. This meant the service had good governance procedures to measure and manage indicators of quality care.

Maternity and family planning

Leadership of service

- The trust's maternity services had clear management and governance structures in place within obstetrics and gynaecology specialties. Staff roles and lines of management were evident for clinical and non-clinical staff throughout the directorates.
- Staff told us senior management were available and visible to staff, including ward and directorate managers. Most staff said they felt supported by their local and directorate management teams. One staff member said, "I hope the new chief executive stays at the trust and carries on with the changes we've made".

Culture within the service

- It was apparent that staff who worked in the maternity services were proud of the care delivered to people, and proud that they worked at the trust. Staff worked well together, and there was obvious respect between the specialties within the directorate and across disciplines. Staff were mostly enthusiastic about the service provided by the maternity services, one staff member told us, "it's a well-led, focused team. I enjoy working for the trust".
- The General Medical Council National Training Scheme Survey 2013 for medical staff showed results that were similar to expected for areas including clinical supervision, workload and local teaching. The result for the quality of regional teaching was better than expected for the trust's maternity services. This meant regional teaching for medical staff was above performance expectations.
- Average sickness levels for midwifery staff between April 2012 and March 2013 were consistently above the average percentage for England. The trust's average midwifery staff sickness level was 6.1% compared to an average of 4.3% for England. Maternity service senior managers confirmed an on-going recruitment programme was in place for midwifery staff. Appointments had been made which would increase the staffing levels for the service, and increase support for staff within the service.
- Managers on the gynaecology ward told us staff were able to arrange family friendly contracts in conjunction with their manager and the needs of the service. This meant managers supported staff with contracts which suited individual staff members, whilst delivering appropriate clinical care.

Public and staff engagement

- A poster prominently displayed on the gynaecology ward provided information to staff, patients and visitors about the future management plans for the ward during the next three years. This meant succession planning for the ward had already begun in a planned, communicated and well-led manner.

Innovation, improvement and sustainability

- We were also told about the maternity service's work in reducing smoking in pregnancy. This used the Rotherham model for smoking reduction, by integrating smoking cessation advice into routine antenatal care, in order to improve outcomes. Staff used visual aids to demonstrate the reduction of oxygen levels to the baby. This clearly and visibly showed women using the service the potential impact and risks of smoking for their babies. The maternity service had reported good rates of smoking reduction by women, which had been consistently maintained throughout their pregnancies. Staff within the maternity service spoke to us with pride and passion about the smoking reduction programme, and the positive feedback from people using the service.

Services for children and young people

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

Information about the service

The trust's children and young people (C&YP) services at King's Mill Hospital provided outpatients, and medical and surgical inpatient care to patients. The services also provided high dependency and intensive care within its neonatal unit. Paediatric care is provided in the emergency department, and has been reported on in the Accident and Emergency (A&E) section of this report.

During our inspection we visited the paediatric ward, neonatal unit, and children and young people services' clinics. We spoke with patients, relatives and staff within the service. We observed care and treatment and looked at care records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust's children and young people services.

Summary of findings

The children and young people services provided safe care. Staffing levels were adequate and the directorate was in the process of recruiting additional nursing and medical staff. Incidents were reported and investigated, and learning was shared with directorate staff. The service had appropriate procedures in place to prevent and control infections, and to manage medications. Wards and departments were spacious, well equipped for patients, and were mostly well maintained.

Effective care was provided in children and young people services. The majority of staff were positive about the provision of care. There was a multidisciplinary approach to care, and staff respected colleagues in different roles and disciplines. However; staff mandatory training and appraisal rates had not met the trust target percentages.

We saw professional and compassionate care delivered to patients. Parents we spoke with were very complimentary about the service provided. Feedback received by the services from patients and families had been mostly positive.

Dedicated services for children and young people were provided, including a nursing outreach team for community-based care, and a children's diabetes nurse specialist. Links with local and regional children and young people services were excellent and worked well. The services had received numbers of complaints which were in line with other trust specialties.

Services for children and young people

There were management and governance structures in place for children and young people services. However, some staff told us they felt the services sometimes lacked trust-wide visibility. Key risks were identified, reviewed and managed by staff and senior managers. Staff were proud to work for the children and young people services within the trust. We found children and young people services provided good care.

Are services for children and young people safe?

Good

The children and young people services provided safe care. Staffing levels were adequate and the directorate was in the process of recruiting additional nursing and medical staff. Incidents were reported and investigated, and learning was shared with directorate staff. The service had appropriate procedures in place to prevent and control infections, and to manage medications. Wards and departments were spacious, well equipped for patients, and were mostly well maintained.

Sealed resuscitation equipment boxes, including adult resuscitation boxes, had been supplied to individual children and young people services wards and clinics by the trust resuscitation team. These boxes were not checked by staff in children and young people services. This issue was highlighted in other trust areas.

Incidents

- Staff reported incidents using the trust incident reporting system, Datix. Staff said they were encouraged to report incidents by their managers. Between September 2013 and February 2014, a total of 70 incidents were reported by staff working on the paediatric ward, ward 25, and neonatal intensive care unit (NICU). This was lower than the number of incidents reported from other wards in the trust during the same period. This meant staff reported incidents; however, not all of the incidents which had occurred in the services may have been reported. Ward and senior managers monitored, reviewed and managed actions following reported incidents on a quarterly basis. Staff told us incidents were discussed, and learning from incidents was shared.
- Between December 2012 and January 2014, one 'never event' occurred within children and young people services. A 'never event' is a serious incident which is so serious that it should never happen. The 'never event' related to a medication dosage error. Senior managers within children and young people services had fully investigated, reported upon and made recommendations following the 'never event'. Staff told us feedback and learning specifically related to the

'never event' had been shared with them. We found staff had implemented the actions required to improve practices and to learn from the outcomes of the 'never event'. The trust had reported the 'never event' in line with nationally-required reporting protocols. Senior managers from children and young people services had communicated with the family of the patient throughout the investigation process.

Safety thermometer

- Safety information posters had recently been displayed at the entrance to each ward. They included information about staffing levels and incidents reported by the ward or clinic, including medication related incidents and falls. The information posters contained comments from one parent which said, “to all staff, thank you for taking such good care of [patient]”. The service was meeting expected standards. Where required, risk assessments were completed appropriately on admission, and patient care plans were updated with relevant information.

Cleanliness, infection control and hygiene

- There was a routine, structured programme of cleaning in place on the neonatal intensive care unit (NICU). We saw completed daily and weekly cleaning schedules. We spoke with a member of the domestic services team on NICU. They clearly described the procedures for cleaning the ward, recording which areas had been cleaned and the regular auditing checks completed by the domestic services supervisors. This meant NICU was cleaned, and audits were routinely completed to ensure clinical cleanliness was maintained.
- MRSA is a type of bacterial infection that is resistant to a number of widely-used antibiotics and can be more difficult to treat than other bacterial infections. C. difficile infections are a type of bacterial infection that can affect the digestive system. There were no recently reported cases of MRSA or C. difficile between September 2013 and February 2014. This meant infection control rates were well controlled, and rates for children and young people services were within expected limits. We saw that information on infection control rates was displayed on posters within wards, and was clearly visible to patients and visitors.

Environment and equipment

- Children and young people services clinical areas were spacious. Staff, patient and visitor access to the paediatric ward, ward 25, and neonatal intensive care unit (NICU) was controlled via an access control system. Local ward or unit managers liaised with the trust’s security management team to control access to their individual areas. This ensured that access was available to staff, patients and visitors, but was managed safely in line with local and trust-wide security requirements.
- There was adequate equipment on the wards to ensure safe delivery of care. Sealed resuscitation equipment boxes were supplied by the trust resuscitation team, in line with trust policy. Staff told us resuscitation boxes were not opened unless equipment was required to deal with an emergency incident. Emergency equipment trolleys were kept in children and young people clinical areas; however, items within these trolleys were not securely stored. Emergency equipment trolleys had not always been checked against an agreed list. Checks had not always been recorded or audited to ensure the equipment was in date and worked.

Medicines

- Medicines were stored correctly in locked cupboards, or fridges where necessary. Controlled drugs were stored in separate, locked cupboards. This meant access to medicines, including controlled drugs, was controlled and medicines were stored securely. The majority of medicines had been correctly signed for by staff. Trust pharmacy staff regularly audited medicines kept in children and young people services.
- Audits had found medicines were correctly stored and administered. During April 2014, there were three occasions when staff had not signed correctly to confirm medicines had been administered. The last pharmacy medicines audit had been completed before these incidents had occurred.

Safeguarding

- The trust safeguarding lead confirmed there was a named nurse and consultant for children’s safeguarding, who staff could contact for advice regarding children’s safeguarding concerns. Staff were aware of the procedures to refer safeguarding concerns to the children’s multi-agency safeguarding hub. They had access to children’s safeguarding information on the trust website. Staff carried and referred to cards containing safeguarding information and advice.
- Medical staff told us a peer review process had recently been introduced, which helped senior paediatric medical staff review and monitor individual cases. The

trust safeguarding lead said there were good relations between the children's and adult's safeguarding teams within the trust, and externally with police and social services. This meant safeguarding procedures were safely applied within the services.

Mandatory training

- Staff mandatory training records were checked for training on infection control, medicines management and safeguarding of adults and children. The trust had a target for each directorate achieving 95% compliance, with a minimum requirement of 75% staff completing mandatory training. Children and young people services had achieved the minimum compliance rate for staff training in most areas, but had not achieved the 95% target. Staff training in hand hygiene and infection control on the paediatric ward, ward 25, was below the minimum required level.

Management of deteriorating patients

- We saw a Paediatric Early Warning System (PEWS), which was in the final draft version. PEWS is a monitoring score for recognising when children and young people deteriorate. Senior directorate managers confirmed this system would be implemented in the next few months throughout children and young people services. This meant a PEWS had been created specifically for children and young people, but had not been implemented within trust services.

Nursing staffing

- Children and young people services maintained adequate staffing levels; however, there were vacancies in staffing. There were vacancies for middle grades of doctors, including registrars, and 11 nurses. Senior directorate managers confirmed recruitment plans had been implemented to address staffing vacancies. This had resulted in nine nurses being offered posts within the services.
- Measures were in place to maintain adequate staffing levels. This included staff working overtime shifts and the use of bank, agency and locum staff. They told us the risks associated with staffing vacancies in children and young people's services were on the directorate and divisional risk registers, which were routinely monitored.
- However, we witnessed that receptionists were not always on duty in children and young people's services. Staff confirmed that receptionists worked part time during the week, and did not work at weekends. Nursing staff had to answer telephone calls, and allow access to wards for patients, their families and visitors. This meant nursing staff were sometimes taken away from caring for patients to complete reception tasks.

Are services for children and young people effective?

Good

Effective care was provided in children and young people services. The majority of staff were positive about the provision of care. There was a multidisciplinary approach to care, and staff respected colleagues in different roles and disciplines. However, staff mandatory training and appraisal rates had not met the trust target percentages.

Evidence-based care and treatment

- The service used National Institute for Health and Care Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH) guidelines to determine the treatment and care provided. Policies and procedures related to children and young people's services were readily accessible via the trust computer systems. These were in line with national guidelines.
- We noted two patients with serious infections had been identified at an early stage using NICE guidance on the meningitis care pathway. This had resulted in 100% effective outcomes for both patients, because staff had used appropriate national guidelines.
- Key guideline performance indicators were monitored and managed monthly for children and young people services. These included staffing levels, complaints and readmissions following elective (planned) and non-elective admissions. The indicators were reported at directorate and divisional levels within the trust and monitored for use of best practice. The performance indicators were slightly above expected levels; however, local area performance dashboards showed patient outcomes were not adversely affected. This meant that there was an on-going assessment of the services' performance in relation to key indicators of clinical care.

Services for children and young people

Pain relief

- Some pain management indicators were included in children and young people services care plans. However, we noted the trust had no pain management guidelines and protocols which were specific to children and young people services.

Patient outcomes

- We observed patient ward rounds on the paediatric ward, ward 25. These were held as 'team around the child' meetings, co-ordinated by the consultant on duty. Consultants ensured all newly admitted patients were fully examined within 24 hours of admission. The 'team around the child' ward rounds worked effectively to deliver medical care which was appropriate to the needs of patients.
- One parent told us, "the doctors explained the symptoms and outcomes. All the staff worked well together". Staff told us consultants and junior doctors worked as a team to manage patient admissions and care. However, nurses were not part of the 'team around the child' ward rounds. This meant communication between medical and nursing teams about the care and treatment discussed for individual patients during ward rounds might not be effective.
- We looked at three patient care plans. They were appropriately completed by both nursing and medical staff. Care plans contained information relevant to the effective delivery of care. Staff completed specific care plans dependent on the requirements of the patient and their identified care pathway.
- Discharge of surgical patients from children and young people services were sometimes delayed. This was a trust-wide issue, with delayed discharge processes due to issues related to pharmacy or the provision of medicines on discharge.

Multidisciplinary working

- Staff told us there were good working relationships between different professional groups and wards. Most staff were positive about the multidisciplinary team approach to patient care. This included trust staff from other departments who worked in children and young people services. A member of the trust's pharmacy team told us, "I feel the staff in paediatrics value my input, very much so".

Are services for children and young people caring?

Good

We saw professional and compassionate care delivered to patients. Parents we spoke with were very complimentary about the service provided. Feedback received by the services from patients and families had been mostly positive.

Compassionate care

- Patients and their families told us staff made them feel welcomed. The majority of comments were positive regarding patients and parents' experiences of children and young people services. One parent said, "staff are friendly and caring. If I've got a question and they don't know the answer they always find the answer for me". A second parent told us, "they're [staff] very caring to patients and the parents".
- We saw that medical staff held 'team around the child' meetings to provide care in a respectful and well managed manner. The patients, their families and the doctors told us the meetings were focused around the patient. These resulted in good outcomes for each patient on a short and longer term basis, because care was delivered to accommodate the patients' needs.
- Staff told us they felt able to deliver care which met patients' needs in a caring and compassionate way. One staff member said, "it's a really caring group of staff. I'd feel happy for children in my family to be cared for here."
- One parent told us they had had mixed experiences of care in children and young people's services. They said, "we've used the hospital for my children. One child received really good care but their older sibling wasn't as well treated. I think it was because they were older and that affected the attitude from some of the nursing staff. It's been great this time for my younger child though".

Patient understanding and involvement

- The trust website provided information about children and young people services, including details about the different wards and departments. The website provided information tailored for children and younger people. This included video clips which provided detailed

information about different aspects of inpatient and outpatient care. This meant people with access to the internet were easily able to view relevant information and contact details for the services.

- Information leaflets on a variety of topics were widely available. Information on how to contact the Patient Advice and Liaison Service (PALS) and how to make complaints to the trust were also available. Most of the information we saw was printed in English, but leaflets were available for people whose first language was not English.
- Children and young people services' play therapy team provided support and additional care to patients. They were able to offer dedicated time to individual patients, and help patients to use the services' facilities. These included a 'sensory room', and an outdoor play area which patients could use, with appropriate staff supervision, which meant patients were able to leave their wards. Staff in other teams, such as physiotherapists, also told us these facilities were very helpful to assist patients with their on-going care and recovery.

Emotional support

- Two bereavement counsellors were employed by children and young people services. Chaplains were also available within the trust to help support parents and families. Staff told us they treated parents with compassion, understanding and told them who was available to help within the trust. This meant patients and families had access to additional staff support if this was needed.

Are services for children and young people responsive?

Good

Dedicated services for children and young people were provided, including a nursing outreach team for community-based care, and a children's diabetes nurse specialist. Links with local and regional children and young people services were excellent, and worked well. The services had received numbers of complaints which were in line with other trust specialties

Service planning and delivery to meet the needs of local people

- Translation services or translators were available, and easily accessible for patients and families whose first language was not English. We saw posters displayed for translation service contact numbers. This meant staff had access to translators or a telephone translation service in order to communicate effectively with patients and their families when English was not their first language

Access and flow

- Senior directorate managers confirmed they had good working relationships with local GPs, clinical commissioning groups (CCG's) and other stakeholders. This included local and regional paediatric and neonatal services networks.
- Senior managers confirmed there were robust measures and procedures should the service need to close the neonatal unit due to lack of capacity. There were good reciprocal arrangements in place with other units within the regional network. Staff also told us the local and regional networks operated effectively.
- Senior directorate managers told us additional work was in progress to increase the availability of community-based children and young people's services. Funding had been secured from CCG's. The expansion of nursing and medical care services in the community aimed to provide appropriate home support, which would encourage earlier patient discharges from hospital.

Meeting people's individual needs

- Children and young people's services provided care specifically to meet their needs. This included a children's diabetes nurse specialist who provided dedicated care to patients. The specialist nurse also provided expert knowledge and training to nursing and medical colleagues within the services. The diabetes nurse specialist told us that the database used by the children and young people's services was out of date, but a new trust database was in development.
- The neonatal outreach nurse provided care and treatment to patients within their own homes, in the community. This meant that the service provided care which responded to people's needs and reduced the

requirement for hospital appointments. However, there was only one nurse providing this service; therefore no cover was available should the nurse become ill, or be absent from work.

- Patients who required child and adolescent mental health service (CAMHS) were admitted to the paediatric ward, ward 25. Staff told us that generally, they could request quality, comprehensive support from the CAMHS team. The CAMHS service for children and young people was run by a neighbouring mental health trust. Staff told us there were good working relationships with CAMHS colleagues, and their services were delivered responsively.
- Ward 25 had facilities to meet the needs of younger people who were treated on the ward. These included a DVD machine, a pool table and TVs. We noted that some of the equipment and rooms on ward 25, particularly for younger people, had become worn, and required replacement or refurbishment.
- The Child Development Centre at King's Mill Hospital offered patients a dedicated unit where they could attend appointments with nursing, medical and allied health teams, such as physiotherapists. The centre was spacious and well equipped.
- One parent, whose child was being cared for on ward 25 during our inspection, told us, "I've been very comfortable and the facilities for my child here have been very good". A second parent said, "we've been to another local hospital recently but the facilities here are much better".

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Staff were encouraged to resolve issues, concerns and complaints reported by people at a local level. If this action did not adequately resolve the person's concerns, they were reported to managers at local and directorate levels for further resolution. Between September 2013 and February 2014, the neonatal unit received one complaint. The paediatric ward, ward 25, received six complaints in the same time period. The numbers of complaints received by children and young people services were in line with those received in other wards in the trust. Staff told us feedback from complaints were discussed at team meetings to improve and respond to people's concerns.

Are services for children and young people well-led?

Good

There were management and governance structures in place for children and young people services. However, some staff told us they felt the services sometimes lacked trust-wide visibility. Key risks were identified, reviewed and managed by staff and senior managers. Staff were proud to work for the children and young people services within the trust. We found children and young people services provided good care.

Leadership of service

- Children and young people services had clear directorate leadership; the senior team had defined plans for the directorate and its specialties. Staff working in the paediatric ward, neonatal unit and clinics were aware of their senior leadership team, and felt supported by them. Staff told us leadership had improved; one staff member said, "I feel supported by the ward manager and the senior team. Board members have come and visited our wards". However, some staff told us they felt children and young people services sometimes lacked trust-wide visibility. They felt children and young people services performed well, but there appeared to be less focus on the services, in terms of strategic development, from the trust board.
- There had been changes in the nursing management structure within children and young people services in the last year. We were told these changes had initially caused some confusion and anxiety for all staff in the services. Staff told us recent appointments and senior management roles had been confirmed, which had alleviated most of their concerns. However, the management and leadership on the paediatric ward, ward 25, continued to be affected. This was due to staff sickness and ward management restructures. Ward 25 staff regularly covered management roles, which included the co-ordination of care and team management.

Culture within the service

- Staff in children and young people services were proud of their work and their teams. Staff worked well together and spoke highly of their colleagues in different

disciplines and roles. Staff were positive about the services, one staff member told us, “people are really supportive and helpful. It’s a good team. We’re respectful of our roles and we work as a team”.

- Average sickness levels were above average percentages for England. Senior directorate managers confirmed a recruitment programme was in place, and new nurses had been appointed to roles. The recruitment work remained on-going in order to attain full staffing compliment, and to support staff already working in the services.
- Staff attended monthly meetings or had access to the minutes of meetings if they had been unable to attend. Staff appraisal rates within children and young people services were above the minimum level required by the trust, but had not achieved the target percentage of 95%. In particular, the appraisal rates in February 2014 had fallen by over 25% compared to previous months, for both the paediatric ward and neonatal unit. This meant staff might not have had the opportunity to raise issues or discuss requirements in relation to their own roles within an appropriate timeframe.

Governance and measurement of quality

- Children and young people services senior managers recorded key indicators of clinical performance using a local quality dashboard. Indicators included medicine management incidents, rates of infection, and complaints received by the service. The indicators were updated monthly and were monitored, reviewed and managed by staff and senior management. The local dashboard showed consistent levels of performance between September 2013 and February 2014, which were in line with other trust services. This meant the directorate regularly assessed the performance of all directorate specialties.
- Directorate senior managers had identified key risks, which included staffing and community-based children and young people services. Staff who worked in the clinical areas were aware of the risks highlighted by their senior management team. The directorate risks were reported at local ward and trust board levels. This meant the services had an oversight of the risks which were likely to impact on the quality of patient care.
- Monthly clinical governance meetings were held. Key risks and performance results were routinely reported at local and directorate levels. The services had completed investigations and action plans to address issues raised from reported incidents or key risks. Children and young people services had fully investigated, reported on and implemented actions as a direct result of the 'never event' which had occurred in the service. The learning from the event had been communicated and shared with staff within the directorate. This meant there were good governance procedures, which measured indicators of quality care and fed back learning to staff from serious incidents.

End of life care

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

Information about the service

King's Mill Hospital has 20 adult wards where people can receive end of life care. King's Mill Hospital experiences around 1000 deaths per year. We also visited Mansfield Community Hospital, where there are less than five deaths a year. The Specialist Palliative Care team for both hospitals is based at John Eastwood Hospice, which is not part of Sherwood Forest Hospitals NHS Foundation Trust.

We visited 13 wards at King's Mill Hospital. We met with 10 patients and 23 relatives of patients who were receiving end of life care. We spoke with 44 members of staff including nurses, healthcare assistants, consultants, doctors, allied healthcare professionals, support staff and senior managers. We visited the mortuary, bereavement suite and the multi-faith centre. We observed care and treatment, and looked at care records. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust's end of life care.

Summary of findings

Care and comfort rounds were carried out regularly to ensure patients were well cared for. We found that most of the patients we reviewed had chosen to stay at King's Mill Hospital for their care. Communication with relatives about their relative's care was not always clear and there was no specific provision made for relatives staying at the hospital for long periods of time.

There was early evidence of a multi-disciplinary education and training programme for end of life care.

Staff had 24 hour access to a hospice by telephone for symptom control and advice. There were systems in place to refer patients to the Specialist Palliative Care team; however, some staff referred patients to the pain team, which had delayed patients receiving the appropriate care.

There were systems in place to provide planned discharges, but there were no specific systems in place for a rapid discharge at end of life.

There was a named executive or non-executive director with a responsibility for end of life care, however this was a very new appointment at the time of our inspection; staff were not fully aware. This meant that end of life care was not previously represented at board level or in the Trust's vision or strategy. Staff no longer used the Liverpool Care pathway, yet the Trust had not implemented guidelines or documentation to all wards that provided end of life care. The Trust had recently started to pilot end of life care guidelines on four wards.

End of life care

There was no system in place for Trust wide learning from complaints or incidents about end of life care as there was no specific governance or communication channels for end of life care. There was no co-ordinated plan for audit to monitor the quality of end of life care. The Consultant within the Hospital Specialist Palliative Care Team represents the end of life care team at the mortality meetings. There was no Trust-wide co-ordinated multidisciplinary training in end of life care.

Records of patients' preferences, decisions and discussions with the medical teams were not always recorded and in some cases there was no evidence that these had taken place. The decision not to resuscitate a patient was recorded on Allow Natural Death (AND) forms which were not always complete, legible or the recorded reason to allow a natural death was not always appropriate.

Are end of life care services safe?

Requires Improvement

Records of patients' preferences, decisions and discussions with the medical teams were not always recorded and in some cases there was no evidence that these had taken place.

The decision not to resuscitate a patient was recorded on Allow Natural Death (AND) forms which were not always complete, legible or the recorded reason to allow a natural death was not always appropriate.

There was no Trust-wide co-ordinated multidisciplinary training in end of life care.

Incidents

- There have been no recent never events or serious incidents in respect of end of life care. Staff were encouraged to report incidents, but the bereavement suite staff stated that they did not have the time to report incidents. There were systems in place to feedback incidents reported about end of life care to the department involved, however, they were not shared with all staff that provided end of life care.
- Themes from incidents were not always discussed at ward level and staff were not able to give us examples of where practice had changed as a result of incident reporting.

Medicines

- The protocols for prescribing medicines to treat symptoms which may occur at end of life were available on the hospital intranet site. Most of the doctors were aware of the protocols and had used them. The medication charts for ten patients receiving end of life care demonstrated the medicines had been prescribed as per the hospital protocol. This meant that patients who were receiving end of life care were prescribed medicines to treat symptoms that may arise.
- The medicines used to treat symptoms which may occur at end of life were available on most of the wards; however, we found that one ward did not have one of the medicines available to help treat restlessness or distress. This meant that any patient requiring this

medication would have to wait for staff to obtain this from pharmacy to treat their symptoms. Appropriate syringe drivers were available to deliver sub-cutaneous medication.

Records

- Senior medical staff signed the Trust documentation to Allow a Natural Death (AND). We found that the recorded reason for the decision to allow a natural death was not always appropriate. Staff did not review the decision to allow a natural death on each admission or during the person's in-patient stay. This meant that there was not always a valid reason to allow a natural death recorded on the Trust's documentation.
- Staff did not record that important conversations with patients or their families with medical staff had taken place, including conversations about the decision to allow a natural death or preferred place of care or death. Where staff had written that there had been a conversation, the writing was not legible. This meant that there was not a clear record of why the decision had been made to allow a natural death and there was no clear evidence that patients and their families had been involved in the decision making.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff did not record that they had assessed patients for their mental capacity to have discussions about decisions at end of life. Where patients had been assessed as not having the ability to communicate there was no evidence of a mental capacity assessment or a meeting to discuss the patient's best interest. This meant that decisions about care at end of life had been made without a record showing that consideration had been made for their ability to be involved, or that decisions were taken in line with the legal requirements of the Mental Capacity Act 2005.

Mandatory training

- There was evidence of multi-disciplinary education and training programmes for end of life care. A number of sessions on Induction Training days have been provided for new staff on the 16 wards not implementing the end of life care tools such as GSF and ACB.
- Junior doctors received half an hour's training for end of life care during their rotation, we spoke with four junior doctors, and they told us that they wanted more clarification of the issues that occur when caring for people at the end of their lives.
- Communication and syringe driver courses were on offer at the neighbouring hospice; we found that some members of staff had attended this training, however, there was no Trust record of who had attended the training or a strategic programme to ensure staff received communication training. Syringe driver training was also available from another source supplied by the Trust.
- The Trust had introduced training in March 2014, on the four wards selected for the pilot of the national initiatives (Gold Standards Framework (GSF) and the Amber Care Bundle). The documentation for the last days of life and assessment tools for GSF and Amber Care Bundle had been used on the wards since April 2014. These initiatives provided staff guidance for four wards. 16 wards in the Trust had been asked to use the principle of the Liverpool Care Pathway (LCP) and the medicine protocols. We spoke with 22 staff who told us that they knew the principles of the LCP very well; however, when we looked at patients' records, we found that the principles of the LCP had not been used as patients and their families had not been involved in the decisions at end of life and patients had not been assessed for their mental capacity to make decisions.

Are end of life care services effective?

Requires Improvement

Records of patients' preferences, decisions and discussions with the medical teams were not always recorded and in some cases there was no evidence that these had taken place. The decision not to resuscitate a patient was recorded on Allow Natural Death (AND) forms which were not always complete, legible or the recorded reason to allow a natural death was not always appropriate. There was no Trust-wide co-ordinated multidisciplinary training in end of life care.

Evidence-based care and treatment

- The trust had followed national guidelines to phase out the use of the Liverpool Care Pathway (LCP) to

document end of life care by July 2014. An audit demonstrated that staff had discontinued the use of the LCP in 2013; however the Trust had recently started to pilot interim multi-disciplinary last days of life guidelines and care plans that had been developed whilst awaiting the final national recommendations to be published on replacing the LCP, on four wards. In April 2014 staff throughout the trust had been advised by email to use the principles of the LCP to provide end of life care until local guidance could be implemented. This reiterated an email sent in July 2013.

- The trust registered on the transforming end of life care in acute hospitals programme in 2013 and pilots began in June 2013. The trust identified in August 2013 that the Gold Standards Framework and the Amber Care Bundle, were to be piloted on four wards; to date, two wards have been implementing the Gold Standards Framework in Acute Hospitals since June 2013 and two wards have been implementing the AMBER Care Bundle since July 2013. These are national initiatives to improve the recognition of dying and allow timely decisions to be made in line with the NICE Quality Standard on End of Life Care for Adults. Local guidelines for the last days of life were being developed and had been introduced as a pilot onto the same four wards from March 2014. This meant that the trust had taken the first steps to introduce recommended guidelines for end of life care.
- Staff at the trust used standard care plans to assess, plan and evaluate care at the end of life. They recorded discussions with patients and their families in the medical notes. Decisions made about care at end of life were also documented in the medical notes. Staff relied on handover sheets to relay the information about end of life care. There were no guidelines to follow and not all staff had received training, which meant that end of life care depended upon the knowledge and skill of the team on each ward. Not all the same information was recorded, and not all teams worked in the same way; this meant that end of life care may not be equitable throughout the trust.
- There was inconsistency in delivery of end of life care and recording of information. The Gold Standards Framework and the Amber Care Bundle were being piloted on four wards; the pilots began in March 2014. There were no guidelines on some wards to follow and not all staff had received training, which meant that end of life care, depended upon the knowledge and skill of the team on individual wards. Information recording was also inconsistent. Some medical notes and nursing notes did not record the discussion with the patient and / or relatives. Staff relied on handover sheets to relay the information about end of life care.
- Medical staff did not have clear guidance about providing end of life care. Two members of nursing staff told us that they had received end of life training in the past, and would prompt medical staff to think about discussions and decisions at end of life. On one ward nursing staff told us that nurses and doctors disagreed with plans of care as there were no guidelines.
- Medical staff had access to the Specialist Palliative Care team via the neighbouring hospice; however, not all doctors were aware of how to contact the team. Timely referral to the Specialist Palliative Care team relied on ward staff being aware of the role of the Specialist Palliative Care team. There was a single point of access to make all referrals. The Specialist Palliative Care team told us that the referral from the single point of access did not provide enough information. Two patients were recently referred to the pain team, instead of the Specialist Palliative Care team, which had delayed patients receiving the appropriate care. This meant that there was not an effective referral system to the Specialist Palliative Care team.

Nutrition and hydration

- Five members of staff we spoke with told us that on reflection, some end of life care planning 'could have been better', in particular mouth care and decisions about intra-venous fluids

Patient outcomes

- The hospital contributed to the National Care of the Dying Audit, the results of which were to be published in May 2014. The audit included a local survey of bereaved relatives or friends perspectives. The hospital achieved three out of the seven key performance indicators.
- There had been no audits to monitor the completion and rationale for Allow Natural Death (AND) forms. There had been an audit carried out by the resuscitation department in June 2013, which demonstrated that lack of end of life care planning had led to the cardiac arrest team being asked to resuscitate patients where there could have been discussions and documentation to allow a natural death. There was no evidence of this information having been shared with the end of life team or any action taken as a result.

End of life care

- There were no audits to measure the trust's performance in delivering end of life care against the outcome set out by the Leadership Alliance for the Care of Dying People. We spoke with the end of life lead who told us that they had intended to carry out an audit of patients' notes; however, the methodology had not been developed.

Multidisciplinary working

- Each ward had their own multidisciplinary team (MDT) meetings for their own specialties. End of life care was discussed at these meetings, and decisions, such as the ceiling of interventions such as antibiotics, allowing a natural death, nutrition, and where patients would receive their care, were made. On some wards, patients and relatives had been involved in the decision-making and on others there were not.
- The Specialist Palliative Care team held their own multidisciplinary team meetings weekly, when they discussed all new patients who had been referred to them, and any particular patients with complex needs. Any outcomes were recorded in patients' notes as a means to communicate with the respective medical teams on each ward. There was no palliative care representative on any of the ward MDT meetings.

Seven-day services

- The palliative care team were available 9am-5pm Monday to Friday. In addition, there was a reduced service available at the weekend from 10am-4pm. Out of those hours support was provided via a telephone hotline to the local hospice.
- The chaplaincy service was available every day at King's Mill Hospital, and a chaplain is currently supporting Mansfield Community Hospital for one day per week.

Are end of life care services caring?

Good

Care and comfort rounds were carried out regularly to ensure patients were well cared for. We found that most of the patients we reviewed had chosen to stay at King's Mill Hospital for their care. Communication with relatives about their relative's care was not always clear and there was no specific provision made for relatives staying at the hospital for long periods of time.

Compassionate care

- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect.
- We saw that call bells were answered promptly.

Patient understanding and involvement

- Where detailed discussions had taken place with patients and families, these were documented very briefly in the notes. We spoke with one family who told us they felt well informed and had been involved in the decision-making. Some notes did not record any discussions with the patient or their families. One family member told us of their dismay at receiving a completed Allow Natural Death form, with the discharge papers, without an explanation.

Emotional support

- Patients and their families we spoke with told us "staff are very kind". Care and comfort rounds were carried out regularly to ensure patients were well cared for. We found that most of the patients we reviewed had chosen to stay at King's Mill Hospital for their care.

Are end of life care services responsive?

Requires Improvement

Staff had 24 hour access to a hospice by telephone for symptom control and advice. There were systems in place to refer patients to the Specialist Palliative Care team; however, some staff referred patients to the pain team, which had delayed patients receiving the appropriate care. There were systems in place to provide planned discharges, but there were no systems in place for a rapid discharge at end of life.

Service planning and delivery to meet the needs of local people

- There were few facilities for families. There was no special provision for meals, parking or washing facilities. Nurses told us that they had suggested that there should be a voucher system for food and parking and the end of life lead had told us of a comfort pack that was being developed for relatives. Where possible, nurses had accommodated families' needs, so that they could stay with their relatives whilst receiving end of life care.

End of life care

- There was no direct communication or effective working relationship between the intensive care outreach team and the end of life care team. This meant that there could be missed opportunities to plan for end of life care.
- The discharge co-ordinator was in the process of setting up systems with departments to facilitate rapid discharge at end of life, including transport, equipment store and continuing healthcare. This meant that communication between departments could be improved to speed up the process of rapid discharge at end of life.
- Interpreters were available when necessary.

Access and flow

- Patients were seen by the Specialist Palliative Care team within 48 hours of referral, and where needed, they were seen at short notice. Staff could access medical and nursing advice from the hospice by telephone.
- Patients who were identified as requiring end of life care in A&E were transferred to a suitable ward where possible. Where patients were admitted to the assessment unit, they would remain there for their end of life care. This meant that patients received their end of life care in one place with the same staff.
- Where possible, side rooms were prioritised for patients at their end of life.
- There was a 'fast track' system, whereby patients who had been identified as in their last 12 weeks of life could be referred to the discharge co-ordinator, who specialised in discharging patients to their preferred place of care. All the staff we spoke with understood how the fast track worked and had seen patients discharged home.
- The discharge specialist nurse was knowledgeable and had some systems in place to facilitate discharge home within a week.
- There had been no audit to demonstrate how many patients were discharged to their preferred place of care, or the time it took to discharge patients.

Meeting people's individual needs

- There was a Macmillan information centre which was easily accessible. This provided information about people's medical conditions, advice on how to access services, and provided financial advice by appointment.
- There were some patients who had dementia and could no longer communicate verbally; these patients had a booklet 'This is me' to describe how they liked to receive their care.
- The bereavement suite provided practical advice for the days immediately after a patient had died. There were systems in place for patients who had no family. There was a registrar available at King's Mill Hospital three days a week, to register the death at the time of collecting the death certificate from the hospital.
- There was not a robust system of recording patients' personal property and valuables, as they were not always documented accurately. One patient's valuables had been given to a visitor with the patient's verbal consent, but this had not been documented. Property that was transferred from the ward to the bereavement suite was also not documented accurately, which at times had caused confusion and distress.
- Bereavement counselling was only available where patients had been referred to the Specialist Palliative Care team, as this service was provided by the hospice. All other families were referred to their own GP.
- Normal visiting times were waived for relatives of patients who were at their end of life.
- We spoke with 11 relatives who told us that the car-parking was expensive, especially over a period of time. Staff told us that they would have liked to offer relatives more help when staying at the hospital overnight. The end of life lead showed us a plan for the provision of comfort packs for relatives which provided vouchers for meals, car parking tokens and other items that made relatives' stay more comfortable.

Learning from complaints and concerns

- Complaints received concerning end of life care were handled by the trust in line with their policy. Each directorate had their own governance meetings where complaints about their service could be discussed. In response to one complaint, there had been an introduction of a 'This is me' booklet for patients that could no longer communicate verbally.
- However, as there were no end of life care governance meetings to discuss complaints, there had been no trust-wide actions taken in response to end of life complaints. This meant that the trust had no system in place to learn from complaints about end of life care, and no opportunity to share the learning throughout the trust.

End of life care

Are end of life care services well-led?

Requires Improvement

There was no named executive or non-executive director with a responsibility for end of life care which meant that end of life care was not represented at board level or in the Trust's vision or strategy. There was no system in place for Trust wide learning from complaints or incidents about end of life care as there was no specific governance or communication channels for end of life care.

Vision and strategy for this service

- A management plan for developing end of life care was created in August 2013. The documentation for this plan demonstrated that some of the target goals had been missed, and re-arranged over a longer time span. Very recently, the executive director of nursing and quality had been appointed as board level lead.

Governance, risk management and quality measurement

- There were no governance meetings held for end of life care. The trust recognised in the trust mortality group meeting in February 2014 that the number of expected deaths, and those with palliative care needs, need to be accurately identified.
- Complaints, incidents, audits and quality improvement projects were not discussed at governance and board meetings. There was no system to feedback complaints to all staff that provide end of life care to facilitate learning.

Leadership of service

- The end of life care team comprised of an end of life lead, who was appointed in August 2013, supported by a deputy executive director of nursing and quality. There was a respiratory consultant, who had shown support and interest in implementing the pilot documentation on four wards. There was a named discharge co-ordinator for end of life care.
- Staff were unable to name the end of life lead, but they were able to name the discharge co-ordinator. Staff did not know how end of life care was developing within the trust.
- Specialist Palliative Care expertise was available from the hospice that provided the Trust's specialist Palliative Care team, however, there was no service level agreement and the expertise had not been fully utilised.

Culture within the service

- Staff relied on end of life experience within their own teams and occasionally from other wards. Staff saw the provision of good end of life care as a priority. There is an end of life care intranet site giving access to policies and guidance in relation to end of life care.

Public and staff engagement

- There had been very little engagement with the staff about end of life care until March 2014, whereby the staff on the four end of life pilot wards had an opportunity to help develop the guidance for the last days of life.

Innovation, improvement and sustainability

- During training sessions held on four wards in March and April 2014, staff were asked to make comments on how to develop the 'Last days of Life' documentation.
- There had been no other opportunities for staff to have an input into the provision of end of life care in the trust.

Outpatients

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

Information about the service

Sherwood Forest Hospitals NHS Foundation Trust provided outpatient services to 337,068 patients in the year April 2012 to March 2013. Clinics are held at King's Mill Hospital in Sutton-in-Ashfield, Newark Hospital, Mansfield Community Hospital, and Ashfield Health Village. The departments are staffed by reception staff, doctors, specialist nurses, nurses, therapists and support workers. Student nurses and therapists attend outpatients on placement as part of their training.

We inspected the outpatient services provided by Sherwood Forest Hospitals NHS Foundation Trust at King's Mill Hospital and Mansfield Community Hospital. We spoke with 26 patients, four relatives and 36 staff, including nurses, healthcare assistants, consultants, doctors, allied healthcare professionals, support staff and senior managers. We received comments from our listening event, and from people who contacted us to tell us about their experiences; we reviewed performance information from, and about, the trust.

Summary of findings

Outpatients departments were clean and staff washed their hands before attending to patients. There were staff shortages which had led to cancelled clinics or lack of chaperones at King's Mill Hospital. The trust had identified shortfalls in radiology and outsourced work to maintain service levels. Patient records were primarily paper files, which sometimes caused a problem when Newark patients received treatment at King's Mill Hospital. Not all staff had received their mandatory training; however, most staff had received their training in safeguarding adults and children. Staff knew how to report incidents, and were encouraged to do so. There was evidence that changes in practice had been implemented following incidents.

There were a wide range of clinics, with most patients receiving their appointments within target times. Staff were competent. Multidisciplinary working was especially evident and effective at Mansfield Community Hospital.

Patients were treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink, and transport arrangements. Emotional support was available in specific clinics when needed.

Most patients had access to outpatient services within national guidelines. However, some patients found

Outpatients

difficulty getting follow-up appointments, as the demand for some clinics could not be met by the service. Telephone reminder systems were available to those patients who had mobile phones.

There had been long waiting times for people attending their appointments in some clinics; the trust had responded by reviewing the delays and capacity in the clinics.

Staff aimed to deal with complaints as they occurred to prevent them being escalated to a formal complaint. Where formal complaints had been made, the trust had not always responded within their own policy guidelines.

Staff perception of the leadership was positive; they thought that directors were approachable and listened to their concerns. The vision for the trust had recently been introduced and had not been embedded.

Staff at Mansfield Community Hospital had high regard for their colleagues, and this was demonstrated by the effective multidisciplinary team working, and the delivery of their services. However, the influence of the Mansfield Community Hospital team in policy and governance decisions was not evident.

Are outpatients services safe?

Requires improvement

Outpatients departments were clean and staff washed their hands before attending to patients. The trust had identified shortfalls in radiology and outsourced work to maintain service levels. Patient records were primarily paper files, which sometimes caused a problem when Newark patients received treatment at King's Mill Hospital. Not all staff had received their mandatory training; however, most staff had received their training in safeguarding adults and children. Staff knew how to report incidents, and were encouraged to do so. There was evidence that changes in practice had been implemented following incidents.

Incidents

- There have been no recent 'never events' or serious incidents reported in outpatients or radiology.
- All staff we spoke with knew how to report incidents and were encouraged to do so by their managers. Staff told us they would be confident in raising any concerns with their managers. Heads of departments at both hospitals met regularly to discuss compliments, complaints and incidents. We spoke with staff, who gave examples where they had shared learning from incidents and changes in practice had been put into place as a result; for example, in radiology we saw that signage had been developed to encourage staff to pause and check to prevent any radiation incidents.

Cleanliness, infection control and hygiene

- Clinical areas in both hospitals appeared clean and well organised. We observed that 'bare below the elbow' policies were adhered to, and we saw staff regularly wash their hands and use hand gel between treating patients.
- There were adequate toilet facilities, which were clean.

Environment and equipment

- The environments in the outpatient areas were safe and fit-for-purpose. All areas were easily accessible.
- The facilities at Mansfield Community Hospital were designed for patient rehabilitation, and provided an area to assess patients using equipment they would use at home, and therapy areas which included computer

games to help with balance. Equipment was appropriately checked, and cleaned regularly. There was adequate equipment available in all of the outpatient areas.
- Resuscitation trolleys in outpatients were centrally-located and checked regularly.

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- Chemotherapy was prescribed and administered using the trust's protocols at King's Mill Hospital.
- Patients were adequately counselled for new medication, and written information was given. The team caring for patients with Parkinson's Disease provided additional support to patients and their families to manage their supply of medication from outside sources.

Records

- There were adequate facilities for patients' records at King's Mill Hospital. Patients who had received their treatment at King's Mill Hospital told us that their notes were available at their outpatient clinics.
- Where patients had previously received treatment from the trust's other hospital at Newark, notes were ordered five days in advance. Seven patients from Newark had made a complaint since October 2013 that their notes were not available for their clinic appointment at King's Mill Hospital. Staff in the ophthalmology team had discussed the matter of missing notes at their monthly meeting in November 2013, and placed a contingency plan for those patients who required urgent treatment, to treat them as a new patient. This meant that there was a risk that patients whose notes were stored at Newark would not have their medical notes available at their outpatient clinic appointment at King's Mill Hospital.
- Regular audits were not undertaken to monitor availability of records. This meant that there was no record of how many patients did not have their medical notes available. The trust was planning to implement electronic patient records in October 2014.
- Diagnostic data from all areas of the trust were available electronically, but were printed out so that they could be filed in patient notes. There was an issue with printed results not being filed in patient notes properly; the clinical management team planned to carry out regular reviews of filing, in case notes stores, pathway co-ordinator offices and wards.
- Patients completed a questionnaire about their medical history before they attended clinics as a new patient.
- Patient records at Mansfield Community Hospital were stored on SystemOne, which was shared with primary care staff in the community.

Safeguarding

- There were systems in place to identify and protect vulnerable people from abuse. Staff demonstrated that they could recognise different signs of abuse and who to escalate their concerns to at the trust. 94% of staff had received safeguarding of vulnerable adults training.

Mandatory training

- Compliance with all mandatory training for the diagnostic and rehabilitation division as of 31 January 2014 was 70%. The lowest attendance rates for training that was required to be renewed were within escort training (48%), fire training (64%) and slips, trips and falls (65%). Whereas, the highest attendance rates were within the Mental Capacity Act (94%), safeguarding adults (94%) and safeguarding children level 2 (90%). We also noted that for doctors that were required to attend MRSA and C. difficile training, the attendance rates were 13% and 16% respectively. Staff at the pathology governance meeting in January 2014 had discussed the issue of mandatory training compliance; they identified that there were not enough available dates within the training and development department, and this had been escalated to the performance management meeting. This meant that not all staff required to attend appropriate training had done so to ensure they had the most up-to-date knowledge to provide effective care and treatment for patients.

Nursing staffing

- At King's Mill Hospital there were five vacancies for nursing staff; the impact of these vacancies had been seen, where chaperones were not always available for patients. Clinics such as orthodontics had been cancelled when there was not a suitably qualified nurse available. Bank staff were used where possible, particularly when extra clinics were created to deal with demands on the outpatient department during national awareness campaigns.

Outpatients

- At Mansfield Community Hospital outpatient staffing consisted of a comprehensive skill mix, which provided for patient's rehabilitation needs.
- Staffing issues in pathology had been identified as a risk to the anti-coagulation service; this had been escalated to the management team.

Medical staffing

- Medical staff vacancies were covered by locum doctors, with the exception of a vacancy for a vascular surgeon, who had not been replaced. The impact of this was seen in the long waiting times for outpatient follow-up appointments for patients who had undergone vascular procedures
- Locum radiology staff were being used in the radiology department, as the trust had found it difficult to recruit staff, but this had been identified as a national problem. Some reporting of scans and X-rays were outsourced to ensure that deadlines for reporting were met.

Are outpatients services effective?

Not sufficient evidence to rate

There were a wide range of clinics, with most patients receiving their appointments within target times. Staff were competent. Multidisciplinary working was especially evident and effective at Mansfield Community Hospital.

Evidence-based care and treatment

- Patient's needs were assessed, and care was delivered in line with best practice clinical guidelines to ensure that they received safe and effective care.
- Nursing staff followed trust's policies and procedures. Specialist nursing staff were expected to follow the National Institute for Health and Care and Excellence (NICE) guidance relating to their specialty, such as cardiovascular disease, diabetes or cancer.
- The Royal College of Nursing and the Royal Marsden national guidelines were followed for clinical nursing procedures. Staff could access clinical guidelines, policies and procedures through the trust's intranet system.

Patient outcomes

- Data was accessible for the months of December 2013 and January 2014 for each clinical discipline's performance report. The data showed that most of the clinics were achieving the expected targets for non-admitted patients receiving an appointment within 18 weeks of referral.
- On the data that was available, we saw that the average waiting time target for clinics was five weeks, most of the clinics were achieving this target.
- The data provided for October to December 2013 demonstrated that the trust met all of their targets for two week wait appointments.
- The customer services team, supported by hospital volunteers, surveyed patients and found that nearly all patients said they would be likely or extremely likely to recommend the hospital to family or friends.

Competent staff

- Staff in outpatients had received their yearly appraisals. There were systems in place to remind staff when appraisals and training were due. Pathology had achieved 95-100% appraisals at end of Dec 2013, for all areas within pathology.
- Staff work in different outpatient areas to widen their knowledge and experience.
- Healthcare support workers underwent training in plaster room procedures and removal of sutures.
- The manager had records of staff training and competencies; due dates for training and appraisals were advertised on staff noticeboards.

Facilities

- King's Mill Hospital provided a wide range of outpatients, including chemotherapy, ophthalmology, orthopaedics, general surgery, cardio-respiratory and gynaecology, with over 300,000 new patient and follow-up appointments in one year.
- Mansfield Community Hospital provided a range of outpatients, including rehabilitation, neurology, Parkinson's Disease and wheelchair services, seeing 761 new patients and 5,491 follow-up appointments from 1 April 2013 to 28 February 2014.
- Specialist teams in neurology and Parkinson's Disease provided consultant and nurse-led clinics, with access to the teams via telephone and drop-in clinics.
- The therapy-led older people's team provided outreach to care homes and patients' homes.
- Mansfield Community Hospital provided wheelchair services, for children and adults. Referrals from GPs and

Outpatients

district nurses were made where there was a medical need for a wheelchair for more than six months. Care homes could refer to this service where the patient required a self-propel wheelchair or for postural needs.

Multidisciplinary working

- Mansfield Community Hospital demonstrated effective multidisciplinary working by running medical, nursing and therapy-led clinics. There were regular meetings where patients' care was reviewed.
- Staff in the rehabilitation team based at Mansfield Community Hospital worked closely with social workers and integrated teams in the community.
- King's Mill Hospital clinics included cancer nurse specialists that provided support; they were involved in their cancer specialty multidisciplinary team planning and review meetings.
- Staff in the pain clinics provided nurse-led acupuncture and consultant-led epidural and injection clinics.

Are outpatients services caring?

Good

Patients were treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink, and transport arrangements. Emotional support was available in specific clinics when needed.

Compassionate care

- Patients were able to feedback about their care; a letter was sent out to their homes, and there were feedback sheets in waiting areas. Patients we spoke with told us that the hospitals had pleasant surroundings, assistance was available, and all the staff were very welcoming. Staff had also installed boards in the waiting area for people to add their comments; the prompts on the boards were 'You said, we did', where staff communicated what had been done in response to patients' comments.
- The results from the feedback showed that some patients were unhappy about the length of time they had to wait to be seen. Staff were working closely with the Patient Advisory and Liaison Service (PALS) to look at the theme of waiting times, to see how this could be improved.
- The customer services team, supported by hospital volunteers, surveyed 484 King's Mill outpatients, and 44 outpatients at Mansfield Community Hospital. 95% of respondents for King's Mill and 100% for Mansfield Community Hospital said they would be likely or extremely likely to recommend the hospital to family or friends.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We observed staff provide care and comfort rounds to ensure patients had food and drink, and transport arrangements.
- The environment in the outpatient department allowed for confidential conversations.
- Chaperones were mostly provided where required, in clinics such as breast and gynaecology.

Patient understanding and involvement

- Patients we spoke with told us that they had the opportunity to ask questions during their appointments. Patients receiving rehabilitation therapies told us that they felt involved in their care and understood their treatment plans.

Emotional support

- Cancer specialty nurses were available in their respective clinics to help with information and support. Specialist nurses, such as Parkinson's, provided on-going support and nurse-led clinics. Patients and their families told us that the access to specialist nurses helped them to understand their care, and they felt like someone understood their needs.

Are outpatients services responsive?

Requires improvement

Most patients had access to outpatient services within national guidelines. However, some patients found difficulty getting follow-up appointments, as the demand for some clinics could not be met by the service. Telephone reminder systems were only available to those patients who had mobile phones.

There had been long waiting times for people attending their appointments in some clinics; the trust had responded by reviewing the delays and capacity in the clinics.

Outpatients

Staff aimed to deal with complaints as they occurred, to prevent them being escalated to a formal complaint. Where formal complaints had been made, the trust had not always responded within their own policy guidelines.

Key responsive facts and figures

- Most of the clinics were meeting their 18 week outpatient follow-up appointment, except for gastroenterology that had achieved between 78 and 88% of their 95% target for patients receiving their follow-up appointment within 18 weeks.
- Patients were being seen in outpatients within a targeted time, with the exception of the haematology clinic, which had a target of five weeks and the average time to appointment was 16-18 weeks.
- New patients with Parkinson's Disease had a 2-3 weeks wait, well within the six week guideline.
- Patients used the 'choose and book' system for GP referral for two week wait appointments. The trust saw around 800 of these patients a month. The trust met all of their targets for two week wait appointments in quarter 3.
- 95% of patients used the 'choose and book' system.
- Follow-up appointments for six weeks were given to patients at reception; if no appointment was available in six weeks, the divisional team organised the appointment and informed patients by post. Where there was an increased demand for appointments, extra clinics were created to increase capacity. National campaigns increased demand for outpatient appointments, and the trust had responded by providing extra clinics. The demand for ophthalmology and colonoscopy meant that the trust were planning on providing additional clinics.
- Follow-up appointments for patients with vascular conditions were not available, as there was no vascular consultant employed; the backlog for these appointments went back to July 2013. We met one patient in the Accident and Emergency department, who was still waiting for results for vascular investigations carried out in October 2013; they told us that despite several calls they had not found out their results or been able to book a follow-up appointment.
- Mansfield Community Hospital had systems in place for patients to contact their therapy team directly to make or change their appointments.
- The Sherwood Rehabilitation team referral time was 2-3 weeks for new patients with fractures or long stays, or 4-5 weeks waiting for home or care homes. Staff told us that patient referrals for rehabilitation from inpatient wards at King's Mill Hospital could have been made earlier in patients' care pathways, in order for them to receive more benefit from their treatment.

Service planning and delivery to meet the needs of local people

- The trust had recognised the issue of patients not attending clinics, and had put processes in place to prompt and remind patients of their appointment, for the clinics that were in the top 10% of non-attenders. The outcome of this initiative was to reduce the number of non-attenders from 11% to 4% for those specialties in six months. The trust had employed a consultancy to work with them to reduce the number of non-attenders in all clinics. This means that the numbers of people actually attending outpatient appointments would be increased.
- Letters were sent to the GP within one week of the outpatient clinic.
- Staff at Mansfield Community Hospital liaised with patients' GPs and care homes, to ensure their understanding of their patient's plan of care; staff would assist care staff to understand how to carry out exercise regimes prescribed by therapists.
- Staff at Mansfield Community Hospital helped patients to make appointments with their GPs, district nurses, advocacy service, social services and to join gyms in the community.
- Staff told us that patients can arrive at the department appearing stressed due to difficulties in parking their cars. Patients told us that car parking could be difficult. We saw that patients were dropped off at the main entrance and sat in comfort whilst their relatives parked their car.
- Patients paid the standard fee for car parking which was £3 for up to 4 hours. The hospital had provided information on their website for patients who were on low income, who may be able to recover the costs of car parking through the Healthcare Travel Costs Scheme.
- There was a volunteer coffee shop in the main reception area with a wide range of snacks, and hot and cold drinks.

Access and flow

- Patients received their appointment letters with information about the location of the hospital and the clinic.

Outpatients

- The trust monitored the number of patients who did not attend (DNA) clinics. New referral clinics, such as plastic surgery, geriatric, rheumatology and cardiac clinics, were within the national average of 8%. However, new referrals for respiratory, endocrine, gastroenterology, haematology, neurology and dermatology were not within national targets. Follow-up clinics for all of these clinics, except for cardiology, were also above the national average. This meant that there were more than 8% of appointments not attended by patients.
- The trust cancelled 4,362 appointments between September 2013 and February 2014; 63% of these were due to lack of staff availability and 18% due to administrative error. These cancellations equated to around 3% of appointments during the time period.
- Feedback from a Patient Advisory and Liaison Service (PALS) survey in October to December 2013 showed that 30% of the contacts were unhappy that their appointments had been changed, and there were concerns about lack of outpatient appointment capacity
- Waiting times were displayed on new communication boards in the outpatient waiting areas; however, these were not being updated. Patients told us that they had been waiting for over an hour, but the communications boards said that the wait was 30 minutes. We also observed a nurse telling patients that there would be lengthy waits, some as much as one hour, and gave people the opportunity to leave the outpatients department to get a drink.
- A consultancy had been employed to monitor waiting times in clinics; the study had not been completed, which meant that the trust did not have information about waiting times.
- Patients who attended the fracture clinic had a system that sent them to the appropriate department on arrival; for example, the X-ray department or the plaster room. This prevented delays in the fracture clinics.
- Patients for ophthalmic appointments were advised to come to the department 25 minutes before their appointment to have their pre-test, to help cut the waiting times in their clinics.
- We observed that one consultant was over an hour late for their own clinic on the day of inspection; patients were advised of the delay.
- Patients requiring a blood test were able to use the drop-in service in phlebotomy.
- There were occasionally staff shortages which had led to cancelled clinics.

Meeting people's individual needs

- Telephone translation services were available for patients who could not understand English.
- Patients who required assistance with their mobility to get to clinics could use the services of the hospital buggy. We met eight people in the main entrance at King's Mill Hospital who required assistance to reach clinics; they told us that there was an efficient and friendly buggy service. We observed that patients were treated with dignity and respect, and were assisted to their clinics by friendly staff.
- Patients attending clinics on the upper floors were assisted by staff who worked together to ensure there was a porter waiting for them outside the lift on the upper floor to take them to their clinic.
- Patients received a reminder by text alert to their mobile phones seven days before their appointment, with an opportunity to reply.
- Patients who did not use mobile phones did not receive reminders; however, the trust had identified this and were in the process of tendering for an interactive voice message service.
- Staff at the appointments call centre could cancel and change appointments. Staff told us that the current system was difficult to use and described it as 'clumsy'. There was a facility to place patients on a cancellation list. Staff expressed concern that the call centre did not have the facility to show how long patients had been waiting for their call to be answered, to allow other staff to step in to take calls at peak times.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. Initial complaints were dealt with by the outpatient manager who resolved the issues face-to-face or by telephone. Where complaints were not resolved, patients were directed to the Patient Advice and Liaison Service (PALS). If they still had concerns following this, they would be advised to make a formal complaint. This process was outlined in leaflets available throughout the department.
- From September 2013 to February 2014 the trust received 103 complaints about outpatient services; this related to 0.2% of all outpatient appointments. 20 of these complaints related to difficulty in getting

appointments and seven where people's appointments had been cancelled without their knowledge. 17 complaints related to the attitude of the staff and seven to missing notes.

- The trust had a target of responding to complainants within 40 days. Of the 103 complaints, 35 were responded to in the 40 working days; however, 29 had been responded to after 40 working days and 39 remain open and unanswered. Five complaints had been re-opened. This meant that the trust had not met its target of responding to patients' complaints within 40 days. A satisfaction survey of complainants was being undertaken.

Are outpatients services well-led?

Good

Staff perception of the leadership was positive; they thought that directors were approachable and listened to their concerns. The vision for the trust had recently been introduced and had not been embedded.

Staff at Mansfield Community Hospital had high regard for their colleagues, and this was demonstrated by the effective multidisciplinary team working, and the delivery of their services. However, the influence of Mansfield Community Hospital team in policy and governance decisions was not evident.

Vision and strategy for this service

- The trust vision had been recently introduced, promoting 'Quality for All', focusing on staff behaviours and quality of care. This had not been embedded, and most staff we spoke with were aware of the vision, but were unable to talk about it in detail.

Governance, risk management and quality measurement

- Quarterly governance meetings were held within the directorate; however, not all staff were encouraged to attend.
- The trust had not ensured that policy and governance decisions about all outpatient services had impacted positively on the services delivered at Mansfield Community Hospital.
- Complaints, incidents, audits and quality improvement projects were discussed at monthly meetings.

Leadership of service

- Outpatients were in the diagnostic and rehabilitation directorate, where clinical leadership was evident. The director visited the sites monthly, and was described by staff as approachable.
- The chief executive had drop-in sessions for staff to have their say. Staff at Mansfield Community Hospital told us that they had met with the chief executive of the trust, as he visited their hospital often.

Culture within the service

- Staff within the directorate spoke positively about the service they provided for patients. Quality and patient experience is seen as a priority and everyone's responsibility.
- Managers and staff recognised that the call centre environment was stressful; however, they told us that they felt it was a good team, which support each other. All staff had received conflict resolution training, and customer service training was available.
- Staff worked well together and there was obvious respect between, not only the specialties, but across disciplines.
- Staff at Mansfield Community Hospital were proud of their effective multidisciplinary and multi-agency working. There were examples of therapy technicians and student nurses who had had their placements at the hospital, and who had returned to work there once they were qualified.
- Openness and honesty was the expectation for the department and was encouraged at all levels.

Public and staff engagement

- Each clinical area had monthly meetings, where all staff were invited to bring innovative ideas. The ophthalmology team had worked effectively, with support of the management team, to improve services and staff morale.

Innovation, improvement and sustainability

- The numbers of patients who did not attend clinics improved from 11% to 4% in targeted clinics in six months. Work continues to identify areas of improvement for all clinics.
- The wheelchair services at Mansfield Community Hospital had introduced electronic assessments to measure the pressure on seating, so that they could

provide accurate and effective prescription of pressure relief. The 'assessment mapping kit' electronically mapped the seating of the patient; the service was aimed at people who have had pressure ulcers.

- The wheelchair services at Mansfield Community Hospital had a purpose-built 'street' for patients to learn how to use their wheelchair on paths, steps, ramps and crossing the road. The service provided practical tuition to patients who had to learn how to use their wheelchairs safely.

Outstanding practice and areas for improvement

Outstanding practice

A&E

Supported learning and training materials developed within the department. For example, the department-specific induction training programme, and junior doctors felt extremely well supported in the department.

Critical Care:

Use of patient diaries.

Maternity and family planning services

Multidisciplinary team working across disciplines and roles throughout the directorate. This was extremely effective and evident in directorate teams.Delivery rates for women were better than national rates. This included higher rates of normal deliveries and lower rates of emergency caesarean sections, compared to national figures.Smoking reduction and cessation work with women during their pregnancies delivered very good results.Gynaecology ward, ward 14, was well-led. Staff were obviously passionate about the care and service they provided.

Care and comfort rounds were completed regularly and 'pillow cards' were left for any patients who were not in their rooms during the rounds.

Children and young people services

- Multidisciplinary team working across disciplines and roles throughout the directorate. This was effective and evident in directorate teams.
- Links with regional paediatric networks and neighbouring trusts worked effectively.

Areas for improvement

Action the hospital MUST take to improve

A&E

Regulation 9

The provider had not "reflected where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment".

Regulation 10

- The provider did not have an effective system to "regularly assess and monitor the quality of the services provided".

Regulation 10 (1) (a)

- The provider did not effectively operate systems to "identify, assess and manage risks relating to the health, welfare and safety of service users and others".

Regulation 10 (1) (b)

- The provider had not made changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to – "(i) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and
- (ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies".

Regulation 10 (2) (c) (i) (ii)

Regulation 22

The provider "must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity".

Regulation 22

Regulation 16

The provider "must make suitable arrangements to protect services users and others who may be at risk from the use of unsafe equipment by ensuring that equipment provided for the purposes of the carrying on of a regulated activity is -

1. Properly maintained and suitable for its purpose

Outstanding practice and areas for improvement

Regulation 16 (1) (a)

Medicine

The trust must ensure that accurate record keeping is maintained with regard to people's observations and hydration.

The trust must ensure that accurate record keeping is maintained on drug administration charts so people receive the appropriate care and treatment for their needs.

The trust must ensure that all staff have the competence to recognise when a person is deteriorating so appropriate care is provided.

The trust must ensure that there are secure systems for storing medicines and that people are given medicines according to their prescription.

The trust must ensure that all people have an effective and current care plan that meets their individual needs and provides appropriate guidance for staff to be able to meet their needs.

Surgery

The provider must ensure there is full medical support for all surgical specialties, in particular vascular services.

The provider must ensure mandatory training and appraisals take place to ensure all staff are appropriately trained and have up-to-date knowledge.

The trust must ensure actions taken and lessons learned are shared with staff at all levels.

Maternity

The provider must ensure that emergency resuscitation equipment boxes are checked and audited regularly.The provider must ensure that staff mandatory training and appraisals are completed to meet trust targets.

C&YP

The provider must ensure that emergency resuscitation equipment boxes are checked and audited regularly. The provider must ensure that all children and young people services wards and departments are stocked with paediatric emergency resuscitation equipment boxes.The provider must ensure that staff mandatory training and appraisals are completed to meet trust targets.

Action the hospital SHOULD take to improve

A&E

Regulation 11

The provider "must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of -

1. Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs

Regulation 11 (1) (a)

Regulation 13

The provider "must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the ... safekeeping, dispensing ... of medicines used".

Regulation 13

Regulation 15

The provider "must ensure that services users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of-

1. Appropriate measures in relation to the security of the premises, and
2. Adequate maintenance

Regulation 15 (1) (b) (c)

Surgery

Equipment should all be portable appliance tested and serviced to ensure they are fit-for-purpose

The trust should ensure that team briefings are completed before and after surgery, including fully embedding WHO surgical safety checklists.

Maternity

Could improve:- Midwifery staffing could be improved by completion of the directorate's on-going recruitment programme.

C&YP

Could improve:- Introduction and implementation of children and young people services specific pain management guidance and protocols.- Nurse presence

Outstanding practice and areas for improvement

and inclusion at all 'Team Around the Child' ward rounds on paediatric ward, ward 25.- Confirm and establish longer term nurse management structures on paediatric ward, ward 25, to provide staff with increased, visible managerial support.- Increased receptionist staffing on paediatric ward, ward 25, including weekends.

Medicine

The trust should ensure that people with a dementia have an accurate and current care plan to provide staff with clear guidance to meet their needs.

The trust should ensure there is an appropriate skill mix of nursing staff on duty so that people's needs are recognised and met.

The trust should plan to provide seven day a week and effective out of hours cover by doctors and consultants for all specialties.

The trust should ensure that effective discharge planning occurs across all specialties for all people who are fit for discharge.