We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Bradford Royal Infirmary

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Date of Inspections: 30 October 2013
24 October 2013
23 October 2013
22 October 2013
14 October 2013
12 September 2013

Date of Publication: January 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

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| Type of services | Acute services with overnight beds  
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Bradford Royal Infirmary had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Management of medicines
- Staffing
- Assessing and monitoring the quality of service provision
- Complaints

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 September 2013, 14 October 2013, 22 October 2013, 23 October 2013, 24 October 2013 and 30 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We were accompanied by a pharmacist, reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities and reviewed information sent to us by local groups of people in the community or voluntary sector. We talked with other regulators or the Department of Health, talked with other authorities, talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor. We used information from local Healthwatch to inform our inspection.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Accident and Emergency (AED)

In the AED we found areas of the department, particularly in and around the main reception and triage areas, to be significantly overcrowded during busy periods and patients were required to openly discuss personal information and injuries/illness. We found people's privacy and dignity was regularly compromised. A patient said they felt the department was confusing and had no privacy when you first arrived. A nurse we spoke with said, "Triage is not private enough here. You get no privacy. People are interrupting all of the time."

Another patient we spoke with said, "I have no complaints, the staff are very good here." We found there were unsafe delays with some people's triage and subsequent treatment,
this was particularly so for people walking in to the department who were moderately/seriously injured/unwell.

We found the staffing levels within the AED were significantly low particularly in relation to nursing staff and senior medical cover; especially from midnight and throughout the night.

Medical Admissions Unit (MAU)

Patients we spoke with felt staff were polite and caring. One patient said, "Staff are respectful" and another said, "Staff were lovely on here." We found, in the majority of cases, people's nursing assessments had been completed accurately including pressure area care and nutritional assessments. We had concerns about the placement of some patients on the MAU into the eight bedded trolley bay area. It was increasingly being used to place significantly unwell patients due to pressures with bed space.

We also had concerns about staffing levels. A senior nurse we spoke with said, "From a consultant point of view we are badly staffed; we don't keep the figures on it though." A patient we spoke with said, "There isn't enough staff, sometimes it takes a while for them to come, but my care has not suffered." The MAU was short staffed in terms of consultant physicians and had two consultants and the Trust would have ideally liked six. The lack of senior medical input and expertise on the ward increased patient safety risk and caused delays in decisions being made in relation to patient treatment and discharge.

Elderly Medical Unit (EMU)

We saw that patients looked comfortable and it was clear people had been supported where necessary with personal hygiene and general cares. We found staff were supportive, particularly during meal times, and encouraged people to sit up and eat where necessary. One patient we spoke with said, "They have been very good to me" and felt they had been well looked after. Staff commented that, on occasion, staffing levels was an issue but we were told this was mainly if people were off sick or nurses were required to make up the numbers of staff on other wards, for example, ward 29.

Ward 9 (Stroke Unit)

During the inspection we observed positive interactions between staff and patients and staff ensured the ward environment remained calm and conducive to the needs of people suffering from neurological disorders. We found the ward to be well coordinated and one patient we spoke with said, from a clinical perspective, "I can not fault it." However, they described how they wanted a little peace and quiet because they had already been on two other wards in the space of a few days. The were some concerns in relation to senior medical cover. We spoke with the Consultant Stroke Physician and Clinical Lead for the service; they told us that according to guidelines the number of consultants required by the Trust was six. The service operated with 2.5 whole time equivalents and there were no registrars (senior doctors) in post for the service.

Ward 29 (Elderly Care)

Our observations and experiences of ward 29 were mixed but there were concerns in relation to dignity, respect and examples of poor practice in terms of basic nursing care. We spoke with one patient and they said, "The care has been fantastic, staff are courteous, I am treated with dignity definitely." From our observations there were examples where ward staff were abrupt in their responses to patients and not respectful.
For example, we heard a patient explaining to a nurse that they did not like the chocolate pudding they had received with their lunch-time meal. The nurse said, "Why did you order it then?" and no alternative pudding was offered.

We spoke with one of the consultant doctors working on the ward and they described the work pressures particularly in terms of staffing and they said, "We are short staffed, everyone knows that." We had concerns around staffing levels but also staffing skill-mix. This was because the needs of the patient group on the ward were specialist and demanded significant input from nursing staff; the problems with the staffing affected continuity of care which in turn affected the quality of care.

Ward 20 (Emergency Surgery and Surgical Assessment Unit)

Whilst on ward 20 we observed elements of care which were not respectful and did not support patients in making certain choices. For example, one person whose first language was not English was not supported in making decisions and nursing staff did not utilise the tools available to help the person understand, in their own language, the choices available to them. This was especially true during meal times.

We also had concerns in relation to staffing levels, especially nursing staff. We reviewed the nurse staffing rota for the previous month and there were significant shortfalls in the numbers of nursing staff on duty.

Ward 23 (Orthopaedic)

Whilst on the ward we observed positive interactions with patients and the caring nature of the healthcare team was noted. One person we spoke with said, "Everyone has been really kind and caring." The patients we spoke with all said that the doctors and the therapists (occupational therapists and physiotherapists) had explained things to them; they said that they understood what treatment they had received and why.

In terms of care and welfare, one person we spoke with said, "I get good care. The staff are generally great and you can have a good laugh with them.

One nurse we spoke with said that the ward was very busy, especially in the afternoon. They told us that it was 'easier' in the morning because the occupational therapists and physiotherapists helped. They said that during the afternoon people had to get ready for theatre and staff didn't always 'see' to people in a timely manner.

Other Areas

During the inspection we also reviewed medicines, quality assurance and complaints. With medicines we had found issues with the ward pharmacy service for a prolonged period and this inspection was the first time we had observed clear progress. This was encouraging but the situation remained, until new staff were in position, that the service was stretched and improvements were needed in key areas.

In relation to quality assurance we noted there had been significant changes to the Board structures including introducing the role of Chief Operating Officer and Director of Informatics. We had significant discussion around the Trust's lack of a specific Board Assurance Framework (BAF) but there were alternative processes in place to monitor and review the Trust's progress in relation to its corporate objectives.
During the inspection we had concerns in relation to the AED, staffing on the wards and management and patient flow. In all cases, the executive team described how they had been aware of the problems. There appeared to have been delays in addressing certain problems in a responsive way. We also noted that, on occasion, feedback to the Board was not timely and/or accurate.

We also assessed how the Trust handled complaints. We noted that the Trust had made changes in several areas to ensure a more timely and detailed responses to complaints.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 25 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Bradford Royal Infirmary to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

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<td>Respecting and involving people who use services</td>
<td>Action needed</td>
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<tr>
<td>People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run</td>
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Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not respected.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

**Accident and Emergency Department (AED)**

The AED was divided into a number of separate areas and included an ambulance arrivals and rapid assessment area. The main AED reception included patient registration, minor injury triage (Triage meaning to assess and prioritise people's injuries/illness) and a main waiting area. We observed people registering for minor treatment at the main reception desk and there were two open-plan triage assessment areas located close to the main reception. Throughout the visit we saw a constant queue of people waiting to be registered and waiting to be triaged for treatment. People were assessed in open-view of other people queuing which affected people's privacy and dignity.

We saw and heard people providing personal information and details of their injury whilst other people were queuing around them. We also noted, and were informed by the clinical service manager (CSM), that the department was used as thorough-fare by people and staff to access and exit the main hospital. Again, these issues/observations were a privacy and dignity concern. We spoke with the triage nurse and they said, "Triage is not private enough here. You get no privacy. People are interrupting all of the time". We observed one person showing the triage nurse their foot and another person showing a burn to their shin; there was very limited privacy.

The area where people arrived by ambulance was also an open area and the information given by the ambulance crews, to the staff, about patients could easily be overheard by other people in the area. The nurse in the ambulance hand-over area did not think it was acceptable because patients did not have any privacy at times and very personal information was often openly discussed.

One of seven patients we spoke with said they had been in the department a long time
and did not know what was happening. We checked with the nurse and were informed the patient was waiting to go to the ward; the nurse said that they had not had time to let them know. Another person we spoke with said, "I haven't been told anything, I'm waiting to see a doctor and I'm fed up of waiting." We observed people sitting in the main waiting area for one hour; during this period no member of staff gave any information to people about the waiting time. We spoke with four other people waiting for further assessment/treatment and none of them were able to tell us who they were waiting to see, in which area of the department they were to be seen or the expected wait. Their waiting times varied from between 30 minutes and two-and-a-half hours. A patient we spoke with on ward 4 said they arrived in the AED at about 12.00/13.00 the day before and were there for about six to seven hours in a cubicle; they found the doctors and nurses to be polite. One of the seven patients we spoke with on the Elderly Admissions Unit (EAU) told us they did not like the AED and said, "It was so confusing down there and no privacy when you first arrive". Another patient we spoke with on the EAU also arrived at the hospital via the AED and said they ended up on a trolley for four or five hours. However, they were happy with their treatment.

Ward 4 (Medical Admissions Unit)

During our visit to ward 4 we observed, on several occasions, staff being polite and respectful in their interactions with patients. We observed staff drawing curtains around beds when necessary and speaking with patients in a supportive way. One of six patients we spoke with said, "Staff are respectful" and they had no problems with the care they had received. Another patient described how they had attended the AED at 23.00 the previous night and was admitted to ward 4 at 04.00; they said, "It's alright here." Another patient we spoke with said their experience of care had been better than their previous stay at the hospital and they said staff were "Lovely on here" and "Attentive, really nice". They described one lady who was wondering the ward slightly confused during the night and they said staff were lovely with her.

Ward 3 (Elderly Admissions Unit)

A relative we spoke with commented that their partner was happy with the care they had received on the EAU and they were kept well informed. Another relative we spoke with said they were impressed with the doctors and everything had been well explained to them. However, they thought the AED was not very nice and the triage area was too open and everybody could hear everyone's business. Another patient we spoke with said the nursing staff were caring and remarked, "I do not understand the doctors, they are so rushed."

From our observations on the EAU we saw that patients looked comfortable and it was clear people had been supported where necessary with personal hygiene and general cares. We observed staff being genuinely supportive to patients, for example we heard one nurse asking a patient, "Can I help you put your slippers on?" and "Shall we put your pillows right for you?" During meal time we observed staff offering salt and pepper and providing choice of meals and pudding in a relaxed way. Staff were supportive and encouraged people to sit up and eat where necessary.

Ward 9 (Stroke Unit)

One of the five patients we spoke with said they had arrived on the ward via the AED after what seemed a very long time and there was very little communication. The patient wasn't
sure why they were on the stroke unit and said, "It was the only bed they had at the time."
Another person we spoke with said they had a five hour wait in the AED and ended up on
the stroke unit. They said no-one knew why they were on the stroke unit and were waiting
to be transferred to a Leeds hospital.

We looked around the ward and observed people being cared for within all three bay areas
and some shared side rooms. We observed positive interactions between staff and
patients and staff ensured the ward environment remained calm and conducive to the
needs of people suffering from neurological disorders.

During the inspection of the ward we observed people's privacy and dignity was respected
by staff; we saw people's bedding and night attire was clean and call bells were in easy
reach for people to use. Staff remained visible and available on all three bays and
provided assistance in a timely way. We observed when people required privacy and
curtains were drawn around beds or blinds closed where necessary. The hyper acute
stroke unit (HASU) was open-plan but males and females were cared for separately.

Ward 29 (Elderly Care)

The ward had four bay areas and twelve side rooms. We were informed the side rooms
were used to nurse patients at high risk of infection or for those patients who were very
poorly; such patients usually came from the AED.

We spoke with eleven patients on ward 29. One person said the nurses were strict and
you had to do as you were told. Another patient we spoke with said, "The care has been
fantastic, staff are courteous, I am treated with dignity definitely; staff knock and people
have talked to me about my care and how I will manage at home". We spoke with two
other patients in the same bay and they felt the staff we lovely and it was comforting to
know there was a buzzer which gets answered”.

During lunchtime one patient was being supported on a one-to-one level and they were
offered a glass of water. The patient said, "Is that it? Is that all you have got?" No
alternative drink was offered to the patient; the patient was then supported to eat a
banana. We also observed one patient wondering the corridors and they were becoming
agitated. We heard a member of staff shout the length of ward asking the person to come
back. This went on for several minutes and a student nurse then approached the person in
a calm manner and gently encouraged them to walk with them and sit down in their bay.
The shouting was not respectful but the actions of the student nurse were more
appropriate and relieved the person's agitation.

We also heard a patient explaining to a nurse that they did not like the chocolate pudding
they had received with their lunch-time meal. The nurse said, "Why did you order it then?"
and no alternative pudding was offered.

Ward 20 (Emergency Surgery and Surgical Assessment Unit)

One of the first things we noticed was that people's information, including their name, was
clearly displayed on a large computer screen directly in front of the door leading on to the
ward and at the nurses' station; this did not protect people's privacy or promote
confidentiality.

We observed the lunch time period during our visit and one person could not speak or
understand English. We noted that a member of staff serving lunch did not attempt to effectively communicate with them. The choice for lunch was different types of sandwiches, soup, yoghurts and orange juice. The staff member did not show the person the different sandwiches and yoghurts to choose from. We observed them shouting at the person; they shouted "Egg will be fine, you can have that. You can have orange and yoghurt too". We observed the staff member take the egg sandwich out of its wrapper and put it on the person's bedside table without a napkin or a plate and they had not cleaned their hands. The person showed signs of distress. This meant that due regard was not made to the person's religious or language needs. We saw the same staff member continued to serve lunch without cleaning their hands and other people were all offered a choice of food; we raised these issues with the ward manager at the time.

We looked at the care record for one person whose first language was not English. The nurse had written, 'Not able to do the assessment as person doesn't speak English. I will wait for the family to come in'. We read the information that was added later and it was basic and did not adequately explain the person's needs or how they should be met. There was no evidence that an interpreter had been requested to assist with the assessment. The trust had a system on their intranet that allowed staff to print off information in different languages; there was no evidence that this had been done by the nursing staff. This meant that the person's dignity was compromised and that they were unable to take part in making decisions about their care.

We observed one staff member making a bed. The person in the next bed had their curtains drawn around them. We heard them groaning and it sounded like they were in pain. During the next ten minutes the person continued to make the bed and did not attend to the patient. We asked them to see if the patient needed anything. We then observed the staff member leave the cubicle and return with a vomit bowl. They told us that the person felt sick. We then observed them throwing the bowl down on to the person's bedside table; they then continued to make the bed. We brought this to the attention of the manager because the behaviour was not respectful or appropriate.

Whilst observing care on the surgical assessment unit (six bedded trolley area) we noted the area was a mixed sex unit and people were separated by screened walls and curtains. We saw that there was only one toilet in the trolley area. The nurse we spoke with said staff attempted to keep the trolley area toilet for females only and asked men to use the toilet at the end of the main ward. There was potential for toileting arrangements to become confused and compromise people's privacy and dignity. We also observed occasions where staff were stripping, cleaning and making beds next to people eating their lunch. This had implications for cross infection and did not promote the concept behind protected meal times and keeping disturbances to a minimum.

Ward 23 (Orthopaedic)

Whilst on the ward we observed positive interactions with patients and the caring nature of the healthcare team was noted. One person we spoke with said, "Everyone has been really kind and caring." Another patient we spoke with said that they had been seen by a team of doctors and nurses and they had waited to go home for the last two weeks. The patient said that the team of staff had explained why they were still in hospital and this was because they had to wait for a care home.

The patients we spoke with all said that the doctors and the therapists (occupational therapists and physiotherapists) had explained things to them; they said that they
understood what treatment they had received and why. We also saw evidence that all of the staff explained what they were going to do before they undertook any intervention. People's screens were closed appropriately which meant that their privacy and dignity was maintained.

One person returned to the ward from theatre following surgery. They were distressed and clearly in pain; the doctor immediately gave them pain relief. The doctor was kind and caring towards the patient and before leaving the bed-side they ensured the person was fully covered with the bed linen and the patient was comfortable. We also observed nurses drawing curtains around people’s beds to maintain privacy and speak with patients in a polite and soft manner.

On our final day of the inspection we held two focus groups; one group consisted of nine staff nurses including both junior and middle grades. We also spoke with a group of 12 doctors and again, grades ranged from junior to middle grade. A positive theme from the doctor’s focus group was around dementia care. The doctors commented that in the AED some patients would have a double time slot that ensured such patients had the right support and on the ‘hip fracture ward’ (Ward 23) staff undertook a ‘dementia simulation’ which allowed them to experience what it was like to have dementia. This enabled staff to have valuable insight into the disease and provide enhanced care and support for those people with dementia. The doctors also felt nurses and doctors took aspects of privacy and dignity seriously but the limitations of some of the ward/department environments could sometimes affect privacy.

A theme coming from the discussions with the nurses centred around patient flow and the conflicts which could impact on people's privacy and dignity. For example, it was strongly felt that patient flow and infection control took a disproportionate priority over other aspects of patient care which were equally, if not more important. For example, on the gynaecology ward, we were informed there was only one side room. There had been times where patients had been in a side room because they were in the stages of miscarriage and had been transferred to a bed on the main ward to enable patients with loose stools from the AED to use the side-room. The nurses felt there was no clinical/nursing judgement applied to the reasons for people's loose stools and such patients took automatic priority. The example we were given was that patients may have said their loose stools were 'usual for them' or there may have been other clinical history that enabled staff to confidently rule out the likelihood of an infectious cause, for example, Crohn's Disease. However, we were informed symptoms alone triggered the need for a side room. It was also remarked that some patients would describe having loose stools knowing they would automatically get a side room.

The nurses also felt there were mixed messages in terms of protected meal times and the priority placed on patient flow. We were told that some wards were very strict in terms of protecting meal times and focused as much as possible on ensuring people were well supported during their meals. Other wards were less strict and patient flow in particular would take priority. The nurses accepted there were priorities but the lack of consistency of approach caused confusion.
Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people’s safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the ‘Action’ section within this report.

Reasons for our judgement

Accident and Emergency Department (AED)

We spoke with several members of staff including nursing sisters, emergency care consultants, junior and middle grade doctors, staff nurses and healthcare assistants. We also spoke with a receptionist, paramedics, the clinical service manager (CSM) and clinical director (CD). The CSM and CD described the AED as one of the busiest in the country for managing paediatric and adult attendees; they quoted a figure of 135,000 people attending the department last year.

During our time in the AED we spoke with seven patients in total; one person we spoke with, who was in the department with their child said, "I have no complaints, the staff are very good here." During our time observing practice, we saw evidence that the nursing staff undertook appropriate assessments of people in the 'majors', high dependency and resuscitation areas. This included people's general observations and early warning scores. We noted that people's level of pain was assessed using a specific pain assessment tool and this was adapted slightly for use with children. This demonstrated some positive practice in terms of assessing people's level of risk, dependency and comfort. We also observed a handover between the morning nursing team and late nursing team; we noted it was detailed and person-centred. The nurse passing on information provided clear instructions of what further care and treatment patients needed. This meant there was adequate continuity of care.

We noted that the department used a number of clinical pathways; these included the management of asthma, head injury (adult), fractured neck of femur (hip) and acute stroke. We saw evidence that the clinical pathways followed the best practice guidance as set out by the National Institute for Health and Clinical Excellence (NICE). For example, one person attended the AED with symptoms of chest pain and staff used the correct clinical pathway and completed it appropriately. The records stated the patient had been given medication but the time had not been documented; this meant staff did not accurately know what time the next dose of medication was due.
One of the care records we reviewed did not have a completed pressure area care assessment for an elderly patient in the AED. We asked the nurse managing the patient about this and they told us it should have been done but they had not had time. Another person we knew about, who was in the AED, had dementia and we noted they had not had a mental capacity assessment; this meant that staff did not know whether the person could make decisions for themselves.

During our inspection we looked at eight care records for people in the AED. One nurse we spoke with said that every patient in a cubicle should have an 'intentional round checklist' done on an hourly basis to ensure a nurse monitored people every hour as a minimum. This included checking people's pulse, blood pressure, assessing pain and determining if people required assistance with anything else. We noted that all eight of the care records we reviewed had gaps in the 'intentional round checklist'; this meant patients could have deteriorated, or be deteriorating, without staff realising.

As discussed in outcome 1, throughout the visit to the AED on the first day of the inspection we saw a constant queue of people waiting to be registered and waiting to be triaged for treatment. Part of the challenge centred on the fact that people walking in to the AED, with either minor or major injury, were all triaged in the same way and queues soon built up. At busy times, people could wait up to one hour to be triaged which was an unsafe period of time without any input from the medical team and/or treatment; this was particularly so for walk-in 'major' patients.

At midday, the AED accepted people referred by their GP. These people should have gone to the medical assessment unit (MAU) but there were no available beds. The clinical service manager (CSM) informed us there were no available beds in the hospital; ten minutes after that the AED had no available cubicles including the resuscitation and high dependency areas. This meant the care and welfare of people attending the AED was compromised due to delays in assessing and treating people. We attended an 'operations' meeting at lunch time involving managers, matrons and site manager. Information was shared at the meeting about the time people had been waiting in the AED but there was no plan to address the shortage of beds throughout the hospital. We did not see evidence of clear decision making or an effective plan to address the shortage of beds. There was also no evidence the information had been escalated to the executive team. This meant that people could have been at risk of unsafe care and treatment because identified risks were not being adequately managed. We asked why none of the medical staff attended the operations meetings and we were informed they never did. This meant medical staff had limited information about the status of the hospital beds.

Ward 4 (Medical Admissions Unit)

We reviewed three sets of care records in detail. In each case, nursing assessment documentation had been completed appropriately including pressure area risk assessments and nutritional assessments. There was one example where the 'malnutrition universal screening tool' (MUST) had not been completed. This is a five step screening tool to identify adults who are malnourished, at risk of malnutrition or obese. This could have had a negative impact on the patient because risk information in terms of their risk of malnourishment could have been missed.

During the ward visit we spoke with two senior nurses and a mixture of other staff, including junior nurses and healthcare assistants, about how the ward functioned. Two themes in particular, which came from the discussions, was around the lack of senior level
medical expertise and relatively frequent admission of unsuitable patients on trolleys from the AED. The medical admission unit (MAU) had an eight bedded trolley area designed specifically to manage patients with moderate to low risk; for example, pulmonary embolism, asthma and gastrointestinal bleeding. The expectation was that such patients were managed relatively promptly and discharged, thus maintaining a smooth flow of patients through the trolley bay. However, acutely unwell patients would, on occasion, be admitted to the eight bedded trolley bay area which was overseen by one nurse. Such an acutely unwell patient may have been having significant medical attention in the AED in order to stabilise their condition and then transferred to the trolley bay on the MAU to receive markedly less medical and nursing attention. This presented a significant risk to the patient's welfare and others; this was because the nurse's attention would be drawn to the acutely unwell patient thus detracting care away from those at minor/moderate risk. One staff nurse we spoke with said the ward was a fantastic place to work and stated that, "We often get patients on the ward who are not suitable."

Ward 3 (Elderly Admissions Unit)

One of the seven patients we spoke with stated, "They have been very good to me" and felt they had been well looked after. Another patient we spoke with said they were impressed that staff were helping people to eat in the morning and they had a wash, were comfortable and had been seen by the doctor. From our observations the ward was calm and patients were promptly responded to where necessary. Staff were observed offering support and encouragement to people and there was frequent hand-washing observed between patient contact; this supported safe practice. The ward sister described the ward as very busy but felt there was a good team of nurses. Most of the nurses had been working on the ward since it opened 11 years ago. The low turn-over of staff positively influenced the quality of care because it promoted continuity of care and is indicative of good staff morale.

Ward 9 (Stroke Unit)

We reviewed two sets of records in detail and noted that documentation was completed accurately, care plans were relevant and up-to-date and daily observation charts were also up-to-date. Care plans related well to be people's assessed needs and were therefore appropriately person-centred. We saw in one person's records an acute stroke integrated pathway and this detailed neurological, physiotherapy and occupational therapy assessments along with their stroke management plan.

We also saw evidence in people's records that "intentional rounds" were occurring and the related charts were completed as necessary. This supported the overall welfare of people because observations and vital signs were regularly recorded.

All stroke patients were admitted directly to beds on the stroke unit and cared for by a specialist team. More than 95% of admissions came via the AED and a recent audit indicated that the service was able to provide specialist treatment to stroke patients within an average of 42 minutes.

Ward 29 (Elderly Care)

Whilst on the ward we reviewed four sets of care records, including care plans, and established the patient's journey from admission through the hospital to the ward. There were numerous screening tools which nursing staff were required to complete, for
example, nutrition, pressure area care and mobility. As part of the care planning process there was a care plan check sheet which included a total of 26 checks for documents and assessments that needed completing. Of the records we reviewed it was a common theme to find specific documents blank, incomplete and/or lacking detail. For example, a document named ‘See who I am’ was not completed in all cases. We were informed families were supposed to complete these which led us to question how families were informed about doing this. We also reviewed a core plan for nutrition and hydration and one person required a feeder cup and moderate supervision with meals. However, the patient's MUST (Malnutrition Universal Screening Tool) was blank. The MUST tool monitors specific aspects such as height, weight, weight loss and supports the content of the care plan. There is added risk if the required tool is not completed for people at risk of malnutrition. However, some elements of the care plans were complete and we noted where in two cases pressure ulcer assessments and falls prevention records were accurate and up-to-date.

An overarching theme was that care records were basic and did not demonstrate clearly that people's care needs were adequately assessed and supported. The care plans were, in many cases, impersonal and generic; there was very little information about people's individual preferences, for example, preferred sleeping pattern, specific support required with eating and/or preferred method of mobilising.

We observed care, including during lunch time, and noted medication was given out during lunch. The ward advertised on the entrance the times for protected meals which was where ward activity was reduced to a minimum in order to support people with meals. We spoke with two staff nurses who were giving out medication during the lunch-time period; one nurse was from the coronary care unit and the other was from the gastroenterology ward. They said the medicines round took a long time because they do not know the patients so it has to be done over the lunch-time period. The third staff nurse was also giving out medication on the other side of the ward during lunch which meant there was limited nurse supervision/leadership during lunch. We observed two patients in one bay where their lunch meals had been left on their bed-side table. The patients were asleep but there was no attempt to encourage the patients to eat for about twenty minutes; the food would have cooled significantly by then.

Some patients on the ward had one-to-one care provided by staff from an agency. On one day during the inspection one carer did not turn up which added to the work-load of the staff based on the ward. The same situation occurred the week previously and the patient who required one-to-one support had a fall. We were concerned about instances when one-to-one care staff did not turn up as planned and the potential impact this had on patient safety.

We spoke with the relatives of one patient who had been on the ward for over two months. The patient had lost a significant amount of weight during their stay and was required to have four bottles of fortified drinks per day; the relatives said their relative had not received anywhere near the necessary amount and were concerned about the level of support provided by staff that ensured patients were suitably nourished. There were also examples where food charts had not been completed and lunch time meals had been missed and/or not documented. The relatives felt the clinical care was a high standard and there were some excellent nurses. However, from their experience, there had been shortfalls in standards of care and continuity of care. For example, they commented they often didn’t see their relative’s named nurse for weeks at a time.
Ward 20 (Acute Surgery and Surgical Assessment Unit)

During our visit to ward 20, we reviewed the care records of ten patients. With all ten records we found gaps in the assessments of peoples’ needs, on-going care and treatment. This had the potential to affect people's care and welfare due to people's care needs not being adequately assessed and managed. The ward manager we spoke with explained that each patient should be monitored every two hours and the information recorded on a monitoring chart (called intentional rounds). The chart included an assessment of people's pain, whether people had a drink and whether they needed any personal cares. We noted that none of the ten charts we reviewed had any two-hourly information recorded and some had gaps on their charts for up to six hours; one person did not have a chart.

We also noted that one person’s care record stated they were at risk of developing pressure ulcers and required ‘turning’ every two hours. We observed that it was nearly three hours since their position had last been changed. A nurse had documented that the person had a 'red sacrum' in the last written entry. This meant that the person was at risk of developing a pressure ulcer. We also noted that they had a fluid balance record. No fluid intake had been documented for the previous six hours. This was because the needle in their hand which enabled fluids to be given in to the body had come out. It had been re-sited by a doctor four hours previously but the nursing staff were not aware of this which delayed the nurses in putting up fluids. This meant that the person was at risk of not having their hydration needs met. We brought these issues to the attention of the manager.

Three other care records out of the ten we reviewed stated that people required their fluid balance to be monitored. All three people had nothing recorded on their fluid balance charts for the previous six hours, despite them receiving intravenous fluids. This meant that there was limited information about how much fluid intake people had received in relation to their hydration needs.

Ward 23 (Orthopaedic)

One person we spoke with said, "I get good care. The staff are generally great and you can have a good laugh with them. Sometimes I have to wait a long time to be seen but it depends how many staff are on and how busy they are".

Another person said, "I understand what has been said. The staff are very kind but I am in pain. I am happy with my care". We raised the fact the person was in pain with a nurse and pain relief was given appropriately.

During our inspection we reviewed people's care records in order to understand the care and treatment they had received from admission to the hospital; all of these people had fractured their hip. We saw evidence that, in general, they had received care and treatment that reflected relevant research and guidance from the National Institute for Health and Clinical Excellence (NICE). This included timescales from diagnosis of a fractured hip to surgery, the involvement of consultants in older people's medicine at the assessment stage, pain management, rehabilitation and planned discharge. This meant that people should have had surgery within 36 hours from diagnosis and assessment by a consultant for older people within 72 hours.

Two of the six people had waited longer than 36-hours for their surgery; we discussed this
with the doctor and they told us that they aimed to take people to surgery within 36-hours but this was not always possible. All six people had been referred to the specialist falls team and had received an assessment by the multidisciplinary rehabilitation team.

We noted that people had received appropriate risk assessments. These included risks relating to nutrition and hydration, blood clots and pressure ulcers. We saw evidence that people’s needs were assessed by the use of a range of tools. These included the MUST and ‘waterlow’ pressure ulcer risk assessment / prevention tool. This meant that each person had a score showing their risk of developing a pressure ulcer. We saw evidence that people at risk were cared for on a pressure relief mattress and regularly turned to change their position.

People had up to date charts relating to their needs. These included fluid balance, vital signs (for example, pulse, temperature and blood pressure) and pain assessment. This meant that staff monitored people to determine any deterioration in their health. One of the six care records we reviewed for people with a fractured hip stated that they had originally been admitted to the ward for a non-orthopaedic problem. During this time, they had fallen and subsequently fractured their hip. We discussed this with the matron and they told us that it had been recorded and investigated. They said that a root cause analysis had been undertaken. This showed that the person’s ‘fall risk strategy tool’ had not been completed by the nursing staff and the falls prevention document had not been updated. The route cause analysis stated, ‘This highlights a need for further training and education on the use of the care plan that assists nursing staff in the provision of care’.

One of the six care records we reviewed concerned a person that had been discharged to a community hospital from the AED following a fall at home. We spoke with the person’s family and they explained that a fracture their relative had sustained had not been spotted on their initial visit to the AED. The fracture only became apparent to the medical team a week and-a-half later when they returned to the AED, via ambulance, after being in pain and discomfort. We raised the issue with the executive team and the case was being closely reviewed.
Management of medicines  

Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We initially found concerns in relation to this outcome during a scheduled review of compliance on 11 December 2012. The overarching conclusion was that the pharmacy service was struggling to meet the demands of the service and patients were not always protected against certain risks. An action plan was submitted to the Care Quality Commission (CQC) in January 2013 stating how the trust planned to address the identified shortfalls. This included a ward pharmacy redesign project to evaluate the service, introduce new ways of working and increase the input of pharmacy technicians in ward areas. The action plan stated that all actions would be completed by the end of May 2013 in order to meet the necessary levels of compliance; this included submitting a gap analysis to the Board of Directors (BoD) meeting by the end of May 2013.

We re-visited the trust on 3 May 2013 and found continued non-compliance with this outcome indicating the service was continuing to not effectively manage the demands being placed on it. The trust's 'SAFE Campaign' steering group initiated a trust-wide audit of prescription charts in quarter 1 of 2013/14, following our visit in December 2012, and this formed part of the evidence to support assurance with this outcome for future CQC inspections. The audit reviewed 325 prescription charts along with 136 discharge prescriptions. The audit further highlighted short-falls with the service, for example, medication doses not given in 36% of cases and in the region of one in ten charts had at least one prescribing error. During the May 2013 inspection, extra resource had been put in to the service by utilising staff from the outpatients dispensary at the trust's other main hospital site. However, existing business cases for additional resources were still being revised and in the process of being submitted for executive level sign-off. With this in mind, it was reasonable and proportionate to extend the existing compliance action. After the May 2013 inspection an action plan was submitted to the CQC in June; it was dated 14 June 2013. The plan listed the key actions the trust were to undertake to ensure compliance with this outcome and included utilising the existence of existing staff resource and commissioning an external pharmacy service review. The external review was conducted in July 2013 and there were four distinct recommendations. The report suggested the level of resource for the pharmacy service at the trust was less than comparative trusts.
We re-visited the trust on 12 September 2013 to see what improvements had been made since the May 2013 inspection; this included the progress regarding the gap analysis, assurance information presented to the executive team and any related business cases. The inspection team included two CQC pharmacists and an inspector from the CQC. During the one day inspection we visited several wards including ward 25 (breast surgery care), ward 4 (medical admissions unit), ward 1 (respiratory), ward 22 (coronary care) and ward 8 (male surgical). We also spoke with a range of staff including ward-based staff, pharmacists, medical staff and executive level staff. We also spoke with 18 patients and reviewed 29 drug charts.

Part of the inspection included assessing progress with the self-medication policy. The latest policy roll-out around this had been suspended, and was still suspended, on all wards. The Director of Pharmacy (DoP) described how self-administration best practice was challenging to implement and maintaining high levels of compliance was not straightforward. There was a revised self-administration policy and it had been evaluated and signed off by the Drug and Therapeutics Committee, Nursing and Midwifery Forum and Communication with Patients Advisory Group. Further education was needed for all staff before the new policy was to be re-introduced and wards 24 and 25 were keen to trial the revised approach.

We visited ward 22 and spoke with the matron, ward sister and a of selection patients. There were mixed standards of practice on the ward. For example, we spoke with one patient and the person was well informed about their medication and understood why they were unable to self-medicate. The person described how the hospital pharmacist checked their medication in their locker and had received adequate information about the medication prior to being discharged. In another example, a patient's medicines had been appropriately reviewed on their admission to the ward and their discharge prescription accurately tallied with their prescription chart. However, in other cases there were examples of poor medicines reconciliation and late medicines reconciliation. The trust policy on medicines reconciliation (July 2013) stated it was the responsibility of all staff groups involved with the prescribing, dispensing and administration of medication. The policy also stated pharmacy staff cannot currently obtain drug histories on admission as no wards receive a daily scheduled pharmacy ward visit, and at weekends the pharmacy department is closed. The trust position was that nursing and medical staff had the primary responsibility for ensuring medication reconciliation was carried out as part of the admission and clerking process.

Whilst on the coronary care unit we spoke a patient where there had been some confusion with a patient's medication and they had been informed the dose of a drug they were taking had been increased. However, the patient confirmed they were already taking the higher dose. The angina nurse specialist, who was meeting the patient about their clinic appointment the following day, realised the confusion with the dose and made the necessary changes. The initial drug history check completed by the junior pharmacist included only one source of drug history and this was taken from the computer which accessed information held by the person's GP. Good practice, and the trust's medicine's policy, stated that whenever possible at least two sources of information should be sought in order to establish medication history. In this case, the patient was able to describe the two tablets they were currently taking to make up the higher dose they were prescribed; this was not taken into account.

We also noted that some medications should have been given approximately 30 to 60 minutes before food. We spoke to nursing staff about how this was managed and they
confirmed that such medication was routinely given with food instead of before food. There was no routine annotation of the drug charts to show which medicines should be given before food. We discussed this with the DoP and they were not overly concerned. The only medication clearly highlighted as needing to be taken before food were 'serious' side effect medications; this was not the case for other medication such as antibiotics and/or tablets to reduce stomach acid.

We also visited ward 8 and spoke with a staff nurse and ward pharmacist. The nurse described in appropriate detail the process for checking drug histories and where to get certain medication from if it was not held as ward stock. One patient we spoke with said their new medication had been discussed in detail with them and they said "The nurses are great." With one medication chart we reviewed the person's current prescription was up-to-date and all doses were accurate. With another medication chart we reviewed a person's medication had been given as prescribed but ticks were used to indicate this rather than a signature. Other charts we reviewed on the ward had gaps in the recordings and we spoke with nursing staff about this. One nurse explained that with gaps with one patient's chart because they had been off the ward during the medication round and they were aware of the problem.

We also inspected ward 25 and the Medical Admissions Unit (MAU). We reviewed four charts on ward 25 and two had been completed correctly and clinically checked by a pharmacist. A third chart had been completed correctly but the prescriber had not entered their General Medical Council registration number. The fourth chart we reviewed had also been completed correctly but a dose of anti-biotic had been missed that was prescribed for 09.00. We spoke with the ward sister and relevant staff nurse about the missed dose and there was a valid reason but this had not been accurately documented.

Whilst on the ward we observed and heard medical staff speaking with patients about their medication. In one particular case, the junior doctor confirmed if the patient had any known allergies and discussed their medication in appropriate detail and in a way that was clear to understand. We spoke with a junior doctor and they felt the trust had a good pharmacy advice service and in the renal team there was a named pharmacist for the ward which they found very helpful. In terms of medicines reconciliation, the junior doctor described how it was a team approach and a role shared between pharmacists and doctors in particular.

We reviewed a patient's discharge summary advice sheet and spoke with a junior doctor and ward sister about the discharge process in terms of prescriptions. In many cases, the discharge prescription was completed a day or two before the patient was discharged from hospital; the doctor would then sign the bottom of the discharge prescription form and date. However, we noted that some medication had been added to the initial list because the writing was different. The doctor confirmed that someone else had added the extra medication to the discharge advice sheet. We raised the point that the person, presumably a doctor, was not required to sign or initial the form to indicate that extra medication had been prescribed. It was therefore assumed that the person's signature at the bottom of the chart was the overriding signature approving all of the medication on the form when this was not always the case.

Whilst on the ward 25 we spoke with one patient about a drug reaction they described to us. The patient had previously had morphine after surgery and it had made them particularly dizzy and sick. The anaesthetist had described how the person had an adverse reaction to morphine and this was stated on the drug chart. However, with an identified
adverse reaction, a separate drug chart is supposed to be completed which had a distinct red and white striped border. On this occasion, this procedure had not been followed and there were no details on the discharge sheet about the person's known adverse reaction to morphine.

On the MAU we reviewed four drug charts and spoke with the ward pharmacist and senior sister. The ward sister described how the pharmacy support on the ward had greatly improved since May 2013 and there was now a pharmacist present on the ward for much of the day and there was also technical support from a pharmacy technician. The pharmacy technician supported the pharmacist and doctors in completing certain tasks. We met with the ward pharmacist and they supported what the ward sister had told us in terms of the recent improvements to the service. We reviewed the notes and prescription charts of four patients and all the charts were accurately completed and medicine reconciliation had been carried out by the pharmacy team; the initial drug history was completed by the pharmacy technician and clinically checked by the pharmacist.

The last ward we visited was ward 1 and we spoke with the senior sister, the ward pharmacist and one patient. The senior sister was enthusiastic about the ward pharmacy service and was positive about the relationship the nursing team had with the ward pharmacy team. We met with the pharmacist on the ward and they explained how it was their regular ward and they spent every morning on the ward. In addition, they usually returned to Ward 1 in the afternoon unless they were covering for another pharmacist.

We reviewed the notes and prescription charts of four patients; three charts had been checked by the ward pharmacist that day and all necessary administration records were complete. The fourth chart were reviewed had not yet been checked by a pharmacist but medication reconciliation had been performed by the pharmacist on MAU.

Towards the end of the inspection we formally met with members of the executive team including the DoP, a divisional clinical director, divisional general manager, chief operating officer and a middle grade pharmacist. The pharmacist spoke positively about the pharmacy service and impetus to improve the service, particularly since our last inspection. However, they did feel the ward pharmacist were 'spread thinly' across the trust and had too much to do. The divisional general manager described the business case that they said had been put forward to the executive team in May 2013. They described how it was the division's preferred option to accept all the elements of the business case including recruiting extra pharmacists. The chief operating officer, who had not been in post long, said the final business case was on the agenda for the September 2013 board meeting and money had been identified to support the business case from the patient safety reserve.

During our recent inspection of the trust in late October 2013, we noted from the September board draft minutes that the business case had been accepted to address the identified gaps with the pharmacy service. This included appointing an admissions team and six new members of the pharmacy team. Job adverts had been circulated and it was felt the impact of the added resource be recognised before the end of the year.
Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Accident and Emergency Department (AED)

We asked the clinical service manager (CSM) what the Trust's preferred staffing levels were for non-medical staff. They told us that these were 11 registered nurses and three healthcare assistants in the morning, 16 registered nurses and five healthcare assistants in the afternoon and evening and 13 registered nurses and four healthcare assistants during the night. On the day of this inspection there was a shortage in these numbers.

We looked at the duty rota for nursing staff covering a four-week period. We noted that there were shortfalls in nursing staff every day. One week there were 18 shifts not covered by a registered nurse and nine shifts not covered by a healthcare assistant. The CSM told us that when shifts needed covering, for example, if someone phoned in sick, then one of the AED staff would normally do the shift. They said that shifts were becoming harder to fill because the staff were tired; this meant that the Trust was reliant on AED nursing staff to work additional hours in order to meet the needs of people attending the department and in many respects was reliant on the goodwill of staff. All the nursing and medical staff we spoke with said that they did not think there were enough nursing staff to adequately care for people in the department. They all said that weekends and night times were inadequately supported by senior medical cover in particular. We were told that the duty rotas we reviewed excluded shifts that were covered by either bank staff, agency staff or staff that could work flexible hours in order to cover identified gaps in the staffing levels. However, our findings during the inspection of the AED support the fact that staffing levels were not adequate to meet the demands placed upon the department.

All of the medical staff we spoke with, including two senior consultants, said that they did not think there were enough emergency care consultants. They said their consultant establishment was below that recommended by the Royal College of Emergency Medicine (RCEM). This meant that there was a shortage of consultant cover with no consultant cover during the night. They said that consultants often worked later than they should in...
In order to help the doctors working during the night and were also the on-call consultant on the same evenings. This meant that at times, consultants did not get their required rest periods between shifts; this could have an effect on the care and welfare of patients if the consultant made mistakes due to tiredness or was called in during the early hours of the morning having already worked way past midnight.

We spoke with one registrar (senior doctor) and one junior doctor; they both said they felt well supported by the consultant staff but felt additional senior staff were required during the night and at weekends in particular. They said that they felt one registrar, working with junior doctors, during the night was not safe, especially when two or more seriously injured or ill people were in the department at the same time.

We looked at the medical rota for 21 days; 17 of these days showed that there was only one senior grade doctor on duty from midnight until 8am. This meant that people's care and welfare could be compromised because there were not adequate numbers of senior doctors. From the figures supplied by the Trust for the last three months, 27% of all attendees arrived between 8pm and 8am and 45% of all majors' patients arrived between 8pm and 8am. In addition, 38% of all patients requiring care on the High Dependency Unit (HDU) arrived between 8pm and 8am with 37% of all paediatric cases also arriving between 8pm and 8am. We were concerned about these figures and the clear short-falls with senior medical cover during these busy periods. The Trust was actively seeking to roster two dedicated senior doctors within the AED throughout the night and invest in additional middle grade doctors in order to more effectively manage patients attending the AED during busy periods.

We spoke with a paediatric registered nurse who worked in the department and they told us that there were only five paediatric registered nurses and they said, "That is not enough". The Trust provided information that there were, more specifically, 5.5 whole-time equivalent children's nurses and, in addition, a further six general nurses who had completed their advanced paediatric nurse training for the AED. We noted from information given by the Trust that 25% of all new attendances were paediatric cases; the nurse said that the children's waiting area and treatment cubicles were not opened in the morning and this was because there were not enough nurses to staff the area. This meant that children had to wait in the main waiting room with adults and treated in the main department during the morning because the paediatric area was closed. This put the child at risk of observing stressful situations, aggression, hearing offensive language and seeing badly injured and/or seriously unwell adults. The management team at the Trust did confirmed that the children's waiting area and treatment cubicles were not open in the morning but maintained that this was because there was no demand for them.

There were five cubicles at the back of the 'majors' area. The CSM told us that these were intended to be used for the rapid assessment of people arriving by ambulance but they were not used for the original purpose because there were not enough doctors or nurses to staff them; the cubicles were used as escalation cubicles instead. This meant they were used when the 'staffed' cubicles in the department were all occupied. The CSM said that they did not think it was safe to use them as escalation cubicles because people could not be easily observed and there was not the additional staff to care for the people occupying them.

There were two occasions during our inspection when the ambulance triage area was not staffed; one for ten minutes and one for 12 minutes. This meant that the two patients who arrived by ambulance had to wait longer to be triaged than they should have. This also
meant that the paramedics' turn-around time was delayed. We spoke with two paramedics and they told us that occasionally they had to wait longer than 15 minutes to hand over their patient over and this was usually due to there not being any available space in the department. We were also informed that ambulance crews would sometimes call the department ahead of their arrival in an attempt to ensure a nurse was ready and waiting in the ambulance triage area.

We spoke with the triage nurse who staffed the ambulance arrival area and they said they documented why people waited over 15 minutes to be triaged. We noted the documentation for the day of the inspection and there had been three occasions between 9am and 2pm when the ambulance crew had to wait. Two occasions were because all of the cubicles were occupied and one occasion was because the triage nurse was not stationed where they should have been. They told us that they had assisted another nurse during this time because the department was short staffed.

There were on average 134 people, per week returning to the AED department to be reviewed by a consultant. These included people with muscular-skeletal injuries and burns. This meant that people were being reviewed in the AED rather than by their GP or a consultant in the fracture clinic. The review clinics were held each morning, seven days a week which meant an AED consultant's time was spent reviewing previous patients rather than attending to patients attending the department with new moderate/major illnesses or injuries.

One AED consultant we spoke told us the department ran 'BRATS' (Bradford Rapid Assessment and Treatment Service) from 12.30pm until 8pm. They said people that attended with 'primary care' conditions, such as a urinary tract infection, would be seen by a consultant in a timely manner. This meant that an AED consultant's time was spent attending to people with conditions where they should have ideally gone to their GP.

The medical establishment during the inspection was as follows:

- 10.60 whole-time equivalent (wte) consultants (1.6 wte paediatric consultants)
- 2.46 wte associate specialists
- 3.32 wte (1.26 wte paediatric only) staff grades
- 8.0 wte (4 trainees in post 2 locums i.e. vacancies) registrars
- wte CT3 (core trainees)
- 7.0 wte VTS (GP trainees)
- wte CT1 (Core/ GP trainees)
- 12.0 wte FY2 (pre-specialist doctors)

The RCEM suggests that departments with 100,000 new attendees should have a minimum of 16 consultants, 12 middle grades and 20 FY2. According to numbers supplied by the Trust, there were 4.7 whole time equivalent (wte) emergency nurse practitioners (ENPs). ENPs were qualified nurses that assessed, diagnosed and treated minor injuries and illnesses. The RCEM suggests that AED departments with over 100,000 new attendees should have 14 ENPs. This meant that the Trust did not have enough ENPs to treat people attending the department with minor injuries and illnesses in a timely manner. This was particularly relevant to this AED because 55% of all new attendees presented with minor conditions.

Ward 4 (Medical Admissions Unit)
During our visit to the ward we spoke with two senior nurses about staffing levels and also spoke with a number of junior nursing staff and healthcare assistants. One senior nurse said, "From a consultant point of view we are badly staffed; we don't keep the figures on it though." A healthcare assistant we spoke with said there were enough staff but they did "struggle with experienced doctors at night." A patient we spoke with said, "There isn't enough staff, sometimes it takes a while for them to come, but my care has not suffered."

One senior nurse described the challenges faced by the ward in terms of staffing; they described how the Trust was aiming to have in the region of six consultant physicians working on the ward and currently had two. However, they did point out the extreme difficulties at local and national level in terms of recruiting acute medical consultant physicians. They described how the consultants were instrumental in making key clinical decisions and decisions in relation to discharge. There were two consultant ward rounds each day, one from 08.00 – 12.00pm and the other from 16.00 – 20.00. A senior registrar worked permanently on the ward and they too were instrumental in making senior level medical decisions. However, we were told the registrar was constantly pulled away from the ward to attend other areas of the hospital which often left people on the ward waiting relatively long periods for a senior medical review. We were told senior house officers worked on the ward as part of their training but they often did not have the confidence to make certain key decisions. This added to the demands placed on the registrar and consultant, which in turn added to their work-load which then added to delays with clinical decisions and discharge. However, they said some improvements had been made and there were now two medical registrars working the evenings.

In terms of medical review, the ward had certain targets. A key target included patients seeing a consultant within 12 hours of their admission to the ward and patients having a medical review within one hour of arriving on the ward; this target was six hours for the assessment area. We were told some of these targets were missed but compliance with the targets was not accurately monitored. This meant the extent and impact of missing the targets could not accurately be determined which in turn affected the assurances provided to the executive team in terms of patient safety.

A concern which was raised during our discussions was around staffing of the eight bedded trolley bay area. Apparently, a named consultant was not responsible for patients in the trolley area and one staff nurse would oversee the patients on trolleys including observations, chasing test results and ensuring people's overall safety. It was felt that the demands placed on the nurse covering the trolley area were too much especially if an un-well patient was admitted there from the AED. Apparently, business cases had been submitted requesting the recruitment of advanced nurse practitioners to ease the pressure on the ward, especially within the trolley bay area, and help fill the gaps created by the lack of consultant physician/senior medical input. It was unclear if the business cases were being considered or not. The lack of senior medical staff also had an impact on people accessing community services; this was because junior staff and/or people on rotation to the ward were often unaware of the community services available which meant that some patients may have experienced delayed discharge because available community services were not utilised effectively.

Ward 3 (Elderly Medical Unit)

During our visit to the ward we spoke with the senior nurse. The ward was described as very busy often seeing approximately 18 patients per day and sometimes up to 30/32. The senior nurse felt there was a good team of nurses and would work extra shifts to cover
sickness and holiday leave. They described how during the day the aim was to have three qualified nurses and three healthcare assistants on duty. However, they added that it did vary and wards 29 and 30 were really struggling for staff and would use staff from ward 3 to cover gaps. We were told the ward was particularly busy in the afternoons and could often be a bit of a 'bottle-neck'. This was because some patients were admitted to the ward to ensure the four hour Accident and Emergency Department target was met and meant patients were waiting around for test results, for example, blood test results.

The senior nurse said staffing was an issue and they were in charge of the ward but still had responsibility for six patients. They felt their line manager was proactive and prepared to listen and they were aware of a management initiative to recruit new staff.

A staff nurse were spoke with had worked on the ward for 7 years and felt that staffing, most the time, was okay. They said staff sickness wasn't an issue but staffing could be an issue when people were on leave and if the ward was particularly busy. For example, they described how the ward could have up to 32 patients admitted in a day but also said the ward had quite periods. The nurse stated that the ward sister was "brilliant" and senior management were approachable. They also felt the ward was well organised and morale was good. This was a positive aspect and there was a sense that staff pulled together during busy periods in an organised way to maintain effective patient flow and patient safety.

During the inspection we spoke with the deputy chief nurse about some of the staffing concerns we had. They said that staffing was on the corporate risk register and we noted that it had been agreed as a new risk at the audit and assurance committee on 29th September 2013. The deputy chief nurse stated that staff, mainly nurses, had been recruited in July 2013 and, at that time, the numbers of vacancies in the Trust were normal. Recruitment was described as a challenge and a recruitment steering group had been set up to stream line the process and address the concerns. The Trust had also focused on healthcare assistant recruitment and this had been done in a more targeted way. We asked about how nursing staff establishments were calculated and it involved a number of approaches including assessing the numbers of staff necessary in relation to numbers of beds and also taking in to account the dependency of patients. Other information which fed in to the decision process included results from spot checks, audits and observations during ward visits from senior staff, such as matrons. The 'safer nursing toolkit', which was relatively new to the Trust, was also used and this brought together all of the above in to a more formalised process. The chief executive also described the use of the 'safer nursing toolkit' and its value in supporting decisions around staffing. They also described how the Trust were applying the tool more frequently and increasing its application from once a year to three times a year. This was a positive step and would provide the Trust with a broader insight into the staffing demands during the varying pressures which can fluctuate throughout a year.

Ward 9 (Stroke)

During our inspection of ward 9 the managers told us that the stroke service included an average daily staffing which included four qualified nurses and two healthcare assistants on both early and late shifts; night cover was provided by three qualified nurses and two healthcare assistants. The stroke coordinator worked 08.00 – 16.00 Monday to Friday and they were responsible for providing support to people who had suffered a stroke on their arrival to the AED.
On the day of our inspection we saw that the morning shift was staffed as described above but the afternoon shift was short by one qualified nurse. We were told that when that occurred people’s roles were altered slightly in order to manage the ward. The managers informed us staff were flexible and covered each other wherever possible at short notice.

We spoke with the Consultant Stroke Physician and Clinical Lead for the service; they told us that according to national and regional stroke guidelines the number of consultants required by the Trust was six. The service operated with 2.5 whole time equivalents using a one-in-three on call rota system which also included a telemedicine rota for thrombolysis (breakdown of blood clots using medication) for three nearby Trusts. We were told there were no registrars (senior doctors) in post for the service. The Clinical Lead explained that the gold standard for qualified nursing cover of the hyper-acute stroke unit based on the ward (which had three beds) was six band 6 (middle grade) nurses on duty every shift. There were periods, particularly out-of-hours and at weekends, where this was not being achieved.

The operations manager we spoke with acknowledged that the existing medical cover needed to be increased to enable the provision of a sustainable medical on-call system. A business case for extra doctors was being considered and likely to be submitted by the New Year. The operations manager also informed us that the safety and quality of the stroke service was at the top of the board's agenda and it had the board's full support.

The ward manager explained how the Trust continued to develop its stroke services through participation in national audits and following best practice guidance. As a result, the Trust had increased its Speech and Language Team and was set to develop an Early Support Discharge team to work within the community which would include specialist therapists, nurses and medical staff.

Ward 29 (Elderly Care)

We spoke with one of the consultant doctors working on the ward and they described the work pressures particularly in terms of staffing. They said that night time staff levels went down sometimes less than they should and stated that, "We are short staffed, everyone knows that." They added that the Trust were trying to address the issues. They said that experienced staff had left, staff were very stretched and people worked very hard. We discussed the layout of the ward because we noticed it was a relatively large ward and had many side rooms. According to the consultant and other staff we spoke with, this made it difficult because there were not enough nurses to cover the side rooms and bay areas. This was a particular risk because there was not sufficient staff to consistently ensure the welfare of people across the ward.

One of the four nurses we spoke with said lots of experienced staff had left and had been replaced with newly qualified nurses which had impacted on skill mix. They described how during the days there were usually four nurses and three healthcare assistants and during the night two nurses and two healthcare assistants. They had worked three night shifts recently and there were three patients who required one-to-one support; the staff compliment included two nurses and two healthcare assistants but they said it was not enough.

We also spoke with a healthcare assistant and they said the ward had been very short staffed recently. The healthcare assistant stated there were only two permanent healthcare assistants on the staffing rota and the rest were agency staff or staff from other
wards. They said the agency staff they got were often pretty good but it was not the same as having your own staff. They described how they got good support from managers and said the trust were trying to recruit but staff don't stay. They said there were three teams on the ward and each was supposed to have a registered nurse in each and a healthcare assistant in each, apart from one team which had two. On the day of the inspection there were three registered nurses on the ward; one was helping out from coronary care and the other was from the gastroenterology ward. This was because ward 29 had recently closed six beds due to staffing shortages and shortly afterwards beds needed to be closed on the gastroenterology ward for refurbishment work. When the work started the closed beds on ward 29 were re-opened and a staff from the gastroenterology were asked to work on ward 29 and oversee the 6 beds. The 6 beds were initially for gastro/renal patients only but they then became general beds. The skill mix on the ward was not consistent and some of the nurses who usually worked on other wards acknowledged the limitations in their knowledge of elderly care and elderly dementia care.

Ward 20 (Acute Surgery and Surgical Assessment Unit)

During the ward visit, the manager told us that they felt there were not enough nursing staff on the ward and they were already overspent by £25000. They said that the staff covered both the ward area and the surgical assessment unit (SAU). We asked them how the nurse establishment had been determined and they said they did not know. They told us that both they and their manager had requested additional nurses but this had not happened. We were informed the situation was particularly difficult with staff on maternity leave because cover for that person's role was not provided for the initial eight weeks whilst the person on leave was receiving their full pay.

The Trust's recommended staffing levels were five registered nurses and one health care assistant during the day and four registered nurses and one healthcare assistant during the night. The manager told us that quite often there were four registered nurses with two healthcare assistants during the day and three registered nurses with two healthcare assistants during the night. They said that this included one nurse being in charge of the ward and one nurse and one healthcare assistant assisting in the SAU.

On the day of our inspection there were four registered nurses and two healthcare assistants. The manager was included in this number and took charge of the ward. Another nurse and healthcare assistant were working in the SAU. This meant that two trained nurses had to care for 22 people with one healthcare assistant to help. Some patients were acutely unwell and waiting for theatre and others had returned from theatre, required hourly observations and in many cases in pain and required pain relief. The demands on staffing were often compounded because nurses were often required to leave the ward with patients while they had tests/scans done. We noted that one nurse left the ward for a total of 55 minutes to stay with someone whilst they had a specialist computerised scan and another nurse left the ward for two hours to stay with someone whilst they had an ultrasound scan. During these times only two nurses were on the ward and this included the nurse in charge.

We reviewed the nurse staffing rota for the previous month during our inspection. There were significant shortfalls in the numbers of nursing staff on duty during this period. Out of 28 possible early shifts, 21 of those had been staffed with fewer nurses than there should have been according to the trust's requirement; 12 of the 28 late shifts and 10 of the 28 night shifts were short staffed.
One patient we spoke with said, "There were not enough nursing staff. It was not possible for nurses to attend to everyone because they were too busy." On the day of the inspection three ward clerks were off sick and the manager told us that because of this, the reception area for the SAU was closed which meant one of the nursing staff undertook the reception duties.

Ward 23 (Elderly Care)

During our inspection of ward 23 we spoke with two junior doctors and they both said that they felt well supported by their seniors. One doctor said that there were problems when a patient under the 'care of older people' was ill on the ward. They said that the medical staff that covered the ward was either from an orthopaedic or endocrine speciality. Older people's consultants did not attend the ward unless it was to see a person with a fractured hip. They said that because of this, it was difficult to escalate concerns about people that became unwell and did not have their speciality doctor based on the ward. Both of the doctors thought people were seen in a timely manner by the medical staff but felt there were not enough nurses. One doctor said, "The ward is often short of nurses, but so is the rest of the hospital".

One nurse we spoke with said that the ward was very busy, especially in the afternoon. They told us that it was 'easier' in the morning because the occupational therapists and physiotherapists helped. They said that during the afternoon people had to get ready for theatre and staff didn't always 'see' to people in a timely manner.

During our observations we monitored how quickly people were attended to when they called for assistance or pressed their nurse call buzzer. We saw that people were seen quickly in the morning and did not wait for more than two minutes on most occasions, with the exception of one person who waited for nine minutes. We noted that there were delays in the afternoon; people waited between 11 and 18 minutes to be attended to. We were informed that the shortage of nurses on the ward was known about and as a result, five beds had been closed to admissions.

We spoke with the ward manager and they said staffing levels had not been fantastic and the ward had changed last year to focus more on the elderly. They did state they felt well supported by the senior management team but had not seen any directors during their hospital walk-rounds.

Focus Group

On the final day of the inspection we spoke with a group of twelve foundation year two (FY2) doctors (pre-specialist doctors). One doctor described how on the intensive care unit (ICU) they were privileged in terms of staffing and there were no staffing issues at all or issues in terms of continuity of care. In relation to ward 29, a doctor felt staffing fluctuated in terms of medical staff and was top heavy with consultant doctors. They also said Tuesdays could be an issue because consultants were not available. They added that ward 29 had staffing issues in general and had recently had to close beds.

In relation to wards 20 and 21 a doctor felt the nurses could not work any harder and if patients were particularly unwell the staff could be very stretched. They felt if there were extra nurses the standard of care would be higher. It was described how there were not always enough nurses on certain wards to take patients and a doctor said they had needed to keep patients on the ICU because of nursing problems 'downstream.'
doctors felt nursing staff on the medical admissions unit were also very stretched which meant people were sometimes discharged later than they should.

There was also discussion about patient flow and the pressures around the four hour AED target. Meeting the target sometimes meant patients were discharged from the AED to inappropriate wards and we were told there was no mechanism for finding where outliers (patients not on their ideal speciality ward) were. The doctors said they found it hard to manage outlier patients and one doctor said, "It takes the staff on the ward to ring around and find the doctor that is caring for the patient, otherwise they get lost in the system. It's very hard to manage our own outliers and they are not safe in the hospital." The management team informed us that a list was circulated every morning showing all the patient outliers but it was apparent that this was not effective because junior medical staff were not aware of this.

We were informed the Trust's tube system for carrying specimens and paperwork (pod system) was broken and there was a shortage of portering staff. We didn't analyse the staffing numbers for porters but the doctors described how they often took blood specimens to the laboratory themselves if test results were urgently needed due to the problems of getting a porter. The response from the Trust informed us that the pod system was being repaired during the inspection and an order had been placed for additional pods in order to positively reduce the frequency that medical staff were required to take blood specimens to the laboratory. Medical staff also described how patients could wait several hours to be taken to the x-ray department because of delays in finding a porter. It was felt porters worked hard but there were not enough.

The doctors felt the hospital was good and the consultants were approachable. They also felt patients were well looked after.
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Those interviewed during the inspection in relation to this outcome were predominantly staff within the executive team. The people we interviewed were able to explain the committee structures in adequate detail. Although some aspects of the structures we particularly new, it was apparent there were several subcommittees of the Board of Directors each with clearly defined roles in terms of the management of complaints, claims, serious incidents (SIs) and never events. All of the subcommittees dealing with these aspects of risk reported into the Quality & Safety subcommittee of the Board.

The Quality & Safety committee was given authority by the Board of Directors with reviewing closely (termed deep-dive) each SI, 'extreme' complaint investigation and never event. This 'deep dive' approach was described by both the Chairman and the Chief Executive as providing assurance to the Board on the effective and appropriate management of these areas of risk within the organisation. Assurance in this respect was complimented by the fact the Quality & Safety committee was chaired by a Non-Executive Director (NED) who was a clinician and that all of the executive directors and two additional NEDs sat on the Quality & Safety Committee. In addition, each Division held its own risk register and there was a corporate risk register which was reviewed every other month by both the Executive and Non-Executive Directors.

Learning from serious incidents was cascaded through the organisation via a traditional SI investigation report but also through a one page summary report which was shared at Divisional Clinical Director, General Manager and Head of Nursing level. SIs and related learning were then cascaded through all levels of each division with the expectation they would be discussed at the monthly speciality-level clinical governance meetings.

Detailed reports on SIs and extreme complaints were presented and discussed at the Quality & Standards meeting and highlight reports presented to the public Board of Directors meetings. There was a clear expectation that each of the three Board subcommittees conducted the in-depth challenge of each SI report and 'extreme'
complaints investigation since it has been deemed inappropriate for such discussions to be held during the now public Board meetings.

These reporting and committee structures were further strengthened by a number of different 'walkabouts' undertaken at the Trust. These included senior leadership walkabouts (Board members); Governor walkabouts; Royal College of Nursing walkabouts and walkabouts undertaken by the Chief Nurse, Medical Director and Chief Operating Officer.

In addition the Chief Executive reported that the roles of Chief Nurse and Medical Director, their teams and underpinning meetings also provided assurance to the Board of Directors on the effective operation of all risk management systems within the Trust.

An open incident reporting culture was described by all those interviewed and the Trust used a computer reporting system called Datix. The Clinical Directors we interviewed viewed themselves as approachable and available to all their staff for the reporting of any concerns relating to patient safety.

Recently, the Trust had been flagged, and alerted, as being an outlier (above average numbers) in terms of death rates (mortality) in relation to fractured hips. The Care Quality Commission (CQC) raised this with the Trust and requested an investigation. Whilst the outlier alert was not detected through the Trust's internal quality assurance mechanisms, once received, a robust response was provided. There was potential the outlier was data was missed due to the absence of a specialised computer programme which enabled performance against peer trusts to be compared. However, this had been recognised and a programme has been purchased; named the Dr Foster package.

In terms of SIs, on more than one occasion, Clinical Directors described one of the roles of the specialty level clinical governance committees to be to discuss and minute their discussion of all SI one page reports and the resulting lessons learnt. The data compiled by the CQC prior to the inspection corroborates the impression given through interviews of a Trust with a good incident reporting culture and a low tolerance for the reporting of Serious Incidents / Never Events. Recent requests for information on the outcome of serious incidents from the CQC were reported to have resulted in the central Risk Management team tightening up their processes regarding the management of serious impact incidents.

We noted with some incident investigations that the severity grading was focused on outcome in terms of impact on the patient/patients involved. We saw on numerous occasions where incidents had been down-graded to 'minor' because the ultimate impact in terms of survival or injury was deemed low, non-adverse and/or no harm. We had concern that the severity of incidents in their own right was often re-graded thus affecting incident data recording and learning. For example, with three SIs, there were confirmed delays in recognising cancer from the results of certain tests. The opinions with each case were that the missed cancer diagnosis was deemed non-adverse, for example, because surgery may not have been possibly even if the correct diagnosis had been at the right time. We were assured by the Risk Management team that such facts did not detract from the severity of the actual mis-diagnosis and an incident of missing a diagnosis of cancer was indeed judged as 'severe' even if the impact on the patient, after investigation, was defined as 'minor' or 'low'.

During the inspection, it became clear that the matrons responsible for each clinical area
did not have an operational role in terms of either line or budgetary management. As a result they did not become involved in day-to-day management issues e.g. ward staffing. It was noted by the inspectors who visited ward areas and interviewed both operational and clinical service managers (OSMs and CSMs) that this created a situation where the OSMs and CSMs felt they were overburdened in terms of operational management. Some Divisional General Managers also noted the fact the matron's role only encompassed governance, quality and risk. This was said to create operational difficulties and led to silo working where the matron focused on quality whilst the OSM and CSM focussed on day-to-day service delivery.

At a focus group of nine junior/middle grade nurses, there was discussion around ward/department nurse leadership. It was felt that matrons only really dealt with complaints and the Band 7 (senior nurse) ran the ward. One nurse said, "We can go a month without seeing the Matron" and another said, "There doesn't seem to be a role for the Matron on the ward." It was also said that the role of Matron was different/seemed different on each ward and senior nurses and matrons did not, in most cases, have expert knowledge of the clinical discipline/ward they were charged with leading/managing. The nurses felt this didn't mean senior nurses/matrons could not manage wards which did not match their clinical knowledge/background exactly but felt it weakened their credibility and 'joined up thinking' with nurses 'on the shop floor.' In relation to the OSM and CSM role, one nurse described how they would only see the CSM or OSM if the ward was really busy or there were patient-flow problems.

During the inspection we noted the absence of a Board Assurance Framework (BAF) document at the Trust. During interviews it became clear that there was a difference of opinion amongst members of the Board of Directors as to the value of a BAF document and a Non-Executive Director said, "No we don't have the old fashioned NHS BAF that ticks the boxes".

The rationale for not needing a BAF was that the Trust had an alternative 'robust' process, namely, reviewing all of the risks on the corporate risk register every two months and judging the impact in relation to the corporate objectives. This also included scrutiny from all Executive Directors, the Chairman, one additional NED and the Trust Secretary. Whilst the discussions around the corporate risk register were described as 'detailed' we were concerned about the detail of discussion which could be had in a meeting which reportedly only lasted one hour. At the time of the inspection there were in the region of 36 corporate risks which would allow for limited discussion per risk over the course of one hour. However, in addition, we were informed there was a process in place which ensured that the Trust undertook a quarterly review of its progress against its corporate objectives. Both the Chief Executive and the Trust Secretary reported that a BAF document would be in place within the Trust by the beginning of the 2014/15 financial year and this had the full support of the relatively newly appointed Chief Nurse.

We discussed assurance and the potential for a BAF at length and the absence of a BAF document did not in itself demonstrate a deficiency in the governance arrangements or an inability to ensure achievement of the Trust's strategic objectives. However, guidance put forward by the Department of Health does describe the BAF as a key interlocking system of control for risk management and is seen as a dynamic tool for driving the board agenda. Whilst dynamic risk management arrangements were described by many interviewees during the inspection, we did not see evidence of the majority of the elements generally included in a BAF document having been documented by the Trust since no BAF document or substitute document was provided.
During the inspection a key aspect was to assess the overall assurance processes including observing systems and processes in practice. There were examples and themes where there appeared to be delayed recognition at executive level, including the board, of certain risks, the severity of certain risks, progress in terms of mitigating the impact of known risks and re-evaluating the progress of agreed actions in a timely way. For example, in relation to our inspection last December (2012) we highlighted significant weaknesses in the ward pharmacy service and the trust's own internal audit, produced in April 2013, pointed to significant weaknesses also. We returned to the trust in May 2013 to find continued problems particularly in terms of numbers of pharmacists. We continued to raise concerns through engagement meetings and the trust commissioned an external review of the service. The external report was produced in July 2013 and also highlighted gaps in the service particularly with staffing. The trust conducted another audit in quarter 2 of 2013 the report of which was produced in July 2013, a divisional director and the deputy chief operating officer we spoke with during the September inspection were not aware of the results of the quarter 2 audit. It highlighted further weaknesses in the service and areas where performance was worsening compared with the results of the quarter one audit. We re-visited the trust again in September 2013 to find continued problems but with some improvement. At that time, the trust had still not reacted assertively to the long-term problems highlighted in relation to the pharmacy service. The September 2013 board did approve a business case for more pharmacists but we were informed it would be late December 2013 before marked improvements would be seen; this is one year on from the initial non-compliance identified by the CQC.

Through our engagement with the trust we were assured that the board understood the shortfalls with the pharmacy service and the business case for more pharmacists had been considered at the May 2013 board. The previous Chief Nurse updated the performance committee in April 2013 on the trust's action plan to improve the pharmacy service from our inspection in December 2012; the on-going issues with the service were not discussed again at the performance committee throughout the year. A CQC update was presented to the Quality and Safety Committee in August 2013 but pharmacy was not discussed. The details in the audit committee meetings minutes were very brief and there is no mention of any CQC inspection, internal pharmacy audits or the external pharmacy audit. We discussed the lack of detail in the audit committee minutes with the NED who chaired the meeting and they stated they were brief in case there were Freedom of Information (FOI) requests. There were no discussions minuted in the audit committee minutes only decisions. In relation to board minutes, CQC is mentioned at the Board in March 2013 but this related to a Mental Health Act Commission visit. There is no evidence within the board minutes, accept for September 2013, where our concerns with pharmacy are discussed or a pharmacy business case is discussed. We were clear in our September 2013 inspection that we still had concerns with the pharmacy service but the minutes from the September 2013 board state that our initial feedback was that there were no outstanding compliance actions; this was at a stage where our decision in relation to compliance had not been made; there is concern hear about false assurance.

Other examples are around the known privacy and dignity concerns in the AED, the known shortages of consultants in the AED and MAU, the shortages of nursing staff on several wards and placement of unsuitable patients on wards including the trolley bay area on the MAU. In relation to the AED, the Emergency Care Intensive Support Team (ECIST) from NHS England, conducted a comprehensive inspection of the department and produced a detailed and constructive report in July 2013. The report highlighted concerns in relation to triage, privacy, dignity, patient flow, escalation and lack of consultant cover. The report does not appear to have been discussed at key executive level meetings.
In terms of governance within the AED were concerned about escalation procedures when the department and hospital became full. There were 'patient flow escalation flowcharts' and these stated what staff should do when there was no available capacity in the AED department or the assessment units. We did not see evidence that these flow charts were put to use during our inspection. This meant that the escalation procedures were not effective. They were not followed at the operations meeting we attended and bed capacity was not generated for people requiring admission from the AED in a timely manner.
People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

During the inspection we assessed how complaints were handled and also spoke with patients and staff about their understanding of the complaints process and their responsibilities.

We spoke with members of the executive team and were told there was a central complaints team in place within the Trust although it was each Divisional Head of Nursing who was responsible at a divisional level for the investigation and response to complaints. In practice, this responsibility was delegated to the divisional matrons who undertook any investigations and drafted the initial complaint response. The response was then approved by the Clinical Director and Head of Nursing before being returned to the central complaints team for review. The responsibility for complaints had been recently transferred from the Corporate Affairs team to sit within the Chief Nurse’s portfolio.

The Trust was described on more than one occasion as being 'on a journey' in terms of its current complaints system with some of those interviewed describing a 'disconnect between the divisions and the central team'. Weaknesses have been identified in the quality of the complaints responses drafted by the matrons and plans were in place for the training of matrons in complaint response writing and for matrons showing good skills in this area to be encouraged to pass these skills onto other matrons. Through our engagement with the Trust, we had noted occasions where there had been delays in responding to complaints and replies/investigations had not always comprehensively addressed the main elements of a complaint. The Trust provided us with information in August 2013 acknowledging their complaints process could be more effective and was something they were in the process of improving. The Trust described how the format of the Complaints Steering Group had altered and this was to enable better oversight of the complaints process. A new module had also been added on to the Trust's risk reporting system in September 2013 which would massively increases the ability to monitor complaints and detect themes. A survey of complainants had recently been carried out (previous survey undertaken in 2012) which corroborated the Trust's concern about the quality of the complaint response letters and initiated a strengthened sign off process involving the Chief Nurse and General Manager for the Medical Director's Office.

An action plan for the improvement of the complaints system has been created and challenged at a recent 'time out' led by the Chief Nurse. This action plan had drawn on the
learning from the Francis Inquiry as well as the recently published Patients Association report into complaints handling. Reporting to the Board had, until recently, been on a monthly basis and contained an analysis of themes from complaints. From October 2013 this changed to a monthly report of complaint numbers by division, severity and response rates for the previous month. Changes also included introduction of a quarterly report to the Board containing a thematic analysis of complaints, lessons learnt and the actions taken.

As discussed early in this report, in relation to serious incidents (SIs), learning from SIs was cascaded through the organisation via a traditional SI investigation report but also through a one page summary report which was shared at Divisional Clinical Director, General Manager and Head of Nursing level. SIs and related learning was then cascaded through all levels of each division with the expectation they would be discussed at the monthly speciality-level clinical governance meetings; this system was soon to be rolled out for the learning from complaints.

During our ward visits we spoke with patients and staff about complaints and also observed the information on display, and available, to people on how to complain and what the process involved. On ward 4, for example, we spoke with a patient and they knew how to complain and explained they would contact the Patient Advice and Liaison Service (PALS). Whilst on wards 29 and 4 and in the AED, we looked around for information displayed in relation to complaints and/or information about the PALS team. We did not see any notices discussing the complaints or contact numbers. However, in the main waiting area in the AED there were leaflets available called 'Being Open – saying sorry when things go wrong.' The title didn't automatically suggest it was about complaints but it did provide comprehensive information the hospital dealt with mistakes and who to contact for further help and advice including PALS. The leaflet also described how the Trust had a formal complaints procedure the details of which were available from the leaflet itself and on all ward and department areas. The leaflet also provided the alternative for people to write directly to the chief executive.
Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activities</th>
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<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Respecting and involving people who use services</td>
</tr>
<tr>
<td>Family planning</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>People's privacy and dignity was not consistently maintained to a suitable standard. People were not consistently treated with consideration and respect. 17. - (1) (a) (b) (2) (a) (b) (e) (f) (h)</td>
</tr>
<tr>
<td>Nursing care</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
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<tr>
<td>Termination of pregnancies</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Regulation</td>
</tr>
<tr>
<td>Assessment or</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Regulation</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td>Family planning</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>There were weaknesses in terms of the responsiveness of the Trust to react to known problems and there were concerns in relation to the accuracy and detail behind the assurance reaching the Board. 10. - (1) (a) (b) (2) (b) (i) (iv) (c) (i) (ii) (d) (i) (ii)</td>
</tr>
<tr>
<td>Nursing care</td>
<td></td>
</tr>
</tbody>
</table>

| 2010 |
| Care and welfare of people who use services |
| How the regulation was not being met: |
| People were not always suitably protected from risk and people’s welfare and safety was not consistently maintained. 9. - (1) (a) (b) (i) (ii) (iii) (2) |
Surgical procedures
Termination of pregnancies
Treatment of disease, disorder or injury

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 25 December 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Staffing</td>
</tr>
<tr>
<td>Family planning</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>Staffing levels in many areas across the Trust were not adequate to ensure the safety and welfare of people. 22.</td>
</tr>
<tr>
<td>Nursing care</td>
<td></td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Termination of pregnancies</td>
<td></td>
</tr>
</tbody>
</table>

For more information about the enforcement action we can take, please see our Enforcement policy on our website.
We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

- **Met this standard**
  This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

- **Action needed**
  This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

- **Enforcement action taken**
  If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.
**Contact us**

<table>
<thead>
<tr>
<th>Phone:</th>
<th>03000 616161</th>
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</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
</tbody>
</table>

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Gallowgate  
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NE1 4PA  

Website: www.cqc.org.uk  

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