

Mid Staffordshire NHS Foundation Trust

**Report on the trust's progress in implementing
recommendations**

July 2010

About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

Introduction

The purpose of our 12-month review was to assess the progress that Mid Staffordshire NHS Foundation Trust had made in implementing the recommendations of the Healthcare Commission investigation report, published in March 2009. We also checked on the trust's progress against our six-month recommendations. We have spoken to patients and their families, and focused on the recent experiences of patients who attended the trust from January 2010.

Collaborative working and sharing of information

We have worked collaboratively and shared information with partner organisations in line with the National Quality Board's review of early warning systems in the NHS.

Over the last 12 months, we have had regular meetings and discussions with Monitor, West Midlands Strategic Health Authority, and South Staffordshire Primary Care Trust to share progress and intelligence. Together we have worked with the trust to support and to challenge it in making the necessary improvements.

During the year, we have also worked with a number of other partners in the West Midlands, to share understanding of the trust's progress. A key part of this was the planned collaborative review in November 2009, which brought together many of the organisations involved.

We asked these partners to comment on progress as part of this 12-month review. We also invited local patient representative organisations to provide feedback about the trust. See appendix 1 for the full list of partner organisations.

During March and April, our assessors, supported by external experts in emergency medicine, surgery and nursing (see appendix 2), made unannounced and announced visits to the trust. West Midlands SHA and South Staffordshire PCT each took part in one of the announced visits. The reviewers carried out observations in the clinical areas, and interviewed patients, carers and staff.

Our findings

Our findings are split into four sections, reflecting the Healthcare Commission's areas of concern in its March 2009 report.

This is the last specific follow-up of the Healthcare Commission report. We will now routinely monitor the trust under the new regulatory framework introduced by the Health and Social Care Act 2008.

Summary

The trust has worked hard over the last 12 months to address issues arising from the Healthcare Commission investigation. It has made considerable progress in most areas. In others, there is still some work to be completed.

Action by the board to oversee the quality and safety of clinical care

Ultimate responsibility for safeguarding the quality of care rests with the trust's board. The culture at the trust has changed over the last 12 months and it is now more open, with a focus on the views and experiences of patients. The level of public engagement at board meetings, which includes listening to a patient relate their experience at the start of each meeting, is good.

The trust has developed a number of ways to actively gather patients' experiences, and it has clearly demonstrated that their views are now more readily listened to and acted on. However, these are mainly at a local level and there is no up-to-date written strategy to recognise the range of this activity.

The trust has also provided examples of how it is learning from incidents, complaints and near misses, and improvements are being made locally. All serious untoward incidents are discussed at the board meetings. However, the sharing of information and best practice across the trust needs to be more systematic, to ensure that people's experiences do help to improve services.

More information is available, both at divisional level and board level, to help ensure that the care given to people is monitored and any shortfalls acted on. The trust has also introduced systems on the wards to check that essential care is given to patients, for example through 'comfort rounds'. Risk assessment at ward level is more systematic and routinely monitored by matrons.

The trust has strengthened its quality assurance processes over the last six months and these now need consolidating. It has not made the progress in handling patient complaints that we would have expected and this needs to improve.

The trust now has a systematic process, involving all clinical directors, for monitoring and reviewing all patient deaths. The trust's board receives data on mortality and other clinical outcomes on a monthly basis and the scrutiny of this information has improved.

Standards of care

In this review, we have focused on whether the experience for patients has improved over the last 12 months. Overall, it has. Most of the patients surveyed in March 2010, both by CQC and other agencies, were positive about care they received. In our direct observations, staff were responsive when patients needed help, and patients told us that their understood the plan for their care. Matrons are having an impact, spending

one day a week delivering care and this is good practice. The trust's data shows that it has sustained its relatively low levels of hospital-acquired infection over the last 12 months.

However, there are still a minority of patients who are unhappy with their experiences of care. The trust needs to continue to raise its standards. The impacts of risk assessments were not always clearly documented in patient care plans and this needs to be reviewed. The trust must also ensure that sufficient pressure relieving devices are routinely available for patients who are at risk of developing pressure sores.

A&E department

Over the last 12 months, the trust has introduced a number of initiatives to improve the care of patients in A&E. For example, patients have very good access to senior doctors in A&E. Consultants spend a large proportion of their time in the department, and are readily available to provide patient care and supervision to more junior staff. The new surgical assessment unit was working well.

Despite these improvements, patients continue to wait in the department for longer than is necessary and this needs to be addressed. Since our visits, the trust is focusing on bed management and discharges from wards, to improve the flow of patients through the hospital and ease the backlog in A&E. There also appears to be an over-reliance on the use of A&E to house patients who fall between acute medical or surgical conditions and 'level 2' high dependency cases. We found two patients who had remained in A&E for a protracted period of time; they may have benefited from being moved to a level 2 high dependency facility sooner. The trust needs to improve its governance of level 2 patients and those who do not 'fit' the conventional medical or surgical ward.

Staffing and capacity

The trust has made good progress in filling its nursing vacancies and is broadly up to its required staffing level. The trust has demonstrated reasonable compliance with mandatory training rates and staff appraisal.

However, absence due to sickness is high in some clinical areas and the trust needs to continue to tackle this. The trust is also aware that further improvements are necessary to improve theatre capacity and organisation and it has a project underway to review this. It has plans to address surgical staffing, specifically the numbers of surgeons and theatre recovery nurses. It must improve management of the hospital at night, including medical cover, and it needs to develop a framework for providing supervision.

1. Action by the board to oversee the quality and safety of clinical care

The March 2009 report required the trust's board to have a systematic way to monitor mortality and other outcomes for patients.

Also, more generally, the board had to look at the way it met its responsibility for the quality and safety of clinical care – among other things, developing an open, learning culture, listening to the views and experiences of patients and acting on them, and investigating and learning from serious incidents.

Culture

The March 2009 report required the trust to develop an open, learning culture. There is now a high level of public engagement at the trust's board meetings, which is good practice. All the board meetings are open to the public. The first item at each meeting is an account from a patient, supported by a member of staff from an area of the trust that the patient is not in contact with, of their experience at the trust.

All serious untoward incidents (SUIs) are discussed openly at the board meetings (while still preserving patient and staff confidentiality). The minutes show that patients' questions are responded to and, at the end of each meeting, the public visitors are asked to evaluate the level of priority given to patient care and safety at the meeting.

We found evidence that staff were raising concerns and that poor performance was being addressed. Most of the staff we interviewed felt that there is now a more open culture at the trust and commented in particular on the openness and visibility of the executive team. There is a programme of director 'walkabouts' across the wards, which is making management more visible and giving directors the opportunity to directly observe the standards of patient care.

There were mixed responses from staff about whether or not they felt they could raise issues, but most felt they could. A new whistleblowing policy (for raising concerns at work) was put to the board for approval in April 2010.

The trust has developed a communication policy that follows the National Patient Safety Agency's guidance *Being Open: communicating with patients, their families and carers following a patient safety incident*. Ongoing communication and dissemination of information to staff was demonstrated, for example through the trust's staff newsletter. During our site visits, we met many staff who are directly involved in making improvements in the trust. However, some staff said that the level of communication about, and engagement in, service changes needs to improve.

Listening to the views and experiences of patients

Listening to patients' experiences and views is vital if any problems and concerns are to be picked up early, and this was a clear requirement of the March 2009 report.

An earlier review by CQC had identified flaws in the trust's complaints system. The trust has subsequently worked to strengthen its management of complaints and it works with the individuals involved in each complaint to ensure that it focuses on the issues raised.

Its revised policy is consistent with the requirements of the NHS complaints standards (introduced in April 2009), which set out the expected timescales for acknowledging and responding to complaints. The trust is achieving a 100% response rate for the acknowledging a complaint within the expected standard of three days from receiving it.

The trust is not always completing investigations and responding to complaints as efficiently as it could. It agrees the timescale for a response with the individuals involved; this depends on the complexity of the issues. However, the trust is not consistently meeting these timescales. We acknowledge that the trust is dealing with a higher volume of complaints, which includes requests to review complaints dating back to 1996. However, it needs to continue to improve the speed with which it responds to complaints. It also needs to make sure that the agreed timescales are kept under review and any changes are communicated more effectively, so that people's expectations can be managed.

It is acting to improve services as a result of the individual comments and complaints it receives and, during our review, it provided many examples of things being done to improve services for patients as a result of learning from issues. Complaints are routinely considered by clinicians at regular divisional complaints review meetings. The resulting service improvements are mainly done at a local level but we were also given examples of trust-wide learning being acted on. There was also evidence that, where appropriate, staff actively reflect on their own practice.

The trust has worked to improve patient and public involvement. This includes capturing information from the wider community as well as trying to involve patients and carers/families more in their own care and treatment. The trust has a hospital user group, a patient carers' council, a patient information group and a patient experience group. The trust's management team is actively involved in, and challenged about, issues and concerns at the meetings of the council of governors. External engagement is undertaken through the local involvement network for Staffordshire and Cure the NHS. The trust said that external partners constructively scrutinise and seek responses from the trust to improve outcomes for patients.

The trust is actively looking for patients' views and opportunities to feedback on the actions it has taken:

- **Patient stories** – the trust is training up to 40 staff to follow a patient's journey through the hospital and to recognise and respond to the concerns of the moment.
- **Mystery shoppers** – the trust is currently developing the role of 'mystery shoppers' in clinical patient areas to observe experiences and standards.

- **Bubble notice boards** – located in both of the trust’s hospitals, these give patients and visitors the chance to make instant comments, compliments and suggestions in speech bubbles. The trust posts up a response to each one, and all the comments are collated and reported to the management board. The trust is also planning a web-based bubble board.
- **Patient experience trackers** – the trust has for some time been using an electronic tool that captures patients’ answers to set questions. In April 2010, the contract was extended for a further two months and the trust took the opportunity to review the questions. Patients are now asked five key questions that research has shown are statistically linked to mortality rates, and it is envisaged that these will act as an early indicator of patient care issues.

However, there is no up-to-date framework or strategy to underpin this activity, and recognise the range of practice and activity that the trust has developed.

Monitoring mortality and other outcomes

We reported at the six-month review that mortality rates had decreased. In an analysis of the trust’s mortality data in April 2010, we concluded that, from about April 2009, standardised mortality for emergency admissions of adults had declined steadily to expected rates. In the last few quarters, there has also been a downward trend in the crude mortality rate for people aged 18 to 74 and also for people over 75. This suggests that the reductions in the standardised mortality rate are real and not just as a result of a change in the way deaths are recorded and coded.

The trust’s board receives reports of other clinical outcomes as well, such as incident trends, serious untoward incidents (SUIs) and complaints. These are broken down by division and by key area, to highlight any trends or areas of concern and ensure that the appropriate action is taken. The trust is developing its ‘dashboard’ of outcome indicators for monitoring the quality of its services – this includes data on mortality, SUIs, falls, readmission rates, and indicators of patient and staff satisfaction.

Since March 2010, specific indicators of nursing care have focused on the essential needs of patients, compliance with two-hourly ‘comfort rounds’, the completeness of fluid balance and observation charts, and consistency in carrying out risk assessments for patients (for example, for those at risk of falling).

At the six-month review, we recommended that clinicians should make more use of their own outcome data. Consultants now review their own mortality data. Also, the trust told us that doctors have access to the Dr Foster outcome benchmarking tool, and that training on this is about to start. However, data on individual clinical outcomes is still not part of the performance appraisal of consultants and this needs to be addressed.

The trust has also developed a more robust approach to scrutinising the cause of all deaths. Clinicians are actively involved in this process. Mortality outcomes, including ‘red bells’ from the Dr Foster real-time monitoring system, are discussed at the multidisciplinary patient safety group (PSG). (A red bell is a signal that the data is

showing higher than expected mortality for a clinically similar group of patients, and triggers the trust to carry out a further review of potential issues of quality of care.)

The PSG is responsible for overseeing changes and making sure that improvements to patient safety are made. It is chaired by the medical director, supported by the information department and includes all clinical directors. All patient deaths are now reviewed using a standard proforma; the consultant responsible for care uses this to check that all clinical information was documented correctly. Dr Foster red bells are followed up by relevant clinicians, generally a clinical director. These reviews are then scrutinised by the PSG.

Investigating incidents

SUIs are investigated at divisional level by local action groups and an action plan drawn up. If needed, consultants from other hospitals will be asked to provide independent advice. The outcome of each investigation is then reviewed by the clinical risk group. This group is responsible for agreeing the action plan, identifying issues and lessons for the wider organisation and reporting these to the PSG.

The clinical risk group also analyses trends in SUIs and reports quarterly to the healthcare governance committee (HGC). The PSG ensures that lessons are learnt from SUIs and provides assurance to the trust board, via the HGC. The investigation incident forms used by the trust require any local action taken as a result of an incident to be documented by staff.

The trust gave us evidence of improvements that have been made following incidents. For example:

- The falls prevention action group has developed interventions to help reduce the number of patient falls, and new information on managing falls was sent direct to staff on the wards caring for older people.
- Clinicians have developed an action card for the use of emergency issue blood as a direct result of two incidents.

The monthly cross-divisional clinical governance meetings provide a mechanism for sharing learning across the divisions. Each division presents a report about patient safety, quality of care, patient satisfaction and continuous improvements. This is a standard item on the agenda. Exception reports are noted and SUIs are discussed.

Governance arrangements

The trust has aligned its governance and reporting frameworks with the five key themes of its strategic vision:

1. Creating a culture of caring.
2. Seeing zero harm as its target by keeping patients safe.
3. Listening, responding and acting on what patients and the community tell the trust.

4. Supporting its staff to become excellent; giving responsibility but holding to account as well.
5. Continuing to do what the trust needs to do to satisfy its regulators.

The board meetings, weekly executive team meetings and healthcare governance committee (HGC) meetings are structured in line with these themes.

The trust has directorate groups as well as groups that lead on each of the five themes (for example the patient safety group leads on seeing zero harm as its target by keeping patients safe). Clinical audit is included in this structure. A formal process for reporting information from the directorates to the HGC has been established. However, these arrangements have been put into place since the governance strategy was developed and this has not been revised to reflect the changes.

Since our six-month review, the trust has further developed its governance arrangements at divisional level. The surgical, clinical support services and facilities divisions all have governance meetings, as do each of the three directorates in the medical division (emergency care, acute medical specialties and out-patient services). All groups meet monthly to discuss patient quality in their services, audits, clinical incidents, complaints, risks and staff training. The minutes of meetings suggest there is more discussion about processes than the detail of the issues and improvements that can be made, which indicates that the trust needs to further embed the governance processes.

We placed a 'compliance condition' on the trust's registration under the Health and Social Care Act 2008 in April 2010, requiring it to ensure that governance and audit systems to assess and monitor the quality of service provision are in place. We formally assessed this condition as part of the review and found that the trust had made good progress.

Managing risk

The trust has processes in place to identify and mitigate risks to the safety of patients. It has a corporate risk register for logging clinical risks, which includes such items as "failure to review medical and surgical equipment and create robust rolling replacement programme". There is also a register for non-clinical risk issues.

The risks are discussed by the trust's board. Specific areas of risk are also discussed at divisional clinical governance meetings, including clinical incidents and SUIs. Issues are documented on divisional risk registers, for example those relating to a specific piece of equipment that may be coming to the end of its useful life and requires replacing.

The trust has continued to develop its systems to ensure that new equipment is purchased appropriately and that all equipment is appropriately maintained. The trust has a preventative maintenance log of when planned maintenance should be carried out. However, there is no rolling replacement programme for larger items of equipment as reflected in the corporate risk register of 20 April 2010. During our visit, staff pointed out that some anaesthetic machines were coming to the end of their useful

life. Since then, the trust has told us that nine new anaesthetic machines have been ordered, and some of these have already been delivered to the trust.

The policy on management of medical devices has been revised and is awaiting ratification. This includes comprehensive information about processes for the appropriate procurement, maintenance, replacement and disposal of medical devices. A medical devices group has been newly formed to oversee implementation of the policy. It first met on 18 May 2010. The trust expects to develop key performance indicators by July to provide assurance to the board of compliance with standards.

There is a process for reporting faulty equipment (including during 'out of hours') and staff told us they were aware of the process. In all the areas we visited, including A&E, staff generally said that there was ready access to equipment. However, a number of ward staff, from different areas, told us that it was sometimes difficult to access pressure relieving devices for patients at risk of developing pressure sores. In our observations in clinical areas, we found that individual items of equipment had been checked, and included relevant information such as the registration number, the date the appliance was next due to be tested, and a 'do not use after' date.

We placed a 'compliance condition' on the trust's registration under the Health and Social Care Act 2008 in April 2010, requiring it to ensure that all medical equipment in use was in full working order and that a maintenance programme was in place. We formally assessed this condition as part of our review and found that the trust had made some progress.

Arrangements are in place at ward level to monitor the quality and safety of services and to make sure that action is taken when risks are identified. Each ward is expected to undertake a monthly audit of its performance against a number of indicators. These include daily checking of controlled drug counts; daily checking of the ward resuscitation trolley; monthly hand hygiene audits; infections rates; and patient risk assessments in respect of slips/trips/falls, whether they need pressure relieving devices to prevent pressure sores, and nutritional requirements. The results are displayed at the entrance to all wards for everyone to see. Ward sisters are expected to produce action plans, which must also be displayed, to quickly address any failings. Matrons hold ward sisters to account for making sure any necessary improvements are made.

To reduce death and complications from embolism, the trust is undertaking risk assessments using the Department of Health's venous thromboembolism tool. It is also implementing the World Health Organisation's surgical safety checklist, designed to reduce death and complications in patients undergoing surgery.

Audit

Clinical audit is led by the medical director. The structure for audit includes staff with responsibility for clinical audit (including a clinical lead in each of the eight clinical directorates) and groups at which audits and their findings are discussed. Audits are prioritised as either 'critical' or 'essential'. However, it is not clear what criteria are

used to determine the topics for audit, or whether they are critical or essential, as the trust did not provide any evidence to demonstrate this.

The original Healthcare Commission investigation found that the trust did not participate in the audits of the specialist medical and surgical societies. It is now taking part in national audits and some audits of the specialist medical and surgical societies. Forty of the 215 (19%) clinical audit projects in the 2009/10 plan were national audits, such as the national bowel cancer audit programme and the Royal College of Physicians' national carotid endarterectomy audit. The 2009/10 programme also included audits of National Patient Safety Agency alerts (for example, concerning anti-coagulation therapy), and the NHS Litigation Authority's record keeping requirements.

The extent to which clinical audit is embedded within the trust's services and structures is variable. Some services, such as obstetrics and gynaecology, reported a long history of clinical audit. A&E has a more recent history of audit and audit is still developing in the surgical division. The new clinical lead for audit in surgery should help improve the trust's performance in surgical audit. Similarly, many audits are undertaken by medical or nursing staff but only two audits in the 2009/10 plan specifically related to either occupational therapy or physiotherapy. Some audits involve staff from more than one profession.

The progress of the audit programme was reported periodically to the trust's board and an annual clinical audit report will be compiled. The trust told us that, at 20 April 2010, out of 215 audits in the 2009/10 plan:

- 92 (43%) had been completed.
- 89 (41%) were ongoing.
- Three (1%) had not been started.
- 28 (13%) had been abandoned.
- The status of three (1%) was unknown.

The trust also gave us a plan of the 131 audits to be undertaken in 2010/11, presented to the Audit Committee in April 2010. Twenty-one (16%) are prioritised as 'critical' and 110 (84%) as 'essential'. Twenty-one (16%) are national audits and 22 (17%) are re-audits.

Action by the board: Where progress has been made

- The trust has shown that it is now actively promoting an open learning culture, in particular through its open board meetings. It has shown that it listens to the views and experiences of patients and that it values this feedback. There is a high level of public engagement at board meetings and this is good practice.
- The trust now has a systematic process, involving all clinical directors, for monitoring and reviewing all patient deaths. The trust's board receives data on mortality and other clinical outcomes on a monthly basis and the scrutiny of this information has improved. Mortality data is also discussed both at divisional clinical governance meetings and at the trust's healthcare governance committee. The trust publishes its mortality rates and hospital-acquired infection rates on its website.

- The trust has provided examples of how it is learning from incidents, complaints and near misses. Divisional governance structures are starting to provide an effective mechanism for learning, and reporting to the trust's board is starting to identify themes and trends. Improvements are made at a local level and a trust-wide approach to learning and action is being developed.
- The trust has revised its arrangements for monitoring the quality of services provided for patients and is able to show that it has governance and audit arrangements in place to assess and monitor the quality of services in each of its clinical divisions.
- The trust has improved its processes to identify and mitigate against risks to the safety of patients, for example by monitoring risk assessments at ward level.

Areas for further improvement

- A trust-wide approach to patient engagement and involvement continues to develop, but there is no up-to-date written framework or strategy to describe what the trust will do, why it will do it and how the information will be used to improve services.
- The use of information and the sharing of learning and best practice across the trust need to be more systematic to ensure that people's experiences help to improve services. Learning and themes from complaints should routinely be reported throughout the trust and to the board. Complaint themes should also inform the trust audit programme.
- The trust needs to continue to develop its management of complaints and how this is monitored. Investigations need to be completed on time to ensure that quality and safety issues are addressed at the earliest opportunity. Key performance indicators could be used to monitor the ongoing effectiveness of the complaints process.
- The trust needs to do more to enable clinicians to use and understand their own clinical outcome data.
- The trust also needs to review its governance strategy periodically to ensure that it remains up-to-date and effective.
- The trust has made good progress in engaging clinicians and developing effective clinical audit, but this is not yet fully embedded. The trust needs to monitor these areas to ensure that the arrangements do become embedded.
- The trust needs to strengthen its assurance processes for maintaining and managing equipment and medical devices.

2. Standards of care

The March 2009 report required the trust to make sure that medical and nursing staff delivered basic aspects of care. It also had to audit its arrangements for a number of interventions including 'nil by mouth', resuscitation and non-invasive ventilation.

Patient feedback on standards of care

Patients are generally positive about the care received at the trust. A survey in February 2010, commissioned by the West Midlands Strategic Health Authority, showed a significant improvement in patients' experiences of care.

A separate survey was sent to patients by the Staffordshire Local Involvement Network (LINK), inviting comments about their recent experiences at the trust (between January and March 2010). Most of the comments were positive overall: 33 out of 46 people surveyed (72%). Five people (11%) provided mixed comments and eight (17%) had an overall negative experience at the trust.

The Cure the NHS group provided information they had received directly from nine people who asked for their help between January and March 2010 in resolving negative experiences. Cure the NHS had forwarded these matters to the trust for handling and action via the complaints process.

This generally positive view was reflected in our unannounced visits to the trust. We asked 51 patients and their carers for their direct feedback. Forty-seven made positive comments, three had mixed comments (i.e. both positive and negative) and one was negative overall.

Observations of care

In our visits, we reviewed written care plans and directly observed the care being provided. Staff interactions across the wards and departments that we visited were good. Call bells were generally accessible to patients and staff were responsive when patients needed help. Patients were generally positive about the food they were given and all patients confirmed that they had access to water (which we observed as well). Patients confirmed that, where they needed it, they were given help at mealtimes. Patients were generally clear about the plan for their care, which indicates that clinical staff were communicating effectively.

Aspects of care

Some initiatives introduced by the trust over the last 12 months have resulted in patients receiving direct care from more senior staff. For example, matrons were consistently working on each of the wards one day a week, focusing on the delivery of care, which is good practice. In addition, patients receive timely reviews by senior

doctors, for example in emergency medicine, where there are systems in place for reviews by consultants, and in surgery, where consultants do 'post-take' ward rounds (to see patients admitted under their care during the previous shift).

The trust monitors basic aspects of care through the quality 'dashboards' on the wards and the patient 'comfort rounds' (which have been in place since 1 March 2010). At ward level, there is a focus on documenting risk assessments in patient records and ensuring that this is done for nutritional requirements, risk of developing a pressure sore, and risk of falls. This is audited regularly and we found that compliance with risk assessment is generally good across all areas. Risk assessments are systematically audited by matrons at ward level.

However, we found that documentation of the impact of risk assessments was not always clearly consolidated and evaluated within care plans. In most cases, staff were making the correct interventions following a risk assessment. However, this was not always the case. For example, there was evidence of some patients, who had been assessed as being at risk of developing pressure sores, not having the appropriate pressure relieving mattress or device. Staff said that access to this equipment was sometimes an issue. Another example was of a nutritional risk assessment, carried by speech and language therapists, that was not clearly reflected within a revised care plan.

The trust has taken steps to improve compliance with its 'nil by mouth' policy. The policy was first audited in August 2009 and identified shortfalls in practice. Our six-month review highlighted the need to address these shortfalls. The trust's re-audit in November 2009 showed a vast improvement since the original audit: it met the six-hour eating standard for 82 out of 101 patients (81%, which compares with just 5% in August 2009). Of those patients fasting unnecessarily prior to surgery, all except one had chosen to fast, despite clinical advice. Also 18 out of 28 patients (64%) had received their prescribed medication within four hours of going to theatre, compared with just 29% in August.

The trust carried out a 'snapshot' audit of 'do not attempt resuscitation' decisions in February 2010. This involved reviewing the relevant forms in patient records and identifying where there was room for improvement. The results were reported to the healthcare governance committee in April 2010, together with recommendations for a training programme, and a full audit will be carried out in October 2010 to check compliance.

In April 2010, the trust opened a non-invasive ventilation unit (one bay on ward 12, its respiratory ward). Four nurses have been allocated to the area and trained in blood gas analysis. The unit will initially run on two open beds until additional staff are recruited. Admission to the unit is against strict criteria based on the British Thoracic Society (BTS) guidelines and the trust has sought input from another local acute trust, University Hospital North Staffordshire NHS Trust, in setting up the unit. Protocols for the unit state that an audit will be conducted at six and 12 months to review admission rates, criteria for admission and patient outcomes.

The report of March 2009 noted improved management of infection control at the trust and compliance with infection control standards. The trust publicises its infection rates on its website and these show that it has sustained relatively low levels of hospital-

acquired infection over the last 12 months. In July 2009, we inspected the trust against the Code of Practice on healthcare-associated infections and related guidance. During that inspection, there was no evidence that the trust had breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

Standards of care: Where progress has been made

- The experience of patients has improved. Our observations during site visits and comments made by patients and their relatives about communication, pain management, nutrition and their overall experience of care are generally positive.
- The trust has been able to show that it is monitoring those areas previously identified as areas of concern. Evidence in some of these areas shows improved outcomes for patients.

Areas for further improvement

- There is still a minority of patients who are having negative experiences and the trust needs continue to improve standards of care.
- Documentation of the impacts of risk assessments was not always evident in patients' care plans and this needs to be reviewed.
- We observed patients who were at risk of developing pressure sores but who did not have access to pressure relieving devices. Staff raised similar concerns. The trust must ensure that sufficient pressure relieving devices are routinely available.

3. A&E department

The March 2009 report required the trust to continue and extend the improvements it had started to make to A&E, so that the service would be safe and the department adequately staffed and equipped.

Staffing and leadership

There is now strong clinical leadership in the A&E department. Consultants spend a large proportion of their time in the department, and are readily available to provide patient care and supervision to more junior staff. The hospital ambulance liaison officer for West Midlands Ambulance Service NHS Trust has been in the post for about a year and is well integrated into the department, providing liaison between ambulance crews and A&E staff and giving advice to the trust about ambulance service issues and practices.

The Healthcare Commission investigation found that problems with nurse staffing in A&E had been prevalent for a number of years. A review by an external adviser in 2007/08 found that the establishment should be 54.9 whole time equivalent (wte) posts, whereas the actual number of posts (in March 2008) was 37.9 wte.

From January to March 2010, the establishment was 53.94 wte nursing staff, with 50.76 wte in post (giving a vacancy rate of approximately 6%). On average during this period, 79% of the total nursing staff were registered nurses. The department used about 4.5 wte bank or agency nurses (split 50:50 between registered and unregistered nurses).

New units

The four-bedded area in A&E is now being more formally used as an observation unit. The trust had developed a policy to clarify the use of this area although, at the time of our visit, this had not been formally approved. The observation unit is under the management of A&E. Admissions are made with the consent of A&E's decision-making doctors, and for a maximum of 24 hours only. The admission criteria are: minor head injury (not awaiting scan); awaiting psychiatric assessment; occupational therapy assessment; and intermediate care team. However, we found that acute medical patients were still admitted to the area, due to bed capacity issues. Use of the observation unit needs clarifying further to reduce unnecessary risks to patients.

Since the six-month review, the trust has opened its surgical assessment unit and all stable patients attending A&E with surgical problems are transferred to the unit. The percentage of eligible patients transferred to the unit from A&E has steadily increased, from 52% in November 2009 to 81% in February 2010. The unit is managed by the surgical division and is open between 8am and 10pm. It has facilities for 10 patients and is staffed with experienced nurses. Patients are seen rapidly and are managed well. The mean length of stay on the unit is between 3.75 hours and 4.25 hours, and

about a third of patients are discharged home rather than being admitted to a ward. This has made a good impact on the care that surgical patients receive.

Governance

Governance in A&E has also improved since the six-month review. The department now has one of the most active clinical audit programmes in the trust. Governance meeting minutes highlight some of the improvements for patients, such as an increased recognition of sepsis and improvements in acting on ECG results. The trust gave us copies of eight A&E protocols. These were clear, but they were undated, did not include references, and there was no indication about their approval status. So the extent to which they were evidence-based, current or approved was not clear.

Waiting times

A number of improvements have been made in A&E over the last 12 months. However, there has been little improvement in managing the time that patients remain in the department. The length of time after which patients are discharged from A&E is similar to that found in the original investigation and there is still a marked drive to admit, discharge or transfer patients in the last 10 minutes before the four-hour waiting target is breached.

During a site visit in March, we found that two of the most unwell patients had been waiting in A&E for 12 hours. This is unacceptable. These patients may have benefited from being moved to a level 2 high dependency facility sooner. One of these patients was waiting for a bed with monitoring facilities and was wheeled to the ward without being monitored. The trust has recognised the need to improve the effectiveness and efficiency of discharge from its wards in order to improve the flows through A&E (and the acute medical unit). A project has started since our visit and early feedback indicates this has had a positive impact on flows through A&E.

Acute medical unit

Patients attending A&E with medical problems are transferred to the acute medical unit (AMU). In 2009/10, the percentage of eligible patients transferred to the AMU from A&E was routinely around 85%. The mean length of stay on the unit ranged between 1.25 days and 1.75 days and a third of patients were discharged home rather than admitted to a ward.

We found that senior clinicians were enthusiastic and committed to improving the AMU. Senior clinical staff were actively involved in the management of acutely ill patients. Staff told us that drug expenditure in A&E had increased, whereas in the AMU it had decreased. This indicates more early active management of acutely ill patients.

We were told that patients referred by their GP are meant to be directly admitted to the AMU. However, when we visited in March 2010, the trust had an outbreak of norovirus

(an infectious diarrhoea and vomiting bug). A number of wards had been closed to admissions during this period, and it had not been possible to fast track GP-referred patients because the space was taken up by medical patients.

We were also provided with documentation describing the admission process for patients who were referred by their GP but who do not arrive by ambulance. These patients are meant to register with A&E reception and be triaged by a nurse in A&E before being admitted to the AMU. This implies that admission is not direct to the AMU, and this needs clarifying as part of the project to improve flows through A&E.

Registration condition

We placed a 'compliance condition' on the trust's registration under the Health and Social Care Act 2008 in April 2010, requiring it to ensure that its procedures for managing patients admitted as emergencies were implemented. We formally assessed this condition as part of our review and found that the trust had made good progress.

A&E: Where progress has been made

- The A&E department has strong clinical leadership and is adequately staffed and equipped. Patients have good access to A&E consultants. We found that the procedures for managing surgical emergencies had improved.

Areas for further improvement

- The trust needs to undertake further work to streamline the arrangements for patients attending as medical emergencies.
- The trust needs to undertake further work to make sure that patients' conditions are stabilised and the patient moved to the most appropriate setting as quickly as possible. There also needs to be improved governance of patients requiring a level 2 high dependency facility.
- The A&E department needs to continue to be supported in its development. Its arrangements for developing and approving clinical protocols, for example, need to be strengthened.

4. Staffing and capacity

The March 2009 report required the trust to recruit additional nursing and medical staff and review their training and supervision. It also had to make sure that its theatres could handle emergency cases without delay, and that staff had access to advice and support from the medical staff in the critical care unit.

Staffing levels

The trust has made significant progress in recruiting nursing staff. At 27 March 2010, it had an overall nursing vacancy rate of around 7%. This ranged across clinical areas from about -24% (i.e. overstaffed) to +17%. In four of the five clinical areas with a vacancy rate of more than 10%, appointments had been made but people had not yet taken up their posts. The trust projected that, with effect from 12 April 2010, the overall nursing vacancy rate would be about 5%. The trust has been closely supported by the SHA on nursing and workforce development issues.

The trust has an effective approach to covering vacancies. Where senior posts such as ward manager are vacant, the relevant matron focuses on that ward, supported by ward nurses 'acting up', until the new post holder is able to start. The trust has also changed its use of bank and agency staff: from 30% bank and 70% agency to 70% bank and 30% agency. This was reported following the September 2009 visit, and has been sustained.

The trust is undertaking a detailed examination of the nurse to patient ratios on the wards to ensure that the numbers of nurses match the needs of the patients. It is using tools developed by the Association of UK University Hospitals (AUKUH). This is a long-term project and the study has been completed twice so far (in September 2009 and January/ February 2010). The trust increased budgeted establishments on the wards by 10.32 wte between the two studies. The findings of the January/ February study indicate that the staffing numbers are generally about right and the trust intends to repeat the study later in 2010.

Absence due to sickness is high in some clinical areas and the trust needs to continue to tackle this. The average sickness rate (reported as 5.86% at 27 March 2010) is near the target sickness rate, but rates range from 0% to around 15% across the trust.

We placed a 'compliance condition' on the trust's registration under the Health and Social Care Act 2008 in April 2010, requiring it to have systems in place to ensure that the numbers of nursing staff available are sufficient to meet the needs of the patients. We formally assessed this condition as part of the review and found that the trust had made good progress.

The trust has not resolved its medical staffing issues within surgery, but it is actively engaging with other organisations and developing a plan for a sustainable service. There is currently a shortage of surgeons in the trust. The consultants are therefore covering both elective and emergency work. At a night site visit, we found there were

two junior surgical doctors (F1 and F2 grades) in the hospital, with senior cover being provided by an on-call consultant. The trust is currently receiving support from a neighbouring acute trust (University Hospital of North Staffordshire NHS Trust) to cover some of the gaps in surgical specialities e.g. colorectal surgery. Discussions are taking place about the possibility of shared appointments with the neighbouring trust. Interim appointments are being made and the trust is developing its plans with a view to providing a more sustainable service. The trust has also liaised with the regional post-graduate medical dean over its medical staffing issues.

Training and supervision

The trust has a draft policy (March 2010) that sets out statutory and mandatory training, and specifies the duration of the training, the 'target population' and the frequency of updates and refreshers. The training includes such topics as blood products and blood transfusion; infection control; risk management and incident reporting; customer care; safeguarding children and adults; medical devices; and cardio-pulmonary resuscitation.

At 17 February 2010, about 72% of staff had attended the statutory and mandatory training day. Divisional figures ranged from 65% (in surgery) to 86% (in clinical support services). The trust also runs mandatory training for clinical staff to raise awareness about their own responsibilities in using medical devices, including accessing training for the safe use of devices and reporting faulty equipment. Overall, 73% of staff have attended this training. This ranges from 71% to 100% of staff in the speciality parts of the medical and surgical emergency pathways. At ward level, average attendance is 81%. However, attendance is poor in maternity, obstetrics and gynaecology, with only around 30% of staff recorded as having attended.

The trust also has a professional development and clinical skills education programme for clinical staff. This includes scheduled courses and training available within clinical areas. The topics include disease specific training (such as epilepsy awareness), clinical skills (such as catheterisation) and use of medical equipment (such as feeding pumps). The trust has specialty education programmes and training days in place for the junior doctors. Departments advertise their own training programmes for staff.

The trust told us that it has established a 'skill matrix', which identifies the statutory and mandatory training needed by all staff. This is being extended to include the essential skills needed for each role and should be completed by the end of June 2010. This will enable the trust to report on met and unmet training needs in detail.

The trust provides supervision to nurses in a number of ways. Examples include the use of matrons and ward managers working shifts during the week; the presence of practice development unit nurses; and the provision of preceptors (clinical tutors) for newly qualified nurses for their first year, supported by workbooks. However, there is no formal structure for supervision and the trust needs to establish one, in line with its action plan and its registration condition, by June 2010.

Junior doctors routinely have access to senior medical staff so they can raise and discuss issues with them. These monthly meetings were originally held with the medical director but will be held in future with the clinical tutor. The medical director

will continue to attend on occasion. On a visit in March 2010, we found that the handover at night was fragmented with handover of different disciplines at different times. The most senior doctor in the trust that night was a locum medical registrar, covering both medical and surgical emergencies. The trust needs to improve the level of overnight cover to surgical patients. The medical and nursing directors are reviewing the junior medical staff rotas and the arrangements for managing the hospital at night, with improvements planned for summer 2010.

At 31 March 2010, around 78% of staff had been appraised within the last 12 months (this figure excluded staff in post for less than 12 months and doctors). The divisional figures range from 55% (in surgery) to 97% (in clinical support services).

We placed a 'compliance condition' on the trust's registration under the Health and Social Care Act 2008 in April 2010, requiring it to ensure there are systems in place for the supervision and appraisal of staff, and for the keeping of proper records of that supervision and appraisal. We formally assessed this condition as part of the review and found that the trust had made some progress.

The trust carried out a baseline audit in March 2010 to determine the competency of ward staff in use of 16 specified pieces of essential equipment. This showed that 88% of nurses were competent on all pieces of essential ward equipment. (Depending on the equipment, the proportion of nursing staff competent to use it ranged from 88% to 97%. Data provided indicates the highest need was for training on 12-lead ECG (12%) and lowest on pulse oximeter (3%).)

A medical devices training plan has been developed and introduced, as a result of the baseline audit, to address the shortfall in skills identified. In addition, all new nursing staff, including agency nurses, are required to sign a declaration about their key competencies and identify any shortfall in skills. The information (currently for 908 qualified and unqualified nurses, broken down by ward) is held centrally on a database and used by the practice development team for monitoring nursing staff competencies. Ward managers have sight of the local data and help ensure that staff do not use devices unless they are signed off as being competent to do so. A separate database of training information is held for laboratory staff and training records are held by the Post Graduate Medical Centre for doctors.

We placed a 'compliance condition' on the trust's registration under the Health and Social Care Act 2008 in April 2010, requiring it to ensure that clinical staff who use medical equipment have been trained and are competent to operate that equipment. We formally assessed this condition as part of the review and found that the trust had made good progress.

Theatre utilisation

The staff we interviewed felt that the system for prioritising emergencies, with a consultant anaesthetist adjudicating, seems to work in promoting better use of theatre space. The trust monitors theatre utilisation by hospital (Cannock and Stafford) and by surgeon. In February 2010, theatre utilisation in Stafford was 85.5%, meeting the target utilisation for the first time in 12 months. (The average utilisation of elective sessions over the previous 12 months was approximately 80%.)

Staff thought that the management of trauma patients on a rolling programme was more efficient than 12 months ago, allowing planned and emergency cases to be seen. All patients requiring surgery that day are seen by an anaesthetist. If a list over-runs, there is no delay caused by awaiting anaesthetic clerking the following morning. In addition, orthopaedics has a dedicated full-day list to minimise delays in operating on trauma patients.

Emergency trauma cases are routed to neighbouring hospitals 'out of hours' and therefore, generally, the trust does not carry out operations at night. However, if a patient does become unwell overnight the policy is to stabilise them wherever possible and operate the following day. When this occurs, problems can arise the next day because of the capacity of general surgeons to undertake the operations first thing in the morning. The consultant may have a 'post-take' ward round (to see patients admitted under their care during the previous shift) or outpatient clinic commitment, and thus the patient may have to wait for surgery until the afternoon. The trust reports that there is some flexibility and they can reutilise a spare theatre or re-prioritise the morning list. The trust is therefore operating in accordance with national guidance (the NCEPOD classification of intervention).

The trust presented its theatre key performance indicators. These include undertaking surgery on patients with a fractured neck of femur within 48 hours of admission. It was noted that, between October 2009 and January 2010, an average of 11% of cases fell short of this target due to the lack of theatre time. This performance is within accepted norms and is an improvement on results reported in the six-month report. The trust is striving to meet a stretch target to undertake the surgery within 24 hours of admission, but is falling short of this.

The trust has a number of initiatives underway that should continue to improve its surgical performance. At the time of the visit, there was a project underway to review theatre utilisation, including a review of the patient journey and of theatre efficiency. The trust was also reviewing its theatre user group terms of reference and its theatre operational policy. The trust has had a period of time with no theatre manager in post and, at the time of our visit, there were four nurse vacancies in theatre recovery. A new theatre manager started in May 2010, with a brief to review nursing establishment, roles and skill mix in theatres.

The Royal College of Surgeons carried out a review at the trust (reported in October 2009) that was commissioned as a result of concerns the trust has about general surgical services, following two SUIs and other poor outcomes. The recommendations made were designed to bring the services into line with other trusts and the trust has made necessary changes in line with the recommendations. For example, new leadership arrangements are in place in the division and joint appointments made with University Hospital of North Staffordshire NHS Trust. Discussion is underway about the development of a longer-term plan for provision of surgery at the trust.

Access to critical care advice

As part of its improvement programme, the trust's critical care consultants agreed an operational policy that supported appropriate advice to those doctors who required

their expertise. The critical care unit operational policy (March 2009) outlines the services for patients meeting admission criteria to the unit. The policy makes reference to the critical care outreach team, which is an integral part of critical care unit. The main objectives of the team are to ensure, wherever possible, that admission to critical care happens in a timely manner and to support appropriate management of patients who require critical care intervention outside of the unit, for example in A&E. Staff interviewed confirmed that there was generally good access to the critical care outreach team for advice and support, although there is no evidence that this has been formally audited yet.

Staffing and capacity: Where progress has been made

- The trust has made very good progress in recruiting to its nursing vacancies and its examination of its nurse to patient ratios indicate that these are sufficient to ensure that patient needs are met.
- The trust provides training to its staff to ensure services are delivered safely. Generally, staff said that there was good access to job-related training.
- The trust has taken steps to ensure that equipment is used correctly and it can show that the majority of clinical staff are competent to use medical equipment. All nursing staff need to demonstrate they are competent in using the equipment before they are allowed to use it. A training programme is in place to support the development of competencies for nurses and this is closely monitored. Separate information is held for doctors and for laboratory staff.
- Critical care outreach services are in place and staff said that access to critical care advice has improved.

Areas for further improvement

- The trust needs to continue to work to resolve its medical staffing issues within surgery.
- In some areas, there are high numbers of nurses being absent due to sickness and the trust needs to continue to tackle this.
- Supervision of nursing staff and junior doctors is provided in a range of ways, but there is no formal structure for supervision and the trust needs to establish a formal structure for supervision in line with its action plan and its registration condition, by 30 June 2010.
- Arrangements for managing the hospital at night are currently being reviewed. The trust needs to review the level of overnight cover provided by doctors to surgical patients.
- The trust is still in the process of reviewing its utilisation of theatres, with a view to further improving the patient experience/patient outcomes. The trust has shown that specific outcomes for patients, relating to surgery, have improved. However, theatre sessions are not always available.

Overall conclusions

The trust has worked hard over the last 12 months to address issues arising from the Healthcare Commission investigation. It has made considerable progress in most areas. In others, there is still some work to be completed. We have outlined these in the boxes at the end of each main section.

This is the last specific follow-up of the Healthcare Commission report. We will now routinely monitor the trust under the new regulatory framework introduced by the Health and Social Care Act 2008.

We have noted throughout this report where we have carried out an assessment of the trust's registration compliance conditions and we will publish a separate report on this in due course.

We will carry out a review in August 2010 of the trust's compliance with all 16 of the essential standards of quality and safety. As part of that review, we will check the trust's progress in addressing the outstanding issues from this report.

Appendix 1: Organisations invited to comment on progress

Age Concern - Stafford & District
Alzheimer's Society - North Staffordshire Branch
Attend
British Heart Foundation - West Region
British Lung Foundation - West Midlands
Counter Fraud and Security Management
Cure the NHS
Cystic Fibrosis - West Midlands
Diabetes UK - West Midlands
General Medical Council
Health and Safety Executive
Marie Curie Cancer Care - Midlands and Anglia
MIND - Mid Staffordshire
Monitor
Multiple Sclerosis Society - Stafford and District
National Association of Citizens Advice Bureau - Central Area Office
NHS Counter Fraud and Security Management Service
Parkinson's Disease Society - North Staffordshire
Patients Association
PMETB
RNIB - West Midlands Regional Centre
RNID -Midlands
South Staffordshire PCT
Staffordshire County Council
Staffordshire Overview Scrutiny Committee
Stafford League of Friends
Staffordshire LINKs
Stroke Association - Midlands
University Hospital of North Staffordshire NHS Trust
West Midlands Strategic Health Authority
West Midlands Ambulance Service

Appendix 2: Inspectors

Sara Reeve, Assessor CQC

Liz Parry, Assessor CQC

Joanna Wooller, Regulatory Inspector CQC

Sue Jordan, Local Area Manager CQC

Rachel Davis, Regulatory Inspector CQC

Joy Hoelzel, Regulatory Inspector CQC

Di Chadwick, Assessor CQC

Amy Hills, Senior Analyst, CQC

George Catford, Analyst CQC

Ann Close, National Clinical Advisor, CQC

David Cade, Medical Director of the Greater Manchester NHS CATS

Alan Sheward, Divisional Nurse Manager Medicine, St James's University Hospital