The Care Quality Commission (CQC) has undertaken the second of its three formal checks on progress following the publication of an investigation report in March 2009 into high mortality rates and the care of patients admitted as emergencies at Mid Staffordshire NHS Foundation Trust.

In spring 2010, one year after the investigation report was published, CQC will conduct a full review against the trust’s action plan.

Summary

This six month review has assessed the extent of improvements made by the trust with specific focus on:

- progress made against the key priorities identified by the trust (11 high plus goals), with emphasis on those that are due to be completed by end August 2009. These are listed at Appendix 1.
- the standard of nursing care on wards, with emphasis on the experience of older patients
- the management and care of patients admitted as emergencies

Overall, CQC have identified:

- Some progress has been made against the key priorities identified by the trust in their transformation programme. Further refinements to the programme are required to ensure sustainability.
- Whilst the majority of patients who fed back to CQC were happy with the care they received, there are exceptions and the Executive Team must work to improve the mechanisms for identifying and acting on issues of concern to patients.
- The trust must improve the complaints mechanism and introduce systems to routinely seek and learn from patient feedback. These systems are in the relatively early stages of development and there is further work to be done to improve public confidence in the trust.
- The impact of recruitment initiatives was visible on those wards visited, however the trust is still using bank and agency staff to supplement numbers. CQC raised concerns about the level of cover on the clinical decision unit (CDU) during a night shift. No other immediate patient safety issues were identified/raised during the visit. CQC will expect significant progress to have been made in this key area at the 12 month review.
- There is evidence of improvement in reviews of care plan and nursing documentation and evidence of active monitoring and routine spot checks being undertaken to further improve the quality of documentation.
- The trust has implemented a number of initiatives to improve the flow of patients, in particular through the emergency care pathway, however CQC found that there is still work to do to improve the patient experience. There is still an over reliance on A&E as an admissions ‘default’ and in particular, urgent action is required to improve timely discharge.
- Work is on-going to improve governance structures and to improve and coordinate the arrangements for learning from data on quality of care, at the point of delivery of care.
- The review found insufficient evidence that the initiatives undertaken as part of the transformation programme are translating into improved outcomes for patients. The trust has established mechanisms to monitor this impact and CQC will expect to see evidence of improved outcomes at the 12 month review.
- The trust continues to monitor mortality rates. Crude mortality rates for emergency admissions for each month in 2009 so far (January to June), have been consistently more than 1% lower than for the equivalent months in 2008.
- The trust must take steps to address the shortfalls in practice identified in the recent ‘fasting audit’ carried out in surgery.
At six months the Care Quality Commission would expect that the trust:

- has a clear strategic vision for achieving transformation
- has sustained progress against its identified key priority areas and can demonstrate that implementation of its transformation programme is on track
- can demonstrate that generally patients are receiving better quality of care
- can demonstrate that mortality rates are appropriately monitored, and show a reduction in standardised mortality rates for patients admitted as emergencies
- can demonstrate that essential medical and surgical equipment is now in place
- has effective governance arrangements that support ongoing monitoring of care and can demonstrate effective remedial action is taken when issues of poor quality arise

Against these expectations, progress is satisfactory in relation to having a strategic vision but the pace of progress in delivering against key priority areas needs to improve in order to translate the strategic vision into better outcomes for patients. The trust has already demonstrated their commitment to progress by asking the Royal College of Surgeons (RCS) to undertake a review. The review was requested by the medical director to address concerns following two serious untoward incidents and poor outcomes in surgery. The RCS report was published after the CQC fieldwork so CQC will monitor the recommendations and report on progress at the 12 month update.

The review has shown that generally patients are receiving better quality care and mortality rates are reducing. The trust needs to ensure that through clear leadership, governance and a culture of listening and learning from patient experience, that it can embed high quality care across all of its services.
Findings of the six month review

1. Progress against trust key priorities

a) Strategic vision
The trust has begun to clarify its vision and align its governance and reporting frameworks. As stated in the summary, greater pace on achieving deliverables for patients through translation of the vision and strategy into effective patient care is now required. Five key aims have been identified by the trust to underpin its vision:

1. Creating a culture of caring
2. Seeing zero harm as its target on keeping patients safe
3. Listening, responding and acting to what its patients and community are telling it about services
4. Supporting its staff to become excellent – giving responsibility but holding to account as well
5. Continuing to do what it needs to do to satisfy its regulators. This aim will require additional attention in the remaining 6 months before final review as the CQC will be assessing the Trust for compliance with the new 16 quality standards for registration.

b) Progress against priority areas
The trust has prioritised its action plan marking its most urgent actions as 'high plus'. In addition, it has agreed eleven key priorities for improving care quickly. Whilst the pace of change has been relatively steady, and broadly in line with the timelines set out by the trust, it is too early to evidence initiatives that have improved outcomes for patients in every case.

The trust has worked to review and develop the transformation programme into a more coherent programme. Implementation is involving engagement with clinicians and utilising external experts to support delivery and change. The transformation programme has recently been aligned to the strategic priority areas listed above at 1a.

Specific progress against each of the goals, including any recommendations, is included at Appendix 1.

2. Quality of Care

a) Standard of care in clinical areas
The inspection team visited wards 10, 11 and 12, the accident and emergency department, the clinical decision unit and the emergency assessment unit.

i) Staffing (also links to high plus goals 3 and 8 Appendix 1)
A shortfall in nursing levels remains. The trust has made efforts to recruit staff to revised budgeted levels. Where there have been increases in numbers of clinical staff, it is having a beneficial effect on patients’ treatment. Work is underway to ensure that nurse staffing levels reflect patient dependency.

Permanent staffing levels continue to be supplemented by bank and agency staff across the trust. There is the potential negative impact with frequent changes in the nursing workforce. Staff also commented about lack of continuity and lack of experience of some agency staff.

CQC was concerned about lack of appropriate nurse staffing levels on the 12 bedded clinical decision unit (CDU) during a night visit. Whilst the emergency department was fully staffed with experienced nurses, the CDU was staffed by one registered nurse who had not worked on the unit before, and one clinical support worker who had worked in the trust for less than a year.
The trust had previously expressed concerns about safety of patients on the CDU. Specific issues related to ‘ownership’ of the unit and appropriate staff cover. A serious untoward incident (SUI) in August 2009, resulting in the death of a patient, added further impetus to close the unit. It closed at the end of September 2009.

Ward staff confirmed increases in the numbers of nurses in some clinical areas, with one nurse commenting that she had previously had to care for 15 patients and now she had to care for 8. Staff told CQC that whilst numbers of staff had increased, further work is required to ensure the appropriate skill mix, and to take account of the dependency of patients. The trust is reviewing acuity (case mix) and nursing establishments using a recognised dependency tool, which is being rolled out during September and October 2009.

Progress is being made in the procurement of a new e-rostering system that should assist ward staff in managing staff rotas.

CQC would expect to see a demonstrable improvement in these key areas at the 12 month review stage.

CQC found the trust is taking measures to ensure that new staff are clinically competent. For example, there is a comprehensive training programme available to staff in the emergency care directorate. The trust has introduced specific education packages to ensure new band 5 and band 6 staff have the knowledge and practical clinical skills required for working in emergency care. Staff interviewed by CQC consistently reported improved access to training.

CQC heard positive reports of the support being provided by the practice development unit. This support included induction support for newly appointed nurses and those returning to work after a long period of absence; the development of self-directed educational packages, and the provision of specific training programmes.

Initiatives to enable earlier contact by senior doctors have meant that decisions about treatment and discharge are being made sooner, thus improving the care patients are given. For example, CQC found more consultants are now available in the accident and emergency department. Staff confirmed that earlier consultant/ senior contact now occurred although it was thought that more could be done to improve contact at night.

Changes have also been made to working practices for the management of medical emergencies in the emergency assessment unit (EAU) and acute medical unit. A system to improve medical consultant presence in EAU until 8:30 pm has been introduced. After this time, overnight and at the weekend, a consultant is on call and available for advice; to return to the trust if appropriate. Consultant ward rounds are also undertaken over the weekend. The aim is that all non elective medical patients are seen and managed by a senior clinician in order that timely treatment is commenced and management plans are in place. The trust plans to audit the implementation of this new model of care. CQC will review the outcomes of this audit at the 12 month review.

ii) Communication with nurses
Patients were generally positive about communication with nurses. All interactions between staff and patients and visitors observed by CQC, were appropriate, with people being addressed respectfully. Privacy and dignity were observed as being appropriately respected.

The comments made by patients about nurses were generally positive, indicating the nurses were helpful and explained things. One patient commented “This is the second time in the last two years that I have been a patient in Stafford Hospital and in each case have been very satisfied with the care what I have received.” Of the twelve people asked about the plan for their care, ten patients had a good understanding of the next steps.
Senior ward staff were clear that their roles involved liaison with visitors and keeping them up-to-date with their relative's condition. The team observed the sensitive handling of a telephone query from a relative.

CQC observed call bells to be appropriately positioned for access by frail patients or those with limited mobility, in most cases. One patient requested that the CQC assessor pass her the call bell as she was unable to reach this. Staff were clear that they needed to respond to call bells as quickly as possible, and response times were being actively monitored in some areas.

### iii) Medicines management and pain relief

The trust has made some changes to improve the management of the medicines. There was evidence of medicines reconciliation and of dedicated pharmacy time now available on the emergency assessment unit (EAU).

The trust has employed pharmacy technicians to visit the EAU to ensure that the medication patients are taking at home is prescribed on admission to the hospital. If the patients do not bring their own medication in with them, the technicians contact the general practitioner (GP) and/or nursing home to check prescriptions. This is good practice.

Technicians also check that information about allergies is recorded. One example was given of a patient with diabetes who reported that his medication was 'sorted out' when he was admitted to the emergency assessment unit but had to be 'sorted out' again when he was transferred to the ward, indicating that the communication about medication between the two clinical areas still needs to be improved.

There was evidence throughout the wards visited of a move towards the NHS Institute for Innovation and Improvement's programme, *Releasing Time to Care: The Productive Ward*. Staff commented that some of these initiatives are working very well.

Regarding pain relief there was some evidence of improved practice but one report of the provision of pain relief taking time to be offered. Staff on the wards stated that they were able to offer patients 'hot packs' to relieve pain and that these were useful.

CQC examined drug charts and found that these were generally completed appropriately, including administration of regular analgesia (where prescribed) and noting where medication was not given, with the reason. CQC found one apparent omission and on further investigation by ward staff it was confirmed that the nurse had signed against the wrong time, in error.

### iv) Food and drink

The trust is working to improve appropriate management of patients with specific nutritional needs, including assessment, review and monitoring of fluid and food intake. However, a recent fasting audit (in surgery) showed poor compliance with recommended guidelines and poor awareness of guidelines amongst staff.

This had resulted in many patients, particularly emergency patients, being ‘nil by mouth’ for longer than was necessary. This is not acceptable and the trust must take urgent steps to address staff awareness and compliance with recommended guidelines.

There are processes to support patients who need help with eating and drinking however, one relative commented that her husband’s food was taken away before help was given.

CQC observed lunchtime on the wards. Staff explained that there are signs above the beds of those patients who need help with eating, and their food trays are coloured red. CQC observed staff helping some patients to eat, with staff making arrangements for alternative dishes to be obtained for those patients just admitted or with limited appetite.
Staff felt they were now better at completing formal assessments of nutritional needs and then documenting what patients had eaten and drunk, where this was necessary. They felt that the increase in the number of nurses had made this possible. The trust is also monitoring compliance with nutritional assessments and CQC observed results on display on some wards. For example on ward 11 compliance between April 2008 and July 2009 was observed to be consistently good at 100%, with two months in this period showing 95% compliance.

CQC examined care records and found evidence of nutritional assessments being undertaken on admission; however the process for continuing and ongoing assessment during patient stays and leading to discharge was less evident. Generally there was regular recording of food and fluid intake, although some gaps were observed. The trust must make faster progress on this key priority area.

b) Mortality rates
The trust has provided evidence that it has clear processes for monitoring mortality rates and applies appropriate scrutiny to all inpatient deaths that occur. Evidence suggests that mortality rates in patients admitted as emergencies have continued to decline since the original investigation, undertaken by Healthcare Commission.

The trust has changed its arrangements for reviewing individual patient deaths. The medical director has oversight of all patient deaths at the trust. All inpatient deaths are reviewed by a senior member of the clinical coding team to ensure consistent and accurate coding. Any ‘outliers’ are reviewed by the head of the division in which the death occurred and further considered by the medical director. The trust stated that national tools are used to identify and review these ‘outlying’ deaths. Not all senior clinical staff were aware of this process. This is of concern and the trust must address through its clinical governance processes.

The clinical outcomes group, chaired by the medical director, receives reports on any review and on overall mortality rates. These rates are also published on the trust’s website. In October 2009, most recent data, for the period June 2008 to June 2009, showed that the hospital’s standardised mortality ratio been not been rated higher than expected during the thirteen months; although these rates are subject to change when Dr Foster refresh their information.

c) Medical and surgical equipment
The trust has made progress in the purchase of and training for use of essential equipment and in addition, introduced a system for monitoring equipment maintenance and replacement schedules.

At the three month review by CQC, essential equipment was still not in place. The situation had changed by the six month review. The inspection team saw new infusion pumps in the clinical areas visited. Staff reported that the company representatives had been in to the hospital to demonstrate how they worked and they felt confident in using the equipment. Staff also confirmed that there was either minimal or no additional equipment that they required.

The trust stated that it had not had a formal asset register to help manage equipment for about three years, but that they had now purchased the necessary computer software and were compiling a register of all equipment costing over £1,000. This should be finished by the end of September 2009 and the trust will then move on to items of equipment costing less than £1,000. The software should help the trust plan the replacement of equipment and help keep the equipment properly maintained.

This will be reviewed at the formal 12 month follow up visit to assess the impact.
3. The management and care of patients admitted as emergencies

The accident and emergency department (A&E) appears to act as the default position for all admissions, not only emergencies, and there are problems related to flow of patients from the department.

At the time of the review the trust had made changes to aspects of the emergency pathway. An end to end review of the emergency care pathway including external partners was underway, and the trust anticipated that the new pathway would be ready for implementation on 30 September 2009. CQC was told that there were still problems with the discharge process and this is an area that the trust needs to continue to improve. The trust is involving relevant partner organisations to support the release of bed capacity.

In accident and emergency the trust has introduced a “pit-stop” process whereby an experienced doctor will undertake rapid assessment, investigation and establishment of a treatment plan for people with major illness. Staff commented that this had eased flows in A&E. CQC found that the nurse coordinator is the pivotal part of the department and appeared to understand plans for all patients. The coordinator manages the flow of patients using a manual process, rather than an IT system. The use of IT to track patients could help free up time to enable the coordinator to focus more on patient care.

CQC found that A&E appears to be the default position for all patients either too complicated or that did not fit in other parts of the organisation. For example, a patient was in the outpatients department and developed breathlessness due to his heart failure. He was sent to A&E rather than the coronary care unit or medical assessment unit, despite being seen in the outpatient department by a consultant physician. In a second example, a lady experiencing some problems rang the oncology nurse who agreed to see her that day. After initial assessment by the nurse she was seen by an oncologist and an urgent CT referral arranged. She was also referred to the medical team and sent to A&E where she spent 3 hours 59 minutes. She had bloods taken and saw the A&E senior house officer (SHO). This lady felt she had received excellent care but didn’t understand why A&E was being used as a waiting room. She was unsure how this time added any value to her care pathway and that of an already cramped emergency department.

CQC found that patients are delayed in leaving the A&E department whilst beds are made in the admission wards. This results in a last minute rush to ensure the patient leaves the department in a timely manner. It is neither in the best interest of the patient, or staff working in the emergency department, that patients are waiting longer than necessary for a bed to become available.

The emergency assessment unit (EAU) comprises four trolleys and 15 beds and is adjacent to a medical short stay unit with 21 beds. The trust has worked to achieve its target and has introduced procedures to enable direct admission of suitable patients to the EAU. However, CQC found that the vast majority of patients are still being admitted via A&E. The written pathway states that for expected GP referrals, patients should still be triaged in A&E. Staff confirmed that that this was the case. CQC was told that patients do not generally get into hospital without going through A&E, although they can book into A&E and then go straight to EAU.

Whilst the trust has agreed its operational policy, by the target date, that aims to limit length of stay on EAU to 48 hours, CQC found that the impact of the policy has not yet demonstrated improvement for patients.

Data provided by the trust for July 2009, showed that whilst average length of stay has continued to fall, approximately 21% of patients (134) stayed on EAU for three days or over. The trust continues to monitor this on a monthly basis with the aim to reduce stay to 48 hours in accordance with the operational policy. Staff reported being unable to move patients from the EAU, due to a lack of patient beds elsewhere.
At the time of the visit, CQC found that surgical emergencies were admitted to several wards. The trust has re-designed aspects of the emergency surgical pathway. The space occupied by the CDU (closed on 30 September 2009) was due to become a surgical assessment unit (SAU) on 1 October 2009, managed by the surgical division. Direct admissions will be possible into the new facility. The trust anticipates that the unit will lead to faster surgical throughput, thus reducing pressure on beds elsewhere in the trust. The trust provided data from a successful pilot SAU that indicated improved outcomes for patients. These included reducing length of stay by an average half a day per patient and fewer surgical cancellations.

The impact of these changes will be assessed at the 12 month review.

CQC was told that directors had begun visiting wards to review the patients who were there in order to identify issues that needed to be addressed. On one ward, they had found that about a quarter of patients were waiting for discharge arrangements to be made. They subsequently had asked the relevant service managers to consider how this could be improved. Two patients made comments about discharge, one commenting that he had been ready for discharge for nearly a week and was waiting for social services, illustrating the issue the directors had also identified. The other commented that “Discharge arrangements need to be reviewed. The use of a ward as a discharge lounge appears to be a total misuse of resources.” CQC was told that the trust had appointed two discharge co-ordinators to liaise between the hospital, social workers and nursing homes and their role was helping improve the management of discharge.

4. Governance arrangements

The trust has identified the improvements that need to be made to its governance structures and processes and there is work in progress to address this. The trust has made changes to improve its systems and processes for ensuring that its services are of a good quality, safe and responsive to patients, but this is an area that it needs to continue to improve. Key performance indicators are associated with the transformation programme and there is evidence that data on quality of care is being made available at the point of delivery of care, but this needs further development.

a) People

The new executive team has demonstrated a clear and realistic assessment of the extent of problems and amount of work needed to improve things at the trust. The trust has appointed a chairman, chief executive and director of human resources, and made other changes at director level, in order to increase the board’s ability to make the necessary improvements.

The chairman, chief executive and other directors have been visiting the clinical areas in the hospital and talking to patients and staff in order to hear about their experiences first-hand. They have also been engaging with local patient groups.

The trust indicated that further work is required to improve the way in which clinical staff are engaged in making improvements and has begun to introduce processes to enable this. For example, allocating leadership of transformation projects to clinicians; improved dialogue between clinicians and managers; and reviews of clinical services, facilitated by external specialists. The medical director has been actively encouraging clinicians to tell him about problems they have so that he can ensure they are addressed.

b) Systems and processes

At its meeting on 18 August 2009, the trust agreed that all future board meetings would be held in public and that clear criteria would be set for any issues which would be discussed in private; this criteria would be made public.

The corporate governance strategy and structure have been revised and clear priorities set for 2009/10 including patient safety; mortality rates; patient feedback; and clinical audit. CQC found that whilst there was evidence of clinical governance activities, divisional structures and arrangements for coordinating local clinical governance activities was less well defined. CQC was told that divisional arrangements were under review in line with the wider governance review.
The trust has continued to make improvements to its complaints process, addressing issues previously identified by CQC in the three month progress report. These include focusing the complaints manager’s role so that she is able to concentrate exclusively on complaints, improving the arrangements for handling complaints, and analysing complaints more systematically. The healthcare governance committee receives reports about complaints but the reports will need to include further analysis to ensure issues are properly identified. Wards are reportedly beginning to have access to data for learning from complaints.

The trust has also continued to make improvements to the way it audits clinical practice. The board approved the 2009/10 clinical audit programme in May 2009, which identified 49 critical clinical audits. The progress of audits and completion of the actions resulting from the audits is to be monitored by both the divisions and the healthcare governance committee. The board will be updated on these issues through the reports from the healthcare governance committee.

The trust is a pilot site for the Clinical Dashboards Programme established within NHS Connecting for Health. The dashboard aims to provide a visual display of timely information required to inform daily decisions that improve the quality of patient care. Nurses audit many of their practices on a monthly basis, including checking the resuscitation trolleys, assessments of patients for risk of malnourishment and pressure sores, and infection control. The graphs on display in many of the areas visited by CQC showed generally good results, although some additional explanation about what they meant would have been helpful for patients and other visitors to the areas.

The trust uses the independent company Dr Foster Intelligence, to provide information on clinical performance. The information provided allows clinicians to benchmark their own practice and clinical outcomes against national and local data. All the consultants have access to this information and additional training has recently been provided to support its use. There are plans to use information about clinical performance in individual appraisals.

**Conclusion**

The review has identified some key areas where the trust has sustained progress against its key priorities, but the pace of change needs to be increased, in particular in key areas such as emergency care pathways management and recruitment of permanent nurses.

New leadership and stability at executive level should help deliver this increased pace of improvement and CQC expects identifiable evidence of the impact of changes at the 12 month review.

There needs to be further consolidation of governance arrangements and alignment with strategic direction will help sustain and embed the progress achieved to date.

The trust needs to continue to develop its use of information such as patient feedback and clinical audit, to support improvement at the point of delivery of care. Whilst CQC found examples of initiatives to improve the patient experience, it is too early to conclude that the initiatives are translating into improved outcomes for patients. It is essential in building public confidence in the trust that patients experience real improvements in the quality of care they receive.

The trust continues to monitor mortality rates and these have continued to decline for patients admitted as emergencies.

The majority of patients who commented to CQC were happy with the care they received, however there are exceptions, and the trust needs to further develop its systems for responding to complaints and feedback from patients.
CQC will continue to engage with the trust and to monitor progress on an ongoing basis. The next planned formal review against the trust's action plan, scheduled for spring 2010, will also report on those issues identified as part of this six month follow up. These are highlighted both within the body of the report and at Appendix 1.
## Mid Staffordshire NHS Foundation Trust Confidence in Care Transformation Programme
### 11 High Plus Goals

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<th>Confidence in Care High Plus Goals</th>
<th>Findings</th>
<th>Conclusions &amp; Recommendations</th>
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| 1 The use and role of the Clinical Decision Unit to be reviewed (055) - Proposed as recommendation in Professor Alberti’s report. | • The trust had expressed concerns about safety of patients on the 12 bedded CDU. Specific issues related to ‘ownership’ of the unit and appropriate staff cover. A SUI in August, resulting in the death of a patient on the unit, added further impetus to close the unit. The trust had made the decision to close the unit at the end of September 2009.  
• During the visit, CQC observed that the CDU functioned as a ward rather than an assessment facility, with outliers awaiting a bed elsewhere.  
• CQC raised a concern about nurse staffing levels on the CDU during a night visit. Whilst the emergency department was fully staffed with experienced nurses, the CDU was staffed by one registered nurse who had not worked on the unit before, and one clinical support worker.  
• A four bedded CDU will re-open within the A&E department, with clear lines of accountability to A&E department. | • The unit was closed at the end of September.  
**Recommendation**  
• Ensure protocols are in place to support admission and management of appropriate patients within the four bedded CDU facility. |
| 2 Review usage of emergency theatre lists to ensure sufficient capacity exists to operate without delay (056) – this review forms part of the wider theatre development project | • The trust has made some progress in reviewing theatre usage and staffing, including on call practice of consultants.  
• A protocol for emergency theatre utilisation has been signed off and is due to be evaluated in November. Monthly analysis of the utilisation of out of hours operating theatre capacity is undertaken and trust data shows that theatre capacity is not yet optimised. CQC was told that | • The trust has made some limited progress to address usage of theatre lists however, improvements for patients is not clearly or consistently demonstrated.  
• For example; the recent fasting audit showed poor compliance with recommended guidelines and poor awareness amongst staff. In addition the trust is not yet meeting its target for operating on patients within 48 hours |
there is theatre capacity however, the ways the surgeons utilise the capacity/make themselves available needs to be reviewed. Staff reported that only 50% of the available time is used at the weekend.

- Key performance indicators (KPIs) including time taken to assess and operate, and fasting times are routinely monitored by the theatre user group. Divisional management team review cancellations on the day of surgery
- CQC was told that lists are still often cancelled on the day of surgery.
- The trust is not yet meeting its target of 80% compliance within 48 hours for time from admission to theatre for # neck of femur (NOF). Results show year to date (YTD) as 72%. Whilst it is meeting targets for emergency readmissions post elective and emergency surgery, it is falling to meet readmission targets for #NOF (7.7% cf target of 6.3% readmissions within 28 days). CQC was told that August was a busy month for T&O and some 26 NOFs presented (average 15-20). Generally surgical patients will get priority over trauma cases over the weekend, due to the severity of their conditions
- Steps have been taken to ensure better engagement with surgeons and the trust is due to undertake a review of surgical division services in October, facilitated by the Royal College of Surgeons, that will assess what surgical procedures should be provided at Stafford Hospital.

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<tr>
<td>3 Recruit to revised nurse establishment</td>
<td>Total investment since March 2008 is</td>
<td>The trust has demonstrated efforts made</td>
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Recommendation
- Ways of working need further review in order to ensure optimisation of theatre capacity.
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| levels against commitment by Trust Board in April and in accordance with Alberti recommendations (070)  
• Due by 30 September 2009 | reported as £2.2m. The trust has reported 35.64 whole time equivalent (WTE) registered nurse vacancies. It reports that 26.8 WTE have been recruited to with start dates between August 09 and January 2010.  
• CQC found that additional nurses obtained from a nursing agency were reflecting an overall increase in numbers in the trust. In addition there is the potential negative impact with frequent changes in the nursing workforce (lack of continuity and lack of experience).  
• The trust is working toward achieving 60:40 spilt nursing workforce between qualified and unqualified staff. Previously the spilt was 40:60 so investment has focused on changing the skill mix rather than solely on new appointments e.g. on wards 10, 11 and 12. CQC was also told that the trust has also been looking at shift patterns and there has been an uplift in budget of 22%.  
• CQC found the trust is taking measures to ensure new staff are clinically competent. For example, there is a comprehensive training programme available to staff in the emergency care directorate. The trust has introduced specific education packages to ensure new band 5 and band 6 staff have the knowledge and practical clinical skills required for working in emergency care.  
• Staff interviewed by CQC consistently reported improved access to training.  
• CQC found that there is a degree of | to recruit to revised budgeted levels however, a shortfall in staff remains. Permanent staffing levels continue to be supplemented by bank and agency staff across the trust. |

**Recommendation**  
• The trust should develop a nursing and midwifery strategy.
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<td>confusion in role within the emergency department. Senior staff nurses,</td>
<td>• The trust does not have a nursing strategy and although there has been clear investment in</td>
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<td>junior and senior sisters all appear to provide the same function. A new</td>
<td>training, the clear aim was not articulated.</td>
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<td>band 7 has recently taken up post and it is envisaged that this will add</td>
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<td>some clarity to the overall structure</td>
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| 4 Conduct a review of acuity (i.e. case mix on wards) and nursing establishments using a recognised staffing tool (073)  
- Due by 31\textsuperscript{st} December 2009 | - The trust is undertaking an acuity review using nationally recognised tools during September and October 2009 (AUKUH association of UK University Hospitals) to assist with ward staffing levels.  
- The trust is focussing on improving rostering. An internal audit, undertaken by Bentley Jennison to review off duty across the trust, demonstrated that pockets of the trust are rostering duty effectively. The audit has resulted in a standard template for duty rostering being introduced across the trust at end August 2009. Aside from adherence to working time directives, it stipulates clear identification of the person in charge, a minimum of one registered nurse from the ward establishment on duty and the monthly monitoring of bank/agency by department manager/matron.  
- Skill mix is routinely reviewed by ward and staff reported that rostering was being audited against the template.  
- A revised rostering policy is in final draft with consideration being given to purchasing an electronic rostering system.  
- New staff have been employed on wards 10, 11 and 12. However, staff commented that numbers do not fully reflect the dependency of patients on ward 10. | - The trust has provided evidence that it is reviewing acuity and nursing establishments.  
- Progress is also being made in procurement of a new e-rostering system that should assist ward staff |
| 5 Develop a range of methods to capture patient experience feedback (100)  
- Due by 30 September 2009 | - There is a range of initiatives planned and in progress to capture patient experience feedback. These include postal surveys and use of patient experience trackers (answers downloaded to Dr Foster website to be analysed)  
- The trust reported to CQC the following | - This work stream is at a relatively early stage of development. The trust has a range of initiatives planned and in progress to capture patient experience feedback. There is also a plan for how it will use feedback from patients’ comments. A patient experience facilitator |
### Confidence in Care High Plus Goals

<table>
<thead>
<tr>
<th>Findings</th>
<th>Conclusions &amp; Recommendations</th>
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<tbody>
<tr>
<td>analysis from patient tracker data; 100% positive feedback has been provided about privacy and cleanliness (N=12). 80% of patients have rated level of dignity and respect as excellent (N=117)</td>
<td>was appointed in July to coordinate the programme.</td>
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<td>- The trust has provided a plan for how it intends to use feedback from patients comments</td>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td>- Ward staff demonstrated an awareness of the patient tracker process although some staff were unaware of findings. Staff told CQC that there are plans to provide more systematic feedback to public and staff about the patient tracker results.</td>
<td></td>
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<tr>
<td>- Staff told CQC that newsletters are used to feedback patient comments to staff in A&amp;E and on some of the wards.</td>
<td>- As it implements the programme the trust will need to develop its mechanisms for dissemination of findings at a local level and sharing learning from patients feedback</td>
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Appendix 1
## Confidence in Care High Plus Goals

<table>
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<tr>
<th>6 Protocols for common conditions should be introduced in A&amp;E (027) – <em>in accordance with Professor Alberti’s recommendation</em></th>
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<tr>
<td><strong>Findings</strong></td>
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<tr>
<td>Six protocols had been ratified with a remaining four provided as draft protocols for common conditions in A&amp;E. Five nursing protocols have also been developed by the practice development nurse. The format of the protocols is not standardised and staff reported that whilst they had been signed off by the emergency care steering group, further peer review was required and they hadn’t yet been signed off through general governance mechanisms. CQC were told that there is a plan that protocols will be audited in the future. Staff clearly described the process for introduction of new protocols to the unit, which is via the practice development team.</td>
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### Recommendation
- Ensure that the audit programme routinely reflects the introduction of new protocols, where appropriate

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<tr>
<th>7 Develop and implement Healthcare Governance performance report which highlights variations in performance and states action being taken (015)</th>
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<tr>
<td><strong>Findings</strong></td>
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<tr>
<td>The newly formed healthcare governance committee first met in May 2009 and a new governance strategy was developed in July 2009. A framework for clinical and quality performance measures has been developed to support scrutiny and management of clinical and quality performance measures. Reports presented in July 2009 include patient safety indicators (trend analysis of infections, SUIs, patient safety incidents), patient experience indicators (complaints, comments, time to theatre for fracture neck of femur, emergency readmissions and discharge arrangements), effectiveness of care (mortality non</td>
</tr>
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*Appendix 1*
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<th>Confidence in Care High Plus Goals</th>
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<tbody>
<tr>
<td></td>
<td>elective and elective and deaths after specific conditions hip fracture, heart attack and stroke</td>
<td>responsibility but holding to account as well; and continuing to do what it needs to do to satisfy its regulators.</td>
</tr>
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<td></td>
<td>• CQC was told that consultants don’t yet receive their own mortality data. However, they do have access to Dr Fosters data and there are plans to begin discussing individual performance such as clinical outcomes and complaints at annual appraisals, this year</td>
<td><strong>Recommendation</strong> • A more robust approach to clinical governance should be developed, with leadership and accountability through the clinical directors and/or lead clinicians. This should be supported with an assurance framework.</td>
</tr>
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<td></td>
<td>• There was a lack of clarity about introduction of a framework for good local governance arrangements that ensured accountability and responsiveness amongst the emergency directorate.</td>
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### Confidence in Care High Plus Goals

8. A new model of care for medical patients who are admitted to be implemented which provides for much earlier consultant contact, prospective discharge planning and pain management (089)

- Due by 31 July 2009

### Findings

- A new model of care came into effect on 1 July 2009. This is outlined in the EAU and Acute Medical Unit Operational policy. The policy includes purpose of unit, and medical/nursing staffing model. This model considered the front end of the pathway and work is underway to further develop the model.
- Dr Ian Sturgess Clinical Lead of the National Emergency Care Intensive Support Team has undertaken an end to end review of the emergency care pathway including external partners. The trust anticipates that the new pathway will be ready for implementation on 30 September.
- A system to improve medical consultant presence in EAU until 20:30 has been introduced. After this time, overnight and at the weekend, a consultant is on call and available for advice; to return to the trust if appropriate. Consultant ward rounds are undertaken over the weekend. The aim is that all non elective medical patients are seen and managed by a senior clinician in order that timely treatment is commenced and management plans are in place.
- CQC found more consultants are now available in A&E, although the trust ultimately wants to increase cover to five consultants. Staff confirmed that earlier consultant/senior contact now occurred now although it was thought that more could be done to improve contact at night (consultants leave at 10pm).

### Conclusions & Recommendations

- Some initiatives have been implemented and have meant earlier consultant contact for patients is possible.
- At the time of the review, it is too early to see evidence of the impact of these improvements on outcomes for patients and this will be reviewed by CQC.
## Confidence in Care High Plus Goals

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<td>and compares this to baseline data relating to predetermined success measures e.g. number of medical outliers, length of stay, waits in A&amp;E. At the time of the review, it is too early to determine whether there has been improvement against the success measures.</td>
<td>The trust has worked to achieve its target and has introduced procedures to enable direct admission of suitable patients to EAU. However, CQC found that the vast majority of patients are still being admitted via A&amp;E.</td>
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<td>A programme of audit associated with the implementation of the new model of care is planned.</td>
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| 9 Allow direct admission of suitable patients to the Emergency Admissions Unit (085)  
  - Due by 31 July 2009 | The trust introduced procedures on 1 July 2009 to enable direct admission of suitable patients to EAU. These patients are walk-in expected GP cases, and volumes have been estimated at 10 patients per day. The dedicated area of EAU for direct admissions operates from 8am-9pm.  
  - The written pathway states that for expected GP referrals, the patients should still be triaged initially in A&E. Staff confirmed that this was the case. CQC was told that patients don't generally get into hospital without going through A&E, although they can book into A&E and then go straight to EAU. |
| 10 Operational Policy to be agreed with the aim of lengths of stay on the Emergency Admissions Unit to be limited to 48 hours and the institution of a short-stay ward to be considered (086) This goal relates to delivery of high plus goal 9 above  
  - Due end July 2009 | The trust AMU/EAU is an assessment unit and short stay medical unit. The operational protocol provided is undated, although the trust reports that it came into effect on 1 July, following ratification by the Emergency Care Steering Group. The policy has subsequently been ratified by the trust board.  
  - The operational policy outlines the process for receipt and admission of | Whilst the trust has agreed its operational policy, by the target date, that aims to limit length of stay on EAU to 48 hours, CQC found that the impact of the policy has not yet consistently demonstrated improvement for patients.  
  - Staff report being unable to move patients off the unit due to lack of patient beds elsewhere. However, the trust is involving relevant partner organisations to support |
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<tr>
<td>patients with a target that first assessment be undertaken within 30 minutes of arrival. • Consultants routinely set a predicted date of discharge on admission. Evidence provided by the trust showed a reduction in average length of stay on EAU (between April and July by ( \frac{1}{2} ) day to just over 1.5 days (range 0-3+ days). With about 21% (134) patients staying 3 days or over in July. • Handover from EAU to the wards is done by the site manager who lets the wards know what patients are waiting on EAU for an appropriate bed.</td>
<td></td>
<td>the release of bed capacity.</td>
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<tr>
<td>11 Arrange for independent review of case notes for those relatives of patients who died during the period of the HCC report (026) • Due by 30 September 2009</td>
<td>200 cases requested to date • South Staffordshire PCT is managing the process in order that the process be independent • [DN update provided by South Staffs PCT on 5/10/09 – expected completion date Jan/February 2010]</td>
<td>Case note review is underway and being led by South Staffordshire PCT. This is expected to be complete by early 2010.</td>
</tr>
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Appendix 2: Methodology

In August 2009, the trust was asked to supply documents relating to the 11 goals it had identified as ‘high plus’ priority in its ‘Confidence in Care’ transformation programme. The information was analysed and used to identify issues for further investigation. The list of information requested is attached as appendix 3. Interviews were arranged in advance with directors on 18 September 2009.

An unannounced visit was made to Stafford Hospital on 15 September 2009, at which members of the inspection team visited wards 10, 11 and 12. The team were shown around the wards, talked with some patients and staff, looked at patient records and spent time observing activity on the wards. On that day, the team advised the trust that it would be in the hospital for the rest of the week and asked for interviews to be arranged with a variety of clinical staff on 17 and 18 September 2009.

On 16 September 2009, the inspection team visited the accident and emergency department, the clinical decision unit and the emergency assessment unit. The visit included a visit during the day and a second visit during the late evening. As before, the team were shown around the clinical areas, talked with some patients and staff, looked at records and spent time observing activity.

On 17 and 18 September 2009, the inspection team interviewed a total of 33 clinicians, managers and other staff.

During the visit CQC sought patient comments about their experiences at the hospital. The team spoke with 20 patients and their relatives during visits to the wards and clinical areas. Informal feedback about care and treatment plans was gathered in this way. CQC also invited patients from each area to complete a brief questionnaire covering three themes. These themes derived from previous complaints from patients and relatives and related to communication, nutrition and pain relief. Patients were invited to return the questionnaire to CQC using an attached freepost envelope. Sixty people consented and this generated an additional six responses from patients and relatives.

The information from the visits, the interviews and the questionnaires was then analysed.
Appendix 3: Inspection team

Sara Reeve, Assessor, Care Quality Commission
Liz Parry, Assessor, Care Quality Commission
Al Sheward, Divisional Nurse Manager Medicine, Leeds Teaching Hospitals NHS Trust
Lindsey Scott, Executive Director of Operations, Avon and Wiltshire Mental Health Partnership NHS Trust
David Harvey, Investigations Analytic & Evidence Manager, Care Quality Commission
George Catford, Investigations Analyst, Care Quality Commission
Lisa Cawthorne, Investigations Analyst, Care Quality Commission
Wayne Martin, Regional Intelligence & Evidence Officer, Care Quality Commission
Appendix 4: Documents requested from the trust

(The first three digit numbers are the reference numbers of the ‘high plus’ priority goals in the trust’s ‘Confidence in Care’ transformation programme.)

055 - 1.1 Details and outcome of the review of the CDU.

056 - 2.1 Details and outcome of the review of emergency theatres.

056 - 2.2 Details, such as audit results, of emergency patients' time to theatre.

070 - 3.1 Nursing establishment by month, grade and ward (location).

070 - 3.2 Numbers of nurses in-post by month, grade and ward (location).

070 - 3.3 Summary details of nursing recruitment initiatives?

073 - 4. Details of a) the methodology being/ to be used to review acuity and b) the recognised tool.

100 - 5. Details of a) the methods being developed b) their current development status and c) summary results of any that have been used.

027 - 6.1 List of protocols developed/ to be developed.

027 - 6.2 Details of the approach taken to developing these, including how identified and how best practice ascertained and included.

015 - 7.1 Copies of the first two reports (if produced).

089 - 8.1 Details of the model, including how it has been developed and implemented.

089 - 8.2 Results of any compliance checks (e.g. audits).

085 - 9.1 Details of protocol and how it was developed.

086 - 10.1 Copy of operational policy.

086 - 10.2 Details (e.g. min, max, mean) of lengths of stay on the emergency assessment unit by month from April 09.

086 - 10.3 Current status of consideration regarding introducing a short stay ward.

026 - 11. Number of cases requested/ independently reviewed.