Care Quality Commission

# The state of care in NHS acute hospitals: 2014 to 2016

Findings from the end of CQC's programme of NHS acute comprehensive inspections


STATE OF CARE

# Contents

# Foreword

This report captures what we have learned from three years' worth of inspections of NHS acute hospitals. It provides a baseline on quality that is unique in the world – and also points to the fact that it is possible, even in this most challenging of times, to deliver the transformational change that is needed if the NHS is to continue delivering high-quality care into the future.

CQC's programme of comprehensive hospital inspections began in September 2013, reflecting the recommendations of the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust and Sir Bruce Keogh's Mortality Review. Between September 2013 and June 2016 we completed inspections of all 136 NHS acute non-specialist trusts and all 17 specialist trusts. Since January 2014 we have routinely provided ratings for a total of 265 non-specialist hospitals (sites or locations) and 27 specialist hospitals operated by these trusts. Across these trusts and hospitals we have inspected and rated 1,804 individual core services (1,649 core services in non-specialist hospitals and 155 in specialist hospitals).

This has given us a detailed understanding of the quality of care across England – not only at an overall trust level, but also at an individual core service level. Our comprehensive inspections – which look at both the combination of core services and how they interact – have helped trusts to understand the specific areas where they need to improve and to take targeted action. They have also provided increased transparency on performance for people who use services.

The scale of the challenge that hospitals are now facing is unprecedented – rising demand coupled with economic pressures are creating difficult-to-manage situations that are putting patient care at risk. During winter 2016/17, hospitals have faced ever-increasing demand for urgent and emergency services and the continuing challenges of delays in discharging patients to community and social care services. But despite these pressures, I have been impressed by the way some trusts have been able to manage that risk by making changes to the way that they deliver services.

The NHS stands on a burning platform – the model of acute care that worked well when the NHS was established is no longer capable of delivering the care that today's population needs. The need for change is clear, but finding the resources and energy to deliver change while simultaneously providing safe patient care can seem near impossible. What this report demonstrates, however, is that transformational change is possible, even in the most challenging of circumstances – we have witnessed it, and seen the evidence that it delivers improved care.

Moving away from an insular approach and actively sharing learning between organisations is a vital way to help drive improvement. We have highlighted good practice here to encourage others to learn from it, to be inspired by it and to adapt what is relevant to use in their own improvement journey. As the boundaries between organisations and sectors become increasingly porous, peer review and transparency will become ever more important.

Even trusts rated as outstanding can benefit from sharing learning – the granularity of our assessments mean that we are able to identify variation in the quality of care not only between hospitals but between different services delivered by the same hospital. While we have found some very high-quality services, and rated five non-specialist acute trusts as outstanding, we have also uncovered some pockets of very poor quality care even in hospitals rated as good. Often we have found that this variation is linked to the quality of leadership, both at a ward and trust level. Across all acute trusts, effective leadership, which is values-driven and has a strong culture of learning, delivers high-quality care.

As we highlighted in our annual State of Care report, the safety of hospitals continues to be an area of concern. While hospitals recognise patient safety as their top priority, this is frequently not translated into an effective and consistent safety culture. Even in the trusts that we have rated as good for safety, we have found problems and areas in which the trust can improve – for example, on record keeping or medicines management – and we have taken action to protect patients where necessary.

There is no doubt, however, that compassion is alive and well. Caring is the most highly rated of the five key questions in acute non-specialist hospitals and, overwhelmingly, we see staff behaving in a caring way, which is supported by what we hear from patients. The most important resource of the NHS is its staff – I would like to thank the people who work in our hospitals for their hard work, dedication and commitment in continuing to deliver the best possible care for patients, even in the most difficult circumstances.

**Professor Sir Mike Richards**
Chief Inspector of Hospitals

# Summary

Following the completion of our comprehensive inspections of NHS acute non-specialist and specialist trusts in England, we now know more about the quality of care in our hospitals than ever before. NHS trusts are facing substantial challenges and these are set to continue as hospitals have to manage a steadily increasing demand for their services, at a time when they are also required to make unprecedented efficiency savings. In particular, hospitals are facing an unprecedented demand for urgent and emergency services this winter, with a third of trusts issuing alerts in December 2016 warning that they needed urgent action to cope with the pressure of patient numbers.

Some organisations deliver very high-quality care despite these challenges and are looking after patients well. Our detailed reports have also highlighted many examples of how hospitals have been able to improve and are continuing to improve the quality of care they offer, even though there are constraints. We encourage trusts to follow the good practice we have cited to improve their own services.

However, we have found that some trusts have blind spots about the quality of care they are delivering in a particular core service, even some of those rated good – in other words trusts that are rated good across all their core services apart from one or two that need to improve.

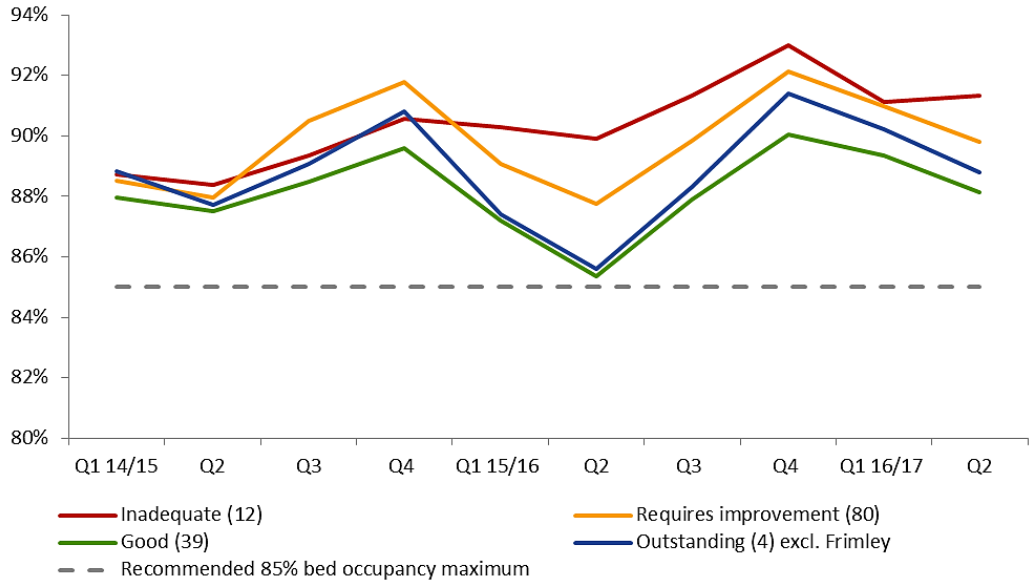
In terms of activity, the number of emergency attendances, emergency admissions and first outpatient appointments rose by 5% in the year to September 2016, compared with the previous year, and the number of elective admissions rose by 2%. At the same time, waiting times have got worse, with almost 10% of patients on the waiting list at October 2016 having waited more than 18 weeks (the target maximum) for referral to hospital treatment.

Bed occupancy rates for general and acute settings have remained very high. In each quarter since at least the start of 2014/15, they were above the recommended maximum of 85% for rated acute trusts (figure 1). This is the bed occupancy at midnight. In reality, during the day it is often much higher. Many hospitals face a daily struggle throughout the year to find suitable beds for both emergency and planned admissions. During the same period, despite the rising demand, the number of acute and general beds available has decreased, with the average number of beds for an acute (non-specialist) trust falling slightly from 718 to 715 in a year. The four acute trusts rated outstanding (excluding Frimley Park, which has now taken over Wexham Park to form Frimley Health) are larger than the average acute trust. The average length of stay for inpatients has also fallen in the decade to 2014/15 from 7.1 days to 5.0 days (and for people 75 and over, falling from 14.4 to 9.1).[1]

Behind this picture of increasing demand is a backdrop of financial challenge. In 2015/16, the deficit for all NHS providers was £2.45 billion. Deficits are no longer restricted to just a few trusts, with 60% of all acute trusts forecasting a year-end deficit for 2016/17 at the end of September 2016.

Analysis of our ratings for acute non-specialist trusts against their financial performance shows a correlation between our ratings and the trusts' deficits. Trusts with higher ratings tend to be better at balancing their budgets (or have smaller deficits) than those rated inadequate (figure 2). In addition, providers with better overall ratings tend to score better for the key question 'are services well-led?'.

## Figure 1: Average bed occupancy rates for acute hospitals by CQC rating (April 2014 to September 2016)




Source: CQC ratings data (31 December 2016) and NHS England

## Figure 2: Ratings versus financial position


Source: CQC ratings data (31 December 2016) and NHS Improvement. Forecast outturn for 2016/17 at quarter 2.

However, there is no simple choice between being financially efficient or providing high-quality care. Some problems with the quality of care do require new resources, but many do not. For example, protecting patients from infection with good hand hygiene and minimising the risks of 'never events' through full use of the World Health Organization Surgical Safety Checklist cost very little, and yet we have seen much poor practice.

## Impact on the quality of care

In general, safer care is considered to be care that is more efficient, through quicker recovery, shorter lengths of stay and reduced need for high dependency units or intensive care. All hospitals told us that patient safety was their top priority, but too often they did not have an effective safety culture or reliable systems to ensure this. Many of the inefficiencies we have seen can be avoided, such as hospital acquired infections, or they are caused by poorly coordinated care, with unnecessary or delayed investigations or treatments. This is supported in the report *Getting it right first time*, which shows that changes to improve pathways of care, patient experience, and outcomes can also have significant cost savings.[2]

Hospitals operate in a complex health and social care system. While we report on individual providers, the performance of an individual hospital should never be viewed in isolation. Hospitals that manage their pathways of care well recognise this and have built up strong supportive relationships with their local partners in the system, such as social care services.

Quality is complex and cannot be measured easily. We have found that trusts often rely on too few metrics to assure themselves about the quality of their services. Overarching measures, such as mortality rates, can be misleading. Although high mortality rates can be a useful indicator that there may be a problem, we have also seen trusts taking false assurance from apparently favourable figures. Trusts that are vigilant about quality look at a range of measures and use them as a driver for improvement.

## The importance of staffing and leadership

The overarching message from our inspections is that effective leadership, which is values-driven and has a strong culture of learning, delivers high-quality care. In hospitals rated good or outstanding, the trust boards actively engaged with staff, asking them how they needed to improve. They had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice. Where the culture was based around the needs and safety of patients, staff at all levels understood their role in making sure that patients were always put first.

Many hospitals have told us that staff recruitment is one of their most difficult challenges; this often leads to too much reliance on temporary and agency staff. While many factors influence recruitment, for many of these same trusts staff report high levels of work-related stress, bullying and discrimination, which are either not recognised or not sufficiently addressed by the trust. This can vary between hospitals and departments within a trust, but we have found that the NHS staff survey is one of the most reliable predictors of the effectiveness of NHS trusts' leadership and of the quality of care they provide for patients.

Frontline staff are the heroes of our reports. We have found high levels of compassionate care in virtually every hospital. The exceptional daily commitment of staff has allowed hospitals to cope with the ever increasing demand, and the values and dedication of individual frontline teams are the fundamental factors in every good and outstanding service. High-quality care cannot be delivered without a focus on continuous improvement in quality, which only these teams can achieve.

However, we have found that many hospitals do not listen effectively to the views of their staff. This is having a major impact on their ability to provide safe, efficient, high-quality care. Our reports are a start to putting this right. The strongest voices in these reports are those of the many patients who have told us about the compassionate care they have received, and of staff who have told us about their concerns about the safety and quality of care and the daily frustrations of their working lives.

# 1. Introduction

In September 2013, we started our programme of comprehensive inspections of acute trusts, completing our inspections of all 136 NHS acute non-specialist trusts in England in March 2016, and all 18 specialist trusts in June 2016.[a] Since January 2014, we have routinely provided ratings for a total of 265 non-specialist hospitals (sites or locations) and 27 specialist hospitals operated by these trusts. Across these trusts and hospitals we have inspected and rated 1,804 individual core services (1,649 core services in non-specialist hospitals and 155 in specialist hospitals).[b]

As a result, we now know more about the quality of care in our hospitals than ever before. The combination of evidence from our inspections and data analysis has given us an unparalleled resource of information, and a detailed and unique picture of acute hospital care across the whole of England. It has also provided us with a baseline against which we can continue to monitor and measure the quality of acute hospital care in England.

Hospital services, particularly urgent and emergency services, are facing increasing demand and pressure. Winter 2016/17 has seen unprecedented numbers of people attending hospital, leading the Secretary of State for Health to call for a review of the four-hour A&E target to relieve the pressure on hospitals.[c]

Despite these challenges, the picture we have from our comprehensive inspections shows that the majority of hospital services are providing good care and looking after patients well. In particular, we have seen professional and dedicated frontline staff providing good and outstanding care to patients. As a result of the good practice we have found across trusts, we have given an overall rating of outstanding to five NHS non-specialist trusts:

- Frimley Health NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Western Sussex Hospitals NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust.

[a] There were 18 specialist trusts at the time of our comprehensive inspections. There are now 17 following the recent merger of Birmingham Children's NHS Foundation Trust and Birmingham Women's NHS Foundation Trust on 31 January 2017.

[b] The figures shown here are the total counts of ratings on 31 December 2016. All trusts, hospitals and core services included will have been rated at least once.

[c] Hospital target for patients to spend no more than four hours in A&E.

We have also rated five acute specialist trusts as outstanding:

- Liverpool Heart and Chest NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- The Christie NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust[d]
- The Clatterbridge Cancer Centre NHS Foundation Trust.

We recognise that – despite increasing demand, financial and other challenges faced by hospitals – trusts have often made and continue to make progress in improving care and delivering change.

However, there remains a great deal of variation in the quality of care both between hospitals and between services of the same hospital, and we have uncovered pockets of poor quality care, even in good hospitals. Often we have found that this variation is linked to the quality of leadership – either at a ward, hospital or trust level. In a relatively small number of cases we have judged the quality of care to be very poor, with 28 NHS acute non-specialist trusts being put into special measures since 2014 to ensure they improve. This includes the 11 trusts recommended by Sir Bruce Keogh following his mortality review.[3]

[d] This trust was renamed Birmingham Women's and Children's NHS Foundation Trust following a merger in January 2017. We inspected Birmingham Children's NHS Foundation Trust before the merger, but published the rating after the merger.

# 2. Ratings

## 2.1 Introduction

We look at the whole picture of acute care, providing ratings at core service level (where patients most directly experience the quality of care being delivered), hospital level and trust level. The hospital rating is determined by aggregating the ratings awarded for all the core services it provides. For example, if two out of eight of the core services are rated as requires improvement for an individual key question (such as safe), then the hospital is normally rated as requires improvement for safe. Further, if two or more of our five key questions are rated as requires improvement, then the hospital is normally rated as requires improvement (figure 3).

Figure 3: Example of ratings aggregation

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

Source: CQC ratings grid for Weston General Hospital, August 2015

Similarly, the trust rating is achieved by aggregating the ratings for all hospitals or locations run by the trust. For example, if the majority of hospitals in a trust are rated as inadequate, the overall rating for the trust will also be inadequate. Ratings provide a snapshot in time of the quality of care at core service, hospital and trust level. The ratings used in this report are the current ratings for acute non-specialist (up until 31 December 2016) and specialist hospitals (up until 22 February 2017). In some cases these differ from the first rating awarded for the trust.

Our inspections have found variation in quality between hospitals, but often that there is also considerable variation in quality between services in the same acute hospital.

## 2.2 Core services

As part of our comprehensive inspection programme, we identified a range of core services that we would always inspect if they were provided. Our core service ratings – those that look at individual services such as urgent and emergency care, medical care and surgery – show that 58% of core services across NHS acute trusts were rated good (53%) or outstanding (5%) as at 31 December 2016 (figure 4).

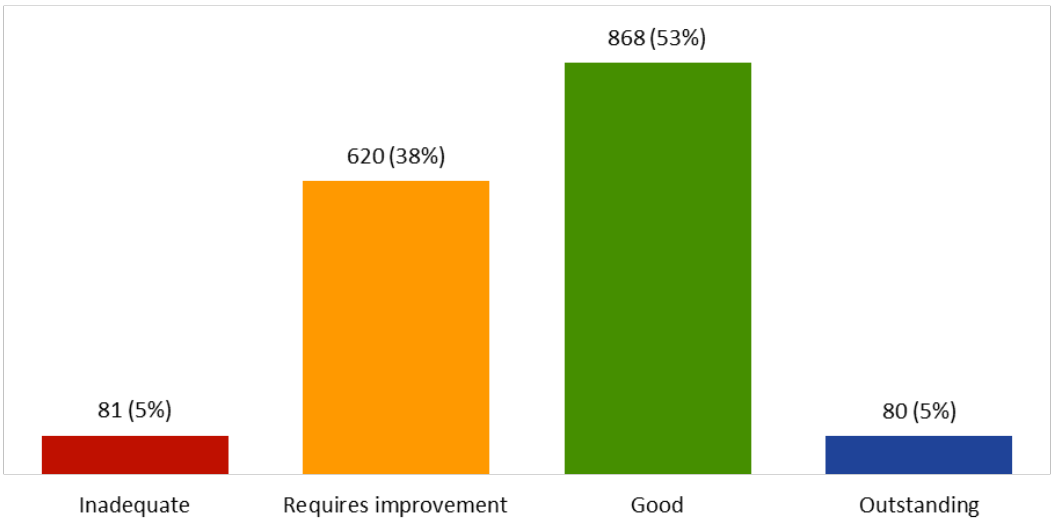
We have continued to see variation across core services. There was a 24 percentage point gap between the proportion of services for children and young people rated good and outstanding (68%), compared with the proportion of medical care services for other patient groups with those ratings (44%).

This suggests that experiences for people can vary depending on the services they need within a hospital and, when taken with the variation in quality that also exists between hospitals, the quality spectrum can look very wide indeed.

Of all the core services we rate, only two – urgent and emergency care and medical care – have more inadequate and requires improvement ratings than good or outstanding ratings. Critical care services received the highest percentage of outstanding ratings (8%).

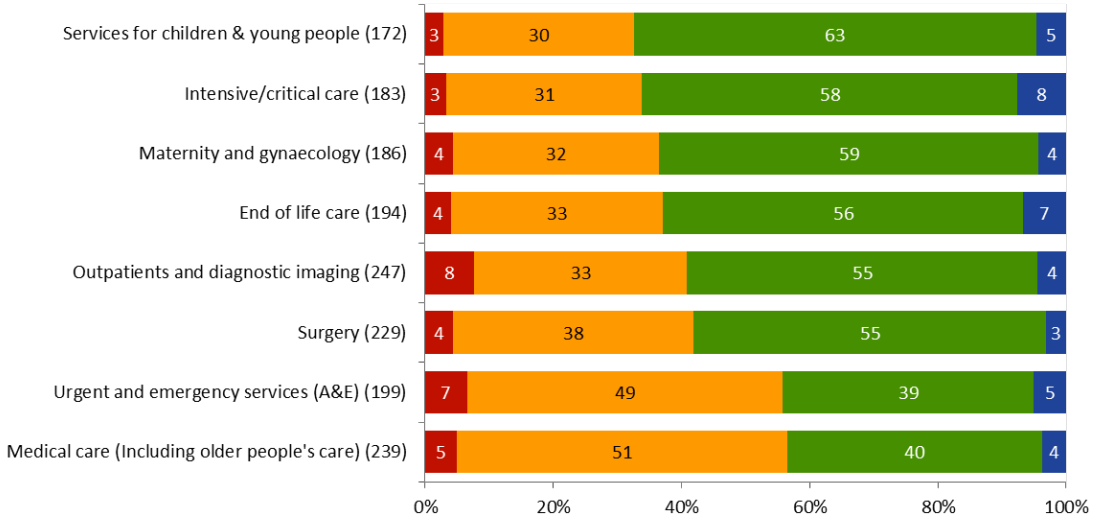
End of life care services are a good example of the variation in quality that exists between hospitals. Over half of the services are rated good or outstanding, with the 7% rated as outstanding providing personalised care that met the needs of individuals. However, 4% were rated inadequate and 33% were rated requires improvement (figure 5).

## Figure 4: NHS acute trust overall core service ratings (1,649 core services)




Source: CQC ratings data, as at 31 December 2016

## Figure 5: NHS acute core service ratings chart (1,649 core services)




Source: CQC ratings data, as at 31 December 2016

## 2.3 Hospital (location) ratings

At hospital level, 42% of acute hospitals were rated good (37%) or outstanding (5%) as at 31 December 2016 (figure 6). Ratings at this level were lower than for core services because of the complexity of most acute hospitals and the variation of quality within hospitals. While many hospitals have some good or excellent services, only a minority have achieved the level of consistently good quality care across all their services that is needed to achieve an overall good or outstanding rating. Many hospitals have one or two poorer performing services, which affect their overall rating.

## 2.4 Trust ratings

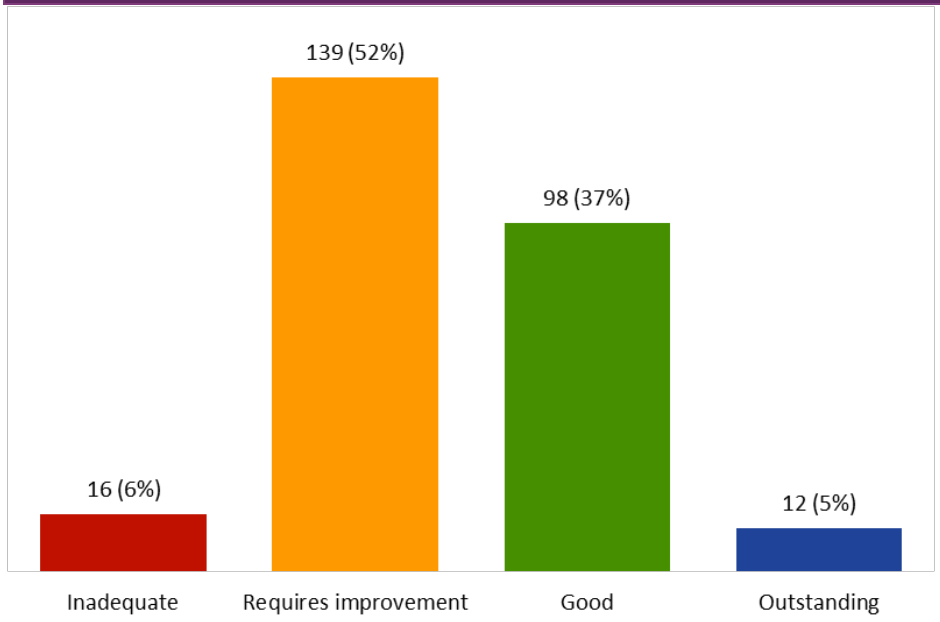
At a trust level, it is again more likely that a few poorer ratings will affect the trust rating. At 31 December 2016, 33% of NHS acute trusts were rated good (29%) or outstanding (4%) (figure 7).

In total, we have rated five acute non-specialist trusts in England as outstanding:

- Frimley Health NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- Western Sussex Hospitals NHS Foundation Trust.

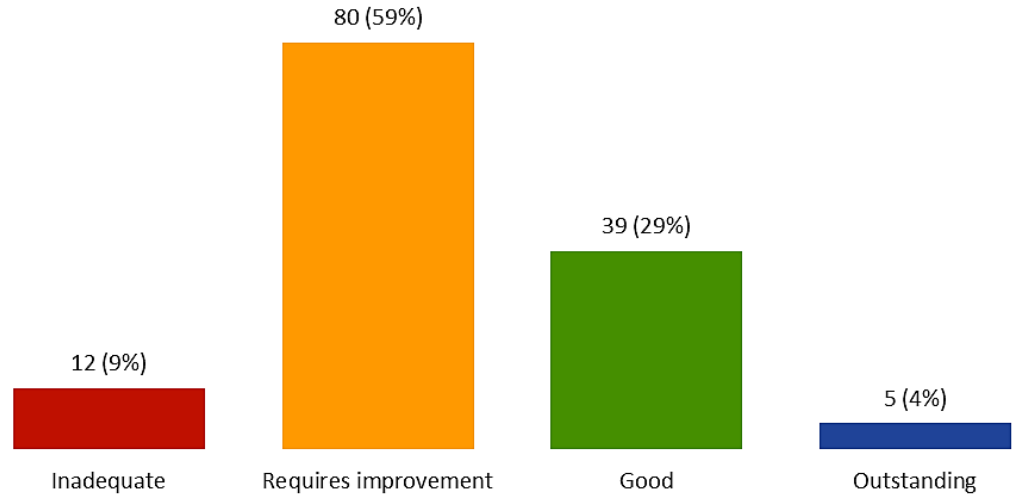
All of these trusts were rated outstanding for both the well-led and caring key questions. Four of the five were also rated as outstanding for the key question 'are services responsive?'. Between them, these five trusts operate 11 hospitals rated outstanding and 45 core services rated outstanding. Not only do these trusts have some excellent services, they have also achieved a high level of consistency in quality across their clinical services.

## Figure 6: NHS acute hospital overall ratings (265 hospitals/locations)




Source: CQC ratings data, as at 31 December 2016

## Figure 7: NHS acute trusts overall ratings (136 trusts)




Source: CQC ratings data, as at 31 December 2016

# 3. Issues across services

**Key points**

- The safety of hospitals remains our biggest concern, with four out of five trusts needing to improve.
- The majority of hospitals were able to show that their care was effective and achieved good patient outcomes.
- We found numerous examples of services rated good and outstanding for being caring. Where we found issues, these chiefly resulted from poor staffing levels.
- The model of acute care has not developed sufficiently to respond to the changing needs of the population, with less than a third of services rated as good or outstanding for being responsive.
- Across all acute trusts, both at a core service and trust level, high-quality leadership is key to the quality of care a trust provides.

This section looks at the common areas of concern we have found across all acute non-specialist hospitals. We look in more detail by each key question: safe, effective, caring, responsive and well-led.

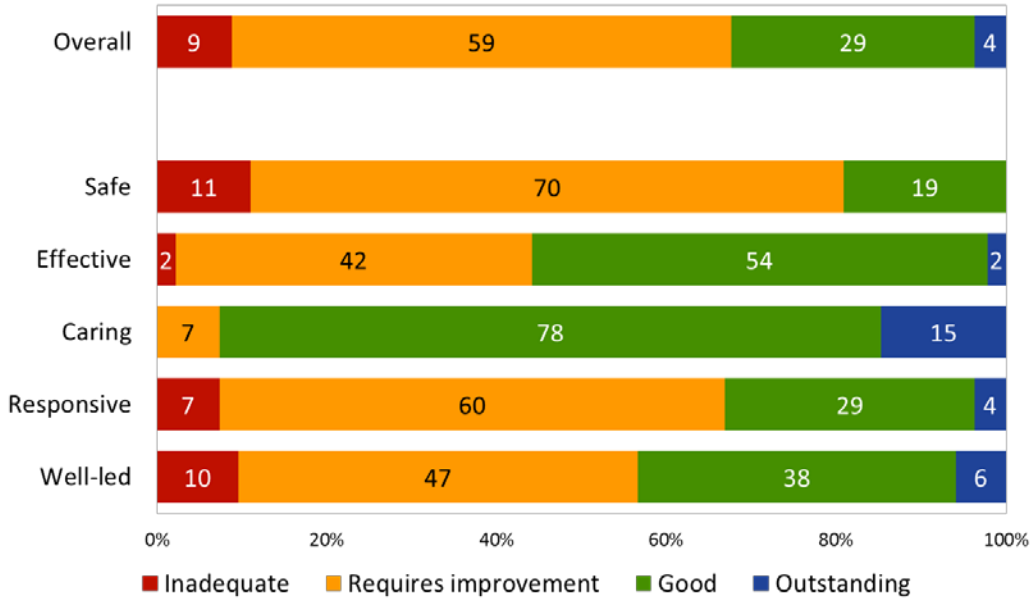
## 3.1 Introduction

Caring is the most highly rated of the five key questions in acute non-specialist hospitals. At trust level, no trust has been rated as inadequate for caring and, overwhelmingly, we see staff behaving in a caring way, which is supported by what we hear from patients. In total, 78% of these trusts were rated as good for caring and 15% were rated as outstanding (figure 8). We observe the majority of staff treating their patients with respect and dignity, for example making sure that they respect patients' privacy and that they explain to patients what their care involves.

The safety of care is our biggest concern, with 11% of NHS acute non-specialist trusts being rated as inadequate for safety. It is also notable that more than half of trusts also need to improve how they organise their services so they respond to people's needs (60% rated as requires improvement and 7% as inadequate).

Over half of non-specialist trusts (56%) are rated good or outstanding for effectiveness, meaning that they are providing care and treatment that is evidence-based and achieves good outcomes. However, 57% of trusts are rated as inadequate or requires improvement for the well-led key question. This is significant as the leadership, management and governance of the organisation has a direct impact on the quality of care provided. Good practice in leadership and improvement activity is slow to be shared and adapted across the NHS.

## Figure 8: NHS acute non-specialist trust current ratings (136 trusts)




Source: CQC ratings data, as at 31 December 2016

## 3.2 Safety

### Safety: what good looks like

**By safe, we mean people are protected from abuse* and avoidable harm.**
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

- There is genuinely a culture that puts safety as the top priority.
- Monitoring and reviewing activity gives staff a clear, accurate and current picture of safety.
- There are clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- Performance shows a good track record and steady improvements in safety. When something goes wrong, there is an appropriate thorough review or investigation. Lessons are learned and communicated widely. Improvements to safety are made and the resulting changes are monitored.
- When something goes wrong, people receive a sincere and timely apology and are told about any actions taken to improve processes to prevent the same happening again.
- Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses, and are fully supported when they do so.
- Risks to people who use services are assessed, monitored and managed on a day-to-day basis.
- Staffing levels and skill mix are planned, implemented and reviewed to keep people safe at all times. Any staff shortages are responded to quickly and adequately. Risks to safety from service developments, anticipated changes in demand and disruption are assessed, planned for and managed effectively. Plans are in place to respond to emergencies and major situations.

Source: CQC acute hospitals provider handbook

When assessing how safe a service is, we look at three broad areas encompassing culture, staffing, and environment. Compared with other sectors, NHS acute non-specialist hospital trusts have the largest proportion of inadequate (11%) and requires improvement (70%) ratings for safety. This means that more than four out of five trusts need to improve on their safety. We have not rated any trusts as outstanding overall for safety, but we have rated 11 individual core services as outstanding for this key question (figure 9).

Figure 9: Core services for acute non-specialist hospitals rated as outstanding for safety

| Hospital name | Core service | Publication date |
|---|---|---|
| Freeman Hospital, Newcastle upon Tyne | Intensive/critical care | 06/06/2016 |
| Royal Victoria Infirmary, Newcastle upon Tyne | Intensive/critical care | 06/06/2016 |
| Salford Royal Hospital | Medical care (including older people's care) | 27/03/2015 |
| Salford Royal Hospital | Urgent and emergency services (A&E) | 27/03/2015 |
| Queen Alexandra Hospital, Portsmouth | Intensive/critical care | 19/06/2015 |
| Frimley Park Hospital, Surrey | Intensive/critical care | 26/09/2014 |
| Frimley Park Hospital, Surrey | Urgent and emergency services (A&E) | 26/09/2014 |
| St Richard's Hospital, West Sussex | Maternity and gynaecology | 20/04/2016 |
| St Richard's Hospital, West Sussex | Services for children and young people | 20/04/2016 |
| Worthing Hospital | Maternity and gynaecology | 20/04/2016 |
| Worthing Hospital | Services for children and young people | 20/04/2016 |

The safety of hospitals remains our biggest concern. While hospitals recognise patient safety as their top priority, this is frequently not translated into an effective and consistent safety culture. Even in the trusts that we have rated as good for safety, we have found problems and areas in which the trust can improve – for example, on record keeping or medicines management.

A key component of safety that is a recurrent concern in our reports is the recognition of deteriorating patients and intervention with appropriate treatment before their condition worsens. Hospitals that do this well have very well integrated multidisciplinary teams, often including critical care expertise that supports staff on inpatient wards. Another important tool is the use of an early warning score system. In many hospitals this is not used proactively or effectively, with staff falling back on their own clinical judgement and not recognising or recording change, or not acting appropriately on the early warning scores. Staff in these cases appear to view the early warning score as a burdensome paper exercise, rather than an essential tool to protect patients.

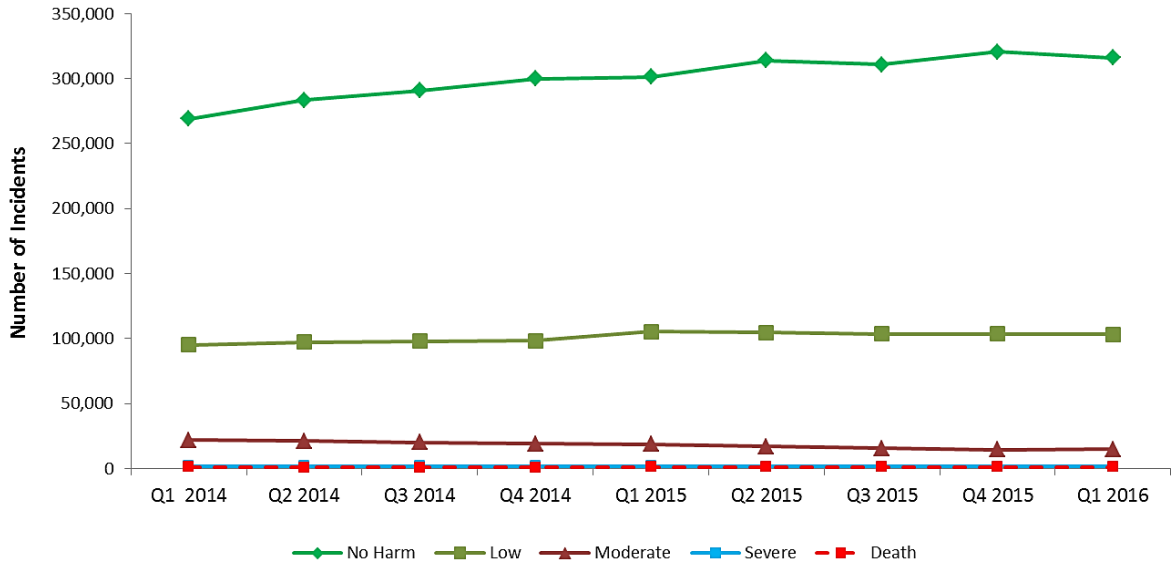
Another area of concern is the management of inpatients that have diabetes in addition to their main reason for admission. The National Inpatient Diabetes Audit shows that 17% of patients in acute hospitals have diabetes; but despite it being such a common condition the audit identifies frequent errors in their management.[4] We have found that many hospitals are not effectively using findings such as these to drive improvements in safety.

For our State of Care report 2015/16, we interviewed a sample of our inspectors to understand the factors that differentiate hospitals rated as outstanding from those rated as inadequate. Most importantly, hospitals/trusts rated as outstanding have an open honest culture, genuinely listening to staff about safety concerns. They are able to monitor and act on issues that are identified, and share the learning from incidents. They have an approach that is communicated and understood by all staff, and they consistently promote a culture of openness in which staff do not feel they will be blamed for problems.

A learning culture in which errors are reported and investigated is key to delivering a safe service. While some staff behave passively about safety and see it as the role of senior management to tell them what to do, others do take reporting seriously and report incidents when they see them. However, some tell us that they feel discouraged when they get no feedback. In an effective safety culture, safety is everyone's responsibility and, as outlined in the NHS duty of candour, all staff have a duty to protect patients from harm. This includes reporting patient safety incidents and being actively involved in learning from them to drive continuous improvements in safety.

High levels of reporting for incidents that result in no harm or low harm are generally considered to be a positive measure of the safety culture within a trust. During 2015, the overall number of patient safety incidents (as reported to the National Reporting and Learning System (NRLS)) continued to increase, which suggests an improvement in the safety culture (figure 10).

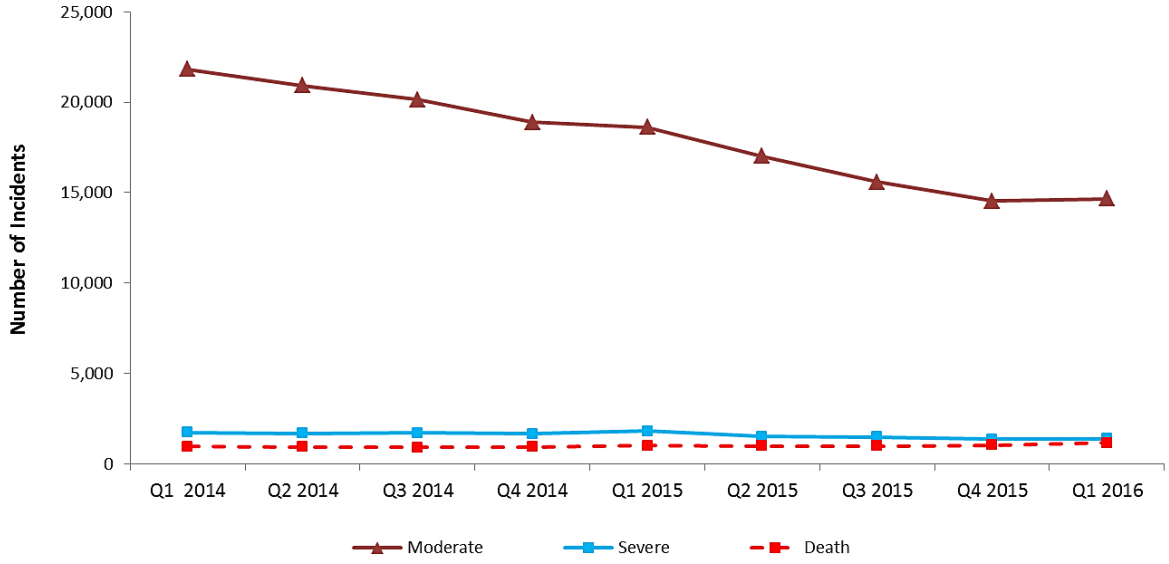
## Figure 10: Number of NRLS incidents by harm for acute/general hospital care setting, April 2011 to March 2016




Source: NHS Improvement

However, during 2011 to 2016, the number of incidents categorised as moderate or severe has declined (figure 11). We have started to look at this against our ratings to assess the safety culture of organisations, but so far we have not seen any significant correlation. We also need to look more closely at any impact from the introduction of the duty of candour.

## Figure 11: Number of NRLS incidents by harm for acute/general hospital care settings, April 2011 to March 2016

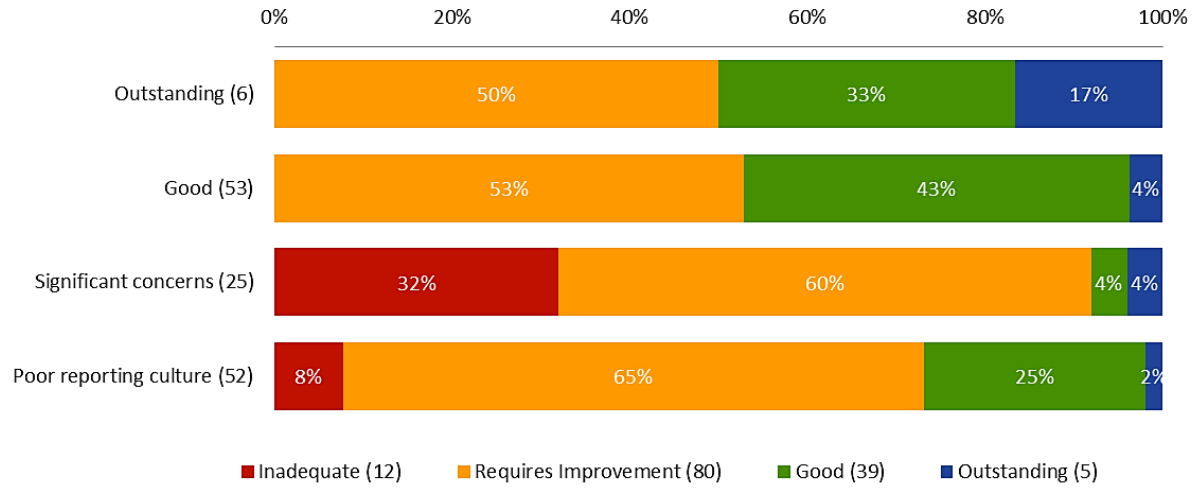



Source: NHS Improvement

Where we saw evidence that patient safety was the hospital's top priority, staff were confident in reporting incidents and viewed reporting and learning from incidents as an important part of safety, rather than a bureaucratic burden. In these trusts, all staff work together, taking responsibility for reporting and learning from incidents, rather than seeing it as the role of particular staff group.

In March 2016, Monitor and the NHS Trust Development Authority (now NHS Improvement) launched the 'Learning from mistakes league', a new league table for NHS trusts and foundation trusts, which is designed to encourage openness and transparency in the NHS. The league table is based on selected metrics from the NHS staff survey, combined with metrics on reporting of incidents. The league rates trusts as 'outstanding', 'good', 'significant concerns' or 'poor'. This is based on their effectiveness in reporting errors, near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their trust. Looking at the league against our overall ratings for trusts, it is notable that the large majority of trusts the league rated as 'significant concerns' (92%) received a CQC rating of requires improvement or inadequate (figure 12).

## Figure 12: Learning organisations vs overall provider rating (136 trusts)




Source: CQC ratings data (as at 31 December 2016), Monitor and NHS Trust Development Authority

In 2016, we carried out a review to specifically look at how acute, community and mental health trusts investigate and learn from deaths of patients. This showed that while there were areas of good practice at individual steps in the investigation pathway, no single trust could demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning was put into practice. In addition, with no single framework setting out what should be done, practice varies widely.[5]

The NHS staff survey asks staff whether they have witnessed potentially harmful errors, near misses or incidents in the previous month, and if they have, whether they or a colleague reported it. Our analysis shows that there is very little difference in these survey responses according to the different trust ratings for safety. This supports the view that, while increased reporting may be a sign of a good safety culture, the numbers of incidents witnessed or reported are not in themselves a measure of the safety of a clinical service.

Ensuring that there are enough staff with the necessary skills to provide consistently safe care remains a challenge for acute trusts. While there have been improvements in staffing and recruitment, staffing levels and skill mix remain an issue in some services and hospitals.

When we inspect we always take a rounded view of staffing levels. This involves listening to patients and staff, observing staff and patient interactions, looking at staffing rotas, and looking at risk registers where trusts themselves have frequently identified risks from low staffing levels and have incident reports related to staffing. We expect trusts to have assessed the number and skill mix of the staff they need to provide safe care, based on the number and needs of their patients. We then examine how consistently they meet this assessed level of staffing.

Most hospitals have been using credible evidence-based tools to do this. However, recruiting the right number of staff to consistently provide the level of staffing needed is a problem, with many hospitals relying heavily on temporary staff to make up numbers. While we have found staffing concerns in many different services and for a variety of staffing groups, nurse staffing in medical and elderly care wards is a common concern. We have particularly observed this on 'escalation wards', which are opened at times of increased pressure. These are often staffed predominantly by agency staff who may not be familiar with the hospital's procedures. We have also found frequent concerns with the numbers of midwives on maternity units and medical staffing shortages in many emergency departments.

In a few clinical areas, there are well-established guidelines for the required staffing level. Where these exist, such as in critical care, we have generally found better and more consistently safe staffing levels.

Where service specific staffing guidelines exist they generally cover the requirements for permanent medical and nursing staff. There is often less clarity about the requirements for other staff such as therapists and doctors in training grades. Junior doctors in many services have told us that their workload affects their morale and their ability to provide consistently safe care.

While staffing levels are a key factor in determining safety, other concerns include:

- inconsistent recognition and management of life-threatening conditions such as sepsis and acute kidney injury
- incomplete, inconsistent and ineffective audits of key safety priorities and quality improvement projects
- poor infection control practice, particularly inconsistent hand hygiene and isolation practices
- staff not consistently receiving essential safety training, including appropriate safeguarding training
- poor management of medicines, out of date medicines, inadequately or insecurely stored medicines
- inadequate checking and maintenance of equipment or of the environment
- insufficient record keeping and information systems that were not fit for purpose with clinical staff having to create work-arounds that were inherently unsafe
- poor sharing of information – leading to incomplete care plans and tests and treatments being delayed or repeated unnecessarily.

## 3.3 Effectiveness

### Effective: what good looks like

**By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.**

- People's care and treatment is planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- People have comprehensive assessments of their needs, which includes consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- Where people are subject to the Mental Health Act (MHA), their rights are protected and staff have regard to the MHA Code of Practice.
- Information about people's care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care.
- Staff are qualified and have the skills they need to carry out their roles effectively and in line with best practice.
- Staff are supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal.
- Care from different staff, teams or services is coordinated.
- Consent to care and treatment is obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- The process for seeking consent is appropriately monitored.
- Deprivation of liberty is recognised and only occurs when it is in a person's best interests, is a proportionate response to the risk and seriousness of harm to the person, and there is no less restrictive option that can be used to ensure the person gets the necessary care and treatment.

Source: CQC acute hospitals provider handbook

The majority of hospitals were able to show that their care was effective and that patient outcomes were good or excellent. Fifty-four per cent of trusts were rated as good and 2% as outstanding for the key question 'are services effective?'.

Hospitals rated as good were monitoring clinical effectiveness across all their services and took immediate action wherever they found concerns. A focus on continuous quality improvement was a key feature of high-quality care. Regardless of their baseline, services rated as good and outstanding were always evaluating their services, and seeking to improve the effectiveness of their care.

In general, clinical services understand the importance of using evidence-based guidelines to ensure that patients receive the most effective investigation and treatment. However, we have found instances where guidelines are not up to date or not readily available for frontline staff.

Audits of whether guidelines are being followed are now widely undertaken. Where they are used effectively, they are an important tool for driving improvement in quality. In services that required improvement or were inadequate for effectiveness, audits were typically poorly planned or ineffective. In addition, the audits were not acted on and there were not enough audits being repeated to confirm that there were improvements. Too many audits were planned around the professional needs of staff, for their training or accreditation, rather than being prioritised by the need to improve care for patients. They often did not involve the whole multidisciplinary clinical team.

All services should be measuring their clinical outcomes and comparing them with what is expected from similar services elsewhere. Most services now contribute to appropriate national audits, for example ICNARC[e], MINAP[f], stroke and fractured neck of femur audits. These audits have been powerful drivers of service improvements. Services without an established national audit were often less able to demonstrate that they were achieving satisfactory outcomes for their patients. In contrast, those services with well-established national audits were often able to show that they achieved good or excellent outcomes.

For a trust to be confident about the quality of its services there must be a comprehensive clinical audit programme supported by a programme of continuous quality improvement. It cannot rely on overarching measures such as standardised mortality. We have not found that such measures show an association with ratings for effectiveness, or any other of our key questions although we have found that some trusts with high mortality rates do seem to have had quality problems. As such, our inspections support the view that standardised mortality measures are a valuable 'smoke alarm' about quality, but not a principal measure of quality of a hospital.[6] We have seen trusts and individual services relying on such measures to an unwarranted extent leading to them to overlook other key indications of problems with their clinical quality.

Appraisal of medical staff is required for doctors to maintain, or revalidate, their license to practice. As a result, we found high levels of appraisal for doctors. This supports the findings of the General Medical Council's recent review of revalidation, which showed that the introduction of revalidation in 2012 has increased appraisal rates.[7] However, appraisal rates for other staff groups were much less consistent. Many services reported poor levels of appraisal and trusts often accepted rates that were greatly less than their stated targets.

[e] Intensive care national audit and research centre (ICNARC)
[f] Myocardial Ischaemia National Audit Project (MINAP)

Poor staff development was also reflected in staff training where, in a minority of services, staff did not have all the competencies they needed to provide effective care.

Excellent multidisciplinary team working was a feature of good and outstanding clinical services. We found many examples of this. Poor multidisciplinary team working has a major impact on the quality of care provided. In a minority of services staff were working in professional silos. Generally, this resulted in a rating of requires improvement. In a few services, we found unacceptably poor relations between different staff groups – these services were rated inadequate.

Understanding about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and in turn seeking patients' consent to treatment, is another area where many hospitals struggle to perform well.

Often acute hospitals do not properly understand the legislation or how to apply the provisions of the Act. Again, we have found that leadership is key. Trusts that performed well had buy-in and leadership from senior management, and a culture of patient-centred care. In these trusts, staff had access to quality training and did not make assumptions about capacity without first completing and documenting an assessment.

## 3.4 Caring

### Caring: what good looks like

**By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.**

- Feedback about the way staff treat people is positive. People are treated with dignity, respect and kindness during all interactions with staff and relationships with staff are positive.
- People are involved and encouraged to be partners in their care and in making decisions, with any support they need. They are communicated with and receive information in a way that they can understand, and understand their care, treatment and condition.
- Staff respond compassionately when people need help and support them to meet their basic personal needs as and when required. They anticipate people's needs. People's privacy and confidentiality is respected at all times.
- Staff help people and those close to them to cope emotionally with their care and treatment. People's social needs are understood. People are supported to maintain and develop their relationships with those close to them, their social networks and community. They are enabled to manage their own health and care when they can, and to maintain independence.

Source: CQC acute hospitals provider handbook

The commitment of staff to providing compassionate care to their patients was impressive. We found numerous examples of good and outstanding services for caring.

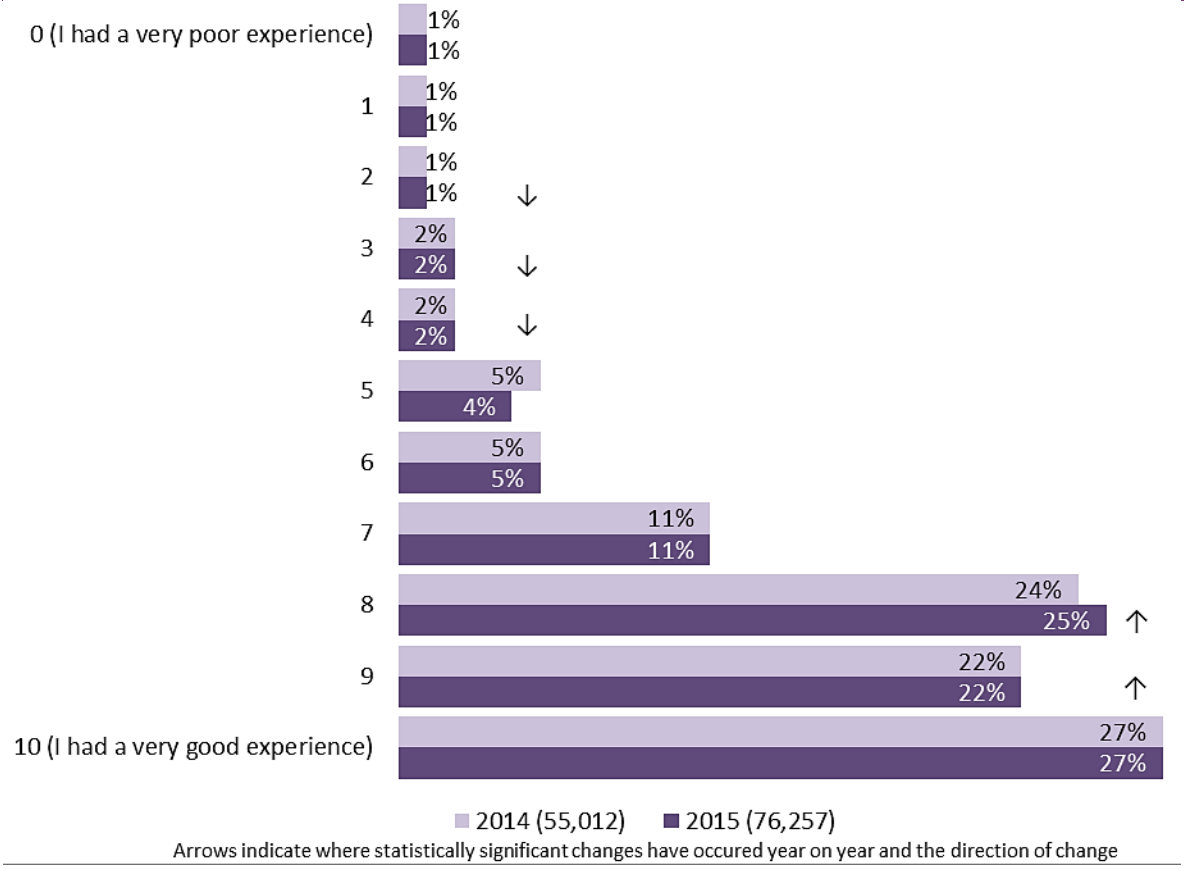
Our evidence for this key question was based on direct observation in clinical areas. To gather this evidence, we use a tool called SOFI, which stands for short observational framework for inspection. Developed with the University of Bradford's School of Dementia Studies, the tool enables us to capture the experiences of people who use services who may not be able to express this for themselves. We also use patient feedback and survey data, such as the CQC patient surveys and, to a limited extent, Friends and Family Test results. A good rating for caring was by far the most common finding. Services that were rated outstanding for caring went to extraordinary lengths to provide individualised care for patients and their families, often under the most difficult circumstances.

In these services every member of the multidisciplinary team was fully committed to providing exceptional care and individual staff went above and beyond their job descriptions; for example bringing in shopping for the patient, arranging trips out for long-stay patients, arranging family events and parties, making special provisions for families and carers.

Good feedback from patients and their families was a common finding in all our inspections and it is clear that they greatly value the dedication and commitment of individual staff. This is reflected in the 2014 and 2015 inpatient surveys, which show that almost three-quarters of patients rate their care as eight out of 10 or higher (figure 13). Even in those occasional services where we have been critical of caring, we saw or heard of examples of individual staff providing exemplary care to individual patients.

We have, however, observed caring in individual core services that we have rated as requires improvement or inadequate overall. In almost all cases, this was related to poor staffing levels and staff being stretched too thinly. In these circumstances, compassion can be lost as staff become focused on the immediate task in hand and not on the person in front of them who they are caring for. Good morale and wellbeing promotes maintenance of empathy and compassion.

## Figure 13: Overall inpatient experience (inpatient surveys 2014 and 2015)




Source: CQC

## 3.5 Responsiveness

### Responsive: what good looks like

**By responsive, we mean that services are organised so that they meet people's needs.**

- Services are planned and delivered in a way that meets the needs of the local population. The importance of flexibility, choice and continuity of care is reflected in the services.
- The needs of different people are taken into account when planning and delivering services.
- Care and treatment is coordinated with other services and other providers.
- People can access the right care at the right time. Access to care is managed to take account of people's needs, including those with urgent needs.
- Waiting times, delays and cancellations are minimal and managed appropriately.
- Complaints and concerns are always taken seriously, responded to in a timely way and listened to. Improvements are made to the quality of care as a result of complaints and concerns.

Source: CQC acute hospitals provider handbook

How providers organise their services so that they meet the needs of local people is the focus of our 'responsive' key question and, in terms of overall performance, one that we pay close attention to. A third (33%) of acute trusts were rated good or outstanding for responsiveness, while six in 10 (60%) were rated requires improvement. A small minority of trusts (7%) were rated inadequate for responsiveness.

The model of acute care has not developed sufficiently to respond to the changing needs of the population and to the increasing demand on acute services. Acute hospitals are seeing a steady increase in emergency attendances and admissions of patients with increasingly complex conditions, reflecting the change in the demographics of the population. This means that the biggest challenge that trusts face is maintaining a consistent flow of patients through the acute medical and surgical pathways. Without adequate flow they are unable to respond effectively to the rising number of urgent patients and to admit elective patients in a timely manner. This has a profound impact on the safety, quality and efficiency of care. Measures of patient flow include:

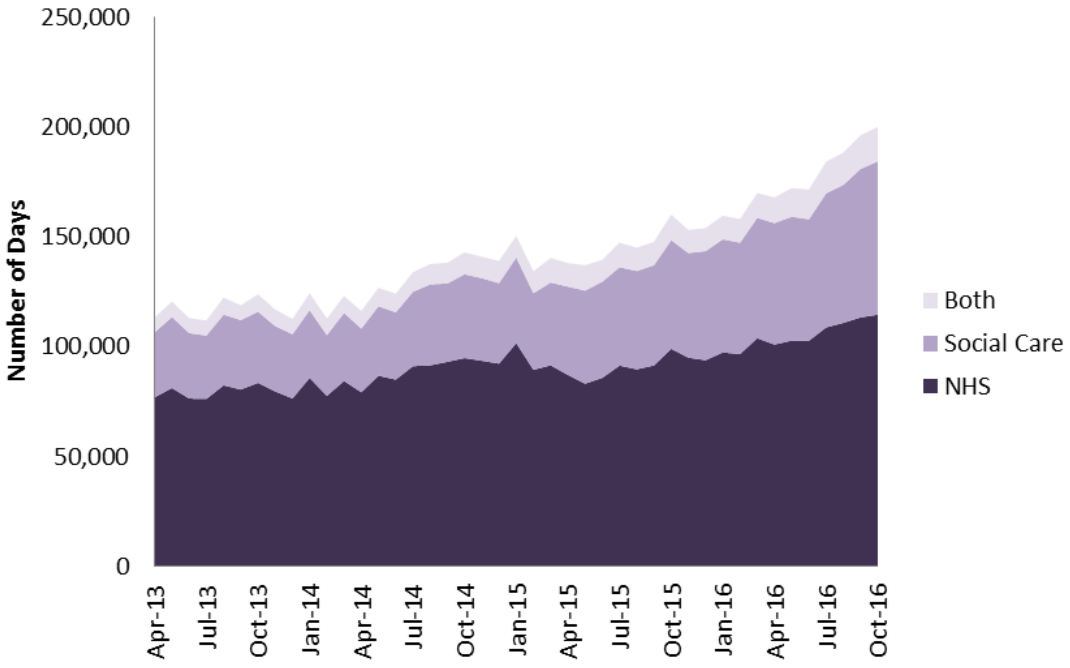
- ambulance handover times
- four-hour wait in A&E
- 12-hour wait to admission or treatment
- delayed discharges from critical care
- cancellation of planned operations

- frequent moves of people between wards
- patients admitted to an inappropriate ward for their illness (outliers)
- levels of bed occupancy
- delayed transfers of care (delayed discharges home or to another provider of health or social care).

The 2015/16 State of Care report highlighted the increasing problems that hospitals have in discharging patients who no longer need medical care, but do need a social care support package at home or nursing home care. Many acute beds in all hospitals are occupied by patients who no longer need them and indeed whose recovery may be jeopardised by them staying in hospital too long (figure 14).

Delayed discharges are not just an inconvenience; they lead to poorer experiences for patients and prevent hospitals providing responsive care for other patients requiring acute care and, frequently, for patients needing admission for planned procedures. Poor flow leads to too many ambulances delayed at the hospital front door, too many patients suffering long waits in emergency departments for admission, too many patients being admitted to an inappropriate ward, too many patients suffering multiple moves between wards, delaying and disrupting their care, and too many patients having operations cancelled at short notice.

## Figure 14: Delayed transfers of care: total days delayed by responsible organisation




Source: NHS England. Note: figures include all delayed transfers of care.

While some hospitals undoubtedly manage these pressures better than others, we have found these problems to a greater or lesser degree in almost all hospitals we have inspected.

Being person-centred and addressing issues from the patient's point of view was a key factor in trusts achieving good and outstanding ratings for responsiveness. Our inspectors noted that the best trusts often had a stronger drive to improve and were focused on how to make services better for patients. Importantly they looked at this from the patient's point of view.

Being responsive to individual needs is particularly important for patients with dementia. Typically 25% or more of patients in acute hospitals have dementia.[8] As dementia can affect people's behaviour and how they react, understanding this is an important part of caring for them. Often hospitals do not know that individuals have a dementia diagnosis and do not recognise that they need additional support. Our report *Cracks in the pathway*, published in October 2014, highlighted the importance of following a dementia care pathway and using tools such as 'hospital passports', which record information such as 'how do you know if I am in pain?'.[9] Similarly, we have found problems with recognising and recording when someone has a learning disability, as highlighted in our report *Learning, candour and accountability*, published in December 2016.[10]

Strong patient engagement was a clear factor in trusts rated good and outstanding. Our inspectors gave examples of trusts inviting key community members (for example, from Black and minority ethnic (BME) populations) to sit on their board, or using local projects led by people with a learning disability to train staff about their experience of using services.

Inspectors also saw trusts that had a culture of innovation to identify and meet patients' unmet needs, for example identifying particular groups in an area, such as refugees or a traveller population, and providing a tailored service for them. Also important was where trusts worked with other bodies, such as working with GP partners, for example to offer training.

## 3.6 Well-led

### Well-led: what good looks like

**By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.**

- The board has the experience, capacity and capability to ensure that the strategy can be delivered.
- There is clear statement of vision and values, driven by quality and safety, which has been translated into a credible strategy with well-defined objectives that are regularly reviewed.
- Staff in all areas know and understand the vision, values and strategic goals.
- The board and other levels of governance work together effectively, with structures, processes and systems of accountability clearly set out, understood and effective.
- The organisation has the processes and information to manage current and future performance, with an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
- Financial pressures are managed so that they do not compromise the quality of care.
- The service is transparent, collaborative and open with all relevant stakeholders about performance. Leaders at every level prioritise safe, high-quality, compassionate care, promote equality and diversity and actively shape the culture of the organisation.
- Candour, openness, honesty and transparency and challenges to poor practice are the norm, with a culture of collective responsibility between teams and services.
- Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted on.
- Information and analysis are used proactively to identify opportunities to drive improvements in care, and there is a strong focus on continuous learning and improvement at all levels of the organisation.

Source: CQC acute hospitals provider handbook

When we look at well-led, we look at leadership through a range of lenses including:

- the capability and capacity of leadership teams
- vision and strategy for the organisation and how it is being implemented
- governance
- culture and staff engagement
- patient engagement
- engagement across the health and care system
- innovation and improvement.

Across all acute trusts, high-quality leadership is a defining factor in how well a trust performs and the quality of care it provides. In trusts rated as good and outstanding overall, we normally find that they perform equally well for the key question 'are services well-led?, with clinical staff and business managers working collaboratively together to drive-up standards. This is also reflected at a core service level, with almost all core services rated outstanding overall being rated as outstanding for well-led. Equally, those rated as inadequate overall were similarly rated inadequate for well-led.

All trusts had stated values. When they were really embedded, this was evident from the behaviour of the senior leaders and staff at all levels in the organisation. In too many cases while they were prominently displayed values were not properly embedded and this was clearly reflected in staff behaviour and in the quality of care provided.

Effective, values-driven leadership, with a strong culture of learning, is central to ensuring high-quality care. Across all trusts, we have found that it is rare for a trust to be well-led, but have substantial problems in terms of safety – only two out of 136 non-specialist trusts were rated outstanding for well-led but requires improvement for safety (none were rated as inadequate for safety).

In hospitals rated good or outstanding, boards were actively engaging with staff, listening to their concerns and asking them how they needed to improve. They had worked hard to create a culture where staff felt valued and empowered to suggest improvements and question poor practice. Where the culture was based around the needs and safety of patients, staff at all levels understood their role in making sure that patients were always put first.

Through our inspections, we have seen the effect that good leadership has on patient care. Where it was being done well we saw embedded values, engaged staff who listened to patients, and services that used incidents to learn and improve. Where services worked smoothly, leaders had created a culture of sharing information, not just within the hospital but with external care providers, carers and patients.

Above all, we found a culture of staff working towards the same goal, confident in raising issues, concerns and whistleblowing, learning from errors and being transparent with patients and families:

- Trusts with good leadership had embedded values, engaged staff who put the needs of patients first, shared information and learned from incidents.
- Inspectors found the key to a well-led organisation was having a visible and approachable leadership team.
- In good and outstanding hospitals, boards actively engaged with staff and there was an open or no blame culture where staff were open and honest, and trusts were transparent when things went wrong.

- In poorly-led organisations, staff were not actively reporting concerns or learning from incidents.
- Where services were failing patients, we found a culture of leaders taking false assurance from inadequate information and a lack of challenge from the board.

The 2015 NHS staff survey further supports our findings. Staff in trusts that have received higher ratings tend to report less harassment and bullying and are more likely to recommend their organisation as a place to work and/or receive treatment (figures 15 and 16). Creating the right culture in which staff feel valued and motivated, and where patients are at the heart of all decisions, is only possible through good leadership and strong clinical engagement.

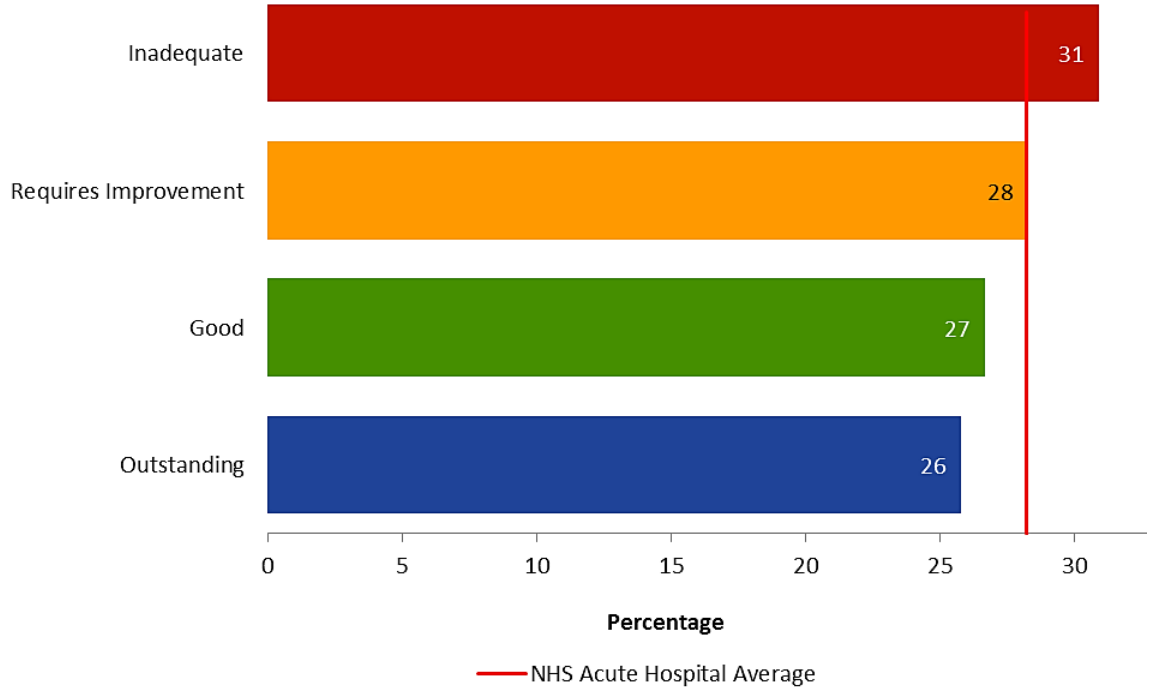
In almost all of the acute specialist and non-specialist trusts that we have rated as outstanding, we have seen leaders who:

- are passionate about the delivery of high-quality care for patients
- actively engage and seek the views of staff and are committed to organisational development
- have a clear vision and strategy – which they have communicated to staff
- ensure that governance is strong, so that emergency problems are dealt with swiftly
- have a clear model for quality improvement across the trust.

The culture of an organisation clearly reflects the quality of its leadership and is essential to the delivery of high-quality care. We test staff culture by listening to the experiences of staff and patients. Staff focus groups are a central part of our inspections. The culture is reflected in the NHS staff survey and the General Medical Council's survey of junior doctors. We have found that measures of staff engagement from these surveys are an important predictor of the quality of care we find at inspection, with hospitals and trusts rated outstanding being better at communicating their values and leadership, for example through communications strategies.

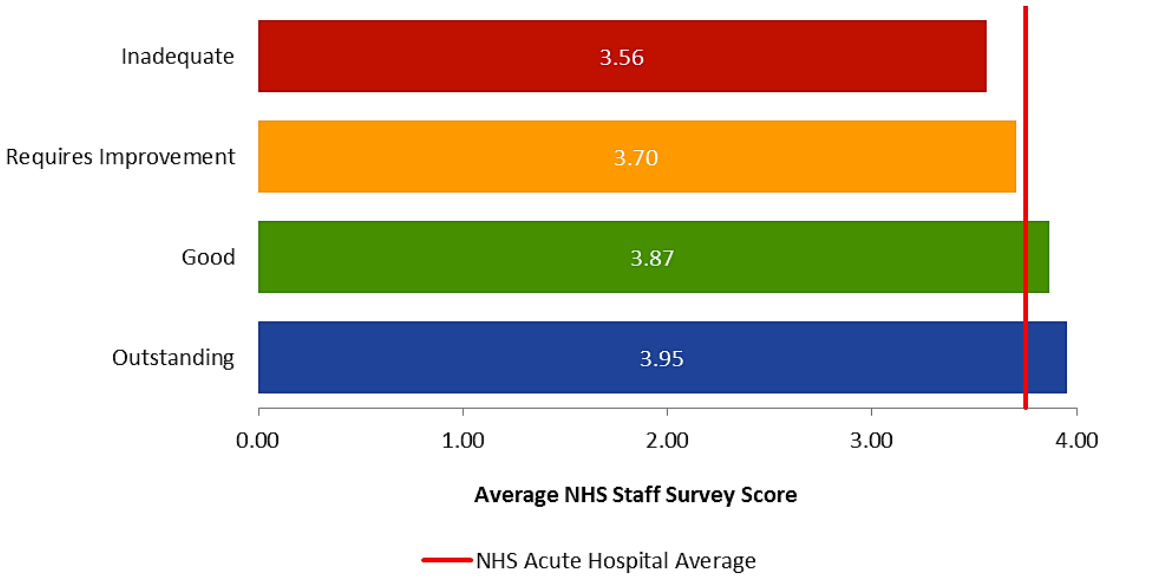
One in four staff in hospitals felt bullied at work by other staff in the 12 months before the 2015 NHS Staff Survey, and more than one in four experienced bullying from patients, relatives or the public. This is a major concern both for staff wellbeing and the quality of patient care. In recent inspections we have included an examination of how compliant trusts are with the NHS Workforce Race Equality Standards (WRES). We have found variable evidence of implementation of the WRES, with some trusts failing to recognise the opportunity of using these standards to promote a positive culture within their organisation. In too many cases, staff survey results and our staff focus groups have shown that staff from Black and minority ethnic groups are less engaged, report more bullying and have fewer opportunities to advance their careers in the NHS.

## Figure 15: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months




Source: CQC ratings data (as at 31 December 2016) and NHS staff survey 2015

## Figure 16: Staff recommendation of the organisation as a place to work or receive treatment




Source: CQC ratings data (as at 31 December 2016) and NHS staff survey 2015

We have observed that more trusts are now carrying out a full census of their staff as part of the NHS Staff Survey, rather than merely sampling a minority of them. We strongly support this direction of travel, which will give trusts far greater insight into staff groups who may be less engaged.

Levels of work-related stress, reflected in the NHS staff survey, are a real concern. We have found that trust boards pay too little attention to this, despite them citing staff recruitment as a key challenge. Poor recruitment is too readily blamed on regional factors, such as costs of housing or travel constraints, while not enough attention is given to retaining staff. Staff tell us that the poor culture of their clinical teams and the barriers they face in delivering good quality care are the most common reasons for them to want to change jobs.

Culture in hospitals can vary substantially within a trust, with individual services having high levels of bullying and poor staff engagement. Local leadership at clinical service level, and sometimes at individual ward level, can be critical in determining the quality of care. When there are local leadership problems, the trust board must tackle these. It is disappointing that some trusts we have inspected have recognised problems with the culture or leadership of particular services, but have not taken action until we have told them to. It is essential that these issues are dealt with quickly and effectively.

During our programme of inspections many staff have privately raised their concerns about the culture of their trust or about specific quality concerns with us. These concerns have been a critical factor in focusing our inspections on key quality issues in many trusts. While we cannot individually acknowledge these whistleblowers in our reports, their contribution to them has been immense. One of the most important lessons from our inspections is the importance of giving all staff the opportunity to speak up about their concerns, without fear of retribution.

We also look at how trusts handle complaints from people who use their services. Many trusts have improved their process for managing patient complaints and we saw a great deal of commitment to getting this right. However, we have not found much innovative practice and many patients told us of their dissatisfaction with their experience of making a complaint. Response to complaints was too often managed inflexibly without considering the needs of the individual complainant. Defensive responses to complaints were still too common, leaving the complainant dissatisfied.

A transparent culture committed to learning from complaints is essential to be able to effectively resolve a complaint. A timely response is critical and typically, with good complaint management, there was early direct contact with the complainant to establish what they were seeking from the complaint and build a relationship of trust. Involvement of the clinical team with the investigation of the complaint, providing them with support where needed, was a key factor in the successful management.

We found varying cultures within boards. We saw many excellent examples, where non-executive directors brought valuable external expertise, maintained objectivity about their trusts, provided constructive challenge and saw our reports as an opportunity to reassess and improve their organisation's delivery of quality care. These boards were outward looking, honest about their quality problems and welcomed any external feedback. However, in some trusts the role and effectiveness of non-executives gave us a cause for concern.

We saw too many examples where boards were too concerned about the trust's reputation and this led them to a lack of openness about quality issues. We also saw examples where non-executives were part of an insular, remote board culture where any external feedback was resented. In foundation trusts, we saw few examples of effective relationships between the governors and the non-executive directors. Boards too often saw councils of governors as a problem to be managed, rather than a valuable resource to represent the population served and to provide challenge.

Many boards told us that culture would take time, but we have seen examples where decisive leadership driven by strong values has turned round damaged cultures in hospitals within a short period. This has to start at all levels of the organisation with honesty about the nature and extent of the problems that it faces.

A key example of this is Wexham Park Hospital in Slough. On our initial inspection in February 2014, we rated the hospital as inadequate. We found that there were unsafe staffing levels, patients were waiting too long for attention and treatment, there were too many cancelled operations, and staff did not have a clear vision about the organisation's direction. On our follow-up inspection in October 2015, a little over a year after it was taken over by Frimley Health NHS Foundation Trust, we found a marked improvement, particularly in the leadership and management culture of the organisation. Staff told us that they felt valued and felt able to put excellent patient care and experience at the heart of their work, and that the trust's values were now embedded throughout their directorates. Over the same period, the proportion of staff who would recommend the trust as a place to work or be treated increased markedly. As a result, we rated the hospital as good (figure 17).

We also look at the digital systems a trust has in place and the quality of the data it holds. In particular, we look at an organisation's ability to plan, deliver and optimise its digital systems so that it can be paper-free at the point of care. As with the overall ratings for well-led, we have found that trusts with good and outstanding ratings have better digital systems in place (figure 18).

## Figure 17: Wexham Park improvement in ratings

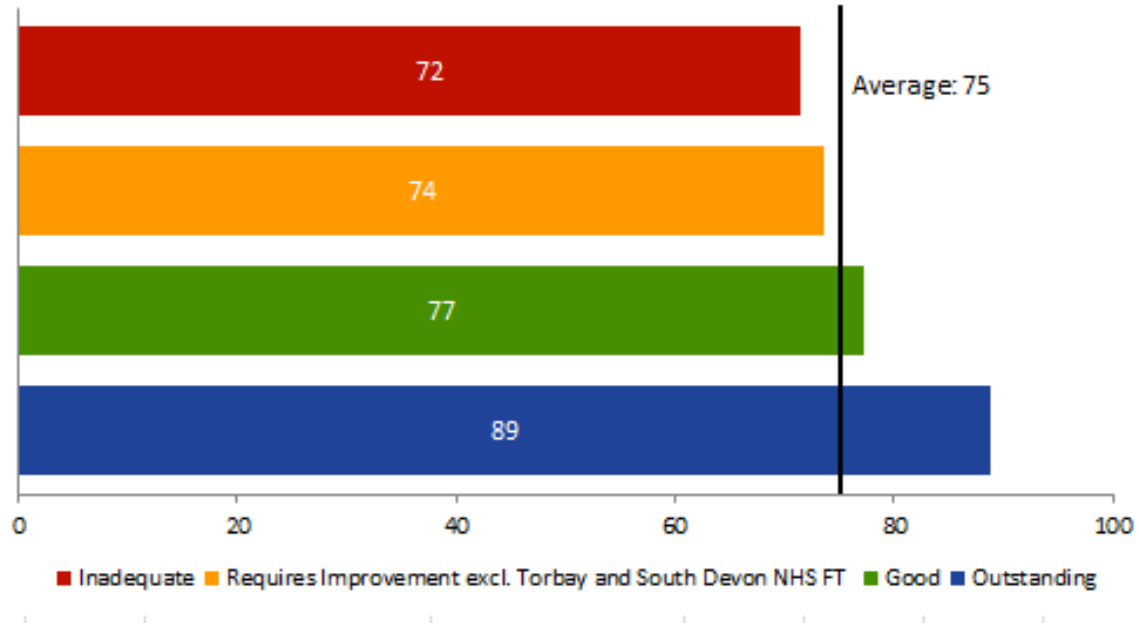
### 2014

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services (A&E) | Requires improvement | Inspected but not rated | Requires improvement | Inadequate | Requires improvement | Requires improvement |
| Medical care (including older people's care) | Inadequate | Requires improvement | Requires improvement | Inadequate | Requires improvement | Inadequate |
| Surgery | Inadequate | Good | Requires improvement | Inadequate | Inadequate | Inadequate |
| Intensive/critical care | Good | Good | Good | Requires improvement | Good | Good |
| Maternity and gynaecology | Inadequate | Requires improvement | Requires improvement | Requires improvement | Inadequate | Inadequate |
| Services for children & young people | Good | Good | Good | Good | Good | Good |
| End of life care | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Outpatients and diagnostic imaging | Requires improvement | Inspected but not rated | Good | Inadequate | Requires improvement | Requires improvement |
| Overall | Inadequate | Requires improvement | Requires improvement | Inadequate | Inadequate | Inadequate |

### 2015

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services (A&E) | Good | Good | Good | Outstanding | Outstanding | Outstanding |
| Medical care (including older people's care) | Good | Good | Good | Good | Good | Good |
| Surgery | Good | Good | Good | Good | Outstanding | Good |
| Intensive/critical care | Good | Good | Outstanding | Good | Outstanding | Outstanding |
| Maternity and gynaecology | Good | Good | Good | Good | Good | Good |
| Services for children & young people | Good | Good | Good | Good | Good | Good |
| End of life care | Good | Good | Good | Good | Good | Good |
| Outpatients and diagnostic imaging | Good | Inspected but not rated | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Outstanding | Good |

## Figure 18: Digital maturity assessment readiness by overall rating




Source: CQC ratings data (as at 31 December 2016) and NHS England

# 4. Core services

This section looks in detail at each of the core services we inspect, and puts a spotlight on the examples of outstanding practice we have seen to encourage services to improve.

## 4.1 Urgent and emergency services

**Key points**

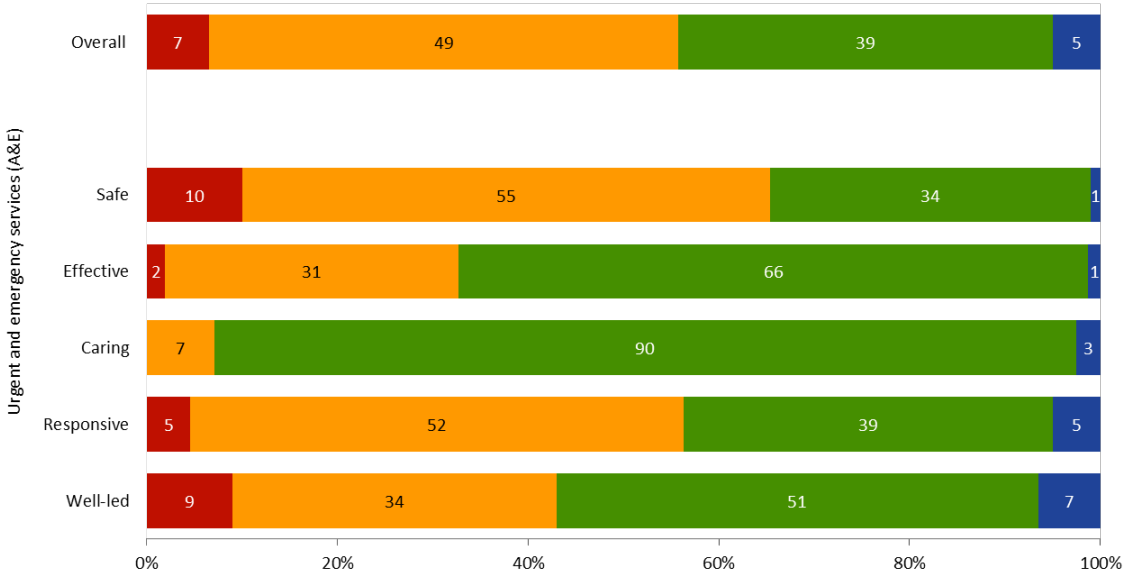
- The number of people attending A&E is continuing to increase year-on-year.
- The four-hour target is a useful measure, but the length of time it takes for patients to receive an initial clinical assessment is equally important for good outcomes.
- Trusts should consider implementing a standardised measure for assessing the acuity of patients' needs in urgent and emergency care, so that those needing the most urgent interventions get assessed most quickly.
- The interval between decision to admit and admission is measured in different ways across the country. This should be standardised, based on the time the person presents at A&E.
- Urgent and emergency services are facing a shortage of specialist staff, with hospitals struggling to recruit the specialists they need.
- Patients with mental health problems have a particularly poor experience in many A&Es.
- The physical environment of A&Es is a big concern. Many A&Es were built at a time when demand was much lower and a lot of these are no longer fit for purpose.

Urgent and emergency care services are provided at the 'front door' of a hospital, treating patients presenting as an emergency or with urgent medical needs. They include emergency departments, commonly called accident and emergency (A&E) departments, and urgent care centres. Services may also include a clinical decision unit, acute medical unit, an ambulatory care unit, a minor injury unit or a walk-in centre.

Overall, we have rated 199 urgent and emergency services. Ten hospitals (5%) have been rated as outstanding (figure 19).

Urgent and emergency care services are working under considerable pressure and, as a result, their performance needs to be seen in the context of the growing demand on the NHS. A steadily increasing number of people are attending A&E, with 2015/16 having the highest number yet for any full year (figure 20). Attendances are continuing to increase in 2016/17.

## Figure 19: Overall ratings for urgent and emergency services




Source: CQC ratings data, as at 31 December 2016. Total of 199 urgent and emergency services.

Often, trusts are not keeping up with this demand, with the whole system struggling to maintain the target of treating or admitting all A&E patients within four hours. The Royal College of Emergency Medicine has recently highlighted the importance of this target as a way of measuring the whole system response to care, and how patients move through the system (patient flow). Not meeting this target could be an indication of overcrowding and can lead to poorer patient care.[11]

In 2015/16, the proportion of patients being admitted, discharged or transferred within four hours was much lower in comparison to previous years, with the annual average percentage of patients managed within four hours decreasing from 91% to 88% since 2014/15. Performance has continued to decline during 2016/17, averaging 86% in each of the first two quarters.

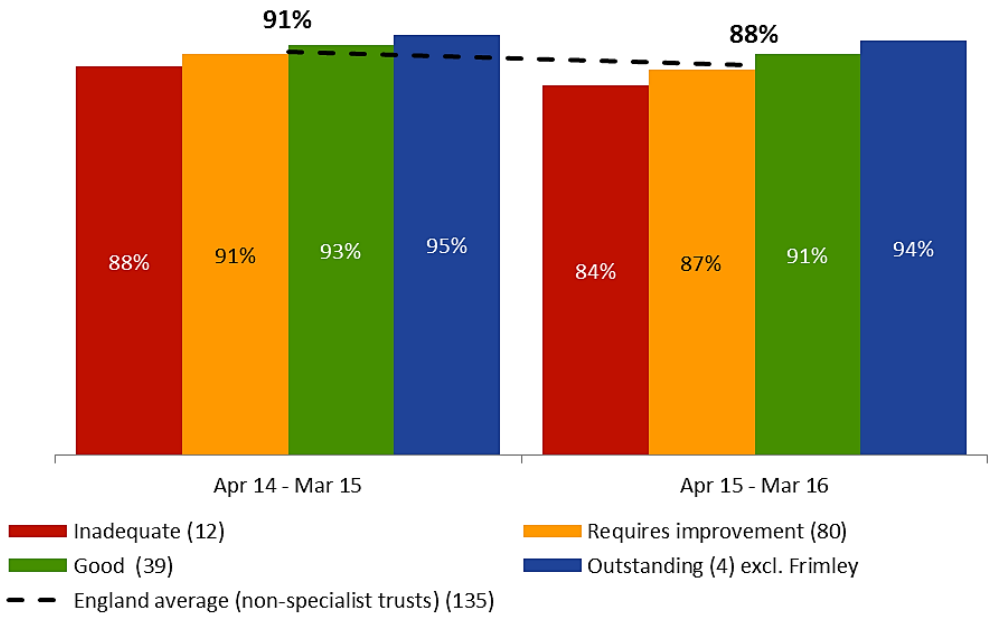
However, as figure 20 shows, this decline in performance is in the context of a continuing rise in attendances each year, during which the total number of patients spending four hours or less in A&E has remained stable (rising slightly from 20.9 million in 2011/12 to 21 million in 2015/16). Meanwhile the number spending more than four hours has risen from 700,000 to 1.8 million.

Comparing this against our ratings of urgent and emergency services, we can see that trusts rated inadequate or requires improvement experienced the largest decreases in four-hour performance (figure 21). A&E departments rated inadequate or requires improvement had a 4% fall in performance on average from 2014/15 to 2015/16. Those rated as good or outstanding had average falls of 2% and 1% respectively.

## Figure 20: Total monthly A&E attendances 2011/12to 2015/16


Source: NHS England

Figure 21: Average percentage of patients spending four hours or less in A&E by trust rating (April 2014 to March 2016)




Source: CQC ratings data (as at 31 December 2016) and NHS England

While increasing demand is consistent, we have found variation in how effectively acute hospitals respond to this demand. A&Es cannot work in isolation and the hospital must manage the acute care pathway as a whole. On some of our inspections, we have found a cultural barrier between the A&E and the rest of the hospital, with the 'door' into the main hospital acting as much a cultural as a physical barrier. A&E needs support from all the acute services in the hospital, with senior clinical decision-makers being available at the front door, where the most seriously ill patients in the hospital are often located.

The acute patient pathway in the hospital is part of a much bigger clinical pathway encompassing community services, primary care and social care as well. The four-hour performance is a measure of how well the whole system, not just the A&E and ambulance services, is coping with the patient demand. A&Es providing good or outstanding care can only do so by working closely with the wider health and social care system.

The four-hour target is an important measure for us to judge how well patients flow through the hospital. However, it is not the only way in which we assess the quality of care in A&Es. We also look at the quality of the care and treatment they receive while they are in the emergency department. In particular, we are concerned about the time it takes for a patient to receive an initial clinical assessment. A&Es that are performing well on the four-hour target may not be assessing patients quickly enough, and in turn not recognising and treating life-threatening illnesses at the earliest opportunity. Trusts should consider implementing a standardised measure for assessing the acuity of patients' needs in urgent

and emergency care, so that those needing the most urgent interventions (for example, those with sepsis) get assessed most quickly.

We also look at the 12-hour target between decision to admit a patient and their admission to hospital. Currently, the time taken between the decision to admit and admission of the patient is measured in different ways across the country. Some hospitals start timing the 12 hours from when the patient is seen by a specialist, not when they first arrive in A&E, meaning that the patient could be waiting in A&E for well over 12 hours. There needs to be clear guidance, with the 12-hour target standardised from when the patient first arrives in A&E.

We have found particular problems with people attending A&E who are having a mental health crisis or who have an underlying mental health problem. Recording of people with mental health problems is inconsistent, but it is estimated that 5% of all A&E attendances (potentially one million people if estimates are correct) are related to mental health problems. Increasingly, liaison psychiatry teams are being seen as essential in providing an effective pathway of care. A close relationship between a liaison service and the A&E department can provide a quicker and more effective assessment to people in crisis. They can also provide frontline staff with basic mental health awareness training.[12]

Many hospitals have told us that they are having difficulty recruiting the specialist staff they need for their urgent and emergency services. Where hospitals are providing good care, we often find that they are responding to this by using staff flexibly, for example using emergency nurse practitioners, paramedics or consultants from other specialities to provide support within the A&E.

Many A&E departments we have inspected were built at a time when the demand was much lower. Many no longer have the physical capacity to cope with the current demand. We have frequently found patients waiting on trolleys in unsuitable environments affecting the safety and dignity of their care. We recognise that when an A&E department faces a surge in attendances it needs to use its physical capacity flexibly. Where it does this, it is important that the hospital has an effective escalation plan and that measures are put in place to ensure that the privacy and dignity of patients are protected, that patients are monitored adequately and that necessary care is provided. In particular, hospitals need to make sure that they have proper areas for resuscitation and to assess and treat children to ensure they are protected and cared for in appropriate environments.

Overcrowding can lead to patients being held in ambulances outside the hospital until room can be found. In some cases, this queuing of ambulance patients has been normalised and is routine, with staff feeling unable to challenge the practice. Some staff described their A&E as being in a state of everyday crisis, even though the demand on most days was predictable and should have been planned for.

As at 31 December 2016, we had rated 10 hospitals as outstanding for their urgent and emergency care services. While the A&Es in these hospitals are not perfect, we have found that they are focused on what is important for patients and cope much better with the increasing demands compared with other A&Es. They also have good links with their local health economies, especially social care services.

Urgent and emergency services rated outstanding overall tended to be rated outstanding for their responsiveness and leadership. Services were able to monitor the demand on the service and take action to reduce the pressure on the department. Escalation plans to cope with surges in demand were well established and successful. These hospitals predicted periods of peak demand and had effective plans in place to increase capacity in the whole acute care pathway and maintain the safe care of patients. Department leaders were visible and approachable to staff and had a clear and committed focus to drive improvements in patient safety and the quality of care and treatment throughout the department.

## Spotlight on outstanding practice

Figure 22: Hospitals rated outstanding for urgent and emergency services

| Hospital | Publication date |
|---|---|
| Frimley Park Hospital, Surrey | 26/09/2014 |
| Homerton University Hospital, London | 24/04/2014 |
| Ipswich Hospital, Suffolk | 10/04/2015 |
| Luton and Dunstable Hospital, Bedfordshire | 03/06/2016 |
| Royal Devon & Exeter Hospital (Wonford), Devon | 09/02/2016 |
| Salford Royal Hospital, Salford | 27/03/2015 |
| St Richard's Hospital, West Sussex | 20/04/2016 |
| St Thomas' Hospital, London | 24/03/2016 |
| Wexham Park Hospital, Berkshire | 02/02/2016 |
| Worthing Hospital, West Sussex | 20/04/2016 |

### Examples of outstanding practice

- St Thomas' Hospital, London had specialist support units that were active within the urgent and emergency department including alcohol, toxicology, homeless, youth support and play therapy for children.
- St Richard's Hospital, West Sussex focused on access and flow and, coupled with the work being done with local stakeholders such as GPs and clinical commissioning groups, had resulted in a department that was mostly able to meet the key performance targets. People were seen quickly and were not kept in the department overly long.

- Royal Devon & Exeter Hospital (Wonford), Devon used a computer system that alerted staff when a child with a long-term illness arrived in the emergency department. Care plans for each child were immediately available so that they received treatment and care that was specific to their condition.
- Luton and Dunstable Hospital, Bedfordshire had a multidisciplinary approach to patient care and a robust process for managing the access and flow in the department, which helped it to consistently achieve the four-hour target since 2012.

## Ipswich Hospital, Suffolk

The urgent and emergency care services showed some outstanding practice in responsiveness and leadership. There was an open culture for quality improvement, incidents were reported and learning was shared. Staffing levels and skill mix were planned, implemented and reviewed, and new staff well supported. Staff took the time to listen to patients, and gave explanations of care, to enable patients to be informed and involved in decision-making. The emergency department had an escalation policy and used a demand trigger tool, developed by the management team. This monitored and linked patient demand to whole trust demand, and enabled a proactive response to clinical demands. The tool triggered when the department was experiencing high demand and set in motion a series of actions to reduce the pressure on the department. This was outstanding as it maintained flow through the department and ensured that patients were admitted in a timely way.

## Luton and Dunstable Hospital, Bedfordshire

The service had an established and experienced leadership team who were visible and approachable to staff at all levels and had a clear and committed focus to drive improvements in patient safety and the quality of care and treatment throughout the department. Staff were encouraged to challenge behaviour in their colleagues that was not in line with the trust's values. Patients described staff as caring and professional. Staff showed an awareness of the emotional and mental health needs of patients and were able to refer patients for specialist support if required. Assessment tools for anxiety, depression and wellbeing were available for staff to use when required.

## Figure 23: Changes in overall rating for urgent and emergency care, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | Wexham Park Hospital, Slough* |
| | From inadequate to good | Southmead Hospital, Bristol |
| ↑ | From requires improvement to good | Addenbrooke's and the Rosie Hospitals, Cambridge |
| | | Burnley General Hospital |
| | | Grantham and District Hospital |
| | | Kent & Canterbury Hospital |
| | | Lincoln County Hospital |
| | | Milton Keynes Hospital |
| | | Peterborough City Hospital |
| | | Pilgrim Hospital, Lincolnshire |
| | | Queen's Hospital, Burton Upon Trent |
| | | Royal Blackburn Hospital |
| | | The Queen Elizabeth Hospital, Norfolk |
| | From inadequate to requires improvement | Broomfield Hospital, Essex |
| | | Hereford Hospital, Herefordshire |
| | | Hinchingbrooke Hospital, Cambridgeshire |
| | | Queen Elizabeth Hospital, Greenwich |
| | | Queen Elizabeth The Queen Mother Hospital, Kent |
| | | St Mary's Hospital, Westminster |
| | | Whipps Cross University Hospital, Waltham Forest |
| | | William Harvey Hospital, Kent |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | Royal Cornwall Hospital, Cornwall |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Diana Princess of Wales Hospital, North East Lincolnshire |
| | | Furness General Hospital, Cumbria |
| | | Royal Lancaster Infirmary, Lancashire |
| | | St George's Hospital (Tooting), Wandsworth |
| | From requires improvement to inadequate | Birmingham Heartlands Hospital |
| | | Kings Mill Hospital, Nottinghamshire |
| | | Princess Royal Hospital, West Sussex |
| | | Royal Sussex County Hospital, Brighton and Hove |
| | | The Princess Alexandra Hospital, Essex |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, there was no change in rating in a further 32 hospitals between first and most recent published inspection; eight remained good, 23 remained requires improvement and one, Medway Maritime Hospital, remained inadequate. Across all re-inspections described in this report, results are drawn from the first and last published inspections. In a minority of cases services have been inspected and rated more than twice.

## 4.2 Medical care

### Key points

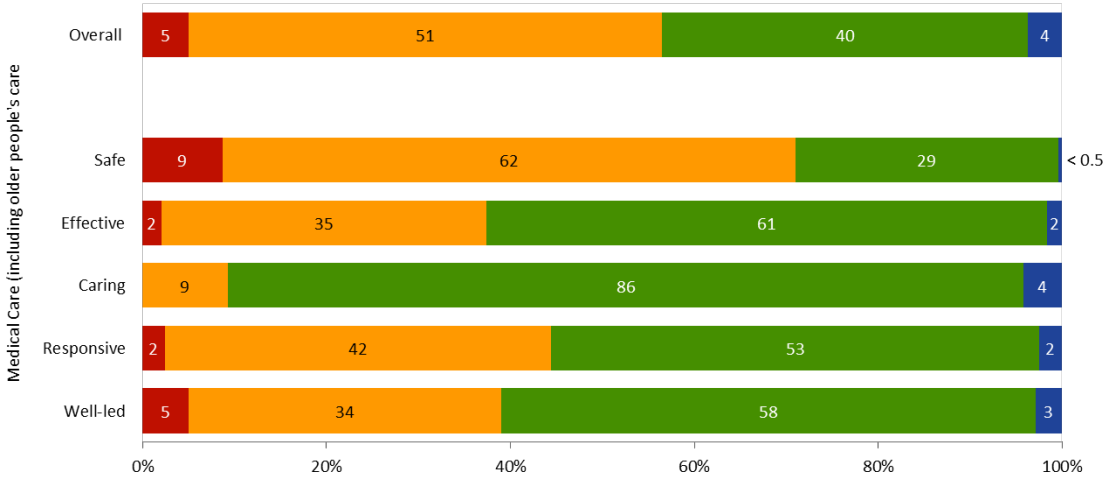
- Medical care is the largest service in most hospitals in terms of wards and beds.
- Local ward leadership, both medical and nursing, is critical to achieving high-quality care.
- Finding a bed to move patients to is a daily challenge for hospitals. Patients are often not treated in a ward that specialises in their problems, and can be moved from ward to ward. This can lead to discontinuity in care.
- Discharging patients in a timely way is also a challenge, with delayed discharges often linked to problems in the wider system. This puts patients at unnecessary risk and leads to poorer experiences for frail and elderly patients.
- Staffing is an issue for medical services, with nursing staff overstretched and growing pressure on junior doctors.
- Staffing pressures and poor use of early warning scores can lead to delayed recognition and intervention for patients whose condition is deteriorating.

In most hospitals, medical care is the largest core service we inspect, usually covering many wards within a trust. In general terms, medical care services assess, diagnose and treat adults through medical interventions rather than surgery. This includes a broad range of specialities not covered in the other core services, including cardiology, respiratory medicine, and gastroenterology, as well as endoscopy and chemotherapy. We inspect general wards, speciality wards – including care of the elderly wards – and acute assessment units, and have rated 239 medical care services in total.

One of the fundamental challenges trusts face is to provide a consistent and good level of care across all of their medical care wards. However, due to its scale and complexity, we may find issues across the service, but often the quality issues are centred on just one or two wards. While the overall leadership culture of the trust is important, often it is the local ward leadership, medical as well as nursing, that is critical to achieving high-quality care. Effective multidisciplinary team working is essential. These wards are often very busy and it is in medical wards that nursing recruitment is generally most challenging.

We have seen excellent ward leadership, providing high-quality care under the most challenging conditions, but as a result of these pressures, medical care services often struggle to achieve an overall rating of good or outstanding. At December 2016, 56% of the services rated were rated as requires improvement or inadequate (figure 24). Nine hospitals (4%) were rated as outstanding for medical care.

## Figure 24: Overall ratings for medical care services




Source: CQC ratings data, as at 31 December 2016. Total of 239 medical care services.

Patients on medical wards are often elderly with multiple illnesses, and demand for medical care beds is always high. Finding a bed to move patients to is a daily challenge for hospitals and is related to the problems hospitals have in discharging patients. As a result, medical patients are often nursed in non-medical wards, where they do not necessarily have access to the staff expertise they require, or are repeatedly moved from ward to ward.

While some services can do more themselves to make sure that patients are discharged at the right time, delayed discharges are often linked to problems in the wider system, for example a lack of capacity within community health services or the social care system. Not only does this have an impact on how patients are moved through the hospital, but it can also be detrimental to the patient's health if they are well but are being kept on a medical ward because there is no social care accommodation to go to or social care support for them to go home. Delayed discharges put patients at unnecessary risk and lead to poorer experiences for frail and elderly patients.

Hospitals rated as good or outstanding for their medical care services make sure that the right patients are in the right wards. Trusts rated as outstanding ensure that inefficiencies within their medical care pathway, for example with diagnostic tests or therapy, do not delay patients' readiness for discharge. They have well-developed discharge planning processes to make sure that all the necessary support for patients to be discharged is available as soon as they are medically fit. They are better able to increase the number of beds, but also have higher capacity. In addition, they work closely with social care and community organisations and have enough consultants in medical and elderly care to make sure that people are seen regularly by senior decision makers, and as a result can be discharged in a timely way.

Staffing is an issue for medical care services. Not only have we found that in many cases nursing staff are overstretched, but we have also seen growing pressure on junior doctors as they are covering large numbers of acutely ill patients, particularly out of hours. However, there are currently no reliable figures on the number of junior doctors working in medical services, and no standards for safe staffing by junior doctors. As a result, CQC will be working with the Academy of Medical Royal Colleges to address this problem.

When staff are overstretched they are less able to monitor patients closely enough and identify when a patient is deteriorating. This highlights the importance of multidisciplinary teams working together effectively and the appropriate use of early warning scores, and clear protocols and effective audits of escalation when pre-determined scores are exceeded.

In good hospitals, we have found doctors and nurses working closely together, and management being flexible with their nursing staff. In these hospitals, the numbers of nurses on duty are decided according to the needs and dependencies of the patients, with bank staff being used flexibly.

Some hospitals are now operating a seven-day service for inpatients on medical wards to make sure that they are regularly seen by consultants and senior decision makers. We believe that this is essential to being able to provide an effective service. However, diagnostic tests, imaging and some treatments and therapies are not always available on a seven-day basis. In addition, social care support for discharges is often lacking at weekends and over holiday periods.

## Spotlight on outstanding practice

Figure 25: Hospitals rated outstanding for medical care

| Hospital | Publication date |
|---|---|
| Freeman Hospital, Newcastle upon Tyne | 06/06/2016 |
| Frimley Park Hospital, Surrey | 26/09/2014 |
| Hexham General Hospital, Northumbria | 05/05/2016 |
| North Tyneside General Hospital, Northumbria | 05/05/2016 |
| Salford Royal Hospital, Salford | 27/03/2015 |
| St Richard's Hospital, West Sussex | 20/04/2016 |
| Wansbeck General Hospital, Northumbria | 05/05/2016 |
| West Suffolk Hospital, Suffolk | 04/08/2016 |
| Worthing Hospital, West Sussex | 20/04/2016 |

**Examples of outstanding practice**

- Salford Royal Hospital, Salford developed the 'emergency village' with its integrated care pathway approach, including medical in-reach, which delivered improved outcomes for people.
- Frimley Park Hospital, Surrey welcomed views and input from staff and the local community allowing for a real sense of engagement and therefore empowerment from those involved in the services to improve the quality of care being provided.
- North Tyneside General Hospital, Northumbria included a psychological assessment for patients who require isolation for infection prevention reasons.
- St Richard's Hospital, West Sussex were involved in a trust-wide NHS Quest initiative, which focused on improving quality and safety. As part of this the trust took part in collaborative improvement projects for sepsis and cardiac arrest. Work was in progress on these initiatives at the time of our inspection.
- Worthing Hospital, West Sussex maintained a dashboard that was used as a tool for monitoring the implementation of the dementia strategy. Worthing have also integrated care for patients admitted as either a medical or surgical case, including frail elderly patients. This ensures holistic assessment of patients' needs.

## West Suffolk Hospital, Suffolk

Consultants stated that they found the input of other clinical teams and specialist nurses to be very good and that it was patient focused. Therapy staff stated that they felt part of a strong multidisciplinary team and their views and opinions were valued by staff across various professional teams. All staff described teams working well together and sharing best practice to improve patient outcomes. Interactions observed between members of the multidisciplinary team were seen as positive and clearly showed mutual respect for each other's roles. There was joint working with discharge coordinators and therapy teams to identify patients awaiting discharge. These staff would review every patient awaiting a rehabilitation bed and attend board rounds to promote early intervention and discharge where possible.

## Wansbeck General Hospital, Northumbria

Doctors used an app, which allowed them to view clinical policies and procedures directly. On Ward 6 we saw a ward round in which a portable laptop was used so x-rays and blood results could be seen at the bedside. Guidelines were stored on the trust intranet system, which was accessible to all staff. There was effective multidisciplinary team working, with the 'hospital to home team' integrated to ensure safe prompt discharge. The hospital to home team was a combined team comprising social workers, occupational therapists, care

managers and nurses. The aim of the team was to "provide safe prompt discharges and provide short and long-term care packages in the community as well as signposting patients to other health services".

## Figure 26: Changes in overall rating for medical care, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to good | Queen's Hospital, Burton Upon Trent, Staffordshire |
| | | Royal Lancaster Infirmary, Lancashire |
| | | Wexham Park Hospital, Slough* |
| ↑ | From requires improvement to good | Addenbrooke's and the Rosie Hospitals, Cambridgeshire |
| | | Broomfield Hospital, Essex |
| | | Derriford Hospital, Plymouth |
| | | Furness General Hospital, Cumbria |
| | | Grantham and District Hospital, Lincolnshire |
| | | Hinchingbrooke Hospital |
| | | Leeds General Infirmary, Leeds |
| | | Lincoln County Hospital, Lincolnshire |
| | | Milton Keynes Hospital, Milton Keynes |
| | | Queen Elizabeth The Queen Mother Hospital, Kent |
| | | Royal Blackburn Hospital, Blackburn with Darwen |
| | | Samuel Johnson Community Hospital, Staffordshire |
| | | St James's University Hospital, Leeds |
| | | The Queen Elizabeth Hospital, Norfolk |
| | From inadequate to requires improvement | Hereford Hospital, Herefordshire |
| | | Pinderfields Hospital, Wakefield |
| | | Whipps Cross University Hospital, Waltham Forest |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | n/a |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Burnley General Hospital, Lancashire |
| | | Princess Royal Hospital, West Sussex |
| | | St George's Hospital (Tooting), Wandsworth |
| | From requires improvement to inadequate | Kings Mill Hospital, Nottinghamshire |
| | | Medway Maritime Hospital, Medway |
| | | West Cumberland Hospital, Cumbria |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, a further 36 hospitals saw no change in rating between first and most recent published inspection; eight remained good and 28 remained requires improvement.

## 4.3 Surgery

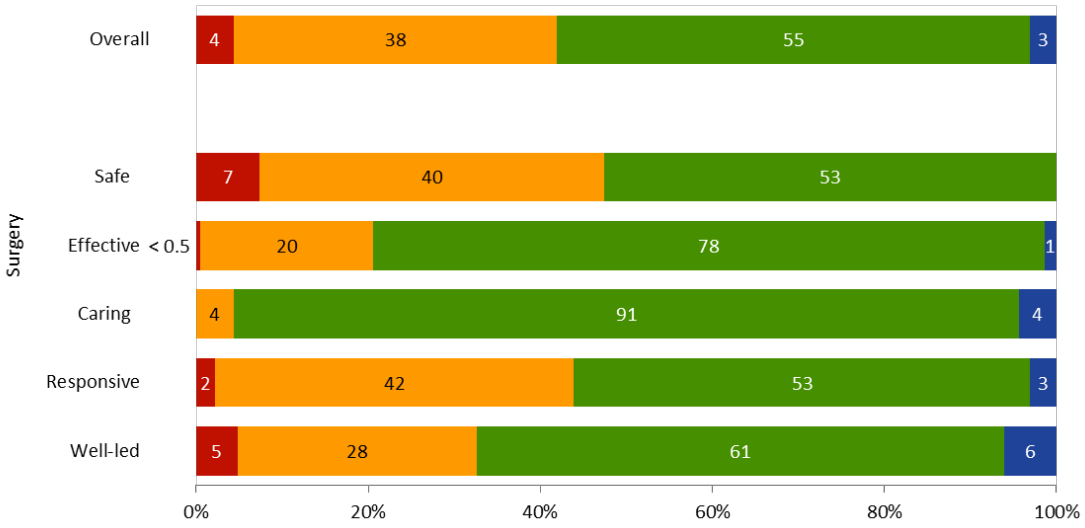
### Key points

- The safety culture in operating theatres is key.
- The World Health Organization (WHO) surgical safety checklist must be completed effectively, taking into account the best evidence from research into human factors and routinely used for all patients.
- An area of concern is the safety of operating theatre environments, including poor maintenance and issues with poor ventilation.
- There are too many last minute cancellations because of a lack of availability of beds (including critical care beds), with the rate of cancelled elective operations steadily increasing since 2011/12. Surgical beds are often occupied by medical 'outliers'.
- Emergency surgery is another area requiring improvement. While there has been some improvement over the last three years, we are still finding delays in assessment of emergency patients and access to theatres for urgent operations.
- Dedicated physician support of surgical patients has led to significant improvements in care for patients with fractured hips, but few hospitals have introduced a similar approach for other emergency surgical patients.

Surgery includes most surgical activity in a hospital, including planned (elective), emergency and day case surgery. We inspect pre-assessment areas, theatres, anaesthetic rooms and recovery areas. All surgical disciplines are included when they are provided, for example trauma and orthopaedics, urology, ear, nose and throat (ENT), cardiac surgery, vascular, ophthalmic surgery, neurosurgery and general surgery. Interventional radiology is included regardless of whether these procedures might be carried out outside the theatre department.

Surgery therefore covers a wide range of specialities and mixture of disciplines, each with their own challenges. We have rated 229 surgery services overall. Many of these services provide highly effective care, but in the last four years, the total number of never events has ranged from 290 to 359 (2012/13 to 2015/16). In particular, the safety and leadership in operating theatres stand out as two key concerns for the core service as a whole. This is reflected in the ratings for this core service with 7% of services rated as inadequate for safety and 5% rated as inadequate for well-led (figure 27). Seven hospitals (3%) were rated as outstanding overall.

## Figure 27: Overall ratings for surgery services




Source: CQC ratings data, as at 31 December 2016. Total of 229 surgery services.

When we assess the safety of a surgical service, we check its safety culture and the operating theatres. Trusts rated good and outstanding have effective clinical audit processes and ensure that audits are used to drive quality improvements. Clinical data and patient outcomes are also used to feed into national audits and drive quality improvements within the hospital. In addition, we have found that these wards have a good culture of reporting and learning from incidents.

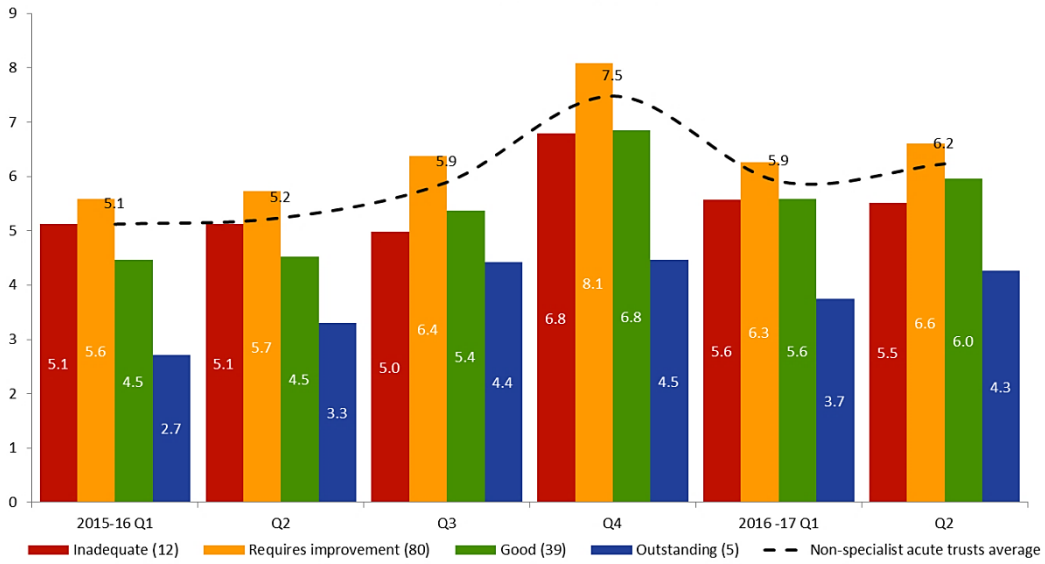
Poor multidisciplinary working between surgeons, nursing staff and others working in theatres can be a barrier to proper implementation of essential safety measures such as the World Health Organization (WHO) surgical safety checklist, Five Steps to Safer Surgery. This must be completed properly and used routinely for all patients, but we have found that it is still not universally used. Many of the approximately 300 never events per year relate to wrong site surgery, which should be avoided if the WHO surgical safety checklist is used properly. Evidence shows that errors in operating theatres are frequently linked to team dynamics and human factors, so the culture and leadership within the operating theatres are essential for this to be used effectively.

Another area of concern is the safety of operating theatre environments. Problems we have found in some operating theatres include issues with poor ventilation, and problems with poor maintenance such as cracked tiles that make it difficult to keep surfaces clean. This does not necessarily mean that trusts need to commission new theatres, but they do need to properly maintain the ones they have.

As with other core services, we have also seen the impact that bed shortages have on surgical wards. We have seen too many last minute cancellations because of a lack of availability of beds, often associated with surgical beds being used by patients with medical conditions requiring emergency admission. Since 2011/12, the rate of cancelled elective operations has increased steadily, with a 49% increase in the average national rate of cancellations from July to September 2011/12 to July to September 2016/17. This is a symptom of poor patient flow through the hospital and not being able to locate patients appropriately on medical wards and free up surgical beds. There is also a clear seasonal variation in the rate of cancellations, with a regular peak in quarter 4 (January to March). Operations are also sometimes cancelled because of a lack of critical care bed availability.

Reducing the number of cancelled operations, as well as improving waiting times, are key areas for improvement. Figure 28 shows the rate of cancelled elective operations against our ratings from the start of 2015/16.

## Figure 28: Average rate of cancelled elective operations for overall ratings (April 2015 to September 2016)




Source: CQC ratings data (as t 31 December 2016) and NHS England

Emergency surgery services are another area requiring improvement. We recognise that services are working under pressure, but we have seen variable results from surgical audits (for example, fractured neck of femur and national emergency laparotomy audits). While some audits have shown improvement over the last three years, there are still delays in emergency patients being assessed by a surgical consultant and delays in access to theatres.

Many hospitals have now recruited physicians who are experts in assessing and managing older patients with fractured hips. These orthogeriatricians have had a major impact and have improved the quality of care. In contrast, in other surgical specialties very few older emergency surgical patients have a medical assessment before surgery. We have also seen problems in many hospitals with access to critical care beds after operations. In many cases patients in A&E with suspected surgical problems are not being seen quickly enough, and often are not being seen by a surgeon with the appropriate experience to make timely decision about the best management of their condition.

## Spotlight on outstanding practice

Figure 29: Hospitals rated outstanding for surgery

| Hospital | Publication date |
|---|---|
| Freeman Hospital, Newcastle upon Tyne | 06/06/2016 |
| Frimley Park Hospital, Surrey | 26/09/2014 |
| Hexham General Hospital, Northumbria | 05/05/2016 |
| North Tyneside General Hospital, Northumbria | 05/05/2016 |
| Northumbria Specialist Emergency Care Hospital, Northumbria | 05/05/2016 |
| Royal Victoria Infirmary, Newcastle upon Tyne | 06/06/2016 |
| Wansbeck General Hospital, Northumbria | 05/05/2016 |

### Examples of outstanding practice

- North Tyneside General Hospital, Northumbria developed a day case mastectomy service that aimed to save 201 bed days each year. It had also reduced the average length of stay to between 2.7 and 4.2 days (depending on the level of risk to the patient at the time of surgery). This compared with a national average of around 4.8 days.
- Wansbeck General Hospital, Northumbria developed a 'block room' for the administration of local anaesthetics, as an alternative to general anaesthetic for some procedures. This led to a more streamlined approach to the recovery of patients following surgery.

## Wansbeck General Hospital, Northumbria

Meeting people's emotional needs was embedded and documented in the care plans, with well-established and skilled staff providing post discharge support after surgery. Performance showed a good track record in regard to patient safety. The service had reported no serious incidents or never events at the hospital. Governance processes were in place to ensure that incidents were discussed, and lessons were learned and communicated to staff in order to improve services. Skilled, competent staff were available across site and recruitment processes were in place to fill vacant posts. Mandatory training at the hospital was attended by all staff groups and overall compliance targets had been achieved. Patients were treated based on national guidance and the division took part in all the national clinical audits that they were eligible for.

## Frimley Park Hospital, Surrey

The surgical services were led by a highly committed, enthusiastic team of staff, each of whom shared a passion and responsibility for delivering a first class service. Staff described leadership as "excellent" and "visible". Staff understood the ethos of the service and the corporate values, and showed a commitment to delivering a high-quality service to patients. The nutritional needs of patients were being assessed and people's religious, cultural and medical dietary needs were met. People who had particular physical or mental health needs were supported by staff who had been trained in these areas, including care needs associated with dementia. There were arrangements in place to respond to complaints in accordance with a local policy.

## Figure 30: Changes in overall rating for surgery, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to good | Conquest Hospital, East Sussex |
| | | Eastbourne District General Hospital, East Sussex |
| | | Wexham Park Hospital, Slough* |
| ↑ | From requires improvement to good | Addenbrooke's and the Rosie Hospitals, Cambridgeshire |
| | | Basildon University Hospital, Essex |
| | | Broomfield Hospital, Essex |
| | | County Hospital Louth, Lincolnshire |
| | | Cumberland Infirmary, Cumbria |
| | | Derriford Hospital, Plymouth |
| | | Hinchingbrooke Hospital, Cambridgeshire |
| | | James Paget Hospital, Norfolk |
| | | Kings Mill Hospital, Nottinghamshire |
| | | Leicester Royal Infirmary |
| | | Queen's Hospital, Burton Upon Trent, Staffordshire |
| | | Royal Blackburn Hospital |
| | | Royal Cornwall Hospital |
| | | Sir Robert Peel Community Hospital, Staffordshire |
| | | Tameside General Hospital |
| | | The Queen Elizabeth Hospital, Norfolk |
| | | West Cumberland Hospital, Cumbria |
| | From inadequate to requires improvement | Kent & Canterbury Hospital, Kent |
| | | The Royal London Hospital, Tower Hamlets |
| | | William Harvey Hospital, Kent |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | Colchester General Hospital, Essex |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Ormskirk District General hospital, Lancashire |
| | | Princess Royal Hospital, West Sussex |
| | | St George's Hospital (Tooting), Wandsworth |
| | From requires improvement to inadequate | Castle Hill Hospital, East Riding of Yorkshire |
| | | Hull Royal Infirmary, Kingston upon Hull |
| | | Southport & Formby District General Hospital, Sefton |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, a further 30 hospitals saw no change in rating between first and most recent published inspection; 11 remained good, 17 remained requires improvement, and two (Medway Maritime Hospital and Whipps Cross University Hospital, London) remained inadequate.

## 4.4 Critical care

### Key points

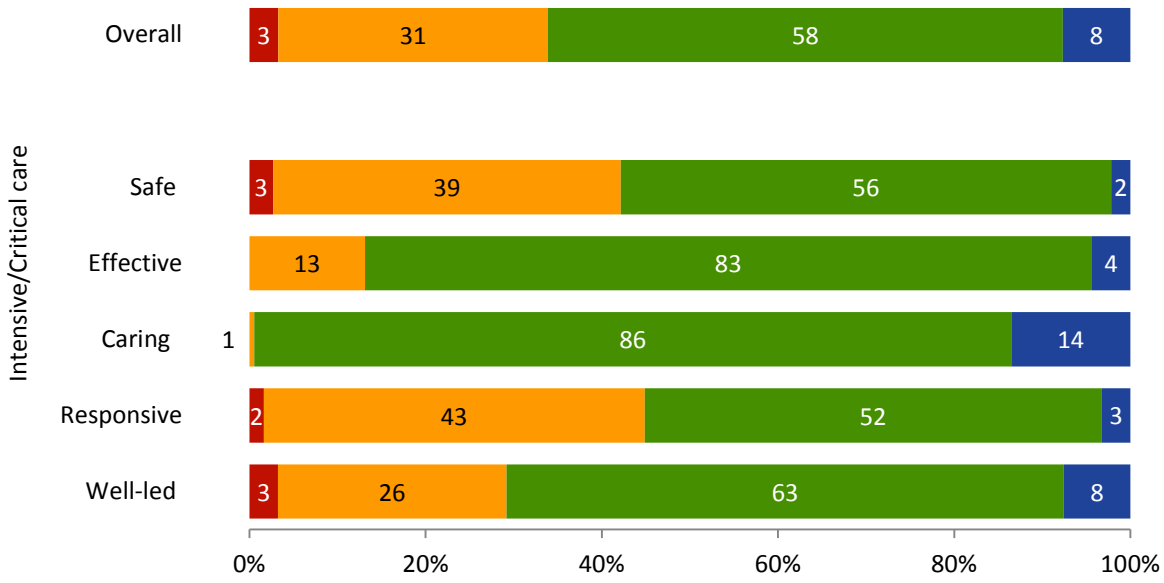
- Critical care services have well-established national standards and audit programmes, such as ICNARC. As a result, we have seen excellent practice and services are generally provided to a high standard.
- Issues include delays in moving people from the operating theatre to the critical care unit; moving people between hospitals when there are not enough beds; or discharging patients to wards.
- We have found varying standards of care between the different levels of critical care units, with high dependency units not as well managed or as appropriately staffed as intensive care units.

Critical care includes areas where patients receive more intensive monitoring and treatment for life-threatening conditions. These areas are usually described as high dependency units (level 2), intensive care units (level 3) or by the umbrella term, critical care units. Outreach services provided in other areas of a hospital are included. We have rated 183 critical care services overall.

Critical care services have well-established national standards and audit programmes. The benefit of this is evident from our inspections. Overall, we have seen a great deal of excellent practice within critical care services and found that, generally, services are provided to a high standard. This is reflected in our ratings, which show that critical care services have the highest proportion (14 hospitals, 8%) of outstanding ratings overall (figure 31), with critical care services having the highest proportion of outstanding ratings for caring compared with all core services.

Over the last two years, we have seen critical care services improving and learning from each other. For example, we have found that services that have performed well are using and contributing to national audits, such as ICNARC (Intensive Care National Audit and Research Centre).

## Figure 31: Overall ratings for critical care services




Source: CQC ratings data, as at 31 December 2016. Total of 183 critical care services.

Where we have occasionally found poor care, this is often associated with services not being well-led at a local level. Issues specific to critical care services include delays in moving people from the operating theatre to the critical care unit; moving people between hospitals when there are not enough beds; or discharging patients to a ward when they are fit for discharge. In addition, some patients are discharged from critical care units out of hours to enable other patients to be accommodated, which is not responsive to their needs.

There is a high level of consensus that level 3 intensive care units require 1:1 staff to patient nursing levels. Staffing is generally good; we check that wards have the right level of staff – for example, whether level 3 patients (the most critical patients) have 1:1 care. In poorer performing trusts, staffing is not always responsive to the needs of the patients and critical care patients are placed in surgery recovery areas, where they do not always have access to the staff or equipment they need.

In contrast, services rated as good are better able to manage the flow of patients on to the critical care wards. For example, many trusts use critical care outreach teams to proactively identify patients in need of critical care, and identify beds for those on critical care wards to be discharged to.

Some large trusts have multiple critical care units serving different groups of patients. We have found good and poor standards of care for patients in neighbouring units that are managed by different teams, with high dependency units not as well managed or staffed as level 3 units. For example, one high dependency unit we visited was managed by intensive care physicians, while surgeons in the same hospital were managing another surgical high dependency unit using different clinical standards. It is essential that trusts make sure that critical care units provide an appropriate standard of care that is of an equal standard across the hospital.

## Spotlight on outstanding practice

Figure 32: Hospitals rated outstanding for critical care

| Hospital | Publication date |
|---|---|
| Cheltenham General Hospital, Gloucestershire | 19/06/2015 |
| Freeman Hospital, Newcastle upon Tyne | 06/06/2016 |
| Frimley Park Hospital, Surrey | 26/09/2014 |
| Gloucestershire Royal Hospital, Gloucestershire | 19/06/2015 |
| Harrogate District Hospital, North Yorkshire | 27/07/2016 |
| Northern General Hospital, South Yorkshire | 09/06/2016 |
| Northumbria Specialist Emergency Care Hospital, Northumbria | 05/05/2016 |
| Nottingham City Hospital, Nottingham | 08/03/2016 |
| Queen Alexandra Hospital, Portsmouth | 19/06/2015 |
| Queen Elizabeth Medical Centre, Birmingham | 15/05/2015 |
| Royal Devon & Exeter Hospital (Wonford), Devon | 09/02/2016 |
| Royal Hallamshire Hospital, South Yorkshire | 09/06/2016 |
| Royal Victoria Infirmary, Newcastle upon Tyne | 06/06/2016 |
| Wexham Park Hospital, Berkshire | 02/02/2016 |

**Examples of outstanding practice**

- Nottingham City Hospital, Nottingham developed a tool to support the complex decision-making process for critically ill patients. The tool was based on an ethical and balanced approach to selecting a suitable treatment plan for patients and act as a base for further clinical decisions. The tool would then be used as a tracking system so that clinicians understood previous treatment choices and clinical outcomes. This was considered to be an innovative development in tracking the decision making process in treating critical care patients.
- Freeman Hospital, Newcastle upon Tyne developed hydrotherapy rehabilitation after critical illness for patients who were ventilated, which enabled them to move their limbs supported by water. This gave psychological support to patients and helped them engage with their rehabilitation programme.
- The critical care pressure ulcer surveillance and prevention group at the Royal Victoria Infirmary, Newcastle upon Tyne had developed a critical care dashboard for pressure ulcer incidence. A new pressure ulcer assessment tool was developed and implemented, leading to a major reduction in pressure injury.
- At Northumbria Specialist Emergency Care Hospital, Northumbria, the 'pit stop' handover for all admissions to the critical care unit had been developed with human factors training using Formula One pit-stop models, to enable a structured handover and improve patient safety.
- At Harrogate District Hospital, North Yorkshire innovative services improved the care of patients on and following intensive care, such as the 'Supporting intensive therapy unit patients' (situp) service and the clinical psychology service to inpatients and outpatients at the follow up clinic in critical care. There was also a critical care online "virtual" journal club.
- The operating services, critical care and anaesthesia care group at Royal Hallamshire Hospital, South Yorkshire developed 'The Magnificent 7', a document outlining seven areas for achievement in the department. The seven areas included zero harm, making every operating minute count and transformation through technology. Each area had a lead, an executive sponsor, an action plan and a review date.

## Cheltenham General Hospital, Gloucestershire

There was excellent support for trainee doctors. One of the intensivists had written an extensive guide on all aspects of working in critical care. Each trainee was evaluated for their competence and not signed off until this was demonstrated. There were two trainee doctors on rotation in the department, working on day shifts. We observed good training and education at the ward round. The trainee staff came across as confident and were encouraged to ask questions and look for guidance. The trainees we spoke with said the department had a high reputation for excellence in teaching and practice.

## Northern General Hospital, South Yorkshire

Staff recognised and respected the totality of patients' needs. We saw the use of patient name boards, which included 'what matters most to me today'. One patient wished to watch a specific television programme at a certain time. The nurse made sure that the patient had the television tuned to the correct channel at the specific time. Staff also helped patients and those close to them to cope emotionally with their care and treatment. A relative told us they were anxious in the middle of the night about their spouse and they persistently kept calling the unit. The relative said that nurses provided good emotional support during every call, and had invited her to the hospital for more comfort.

## Figure 33: Changes in overall rating for critical care, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to good | Tameside General Hospital, Tameside |
| | From good to outstanding | Wexham Park Hospital, Slough* |
| ↑ | From requires improvement to good | Addenbrooke's and the Rosie Hospitals, Cambridge |
| | | Bradford Royal Infirmary, Bradford |
| | | Furness General Hospital, Cumbria |
| | | Hereford Hospital, Herefordshire |
| | | Leeds General Infirmary, Leeds |
| | | Queen's Hospital, Burton Upon Trent, Staffordshire |
| | | Southmead Hospital, Bristol |
| | | Southport & Formby District General Hospital, Sefton |
| | From inadequate to requires improvement | Diana Princess of Wales Hospital, North East Lincolnshire |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | Royal Sussex County Hospital, Brighton and Hove |
| | From outstanding to requires improvement | n/a |
| | From outstanding to good | St George's Hospital (Tooting), Wandsworth |
| ↓ | From good to requires improvement | Colchester General Hospital, Essex |
| | | Dewsbury and District Hospital, Kirklees |
| | | Kings Mill Hospital, Nottinghamshire |
| | | Medway Maritime Hospital, Medway |
| | | North Middlesex University Hospital, Enfield |
| | | Princess Royal Hospital, West Sussex |
| | From requires improvement to inadequate | The Princess Alexandra Hospital, Essex |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, a further 18 hospitals saw no change in rating between first and most recent published inspection, 15 remained good and three remained requires improvement.

## 4.5 Maternity and gynaecology

### Key points

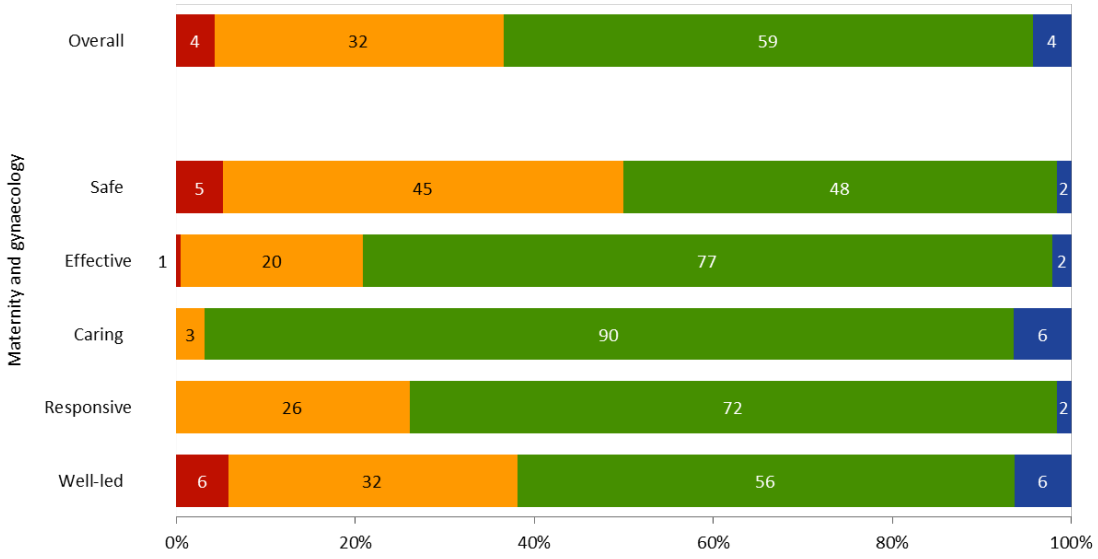
- The safety of a service, and the safety culture within the unit, are linked closely to how well-led the service is.
- Effective multidisciplinary team working is essential for high-quality, safe care.
- Staffing is a problem on some units, with safe levels of staffing and one-to-one care during labour not achieved.
- Virtually all maternity services used a clinical dashboard to monitor patient outcomes. However, these are not standardised across the country, so individual services cannot compare their outcomes with other services.

Maternity and gynaecology services include all services provided to women that relate to gynaecology and pregnancy (including the planning and/or prevention of pregnancy). Ante-natal and post-natal services are included, as well as labour wards, and theatres providing obstetric and gynaecology-related surgery. Termination of pregnancy is included within this core service.

Overall, we have inspected and rated 186 maternity and gynaecology services. As with urgent and emergency care, increasing demands – including a greater number of women giving birth with increasingly complex pregnancies – are putting maternity services under growing pressure. As a result, maternity services are a key focus of the NHS Five Year Forward View. The 2015 review of services, led by Baroness Julia Cumberlege, showed that despite the increases in the number of births and the increasing complexity of cases, the quality and outcomes of maternity services have improved over the last decade.[13]

While we have seen some excellent practice over the course of our inspection programme, quality in maternity services is a concern, with national shortages of midwives and obstetricians. In particular, we have some concerns around safety, with safe levels of staffing and one-to-one care during labour, not being achieved. This is reflected in our ratings for safety, with 5% rated as inadequate (figure 34). However, eight hospitals (4%) were rated as outstanding.

## Figure 34: Overall ratings for maternity and gynaecology services




Source: CQC ratings data, as at 31 December 2016. Total of 186 maternity and gynaecology services.

The most recent national survey of people using maternity services (from women who gave birth in early 2015), published in December 2015, showed four key areas of improvement since the previous survey:[14]

- There was an increase in the number of women who said they were always treated with dignity and respect during labour and birth (87% in 2015, compared with 85% in 2013).
- More women said they were offered a choice of giving birth in a midwife-led unit or birth centre (41% in 2015, compared with 35% in 2013).
- There has been an increase in the number of women who said that they saw the same midwife at every antenatal appointment (36% in 2015, compared with 34% in 2013).
- More women said they felt they were "always" given the information or explanations they needed while in hospital and after the birth of their baby (62% in 2015 compared with 59% in 2013).

However, there were also some areas that showed a decline in performance in the survey. For example, slightly more women than in the previous survey reported being left alone at a time that worried them. Since 2010, there has been a steady increase in the proportion of women having a normal vaginal delivery who gave birth in stirrups, which is contrary to best practice guidance, which recommends that women are able to move about throughout their labour unless they need assistance.

The leadership of a service is linked closely with how safe the service is, and the safety culture within the unit. Effective multidisciplinary team working is essential for high-quality, safe care. We have seen examples of poor multidisciplinary cultures, which undermine the quality and safety of the service. Good services are run jointly by a head midwife and lead obstetrician, have a strong risk management culture, and make sure that learning is shared between teams. There is a focus on measuring a range of outcomes for mothers and babies and action is taken when there are any concerns.

In these units, we see midwives, obstetricians, paediatricians and anaesthetists all working together, with a transparent culture that manages clinical risks effectively. An open culture where there is learning from patient safety incidents and errors is vital for the delivery of safe maternity care. While this is widely recognised as a necessity by maternity services, we found much variation in the reality of their approach to clinical risk management. Some learning cultures were strong, some superficial.

Virtually all maternity services used a clinical dashboard to monitor patient outcomes, but these are not being used consistently across the country. Some used this information to drive a culture of continuous improvement, but many did not. Poor outcomes were too often explained away as a reflection of the characteristics of the population served rather than used as a spur for improvement. Services need to make sure that they use audit results and outcome data, such as the MBRRACE-UK Perinatal Mortality Surveillance report, to identify areas for improvement.[15]

As part of this core service, we also look at gynaecology services. Most non-cancer related gynaecology treatment is in outpatients or on a day case basis and many hospitals do not have dedicated gynaecology wards. As a result, many inpatients find themselves on surgical or other wards and the care that they receive is not always appropriate for their needs. We found problems in gynaecology similar with other surgical services and there were few services that were satisfactorily and consistently assessing their patient outcomes. Good gynaecology services had similar characteristics to those of other good surgical services, together with facilities that enabled women to have care specific and sensitive to their needs.

## Spotlight on outstanding practice

Figure 35: Hospitals rated outstanding for maternity and gynaecology

| Hospital | Publication date |
|---|---|
| Basildon University Hospital, Essex | 03/08/2015 |
| Cossham Hospital, Bristol | 11/02/2015 |
| Queen Elizabeth Hospital, Gateshead | 24/02/2016 |
| Royal Hallamshire Hospital, South Yorkshire | 09/06/2016 |
| Royal Victoria Infirmary, Newcastle upon Tyne | 06/06/2016 |
| St Richard's Hospital, West Sussex | 20/04/2016 |
| Worthing Hospital, West Sussex | 20/04/2016 |
| The Princess Alexandra Hospital, Essex | 19/10/2016 |

### Examples of outstanding practice

- At Royal Hallamshire Hospital, South Yorkshire one-to-one team and specialist midwife clinics gave greater assurance that high risk women continued to have a choice on the care they received in pregnancy.
- Facilities for women in labour at Cossham Hospital, Bristol promoted the use of water for both pain relief and delivery and care, in a calming and relaxing environment for normal births.

## Cossham Hospital, Bristol

Time spent with women was not rushed, and care was delivered with kindness, compassion and understanding, which extended to the whole family. Women were fully informed and involved in choices, and feedback was actively sought. Women with complex social needs were not excluded from delivering in the birth centre, with protocols in place to ensure the involvement of specialist midwives as required. Information was available in formats to meet the needs of the local population, and translation services were easily accessible. Efforts to engage hard-to-reach members of the community and overall public engagement were outstanding. Strong networks existed and staff used a wide variety of methods to encourage and promote public engagement.

## St Richard's Hospital, West Sussex

Patients were protected by a strong comprehensive safety system, and a focus on openness, transparency and learning when things went wrong. This was demonstrated in safety thermometer results, which showed the maternity service had achieved 100% since December 2014. The service provided effective care in accordance with recommended practices. Outcomes were good and the service frequently performed better than the trust's own target. This was especially true of the work being done to reduce stillbirths and admissions to the Special Care Baby Unit (SCBU) and Neonatal Intensive Care Unit (NICU). The service continually monitored outcomes for women and used incidents and complaints as opportunities for learning and improving services. There were high levels of multidisciplinary team working, both within the service and with external partners.

## Figure 36: Changes in overall rating for services for maternity and gynaecology, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to good | Addenbrooke's and the Rosie Hospitals, Cambridge |
| | | Blackpool Victoria Hospital, Blackpool |
| | | Wexham Park Hospital, Slough* |
| | From good to outstanding | The Princess Alexandra Hospital, Essex |
| ↑ | From requires improvement to good | Broomfield Hospital, Essex |
| | | Dewsbury and District Hospital, Kirklees |
| | | Furness General Hospital, Cumbria |
| | | Lincoln County Hospital, Lincolnshire |
| | | Medway Maritime Hospital, Medway |
| | | Pilgrim Hospital, Lincolnshire |
| | | Pinderfields Hospital, Wakefield |
| | | Royal Lancaster Infirmary, Lancashire |
| | | Southmead Hospital, Bristol |
| | | Whipps Cross University Hospital, Waltham Forest |
| | From inadequate to requires improvement | Conquest Hospital, East Sussex |
| | | Ormskirk District General hospital, Lancashire |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | n/a |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Homerton University Hospital, Hackney |
| | | Kings Mill Hospital, Nottinghamshire |
| | | Leicester General Hospital, Leicester |
| | | North Devon District Hospital, Devon |
| | | North Middlesex University Hospital, Enfield |
| | | Queen's Hospital, Burton Upon Trent, Staffordshire |
| | | Royal Cornwall Hospital, Cornwall |
| | | Solihull Hospital, Solihull |
| | From requires improvement to inadequate | The Royal London Hospital, Tower Hamlets |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, a further 29 hospitals saw no change in rating between first and most recent published inspection; one (Basildon University Hospital) remained outstanding; 15 remained good and 13 remained requires improvement.

## 4.6 Children and young people

### Key points

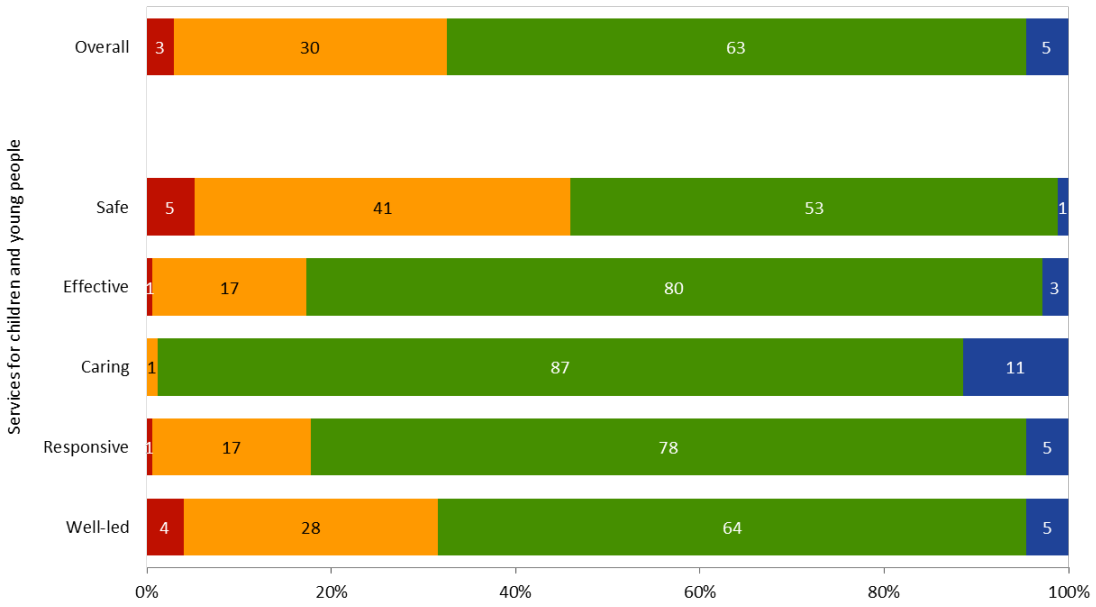
- Services for children and young people are generally good.
- The quality of the children's services sometimes differ from the overall ratings for the trust; some trusts rated as inadequate overall had children and young people's services that were rated as good or outstanding.
- Where we have found issues in relation to the care of children, these often relate to general areas such as surgery and outpatients.
- Very few hospitals have well established services to support the transition of children with long-term conditions from children's to adult services.

This core service includes all services provided for children up to the age of 18, excluding child and adolescent mental health services. It includes inpatient wards, surgery, outpatients, end of life care and the interface with maternity services. However, it does not include care provided in the emergency department, which is covered under urgent and emergency services.

The quality of the children's services sometimes differ from the overall ratings for the trust. Five non-specialist trusts that have been rated as inadequate overall are currently rated good for children and young people's services and one, the Royal Alexandra Children's Hospital (part of the Brighton and Sussex University Hospital NHS Trust) as outstanding.

We have rated 172 services for children and young people overall. Children and young people's services have performed well, with the second highest proportion of outstanding ratings (11%) for the key question 'are services caring?' after critical care services (figure 37). Eight hospitals (5%) were rated as outstanding for children and young people's services.

## Figure 37: Overall ratings children and young people's services




Source: CQC ratings data, as at 31 December 2016. Total of 172 children and young people's services.

The ability to achieve a good or outstanding rating for a service within a trust, that is otherwise struggling to provide a good service, highlights the importance of leadership within the core services. As with maternity services, children's services that are performing well are well-led, with the multidisciplinary team working collaboratively.

Where we have found issues in relation to the care of children, these are often outside of the children's service itself in general areas such as surgery and outpatients, with children being seen and treated in unsuitable environments.

Another key issue is children's safeguarding. While in the majority of children's services staff were trained to the appropriate level to recognise neglect and abuse and children at risk of abuse, many staff looking after children outside the children's services (for example, in the emergency department, outpatients and surgical services) were not. Hospitals should risk assess all their services where children are seen, to make sure that staff have the right training to be able to recognise and prevent abuse of children.

We saw examples of excellent services that managed the transition of children with long-term conditions from children's services into adult services, but these were exceptional. In many cases, even for common conditions such as asthma, epilepsy and diabetes these services simply did not exist or they were underdeveloped.

Those hospitals that consistently provided the best standards of care for children had very clear leadership for children's services, both locally and within the trust board. This was supported by the findings of *From the pond into the sea*, our thematic review of the transition of care from child to adult health services.[16]

## Spotlight on outstanding practice

Figure 38: Hospitals rated outstanding for services for children and young people

| Hospital | Publication date |
|---|---|
| Freeman Hospital, Newcastle upon Tyne | 06/06/2016 |
| Luton and Dunstable Hospital, Bedfordshire | 03/06/2016 |
| Northumbria Specialist Emergency Care Hospital, Northumbria | 05/05/2016 |
| Royal Victoria Infirmary, Newcastle upon Tyne | 06/06/2016 |
| St Richard's Hospital, West Sussex | 20/04/2016 |
| St Thomas' Hospital, London | 24/03/2016 |
| Worthing Hospital, West Sussex | 20/04/2016 |
| Royal Sussex County Hospital, Brighton and Hove | 17/08/2016 |

### Examples of outstanding practice

- The paediatric services at Luton and Dunstable Hospital, Bedfordshire had developed new models of care for the child in the right place, with the right staff, across tertiary, secondary and primary care boundaries.
- The paediatric cardiology service at St Thomas' Hospital, London had introduced a home monitoring programme for infants following single ventricle palliation surgery. This allowed these patients to safely live at home with their families while they recovered and prepared for the second stage of their treatment.
- Managers at Northumbria Specialist Emergency Care Hospital, Northumbria fully engaged staff in planning. This allowed for a smooth transition into the new build and services getting up and running. Following a training needs analysis, staff had received additional training to ensure they had the correct skills to deliver the new model of care. There was ongoing work to further support staff in adjusting to the new services, especially in the Children's Unit.
- Staff at Worthing Hospital, West Sussex had a good knowledge about safeguarding vulnerable adults and children and how they should proceed if concerns arose. There was very good joint and interagency working. The transfer of responsibility for the management of 'at risk' babies from maternity (during the antenatal period) to paediatrics (following delivery) was seamless.

## Northumbria Specialist Emergency Care Hospital, Northumbria

Staff provided compassionate care and treated children and parents with kindness and respect. We heard consistent praise from children and parents who told us they felt well informed and involved in decisions about their care. Both the Children's Unit and the Special Care Baby Unit (SCBU) scored highly in patient surveys. In the Special Care Baby Unit, we saw that staff gave special attention to siblings to help them feel included. They also gave parents a call 48 hours after discharge to offer advice and support. Emotional support was good with the availability of specialist bereavement midwives in SCBU and easy access to in-reach mental health services in the Children's Unit.

## Freeman Hospital, Newcastle upon Tyne

Parents told us that staff understood the impact that the condition and treatment had on their children and provided emotional support. One parent told us that staff constantly offered reassurances and support throughout the treatment process. Parents felt empowered to ask questions and were very confident their children were receiving the best care possible. In recognition of the emotional toll a child's illness has on parents, staff had also recently arranged an evening offering holistic therapy treatments, including massage and aromatherapy. Children, young people and families could access support from psychologists at clinics and on the ward. A senior nurse told us they were also hoping to introduce pet therapy on the ward, recognising the benefits of such a service in meeting the emotional needs of children and families.

## Figure 39: Changes in overall rating for services for children and young people, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to good | Whipps Cross University Hospital, Waltham Forest |
| | From good to outstanding | Royal Sussex County Hospital, Brighton and Hove |
| ↑ | From requires improvement to good | Colchester General Hospital, Essex |
| | | Cumberland Infirmary, Carlisle, Cumbria |
| | | Dewsbury and District Hospital, Kirklees |
| | | Furness General Hospital, Cumbria |
| | | Kent & Canterbury Hospital, Kent |
| | | Leeds General Infirmary, Leeds |
| | | Lincoln County Hospital, Lincolnshire |
| | | Pilgrim Hospital, Lincolnshire |
| | | Pinderfields Hospital, Wakefield |
| | | Queen's Hospital, Burton Upon Trent, Staffordshire |
| | | Royal Lancaster Infirmary, Lancashire |
| | | West Cumberland Hospital, Whitehaven, Cumbria |
| | From inadequate to requires improvement | The Royal London Hospital, Tower Hamlets |
| | | William Harvey Hospital, Kent |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | n/a |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Leicester Royal Infirmary, Leicester |
| | | North Middlesex University Hospital, Enfield |
| | | Ormskirk District General hospital, Lancashire |
| | | St George's Hospital (Tooting), Wandsworth |
| | From requires improvement to inadequate | n/a |

Ratings to 31 January 2017. In addition to the above, a further 22 hospitals saw no change in rating between first and most recent published inspection; 15 remained good and seven remained requires improvement.

## 4.7 End of life care

### Key points

- End of life care is a hospital-wide concern and leadership must be provided at board level and across directorates to achieve high standards.
- However, some hospitals still regard end of life care as a peripheral activity solely managed by specialist teams.
- We have found some excellent palliative care services, but in some cases the majority of patients are not being referred to them.
- We have also found issues with 'do not attempt cardiopulmonary resuscitation forms' not being completed properly.

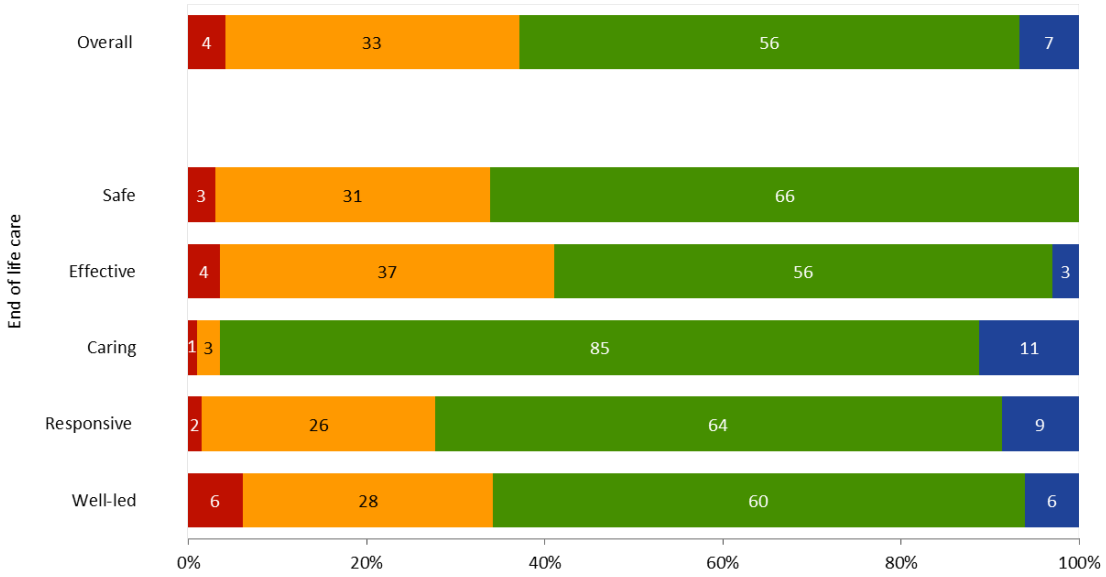
End of life care encompasses all care given to patients who are approaching the end of their life and to their bodies following death. It also encompasses the care given to relatives and carers as patients approach the end of life and after their death. The care may be delivered on any ward or in any service of a trust. It includes aspects of basic nursing care, specialist palliative care, bereavement support and mortuary services.

We have rated 194 hospital-based end of life care services overall. We have found a huge degree of variation in end of life care and have seen some excellent services, as well as many that need improvement. This is reflected in *A different ending*, our thematic review of end of life care services. Not only did our review highlight this variation, but it also shone a spotlight on the fact that people from certain groups in society may experience poorer quality care because providers and commissioners do not always understand or fully consider their specific needs.[17]

Unlike other core services, end of life care is an issue that affects all departments of an acute hospital, and should therefore be a concern for all staff. As a result, leadership at both a core service and senior management level, including at board level, is key.

However, as our ratings illustrate, this is often an area where services fall down, with some hospitals viewing end of life care as a peripheral activity managed solely by a specialist palliative care team, rather than a core activity of the hospital. Some boards we met did not know how many patients died in their hospital. End of life care is a hospital-wide concern and leadership must be provided at board level to achieve high standards (figure 40). Thirteen hospitals (7%) were rated as outstanding.

## Figure 40: Overall ratings for end of life care services




Source: CQC ratings data, as at 31 December 2016. Total of 194 end of life care services.

Hospital specialist care services should provide a dual role: directly managing patients with complex physical, psychological, social and/or spiritual needs, and supporting other services to provide high-quality end of life care for other patients. This can often be addressed through training and supporting link nurses on medical and other wards. In 2008/9, 87% of referrals to specialist palliative care services were for patients with cancer.[18] In hospitals that provide high-quality services to all who need them, the balance between cancer and other diagnoses is now typically closer to 50:50.

Across the hospitals we have inspected, we have also found issues with the recording of decisions not to attempt cardiopulmonary resuscitation. Often forms are not properly completed so the decision is ambiguous. It was often not clear whether staff had the required detailed discussions with patients and their relatives about their wishes. Such forms should be signed by a senior doctor, but we have found that they are often being signed by junior doctors.

Services that we have rated as good or outstanding look at how well people nearing the end of their lives are being identified and if their needs are being met. These trusts often have proactive teams who seek out patients nearing the end of their life from whatever cause and actively work alongside other teams. These teams work with the ward staff to make sure that they have relevant training in end of life care, and help them to support families.

The National Survey of Bereaved People (VOICES) 2015, which asks about the quality of care a friend or relative received in the last three months of life, shows that 7 out of 10 people (69%) rated hospital end of life care as outstanding, excellent or good.[19] Where we have seen good palliative care, staff are caring, symptoms are controlled as well as possible and patients are supported to achieve their preferred place of death. In some cases this may be the patient's home, so hospitals need to ensure that they are able to rapidly discharge the patient with the appropriate support at home.

On our inspection of Furness General Hospital, part of the University Hospitals of Morecambe Bay NHS Foundation Trust, we found some excellent examples of end of life care. For example, each ward had electronic smart boards displaying patient information, enabling staff to receive 'live' information at a glance. The boards displayed information about patients, using coding known only to nursing and medical personnel, meaning that patient information was anonymous to onlookers.

As part of our inspection of end of life care services, we also look at the quality of mortuaries. Again, the standards we find are variable. We have seen excellent facilities and staff who provide exemplary care for patients and families. However, we have also found serious issues at some mortuaries relating to the environment and equipment, including poor hygiene and poor viewing facilities for relatives.

## Spotlight on outstanding practice

Figure 41: Hospitals rated outstanding for end of life care

| Hospital | Publication date |
|---|---|
| Andover War Memorial Hospital, Hampshire | 12/11/2015 |
| Basingstoke and North Hampshire Hospital, Hampshire | 12/11/2015 |
| Frimley Park Hospital, Surrey | 26/09/2014 |
| North Tyneside General Hospital, Northumbria | 05/05/2016 |
| Northumbria Specialist Emergency Care Hospital, Northumbria | 05/05/2016 |
| Royal Albert Edward Infirmary, Greater Manchester | 22/06/2016 |
| Royal Hampshire County Hospital, Hampshire | 12/11/2015 |
| Royal Liverpool Hospital, Liverpool | 29/07/2016 |
| Royal United Hospital Bath, Somerset | 10/08/2016 |
| Salford Royal Hospital, Salford | 27/03/2015 |
| St Richard's Hospital, West Sussex | 20/04/2016 |
| Wansbeck General Hospital, Northumbria | 05/05/2016 |
| Worthing Hospital, West Sussex | 20/04/2016 |

**Examples of outstanding practice**

- The model of end of life care services at North Tyneside General Hospital, Northumbria saw dedicated palliative care beds being operated alongside a specialist palliative in-reach service to general ward areas. This meant that specialist staff worked alongside general staff to deliver effective, coordinated care within a holistic approach.
- At Northumbria Specialist Emergency Care Hospital, Northumbria, specialist palliative care was aligned with emergency care to make sure patients received specialist palliative care at the earliest opportunity.
- Frimley Park Hospital, Surrey provided a high standard of care for patients at the end of their life. Staff went to great lengths to respect and accommodate the wishes of patients and their families, including the use of the 'Time Garden'.
- Royal United Hospital Bath, Somerset implemented new documentation called *The Priorities of Care* for recording a personalised care plan for the dying patient.

## Royal Albert Edward Infirmary, Greater Manchester

End of life care services were provided by compassionate, caring staff who were sensitive to the needs of seriously ill patients. The service was delivered by staff who were committed to providing a good service and there was good clinical leadership from a consultant in palliative medicine. There was a coordinated approach across the Wigan borough to design end of life care services to meet the needs of the local population. Facilities and systems were in place to minimise stress for families staying with their relatives and to allow them to spend as much time as they wished with them in their last days and hours. This included the use of the swan logo that identified patients receiving end of life care and their families, enabling staff to treat them accordingly.

## Royal Liverpool University Hospital, Liverpool

Palliative care was considered integral to the trust, which had a well-developed and substantial palliative care directorate, part of the medicine division. The trust had an embedded strategy for end of life care driven by effective leadership and delivered by committed staff who were highly satisfied with their workplace. Staff frequently went 'above and beyond' to deliver compassionate, high-quality care that took into account patients' wishes. The service was complemented by a group of trained volunteers who offered respite and emotional support, ensuring no patient died alone. The service was designed with the needs of the local population in mind, and the trust adopted a multidisciplinary approach with input from a variety of external stakeholders to ensure joined-up continuity of care.

## Figure 42: Changes in overall rating for end of life care, from first rating

| | | |
|---|---|---|
| **Improved** | | |
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to good | n/a |
| | From good to outstanding | Furness General Hospital, Cumbria |
| | | Royal Lancaster Infirmary, Lancashire |
| ↑ | From requires improvement to good | Addenbrooke's and the Rosie Hospitals, Cambridge |
| | | Broomfield Hospital, Essex |
| | | Burnley General Hospital, Lancashire |
| | | Friarage Hospital, North Yorkshire |
| | | Hereford Hospital, Herefordshire |
| | | Hinchingbrooke Hospital, Cambridgeshire |
| | | James Paget Hospital, Norfolk |
| | | Lincoln County Hospital, Lincolnshire |
| | | Queen's Hospital, Burton Upon Trent, Staffordshire |
| | | Royal Blackburn Hospital, Blackburn with Darwen |
| | | Tameside General Hospital, Tameside |
| | | The James Cook University Hospital, Middlesbrough |
| | | Wexham Park Hospital, Slough* |
| | From inadequate to requires improvement | The Royal London Hospital, Tower Hamlets |
| | | Whipps Cross University Hospital, Waltham Forest |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | Royal Cornwall Hospital, Cornwall |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Glenfield Hospital, Leicester |
| | | Leicester General Hospital, Leicester |
| | | Leicester Royal Infirmary, Leicester |
| | | West Cumberland Hospital, Cumbria |
| | From requires improvement to inadequate | Colchester General Hospital, Essex |
| | | The Princess Alexandra Hospital, Essex |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, a further 34 hospitals saw no change in rating between first and most recent published inspection; 15 remained good, 18 remained requires improvement, and one (Northampton General Hospital) remained inadequate.

## 4.8 Outpatients and diagnostic imaging

### Key points

- Outpatient services have the largest numbers of attendees in almost all hospitals.
- We have found examples of excellent practice, but outpatient services are sometimes overlooked, and not given enough priority at senior management and board level.
- Many outpatient services appeared to be organised around the needs of staff, with frequent changes or cancellation of outpatient appointments.
- A key area of concern is trusts' ability to effectively record and manage their waiting lists.
- Medical records were not always available, creating a significant clinical risk that patients were being seen without their medical history being known.
- Increasing demand for imaging services and shortages of staff have led to serious backlogs of reporting in some hospitals.

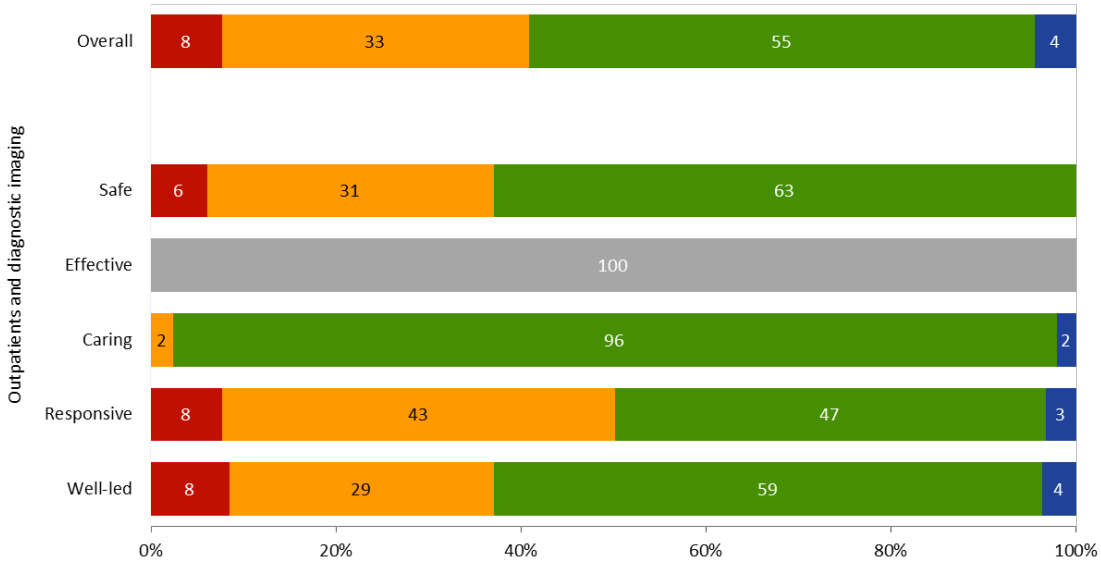
Outpatients includes all areas where people undergo clinical assessments, physiological measurements, diagnostic testing, receive diagnostic test results, are given advice or receive care and treatment without being admitted as an inpatient or day case. This core service includes imaging services, such as x-ray, CT scanning, MRI, and non-obstetric ultrasound services. We have rated 247 outpatients and diagnostic imaging services overall.

The majority of patients who experience hospital care do so as outpatients. We have found some excellent examples of outstanding outpatient care where services are planned around the needs of the patient, with waiting times well managed and patients seen in a timely way. Eleven hospitals (4%) were rated as outstanding. For example, at Harrogate District Hospital, North Yorkshire, we found that services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. Initiatives including virtual clinics, and nurse-led services meant patients could easily access specialist advice and support. The trust was consistently exceeding its performance targets and England averages for referral to treatment times (RTT) and for diagnostic waits.

Similarly at Hexham General Hospital, Northumbria, we found that waiting times for all types of appointments consistently met national targets. Clinics and related services were organised so patients only had to make one visit for investigations and consultation or, if possible, did not have to return to hospital for unnecessary appointments. In addition, staff respected patients' privacy, dignity, and confidentiality at all times. For example, diagnostic imaging staff took patients to private changing facilities and managers had invested in additional privacy screens for use during some procedures.

However, we have also found that outpatient services often struggle to provide a consistent standard of care, with services overlooked and not given enough priority at senior management and board level. This is reflected in our ratings for the core service, which show that 8% of services are inadequate for the key question 'are services well-led?' (figure 43).

## Figure 43: Overall ratings outpatients and imaging services



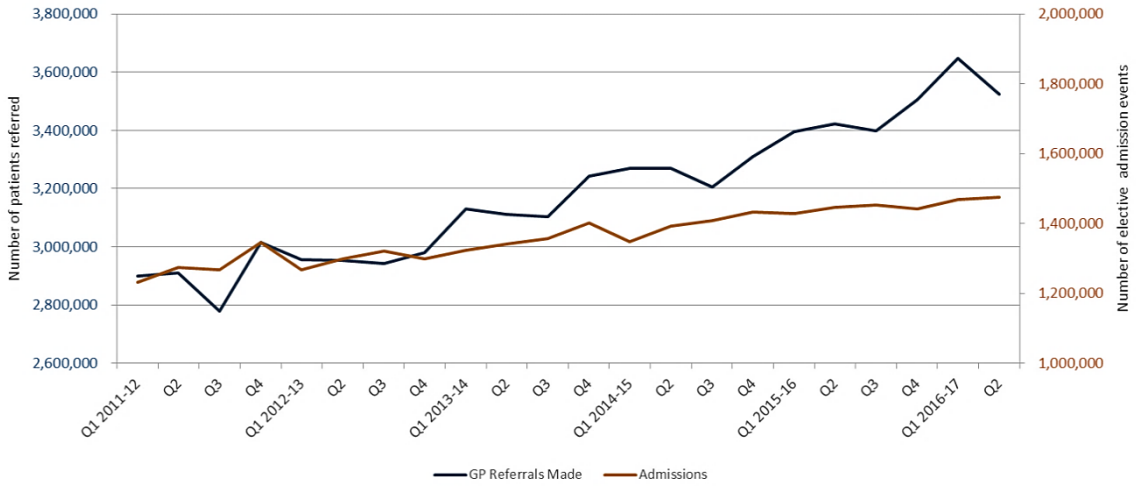

Source: CQC ratings data, as at 31 December 2016. Total of 247 outpatients and imaging services.

In these cases, many outpatient services we inspected appeared to be organised around the needs of staff, not the needs of patients. Patients told us about their frustration about the frequent changing of their outpatient appointments. Clinics were often cancelled, sometimes at short notice, sometimes repeatedly. We saw many clinics that were running unacceptably late. We also frequently found poor confidentiality of medical records, which were left unattended in the waiting area. In some cases there were very high levels of unavailability of medical records creating a significant clinical risk that patients were being seen without their medical history being known.

This is set against a backdrop of increasing demand, with numbers of GP referrals rising faster than elective inpatient admissions (figure 44). It is also compounded by patients failing to attend their first appointments following a referral from their GP, the cost of which the National Audit Office has estimated at £225 million a year.[20]

Trusts rated inadequate appear to be worse at deploying methods to reduce instances where patients failed to attend their first outpatient appointment following a GP referral, which in turn has an impact on efficiency and management of demand. For example, over the last two years trusts rated as outstanding have on average achieved 'did not attend' rates for first outpatient appointments below 8%, while trusts rated inadequate averaged more than 9.5%.

## Figure 44: GP referrals and inpatient elective admissions (2011/12 to 2016/17 (July to September))

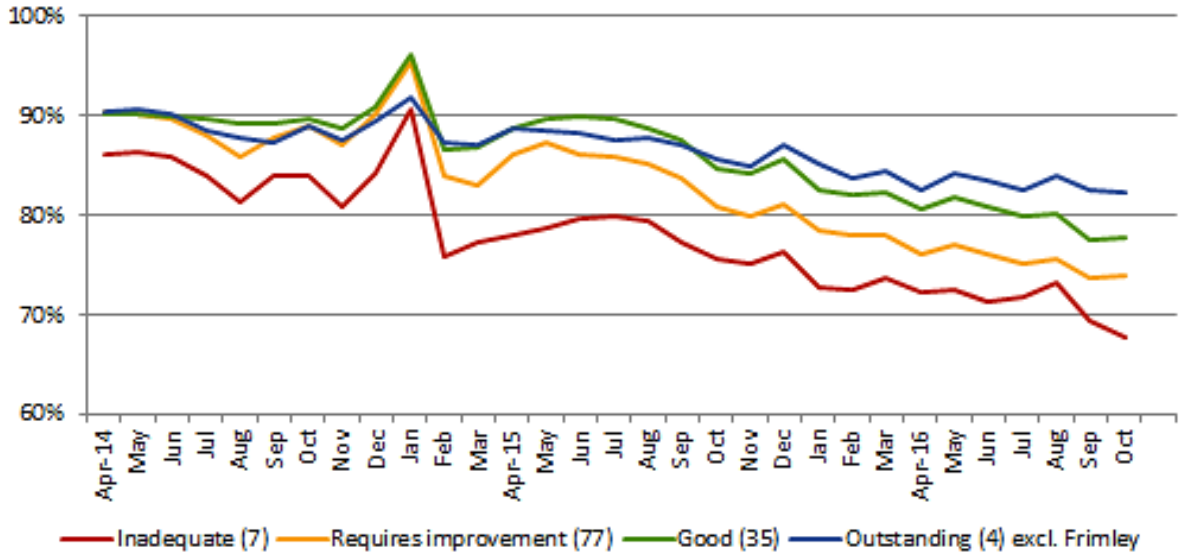



Source: NHS England

Another key area of concern is trusts' ability to effectively record and manage their waiting lists. Trusts report their initial referral to treatment times against the national standard of 92% of patients seen within 18 weeks. The quality of the data used to report against this standard was poor in some instances, meaning reported waiting lists were not accurate. Comparing data from NHS England with our ratings of trusts we can see that all trusts, regardless of rating, are struggling to achieve the 18 weeks from referral to treatment standard (figure 45). Inadequate trusts are consistently performing worst. By October 2016, less than 70% of patients starting treatment at inadequate trusts had waited less than 18 weeks.

The standard does not apply to patients returning for follow-up appointments and we often found that waiting lists for these patients were not being monitored or managed. Many hospitals could not tell how many patients they had waiting for a follow-up clinic appointment.

## Figure 45: Percentage of referral to treatment within 18 weeks April 2014 to October 2016




Source: CQC ratings data (31 December 2016) and NHS England. A number of trusts have been excluded from the analysis due to incomplete reporting of 18 weeks data.

Imaging services are generally of a good standard, with effective use of clinical standards and a good approach to risk management. Demand for imaging services is increasing. Monthly average activity for MRI scans has risen from 213,000 a month in the year to November 2013 to 279,000 a month in the year to November 2016 (a 31% increase in three years). Likewise the average number of CT scans performed each month is up from 346,000 to 438,000 over the same period (a 26% increase). All diagnostic tests have risen from a monthly average of 1.5m to 1.75m (an increase of nearly 20%).[21] Over this time, the proportion waiting more than six weeks for any test has slightly fallen, although there has been a rise in the proportion waiting more than six weeks for an MRI scan.

This increasing demand for imaging services and a national shortage of radiologists means that trusts do not always have enough staff. This can create problems with backlogs of reports of imaging studies, creating a risk that important findings might not be recognised and acted on in a timely way. Trusts need to have systems in place to mitigate this, but the current quality of these systems is variable.

## Spotlight on outstanding practice

Figure 46: Hospitals rated outstanding for outpatients and diagnostic imaging

| Hospital | Publication date |
|---|---|
| Harrogate District Hospital, North Yorkshire | 27/07/2016 |
| Hexham General Hospital, Northumbria | 05/05/2016 |
| Luton and Dunstable Hospital, Bedfordshire | 03/06/2016 |
| North Tyneside General Hospital, Northumbria | 05/05/2016 |
| Northern General Hospital, South Yorkshire | 09/06/2016 |
| Northumbria Specialist Emergency Care Hospital, Northumbria | 05/05/2016 |
| Royal Hallamshire Hospital, South Yorkshire | 09/06/2016 |
| St Helens Hospital, Merseyside | 19/01/2016 |
| Thomas Linacre Centre, Greater Manchester | 22/06/2016 |
| Wansbeck General Hospital, Northumbria | 05/05/2016 |
| Whiston Hospital, Merseyside | 19/01/2016 |

### Examples of outstanding practice

- There was a clear leadership, governance and culture in outpatient services at Luton and Dunstable Hospital, Bedfordshire that was used to drive and improve the delivery of quality, person-centred care. Divisional leads were frequently involved with patient care and problem solving to ensure a smooth patient pathway through departments.
- Northumbria Specialist Emergency Care Hospital, Northumbria had provision for a seven day a week, consultant-led outpatient trauma service for people from across Northumberland and North Tyneside, as well as a teleconference clinic for patients who lived in Berwick, almost 60 miles away.
- The main outpatient department at Harrogate District Hospital, North Yorkshire was an accredited centre for the treatment of faecal incontinence using percutaneous tibial nerve stimulation. Staff told us they were the first NHS centre to be awarded this accreditation.
- The breast team at Thomas Linacre Centre, Wigan, Greater Manchester achieved screening targets above the national average and managed a large catchment area of patients. The specialist nurses ensured a holistic patient approach and considered the psychological aspects of women who have breast surgery, offering a complete service. There is evidence of continuous learning and participation in audits.
- Whiston Hospital, Merseyside had improved response times and access to timely treatment for patients by enabling radiology staff to book a follow-up appointment with the appropriate specialist at the time of reporting, if a critical or abnormal finding on an x-ray was detected.

## Whiston Hospital, Merseyside

There were good examples of a clear pathway and assessment planning for patients with additional needs. This included identifying the need for pre-appointment visits to relevant departments if required. The service had a range of forums to seek patients' feedback such as the "patient power" group. Many of the departments had awards on display and staff and patients were proud to show us what they had achieved. There were many examples of national targets being shortened by internal targets to drive improvements throughout the service. Leadership within the outpatient and diagnostic imaging service was positive, visible and proactive. Managers had a strong focus on the needs of patients and the roles that staff needed to play in delivering good care.

## Thomas Linacre Centre, Greater Manchester

Pagers for patients were available, enabling them to leave waiting areas while waiting for their appointment. Local community groups were involved in the planning and development of the outpatient clinic environment to ensure that the service best served the population. The groups had developed a child friendly waiting area and work was ongoing to develop a dementia friendly suite. There was a proactive approach to caring for individuals with learning difficulties. Out-of-hours visits to clinics were organised every two months for patients to become familiar with the clinic and staff before their appointment for treatment. Translation services were available and staff knew how to provide this service for patients if required. Dementia care was promoted on notice boards.

Figure 47: Changes in overall rating for outpatients and diagnostic imaging, from first rating

| **Improved** | | |
|---|---|---|
| ↑↑ | From requires improvement to outstanding | n/a |
| | From inadequate to goo | Addenbrooke's and the Rosie Hospitals, Cambridge |
| | | Derriford Hospital, Plymouth |
| | | Dewsbury and District Hospital, Kirklees |
| | | Pinderfields Hospital, Wakefield |
| | | The Princess Alexandra Hospital, Essex |

| | | |
|---|---|---|
| ↑ | From requires improvement to good | Broomfield Hospital, Essex |
| | | Castle Hill Hospital, East Riding of Yorkshire |
| | | County Hospital Louth, Lincolnshire |
| | | Furness General Hospital, Cumbria |
| | | Hull Royal Infirmary, Kingston upon Hull |
| | | Royal Lancaster Infirmary, Lancashire |
| | | Tameside General Hospital, Tameside |
| | | West Cumberland Hospital, Cumbria |
| | | Westmorland General Hospital, Cumbria |
| | | Wexham Park Hospital, Slough* |
| | | William Harvey Hospital, Kent |
| | From inadequate to requires improvement | Bradford Royal Infirmary, Bradford |
| | | Conquest Hospital, East Sussex |
| | | Eastbourne District General Hospital, East Sussex |
| | | St Luke's Hospital, Bradford |
| **Deteriorated** | | |
| ↓↓ | From good to inadequate | Diana Princess of Wales Hospital, North East Lincolnshire |
| | | Scunthorpe General Hospital, North Lincolnshire |
| | | St George's Hospital (Tooting), Wandsworth |
| | From outstanding to requires improvement | n/a |
| ↓ | From good to requires improvement | Glenfield Hospital, Leicester |
| | | Good Hope Hospital, Birmingham |
| | | Leicester General Hospital, Leicester |
| | | Leicester Royal Infirmary, Leicester |
| | | Royal Cornwall Hospital, Cornwall |
| | From requires improvement to inadequate | Colchester General Hospital, Essex |
| | | Kings Mill Hospital, Nottinghamshire |
| | | Medway Maritime Hospital, Medway |
| | | Newark Hospital, Nottinghamshire |
| | | Royal Sussex County Hospital, Brighton and Hove |

* Acquired by Frimley Health NHS Foundation Trust between ratings

Ratings to 31 January 2017. In addition to the above, a further 23 hospitals saw no change in rating between first and most recent published inspection; eight remained good, 12 remained requires improvement, and three remained inadequate (St Mary's Hospital Westminster, Lincoln County Hospital and Whipps Cross University Hospital, Waltham Forest).

# 5. Specialist hospitals

**Key points**

- There were 18 specialist acute NHS trusts in England at the time of our comprehensive inspections, each providing a limited range of services. There are now 17 specialist trusts following a recent merger of two trusts.
- Five of the 17 (29%) have been rated as outstanding and a further eight rated as good. No specialist trusts have been rated as inadequate.
- The better ratings for specialist trusts than for non-specialist trusts relate in part to the fact that they do not have to manage the problems associated with acute (non-specialist) care and 'flow'.
- Some specialist trusts are over-reliant on personal networks to assure themselves of quality and need to develop broader assurance processes.

Currently there are 17 specialist NHS acute trusts in England. As such, they provide only a limited range of services and do not take in a full range of emergency cases. These comprise:

- three specialist children's trusts
- three specialist cancer trusts
- three specialist heart and lung trusts
- three specialist orthopaedic trusts
- one specialist women's trust
- one combined children's and women's trust
- one specialist eye trust
- one specialist burns and plastic surgery trust
- one specialist neurology and neurosurgery trust.

It should be noted that some non-specialist trusts provide these services, but these have been considered in the preceding chapters of this report.

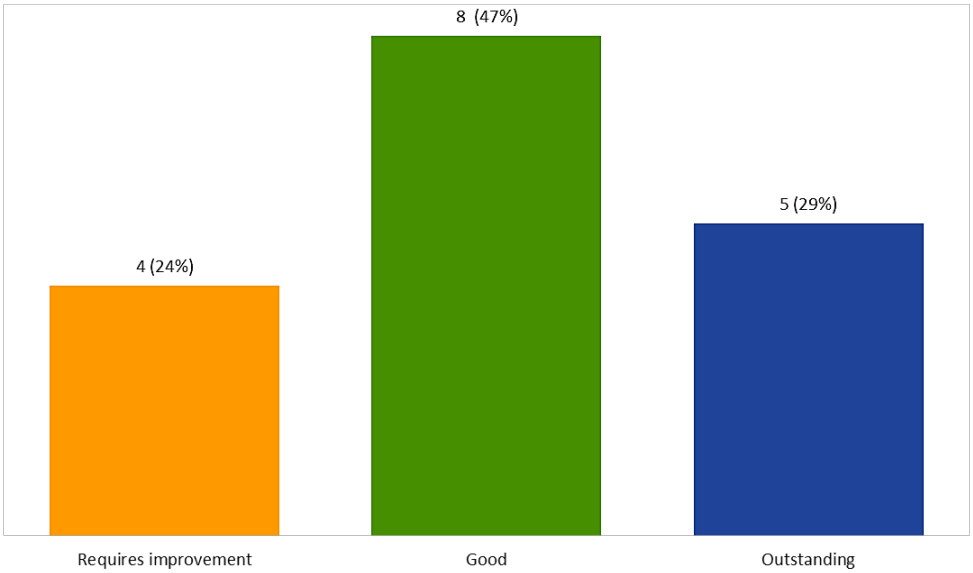
Our inspections of specialist trusts are tailored to the services provided. For example, in specialist cancer trusts we assess chemotherapy and radiotherapy services as 'core services', which we do not at present assess (or not in such detail) in non-specialist trusts unless concerns have been raised. In each service we use the same five key questions (safe, effective, caring, responsive and well-led) as in other core services. We also assess well-led at provider/trust level.

Five of the 17 (29%) specialist trusts have been rated as outstanding:

- Liverpool Heart and Chest NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- The Christie NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust
- The Clatterbridge Cancer Centre NHS Foundation Trust.

A further eight (47%) have been rated as good. No specialist trusts have been rated as inadequate (figure 48).

## Figure 48: NHS acute specialist overall ratings (17 trusts)




Source: CQC ratings data, as at 22 February 2017

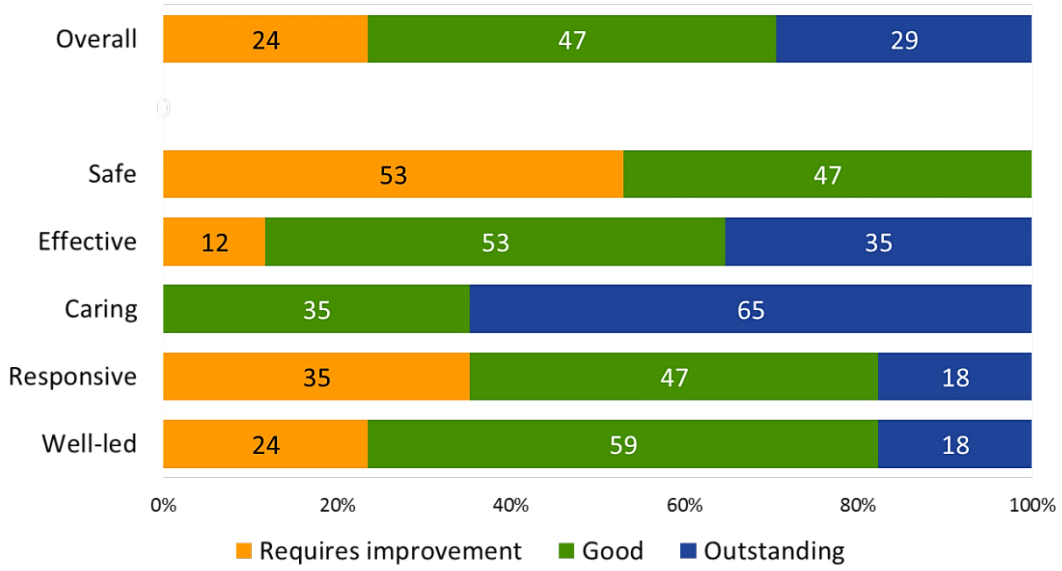
Safety is again a concern with more than half (53%) of specialist trusts rated as requires improvement for this key question. We are also concerned that some may be over-reliant on their reputation and not assuring themselves of the quality of care they are delivering, with six (35%) trusts rated as requires improvement for the key question 'are services responsive?' (figure 49).

As may be expected, specialist trusts score well for effectiveness (achieving good outcomes and promoting a good quality of life) with 15 (88%) rated as good or outstanding. They also perform very well in terms of being caring, with two-thirds (65%) being rated as outstanding.

None of the specialist trusts were rated as inadequate for the well-led key question, although four (24%) were rated as requires improvement. These hospitals were generally smaller than most acute non-specialist hospitals. Their governance systems were sometimes underdeveloped, with senior management relying too much on personal networks to assure themselves about the quality of care. For example, they might only benchmark themselves against the few other specialist hospitals and not against the majority of specialist services in larger acute trusts. Non-executive directors sometimes appeared overawed by the reputation of the hospital's services and unable to provide effective challenge on quality issues.

As with non-specialist hospitals, specialist hospitals appear to struggle to provide a consistently good standard of care in outpatient services, with the highest proportion of requires improvement ratings for this core service.

## Figure 49: Specialist trusts overall ratings by key question




Source: CQC ratings data, as at 22 February 2017

## Figure 50: Specialist hospitals ratings grid (by key questions)

| Organisation | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Alder Hey Children's NHS Foundation Trust | Good | Good | Requires improvement | Good | Good | Good |
| Great Ormond Street Hospital for Children NHS Foundation Trust | Good | Requires improvement | Requires improvement | Inadequate | Inadequate | Good |
| Sheffield Children's NHS Foundation Trust | Inadequate | Good | Good | Good | Good | Good |
| Birmingham Women's and Children's NHS Foundation Trust | Inadequate | Requires improvement | Requires improvement | Requires improvement | Good | Requires improvement |
| Liverpool Women's NHS Foundation Trust | Inadequate | Good | Good | Good | Good | Good |
| The Christie NHS Foundation Trust | Good | Requires improvement | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| The Clatterbridge Cancer Centre NHS Foundation Trust | Inadequate | Good | Requires improvement | Good | Requires improvement | Requires improvement |
| The Royal Marsden NHS Foundation Trust | Good | Good | Requires improvement | Good | Good | Good |
| Liverpool Heart and Chest Hospital NHS Foundation Trust | Good | Good | Requires improvement | Requires improvement | Requires improvement | Requires improvement |
| Royal Brompton and Harefield NHS Foundation Trust | Inadequate | Good | Good | Inadequate | Good | Inadequate |
| Papworth Hospital NHS Foundation Trust | Good | Requires improvement | Requires improvement | Good | Good | Good |
| Royal National Orthopaedic Hospital NHS Trust | Inadequate | Requires improvement | Requires improvement | Inadequate | Inadequate | Inadequate |
| The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust | Inadequate | Inadequate | Good | Inadequate | Inadequate | Inadequate |
| The Royal Orthopaedic Hospital NHS Foundation Trust | Inadequate | Inadequate | Good | Inadequate | Inadequate | Inadequate |
| Moorfields Eye Hospital NHS Foundation Trust | Inadequate | Good | Good | Inadequate | Good | Good |
| Queen Victoria Hospital NHS Foundation Trust | Good | Good | Requires improvement | Good | Good | Good |
| The Walton Centre NHS Foundation Trust | Good | Requires improvement | Requires improvement | Good | Good | Requires improvement |

Source: CQC ratings data, as at 22 February 2017

# 6. Improvement, deterioration and special measures

**Key points**

- Thirty-seven trusts have been re-inspected since they were first rated: 13 have improved their overall rating and four have seen a deterioration.
- Most improvements have been against our safe and well-led key questions.
- Effective leadership and a positive and open culture that welcomes external feedback are important drivers for change.
- Twenty-eight acute trusts have entered special measures since July 2013; 15 have since exited.
- Trusts that improve and are able to exit special measures most quickly are those that accept our findings and resolve to tackle them straight away.

CQC has a statutory role to encourage improvement in the quality of care delivered by providers, a role that we also make clear in the statement of our purpose.

Since the start of our new inspection programme, we have re-inspected 37 of the total of 136 acute non-specialist trusts. We have seen an improved quality of care in a number of trusts and poorer care in others – overall, the improvements have substantially outweighed the deteriorations. However, a majority of trusts have seen no change in their overall rating.

Of the 37 trusts re-inspected, 13 (35%) had improved enough to achieve a higher overall rating (figure 51). Four went from inadequate to good, three went from inadequate to requires improvement and six went from requires improvement to good.

In contrast, four trusts (11%) received a lower overall rating on re-inspection: one went from good to inadequate, and three went from requires improvement to inadequate. The remaining trusts (20 out of 37; 54%) saw no change in their overall rating.

These re-inspections also involved updated assessments of many of the hospitals within these trusts. Overall, we re-inspected 80 NHS acute non-specialist hospitals up to 22 February 2017. Of these, 22 (28%) improved their rating, whereas six (8%) saw a deterioration (figure 51). The remainder (52 hospitals, 65%) saw no change in their rating.

## Figure 51: Re-inspections of NHS acute trusts and hospitals: changes in overall rating, up to 22 February 2017

| | Acute trusts | | Acute hospitals | |
|---|---|---|---|---|
| | **Number** | **Percentage** | **Number** | **Percentage** |
| Rating improved | 13 | 35% | 22 | 28% |
| No change | 20 | 54% | 52 | 65% |
| Rating deteriorated | 4 | 11% | 6 | 8% |
| **Total** | **37** | **100%** | **80** | **100%** |

We have seen examples of major improvements in individual services and across whole trusts following our inspections. These trusts are complex organisations and, in many cases, need to attend to a variety of different problems affecting the quality of the care they provide across a range of services and locations.

For some trusts, the step from requires improvement to good is a large one (for example, where almost all the services have been rated as requires improvement). For others, they may only need to improve on a small number of aspects of care to achieve an improved rating. We are looking to better understand the reasons why some providers do not improve enough to warrant a change in their rating, as part of our commitment to help people get safe, high-quality and compassionate care.

We have seen the most improvements against our safe and well-led key questions – largely matching the levels of concern we see at key question level (see figure 8 on page 18). From the start of the programme, 14 acute trusts have improved their rating for safety, out of 37 trusts re-inspected (38%); for well-led, 13 out of 37 trusts have improved their rating (35%).

To better understand the changes that we have seen within acute trusts after their first comprehensive rating inspection, it is helpful to look more closely at the core services within the trusts that have been re-inspected. Figure 52 shows the changes in ratings for the 433 core services re-inspected, out of the total of 1,649 core services rated overall.

Figure 52: Ratings changes in core services that have been re-inspected, up to 22 February 2017

| | Re-inspections | Rating up | | No change | | Rating down | |
|---|---|---|---|---|---|---|---|
| **Core service** | **Number** | **Number** | **%** | **Number** | **%** | **Number** | **%** |
| Urgent and emergency care | 63 | 21 | 33% | 32 | 51% | 10 | 16% |
| Medical care | 62 | 20 | 32% | 36 | 58% | 6 | 10% |
| Surgery | 60 | 23 | 38% | 30 | 50% | 7 | 12% |
| Critical care | 38 | 11 | 29% | 18 | 47% | 9 | 24% |
| Maternity and gynaecology | 54 | 16 | 30% | 29 | 54% | 9 | 17% |
| Children and young people | 42 | 15 | 36% | 23 | 55% | 4 | 10% |
| End of life care | 58 | 17 | 29% | 34 | 59% | 7 | 12% |
| Outpatients and diagnostics | 56 | 20 | 36% | 23 | 41% | 13 | 23% |
| **Total** | **433** | **143** | **33%** | **225** | **52%** | **65** | **15%** |

Again, the improvements we have seen at core service level generally align with the quality of each core service in the original inspections – in other words, those core services with the poorest original ratings (urgent and emergency care, medical care, surgery and outpatients – see figure 5 on page 14) are among those that have seen the biggest improvements. However, we have seen the biggest improvements in surgery services, with 38% of services improving their rating on re-inspection.

## Urgent and emergency services at Southmead Hospital, Bristol

We inspected Southmead Hospital in November 2014 and found the urgent and emergency care service inadequate because patients were waiting too long for assessment and treatment. When we re-inspected in December 2015, we rated the service as good. We saw strong leadership in the emergency department, which had resulted in improvements in the quality of patient care. Patients were now receiving timely assessment on arrival, and openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses, and were fully supported when they did so. Adverse impacts on patients following safety incidents had reduced considerably in the last year and patient safety remained a priority.

## Surgery at Wexham Park Hospital, Slough

We inspected Wexham Park in February 2014 and rated surgery as inadequate because of unsafe staffing levels, a heavy reliance on agency staff and too many cancelled operations. When we re-inspected the service in October 2015, we changed the rating to good, due to improvements throughout the surgical division. Managers had live information as to the current staffing on the wards and in theatres and were able to take immediate action where staffing levels fell below the required levels. Although there were still vacancies across the surgical wards and theatres, the situation was being proactively managed, which meant that understaffing did not affect the quality of care for the patient. As a result of learning from incidents, different sized syringes were now used following an incident where a drug was administered incorrectly. We saw minutes from staff meetings where feedback and learning from incidents was cascaded to staff both in theatres and on the wards.

We have found that effective leadership and a positive, open culture that welcomes external feedback are important drivers of change. Where the leadership recognised the problems that we identified and saw our report as an opportunity to drive change they were often able to make rapid improvements. Where leadership teams were in denial about problems little or no progress was made. When trusts needed to improve, staff were often keen for CQC's follow-up inspection to happen: our inspectors have reported examples where they had met people at the trust who wanted them to come back and see the changes and improvements that had been made.

Where trusts were performing well, the culture almost always meant that staff at all levels were engaged in the ethos of learning and improvement. One example was a programme of cross-working between office and operational staff to allow them to understand each other's roles better. This was in contrast to trusts that worked in a 'top-down' way, which inspectors found was ineffective, or where there was a cultural or structural disconnect between ward and board that could be a significant barrier to change. Also important was the development of effective links and partnership working between different areas of trusts.

The importance of values-driven leadership and a visible and listening senior leadership team cannot be underestimated. Our inspectors said that these were crucial elements in turning around trusts where improvements were needed, and vital to a trust becoming a high-performing provider. Where we have seen an improvement in ratings, hospital staff commented that leadership had improved and they felt better connected with the rest of the hospital.

## Special measures

We want to ensure that services found to be providing very poor care do not continue to do so. Special measures were introduced in 2013. They apply to NHS trusts and foundation trusts found to have serious failures in the quality of care (usually with inadequate ratings in at least two out of the five key questions at trust level) and where there are concerns that existing management cannot make the necessary improvements without support.

When we rate a trust as inadequate, we normally recommend to NHS Improvement that it should be placed in special measures. Exceptions to this can occur if strong leadership has very recently been put in place in the trust. To date, CQC's recommendations for special measures have always been accepted.

Trusts in special measures are given support to make the necessary improvements. This involves the appointment of an improvement director by NHS Improvement. In addition, external support from another trust is usually secured. Senior leadership within the trust in special measures may also be strengthened. We usually re-inspect the trust within 12 months unless we have significant concerns, in which case we will carry out another inspection sooner.

The challenge for the staff and leaders of a trust in special measures should not be underestimated. Trusts have told us that the label of special measures damages their reputation and affects their ability to recruit staff, including key leaders. Conversely, we also hear from existing staff at these trusts that they are glad that the extent of the problems they face has now been recognised. There are few greater leadership challenges in the NHS than turning round a trust in special measures, but it is one of the most important roles in the hospital sector. We are concerned that there are too few senior experienced leaders willing to take on this challenge. This is why the support they receive is so essential if they are to make improvements.

Some problems facing trusts in special measures are longstanding issues, often caused by structural or cultural weaknesses in the way the trust operates. It is good to be shining a light on these problems, but it does mean they can take time to improve. But given this time, there have been some remarkable turnarounds. Of all the trusts placed into special measures, six have gone from being in special measures to being rated as good overall – Basildon, George Eliot, East Lancashire, Hinchingbrooke, Cambridge University Hospitals and Morecambe Bay.

Overall, since the regime was introduced in 2013, there have been 28 NHS acute trusts placed into special measures (figure 53). As at January 2017, 15 acute trusts had improved enough to exit special measures, and 13 acute trusts remained in the regime.

## Figure 53: Acute trusts in special measures, July 2013 to March 2017

| | Entry | Exit** |
|---|---|---|
| Basildon and Thurrock University Hospitals NHS Foundation Trust | July 2013 | June 2014 |
| Buckinghamshire Healthcare NHS Trust | July 2013 | June 2014 |
| East Lancashire Hospitals NHS Trust | July 2013 | July 2014 |
| George Eliot Hospital NHS Trust | July 2013 | July 2014 |
| Northern Lincolnshire and Goole NHS Foundation Trust | July 2013 | July 2014 |
| United Lincolnshire Hospitals NHS Trust | July 2013 | March 2015 |
| Tameside Hospital NHS Foundation Trust | July 2013 | September 2015 |
| Burton Hospitals NHS Foundation Trust | July 2013 | October 2015 |
| North Cumbria University Hospitals NHS Trust | July 2013 | |
| Sherwood Forest Hospitals NHS Foundation Trust | July 2013 | November 2016 |
| Medway NHS Foundation Trust | July 2013 | |
| The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust | October 2013 | July 2015 |
| Colchester Hospital University NHS Foundation Trust | November 2013 | |
| Barking, Havering and Redbridge University Hospitals NHS Trust | December 2013 | |
| Heatherwood and Wexham Park Hospitals NHS Foundation Trust* | May 2014 | October 2015 |
| University Hospitals of Morecambe Bay NHS Foundation Trust | June 2014 | December 2015 |
| East Kent Hospitals University NHS Foundation Trust | August 2014 | March 2017 |
| Wye Valley NHS Trust | October 2014 | November 2016 |
| Hinchingbrooke Health Care NHS Trust | January 2015 | August 2016 |
| Barts Health NHS Trust | March 2015 | |
| Cambridge University Hospitals NHS Foundation Trust | September 2015 | January 2017 |
| East Sussex Healthcare NHS Trust | September 2015 | |
| West Hertfordshire Hospitals NHS Trust | September 2015 | |
| Worcestershire Acute Hospitals NHS Trust | December 2015 | |

| | | |
|---|---|---|
| Walsall Healthcare NHS Trust | January 2016 | |
| Brighton and Sussex University Hospitals NHS Trust | August 2016 | |
| The Princess Alexandra Hospital NHS Trust | October 2016 | |
| St George's University Hospital NHS Foundation Trust** | November 2016 | |

* Heatherwood and Wexham Park Hospitals NHS Foundation Trust exited special measures on acquisition by Frimley Health NHS Trust.
** St George's is a combined trust
Source: CQC enforcement data

The fact that so many trusts have achieved major improvements, and in some cases moved from inadequate to good, is of great credit to the quality of leadership and the dedication and commitment of staff.

We have observed that the trusts that improve most quickly are those that acknowledge our findings, and use them to be clear about where they need to improve services for their patients and culture for their staff, and then act to tackle them straightaway, and taking the support that is offered. Initial denial of the extent of the problems faced by a trust and resentment at being put into special measures means that trusts often take longer to make progress.

There is no simple formula for trusts to make the improvements needed to exit special measures. Good leadership is important, but that can come from a number of directions: improvement directors, new leaders, outstanding staff already in trusts, clinical managers 'stepping up' – all of these have been involved in turning trusts around. Also key to success is building in sustainability, so strengthening internal leadership and middle management is important.

Equally important is fostering a learning culture. This means learning from outstanding trusts and hospitals, but also influencing the standard setters at commissioning level, in the Royal Colleges and in other bodies that comment on the performance of the hospital sector.

## Special measures improvement: Cambridge University Hospitals NHS Foundation Trust

Cambridge University Hospitals NHS Foundation Trust was placed into special measures after being inspected in April 2015. One of the main reasons for this was a disconnect between what was happening on frontline operations and the senior management team, with some staff not always understanding the decisions made by the senior management

team. There was also an over-reliance on bank and agency staff, frequently cancelled operations, and long waiting times for operations. When we re-inspected in September 2016, the trust had made significant improvements and was given a good rating. The current leadership focused on communication by holding drop-in sessions to meet the senior team, which was well received by staff. The senior team were increasingly visible within the hospital, and held meetings that any member of staff could attend. There had also been an increase in permanent staffing levels, and a system of monitoring that allowed senior managers and clinical staff to adjust staffing levels to meet patients' needs.

## Special measures improvement: East Lancashire Hospitals NHS Trust

East Lancashire Hospitals NHS Trust was placed into special measures after being inspected in July 2013. There were concerns relating to the quality of governance assurance systems and patient experience. Following re-inspection in July 2014, the trust was found to have made significant improvements. A further inspection in September 2016 led to the trust being taken out of special measures due to evidence of strong governance processes. This included well-managed risk registers feeding in to the board, which ensured a robust overview of the risks within the hospital. Staff demonstrated their involvement in the solutions to the risks identified, which promoted staff ownership of risk and solutions. The emergency department had introduced a number of quality innovations that improved patient experience, care and safety, such as the introduction of a mental health triage tool and observation policy; rapid assessment review; introduction of a sepsis nurse lead; creation of a dementia friendly environment and development of the paediatric emergency department.

## Special measures improvement: Hinchingbrooke Healthcare NHS Trust

Hinchingbrooke Healthcare NHS Trust was placed into special measures after being inspected in September 2014. This followed serious concerns surrounding staffing numbers and risks to patient safety, particularly in the A&E department and medical care. On re-inspection in May 2016, the trust was found to have made significant improvements in staffing and patient safety. Nurse staffing had improved in the A&E department, and more broad visiting times had been introduced, so that families had more opportunity to speak to surgical staff during ward rounds. The trust had developed a learning culture, where incidents were reviewed for trends and learning was highlighted to the board through the governance report. Mortality and morbidity meetings had also been instigated across all divisions.

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