CareQuality Commission

The Dudley Group NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

The Dudley Group NHS Foundation Trust is a combined acute and community trust based in the borough of Dudley in the West Midlands. The Dudley Group currently serve a population of around 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. The trust provides a full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The Dudley Group also provide specialist adult community-based care in patients' homes and in more than 40 centres in the Dudley Borough Council community. The only acute trust in the area to be awarded Foundation Trust status in 2008, trust provides a wide range of medical, surgical and rehabilitation services.

The trust has one acute hospital with two smaller outpatient centres that are run as one main unit, details of these are listed below. The trust also provides community services for adults (including sexual health) and end of life care. There are no community services for inpatients or children and young people.

Name of acute hospital site	Address	Details of services provided at the site	Geographical area served
Russells Hall Hospital	Pensnett Rd, Dudley, West Midlands, DY1 2HQ	Full range of medical services including acute and urgent care, medical care, surgery, children and young people, maternity,	Currently the trust serves a population of around 450,000 people from

		outpatients, diagnostics, end of life and critical care.	Dudley, large parts of Sandwell borough as well as communities in South Staffordshire and Wyre Forest.
Guest Outpatient Centre	Tipton Rd, Dudley, West Midlands, DY1 4SE	Satellite hospital which offers additional outpatient facilities.	
Corbett Outpatient Centre	Vicarage Road, Stourbridge, West Midlands, DY8 4JB	Services include day case treatment alongside a range of outpatient services which include radiology, pharmacy, gynaecology, women's, physiotherapy, rehabilitation and a wheelchair service.	

(Source: Trust website / Routine Provider Information Request (RPIR) – Sites tab)

Is this organisation well-led?

Leadership

Not all trust leaders had the right skills and abilities to run a service providing high-quality sustainable care.

The executive and non-executive board had changed significantly in the last two years. Ten out of 17 positions had been appointed to, including the chief executive, medical director and chief operating officer. The chief nurse had most recently been appointed, as an interim in January 2019. The longest serving executive director was the chief information officer who was appointed in 2014. Four out of six non-executive directors (NED's) had been appointed in 2017 and 2018 with the longest serving director being appointed in 2012.

Since our last inspection the trust had improved its proportion of women and those from a British Minority Ethnic (BME) background among the executive and non-executive team. The percentage of BME among all board members had increased from 0% to 6.3% with women increasing from 33.3% to 37.5%. The local population served by the trust had a 17.4% BME background.

Of the executive board members at the trust, one was British Minority Ethnic (BME) and 28.6% were female.

Of the non-executive board members none were BME and 28.6% were female.

Staff group	BME %	Female %
Executive directors	11.1%	44.4%
Non-executive directors	0.0%	28.6%
All board members	6.3%	37.5%

(Source: Routine Provider Information Request (RPIR) – Board tab)

The trust board was immature in its development. A board development programme had been implemented from July 2018 with the support of an external provider focusing on:

- Team effectiveness

- Feedback

- Business chemistry

- Executive development

- Executive coaching.

Three sessions had been conducted by the time of our inspection in February 2019. Areas covered included reflection on board dynamics and traits of effective unitary boards.

The chief executive recognised that the board was not consistently delivering the required level of scrutiny, oversight and challenge. As such the CEO was directly supporting some executive members of board to deliver their roles.

The chair and chief executive were well established in their working relationship. We heard examples where the CEO or Chair had commissioned external reviews to inform board insight and, or approach, ensuring external fresh eyes reviews where the trust faced challenges of insight.

The CEO understood the resilience capability of the executive team and wider organisation. In addition, the CEO demonstrated insight in to the strengths and areas for development of members of the executive team.

We heard from a variety of trust staff at all levels that there was a variance of confidence in the capabilities of different members of the executive team. Some staff told us they were encouraged and supported within their roles and of an open and honest culture. However, some staff reported to us they felt unsupported, intimidated and were unable to raise concerns in their roles and members of the management and executive teams were unapproachable.

Some staff reported they were not confident that all deputy directors had the skills and expertise to manage the sub groups they had been appointed to lead.

The chief executive and non-executive directors were appraised twice per year. We reviewed one appraisal in full and saw it was completed in line with trust values. Progress against set goals and projects as well as development was discussed. An appraisal window had been introduced to ensure all appraisals were delivered within a set time frame, not across the year. The trust had since seen an improved and sustained appraisal rate of 96.5% However, some staff reported not being able to access the supervision, training or appraisal they needed to ensure they were competent for their role. Some staff members told us they had raised their concerns outside of the trust to seek support.

Three Non-Executive Directors (NEDs) had been appointed since our last inspection. The chair had performed a gap analysis to ensure new appointments brought the skills and capabilities required to address the ongoing challenges faced by the trust.

We attended a public and private board meeting on the 10 January 2019. We found the meeting was well attended by both the executive and non-executive directors. Agenda items included, committee reports, performance dashboards, finance and Brexit planning. The board assurance framework was listed as an agenda item however, the discussion was based around its format and reviewing risks with little time spent discussing the current risks and mitigations upon it. The challenge provided at board level needed strengthening, assurances were taking on face value

with qualitative reporting from executives. We were not assured that in-depth discussion and challenge was happening on all points.

Various committees and groups operated within the governance structure with their reports presented to the board where appropriate. For example, we saw the Clinical Quality, Safety, Patient Experience Committee (CQSPE) report had been presented to the board with discussion around it documented. It was noted in board minutes that the chairman and the board accepted the assurances given in the report around the issues raised.

Executives, non-executive directors and the chair all told us of efforts to ensure they were visible within the trust by performing walk arounds, visiting wards and by being present at meetings. Members of the executive team had spent a lot of time within the emergency department over the past year speaking to staff and directly supporting with flow issues. Whilst this was supportive for front line staff, the approach was unsustainable in demand of executive team members and senior trust leaders.

Clinical delivery was structured across three divisions, each with reporting lines and managed by a triumvirate leadership team.
Accountabilities and responsibilities were not always clear or understood by deputies and divisional leaders. This presented a risk, as executive team members did not consistently have confidence in assurances. Executives were highly involved in operational detail and acting down through divisions and directorates as a mechanism to directly seek assurance. This had been recognised by the executive team and work was underway to instil structures and standards across the management levels with responsibilities and accountabilities clear. The chief executive had insight into the strengths and weaknesses and the areas for development in each of the divisions.

Ineffective clinical leadership had been noted as an area for improvement when the strategy was developed. At the time of inspection, the job plans for each of the divisional medical chiefs were under review. However, there had been a multi-faceted focus on improving the effectiveness of clinical leadership. This had secured more positive engagement of the teams since our last inspection and furthered the agenda for quality and safety. The medical director had established a medical leadership team over the last 12 months and was actively supporting leadership development within the medical workforce.

The strength of nursing leadership and structure had been inconsistent. This had recently been recognised by the trust and we were informed a review and improvements would be implemented. The trust had a learning and development strategy which provided a framework for leadership development. This connected to five key areas: Workforce Planning; Recruitment and Retention; Developing better insight through training needs analysis; leadership development and broader learning and development activities. The organisation had a framework for talent management agreed and talent conversations were part of the appraisal conversation.

The trust offered a range of leadership programmes. A new leadership programme aimed at middle grade leaders had been launched in April 2018. Data provided by the trust showed that 1,200 eligible leaders had participated in some form of leadership development programme in the preceding 12 months to inspection.

Plans were in place to develop an emerging leaders programme and development for Matron/Directorate manager and Clinical leads through a triumvirate approach to be launched by April 2019.

The Stepping up Programme, a leadership development programme for aspiring black, asian and minority ethic (BAME) staff had also been introduced in order to ensure sustainable levels of inclusion of BAME staff in leadership roles.

We interviewed the interim chief pharmacist (ICP) and held a focus group with staff from across the pharmacy team. The pharmacy department was understaffed, and this was recorded on the risk register. The ICP could explain the structure of the department and how succession planning supported the delivery of the pharmacy departments priorities. The pharmacy teams were responsible to ensure that all key clinical and senior organisational groups were supported by the senior pharmacy team. Staff could explain how the medicines management structure ensured members of the team were embedded within several Hospital Pharmacy Transformation Programme (HPTP) work streams.

The trust had recognised from the Model Hospital the scale of the finance team was smaller than trusts of comparable size. The director of finance was working to increase capacity and to improve succession planning. The trust was aligned to segment three under the NHSI Single Oversight Framework. This meant the trust has mandated support needs. The mandated support related to quality and governance. As a result of the combination of finance and quality concerns, the trust was in receipt of an enhanced package of support from NHS Improvement.

<u>Fit and Proper Persons Requirement</u>

Trusts are required to meet the Fit and Proper Persons Requirement: directors (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are of good character and have the right qualifications and experience to carry out this important role. The trust had a fit and proper persons requirement policy in place, which had been reviewed in February 2019. During the inspection we carried out checks to determine whether appropriate steps had been taken to complete employment checks in line with the FPPR requirement. We reviewed six board member files to assesses compliance and found that not all the required checks had been carried out. We found gaps in five of the six files reviewed.

Three files had inconsistencies with DBS checks when the director had started their role including, no evidence of DBS being completed, enhanced disclosure not being completed and insufficient risk assessments of DBS findings. Three of the six files did not have evidence of robust recruitment such as interview notes or pre-employment conversations where they had been appointed through an agency. One file had references that were from their interim post at the trust and did not adequately cover employment prior to this trust. Directors were required to complete a self-declaration form for compliance with FPPR, we saw that these were completed but not always at the time of the director taking post.

Vision and strategy

The newly refreshed strategy presented a clear two-year plan for the organisation, though needed to remain dynamic to the uncertainties faced by the trust in the wider system.

The trusts vision was 'Trusted to provide safe, caring and effective services because people matter – care better every day'. Six key objectives that interlinked to the achievement of the vision were to:

- Deliver a great patient experience

- Deliver safe and caring services

- Drive service improvement, innovation and transformation

- Be the place people choose to work.

- Make the best use of what we have

- Deliver a viable future.

Three overarching strategic aims then combined these objectives, to deliver:

- Integrated care closer to home

- High quality hospital based care

- Specialist services locally.

Three values were promoted to staff across the trust in the completion of their work these were: care; respect and responsibility.

The trust strategy for 2019-2021 was approved by the trust board in February 2019 and replaced the 2015-2020 strategy. The strategy had been devised to reflect the NHS long term plan and the Dudley Health and Wellbeing board strategy. Patients and staff had been involved in the formulation of the new strategy through engagement events during the first phase of the strategy development. We saw that workshops on strategy development and progression had been held with the board and the governors. The trust had a roadshow launch planned for March 2019 to raise awareness of the new strategy.

It was acknowledged that the strategy only covered a short time frame as two years, however, this was due to large changes in the wider system with the development of the Multi Professional Community Provider (MCP) and Sustainability and Transformation Partnership (STP). The strategy was an interim strategy whilst changes in the wider health economy were implemented.

Following the NHS five year forward view document in October 2014, Dudley CCG were selected as one of 29 areas/six CCG's to test the new model of MCP care. The model will change the way care is delivered in Dudley and is based on shared ownership, shared responsibility and shared benefits for providers and as far as possible services will be developers to patients in the community.

We were told the MCP presented risks for the trust such as finance, workforce and longer-term viability. The trust had played an active part in the MCP development and was successful in being the lead bidder in the setup of the provider. The trust bid included caveats and mitigations to address any potential sustainability risks arising from the introduction of the MCP model. The trust strategy would be revisited after the MCP had gone operational, planned for April 2020. There was not an internal strategic contingency plan in place for if the MCP did not go ahead.

The trust was a member of the Black Country Sustainability and Transformation Partnership (STP), which is a collaboration of 18 organisations delivering primary care, community services, social care, mental health as well as acute and specialised services.

The trust had a work force strategy in place for 2018-2019 focused around six strategic priority areas: Leadership, Development and values; Staff well-being and Engagement; Innovation and Change; Workforce capacity; Recruitment and retention and performance and productivity. One to three-year workforce plans were being developed for each division for these to be directly linked to service planning. These were expected to be provided to all areas by April 2019.

Nursing levels had been revised across the trust using the Shelford acuity tool. We were told this

resulted in an increase to establishments needed across the trust. Vacancy rates had increased significantly as a result. Different approaches to workforce were being considered, such as utilising paramedics in the Emergency Department. Actions had been taken to improve recruitment and engagement at the trust, including holding listening events to hear staff opinion on ways to improve retention.

We were not confident robust plans were in place for the long-term sustainability of the safeguarding team. At the time of inspection one staff member was off from work and one due to retire with no formalised long-term plan in place to ensure continuity of provision in those roles. Since the inspection the trust have strengthened their safeguarding team with the addition of three new staff members.

Culture

We heard inconsistent views of trust culture from staff of all levels. Whilst some feedback remained negative, outlining the continuation of feelings of fear and intimidation, we also heard of staff and patients being proud of trust association and the positive approach of colleagues.

The local CQC relationship team received numerous enquiries since early 2018 to current date raising concerns about the culture and leadership of the trust. The enquiries had been consistent in their content from different staff groups. Trust staff had informed CQC staff of a culture of bullying, harassment and covering up of negative findings. Staff reported being forced from their positions and managed out of roles due to raising safety concerns.

This had been corroborated by a signed letter submitted to CQC, NHS Improvement (NHSI) and NHS England in the summer of 2018. The letter outlined several examples of bullying and harassing behaviours from senior trust leaders and was signed by over 40 staff across all areas of the trust. This resulted in an independent review being commissioned by NHSI and the trusts chair to investigate these allegations, at the time of inspection, the trust was awaiting the finial findings of this investigation. The CQC inspection team had seen the draft findings of this report in preparation for this inspection.

Executives and senior leaders told us of an improved culture of openness and honesty where individuals were encouraged to raise concerns. However, this was not consistently reflected in conversations that we had with staff.

Many staff spoke with CQC during the inspections of services and attended the drop-in session. Some staff described unsafe practices and not feeling able to raise concerns. We were also told that some staff had been told by their line managers not to challenge or raise concerns with the executive team. We also found examples of patient safety concerns raised by staff directly to the executive team. Whilst some were responded to and addressed in a timely manner, others were not.

Systems oversight partners agreed an action with the trust to ensure mediation between executive colleagues and senior clinical leaders. The action was agreed in August 2018 following receipt of the letter of concerns. At the time of inspection this had not taken place as both parties were awaiting the findings of the independent investigation which had been delayed. We heard this delay had caused some frustrations for staff and senior leaders.

The chief executive acknowledged that the trust had faced challenges over the past 12 months and that these may not always have been addressed in the right way. Other leaders acknowledged they had tried to do the right thing but not always in the right way and management styles were not always well received.

Some staff told us that the culture had improved since August 2018 and felt that was due to some senior leaders leaving the trust, rather than action being taken to improve the culture. Some staff told us that they were not supported to deliver high quality care due to the lack of support, training and concerning staffing levels.

Ophthalmologists told us of improved culture and engagement. They had been provided with facilitated away days to allow discussion around their service and enabling staff to focus on learning from incidents. Some Consultants told us that there was improved recognition of working and engaging together across the hospital to ease the strain on the emergency department. Consultants reported feeling more proactive and an increased sense of shared solidarity since our last inspection.

Freedom to speak up guardians

The trust had a raising concerns policy and had appointed two part-time freedom to speak up guardians. However, we found the established freedom to speak up function was under resourced. We heard inconsistent views from staff as to confidence in the support from and impartiality of the freedom to speak up guardians. The issue of resource and approachability were both recognised by the chief executive.

The freedom to speak up guardians met bi-monthly with the chief executive for discussions around issues and concerns raised. Freedom to speak up guardians were advertised across the trust and new starters were informed about them and their role as a part of the induction process. The trust had recently taken on 13 freedom to speak up and patient safety champions from various levels and disciplines across the trust. A new NED had been appointed as the non-executive lead for the speak up guardians and they had confidence that they would be pro-active in their role.

The freedom to speak up guardians acknowledged that some staff within the trust felt concerned and scared when speaking up. The guardians reported they need more time to be proactive in their role and to raise awareness across the trust. The guardians also reported that staff were concerned to be seen with them, and there was difficulty in finding a confidential place to talk where staff wouldn't be seen with them.

We reviewed some examples of the topics of the concerns raised by staff. Themes appeared around recruitment process, poor clinical practices, lack of communication on redeployment, inappropriate discussion about patient details, unclear management decisions on working hours, inappropriate management behaviour, inappropriate access to departments and staffing levels. We reviewed the actions that were taken as a result of the concerns. We found that changes had been implemented to address the key themes.

We reviewed the paper submitted to the board from the speak up guardians in December 2018. It showed that in 2017/2018 44 concerns were raised with the guardians, nine related to patient safety, 22 in relation to perceived bullying/harassment and 13 related to perceived unfair/ inappropriate behaviour.

Staff Diversity

The trust provided the following breakdowns of medical/dental, nursing/health visiting and nursing/midwifery staff by ethnic group.

Ethnic group	Medical and dental staff	Qualified nursing & health visiting staff	Qualified nursing & midwifery staff
White British/Irish/Any other white background	34.6%	69.3%	83.2%

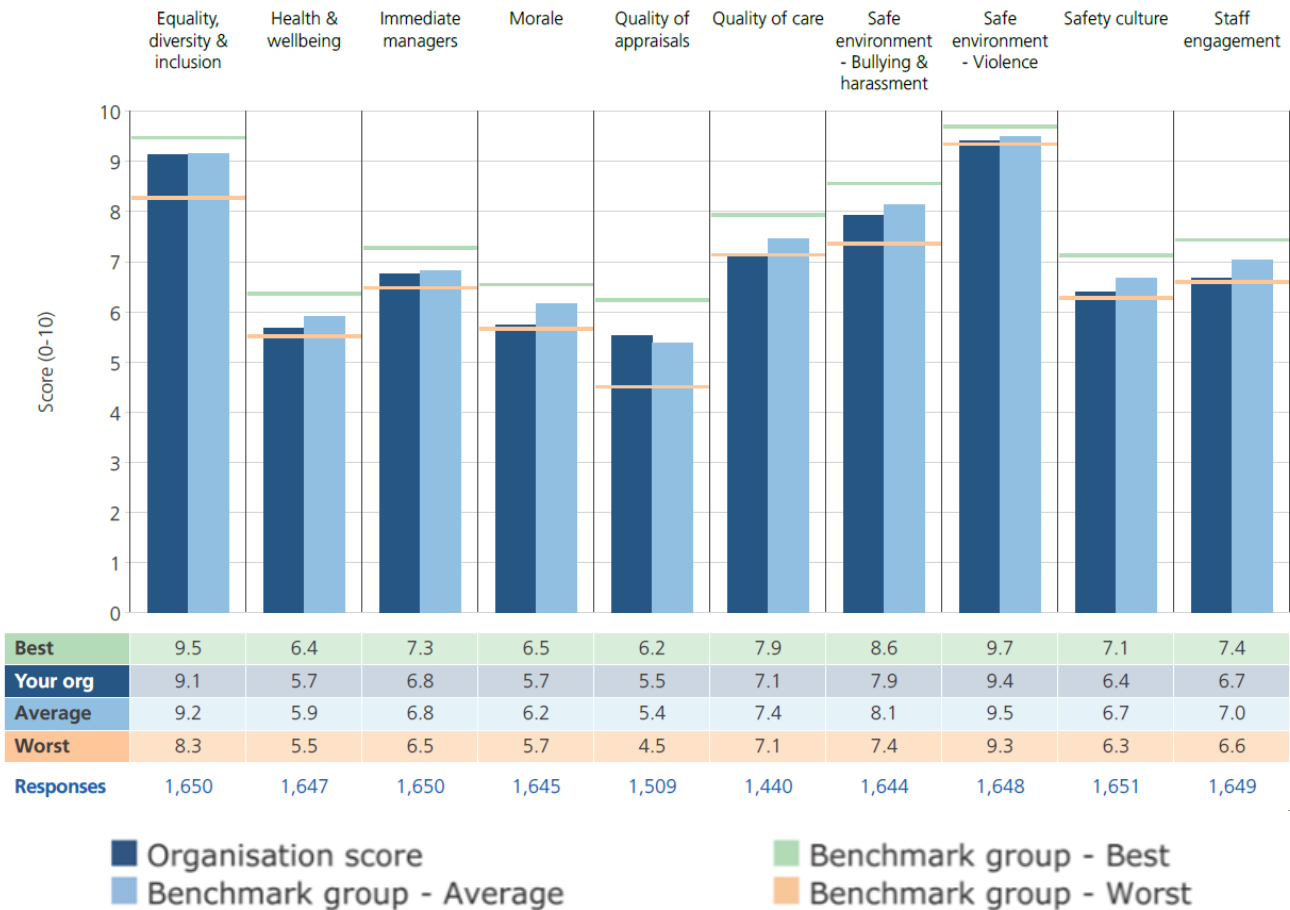|			
BME British	40.6%	11.1%	4.6%
BME Non - British	12.1%	3.6%	1.7%
Not stated	12.7%	16.0%	10.4%

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

NHS Staff survey

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.5	6.4	7.3	6.5	6.2	7.9	8.6	9.7	7.1	7.4
Your org	9.1	5.7	6.8	5.7	5.5	7.1	7.9	9.4	6.4	6.7
Average	9.2	5.9	6.8	6.2	5.4	7.4	8.1	9.5	6.7	7.0
Worst	8.3	5.5	6.5	5.7	4.5	7.1	7.4	9.3	6.3	6.6
Responses	1,650	1,647	1,650	1,645	1,509	1,440	1,644	1,648	1,651	1,649

■ Organisation score   ■ Benchmark group - Best
■ Benchmark group - Average   ■ Benchmark group - Worst

The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Health & wellbeing
- Quality of care
- Safe environment - Bullying & harassment
- Safety culture
- Staff engagement

(Source: NHS Staff Survey 2018)

Five areas were significantly worse than in the 2017 NHS Staff Survey, these were health and wellbeing, quality of care, safe environment – bullying and harassment, safety culture and staff engagement. The trust had taken initial steps to respond to the staff survey data which was released in late February 2018 including, presenting the results in a public board meeting with key actions for the year outlines, contacted other trusts to gather information on best practice ideas

and arranged a local work-group to focus on bullying and harassment with a view to run an anti-bullying campaign within the trust.

Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between…	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	3.1%	3.3%	●	0.5% →
1b. Proportion of non-clinical staff in senior roles, band 8+	12.2%	6.8%	●	4.6% →
2. Proportions of shortlisted staff being appointed to positions	13.7%	17.0%	●	-0.5% →
3. Proportion of staff entering formal disciplinary processes	4.7%	2.3%	●	0.2% →
4. Proportion of staff accessing non-mandatory training and CPD	6.0%	5.1%	Not assessed	

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there significant differences between…		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	30.2%	28.5%	28.0%	●	●	4.6% →
	Peer group	27.9%	25.3%	26.3%			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	36.3%	25.7%	27.1%	●	●	6.9% →
	Peer group	29.3%	23.6%	25.1%			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	74.2%	84.3%	83.0%	●	●	-3.5% →
	Peer group	69.5%	87.3%	84.2%			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	11.6%	5.3%	6.1%	●	●	-2.9% →
	Peer group	15.6%	5.9%	7.6%			

Trust staffing numbers (*)	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[0]	●	[0]	●

Key

- 🔶 Statistically significant or negative finding
- ⚪ Not statistically significant
- 🟢 Positive finding
- ⚪ Statistical analysis not undertaken as less than 30 BME staff responded
- 🔼 Statistically significant improvement
- ➡ No statistically significant change
- 🔽 Statistically significant deterioration

As of 2018, the following ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

- In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (13.7% of BME staff compared to 17.0% of White staff). This has remained similar to the previous year, 2017.

- In 2018, BME staff were significantly more likely than White staff to be disciplined (4.7% of BME staff compared to 2.3% of White staff) when compared to White staff. This remained similar to the previous year, 2017. This indicator looks that the relative likelihood of staff entering the formal disciplinary process, as measured by the start of a formal disciplinary investigation.

Of the four indicators from the NHS Staff Survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BME staff:

- 36.3% of BME staff experienced harassment, bullying or abuse from staff in the past year (2018 NHS Staff Survey) which was significantly higher when compared to 25.7% of White staff. The score had increased by 6.9% when compared to the previous year, 2017.

- 74.2% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS Staff Survey) which was significantly lower when compared to 84.3% of White staff. The score had decreased by 3.5% when compared to the previous year, 2018.

- 11.6% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS Staff Survey) which was significantly higher when compared to 5.3% of White staff. The score had decreased by 2.9% when compared to the previous year, 2017.

- There were no BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

*(Source: NHS Staff Survey 2018; NHS England)*

The trust did not have an equality and diversity policy and the strategy was being written at the time of the inspection. An equality and diversity statement was included in all policies and recruitment documents.   We reviewed the trust WRES and Equality Diversity System (EDS)2 documentation which was last updated in August 2018, this presented an action plan based on gaps identified from the 2017/2018 WRES submissions. Actions such as increasing BAME employees in clinical leadership roles and developing diversity champions were noted, each with a lead appointed to monitor that action. Training in equality and diversity was available to all staff as a part of induction, the General Medical Council had also delivered an equality and diversity session to the senior medical team in December 2018.

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

From October 2017 to September 2018 the trust score for recommending the trust as a place to receive care has started to drop below the England average with an overall downwards trend. Please see graph below.

We saw that friends and family tests results were discussed with the patient experience group, with wards that consistently underachieve being highlighted and their actions plans to improve being monitored
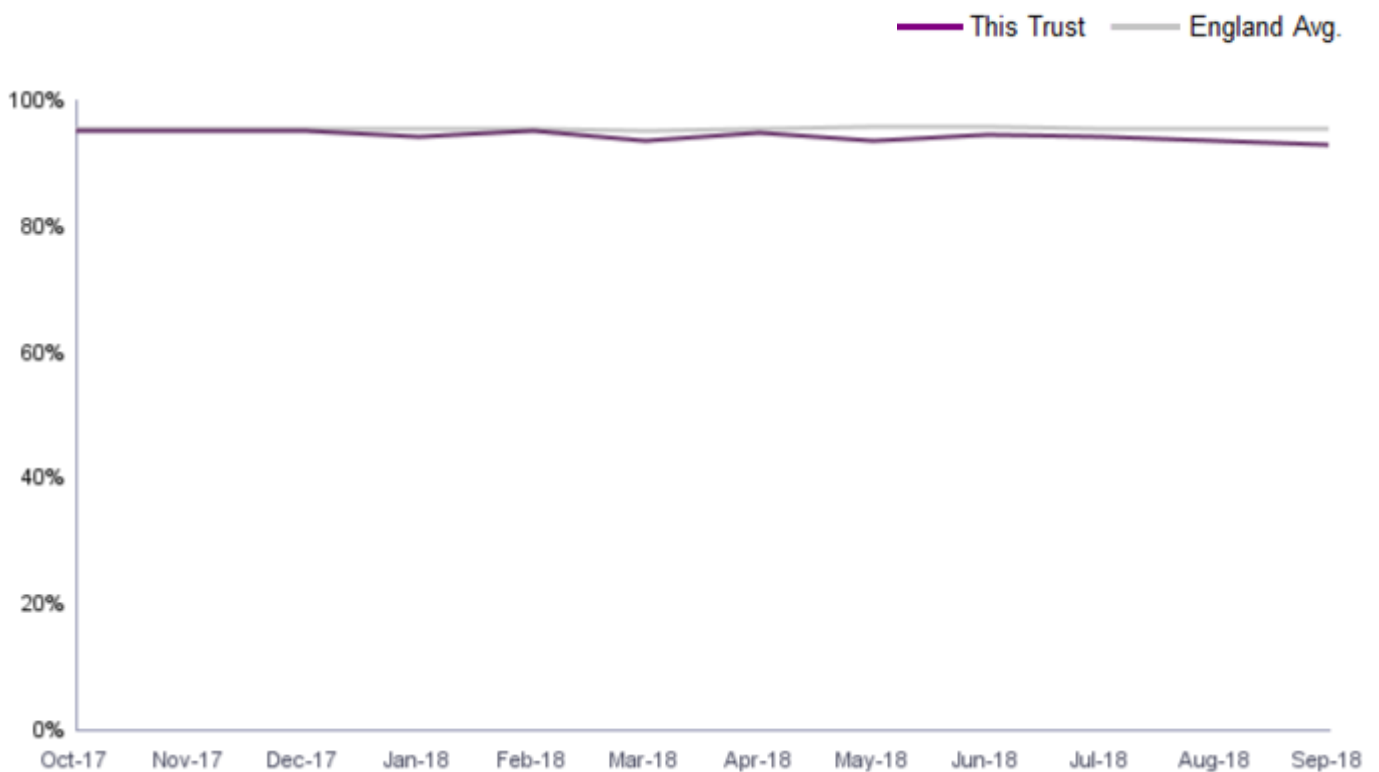
(Source: Friends and Family Test)

Sickness absence rates

The trust's sickness absence rate from September 2017 to August 2018 was consistently higher than the England average and followed a similar trend to national levels.
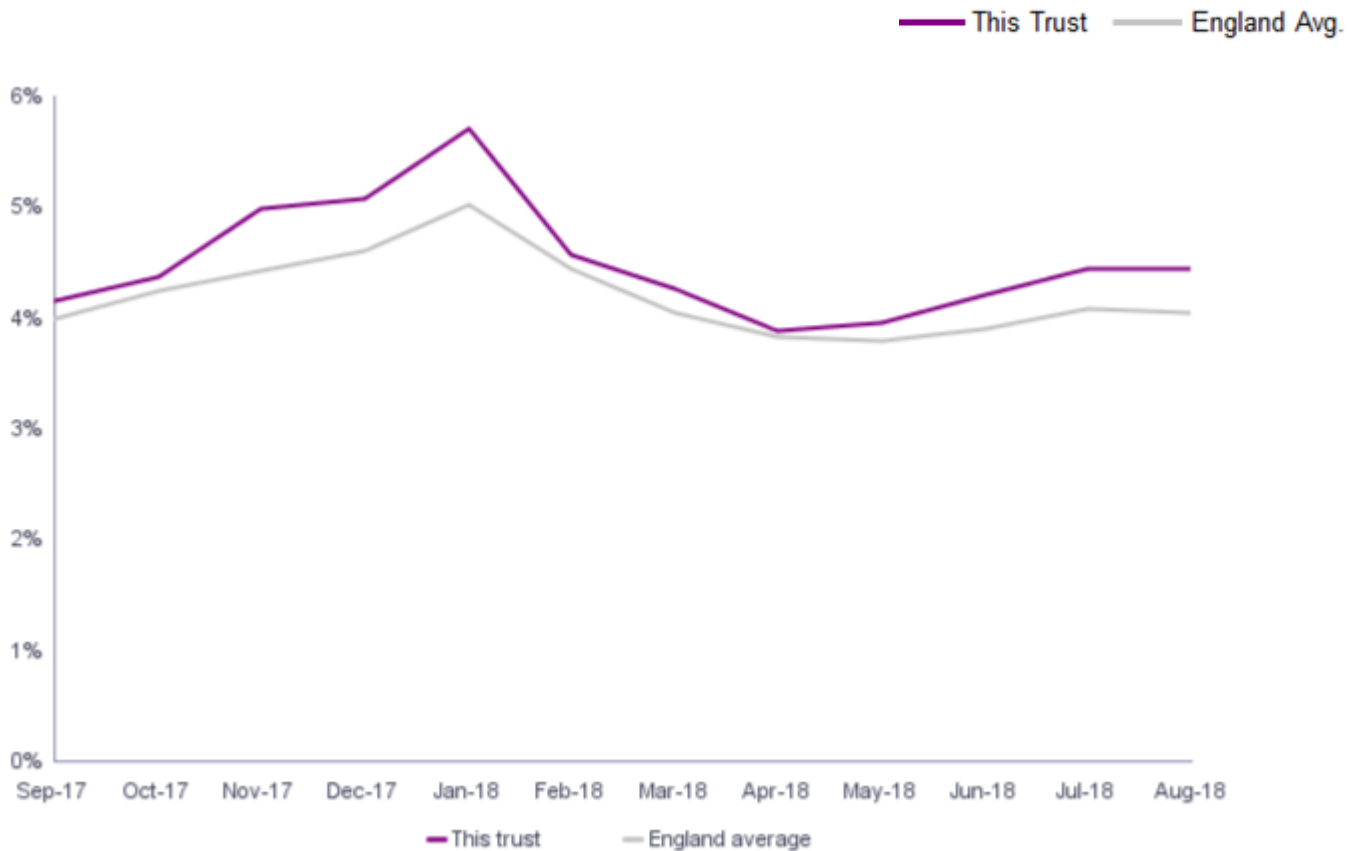
(Source: NHS Digital)

The trust's sickness absence rate from September 2017 to August 2018 was consistently higher than the England average and followed a similar trend to national levels. This was also reflected in the results of the 2017 NHS Staff Survey which showed that the percentage of staff feeling unwell due to work related stress in the last 12 months was higher than the national average.

Stress and musculoskeletal injuries were two of the leading causes for staff being absent from work so increased access to physiotherapists and counselling had been made available. Health and wellbeing events were also held for staff every quarter. At the time of inspection overall sickness levels stood at 4.28%.

General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed better than expected for no indicators, worse than expected for one indicator (induction) and the same as expected for the remaining 12 indicators.

● Better than expected　　○ Same as expected　　◆ Worse than expected

Survey area	RAG
Overall satisfaction	○
Clinical Supervision	○
Clinical Supervision out of hours	○
Handover	○
Induction	◆
Adequate Experience	○
Supportive environment	○
Work Load	○
Educational Supervision	○
Feedback	○
Local Teaching	○
Regional Teaching	○
Study Leave	○

(Source: General Medical Council National Training Scheme Survey)

A guardian of safe working hours had been appointed in response to the new junior doctors contracts. The guardian's role was to support junior doctors and to escalate issues with extended working hours to the medical director. The guardian reported to the board on a quarterly basis. If an exception report for working hours was entered by a junior doctor the trust aimed for this to be discussed with their supervisor within seven days however we saw from 20 exception reports presented only three were addressed within seven days. Information about the guardian of safe working hours and their role was available on the trust intranet for staff to read. The guardian's report to the board in December 2018 focused on challenges, exception reports and also vacancies. Challenges included engagement with the junior doctors, but details of the engagement strategy were presented. It was also seen that after investigation into complaints received from junior doctors that the extra cover rota does not fulfil the service requirements and needed fundamental changes. The trust was taking steps to address these concerns.

Duty of Candour

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that related to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and offer reasonable support to the person.

There was a duty of candour policy in place, ratified by the Clinical Quality Safety and Patient Experience Committee in April 2018 and due for review in October 2020. The policy outlined the steps that should be taken dependant on the grading of the incident with an easy to follow flow-chart of the process included. From January to December 2018 the trust exercised duty of candour 106 times.

Governance

Governance efficiencies were inconsistent across divisions and flow to board. Whilst this had been acknowledged with a review underway, the arrangements in place at the time of inspection posed a risk from ongoing gaps in scrutiny. We saw examples of reactive approaches to managing risk.

The trust held monthly board meetings with a public and private session. Both sessions had clear agendas, however we were told sometimes these agendas were too large and took a long time to get through, with a lot of the meeting being focused upon the emergency department. It had been acknowledged that the executive and clinical scrutiny of some issues was not happening or being recorded consistently and this process needed formalising and that meeting minutes did not always reflect the challenge given at board meetings.

Beneath the board was a committee structure which governance streams fed into. Although the committees had clear terms of reference we were told how some committees oversaw a vast amount of information and may have had to broaden scope to manage effectively. The three divisions that made up the trust services were managed by a triumvirate team, which reported monthly into the Risk and Assurance Group to escalate any issues and to report on performance. We were told how these governance meetings had become more robust over the past year. Staff also reported a feeling that governance structures and communication had improved across services over the past year.

The trust chair had recognised the need to strengthen the flow of information, oversight and escalation of risk since our previous inspection. An entry to the corporate risk register in September 2018 reflected this 'Governance arrangements from floor to board through divisional structures do not provide information on developing risks.'

The trust has a Finance Committee which is a formal sub-committee of the Board. NHSI had attended a committee and observed good discussion and challenge. It was noted that a significant amount of data was shared with the committee each month, this could be improved and more analysis and explanation included. There were three reports presented to Finance Committee: income and expenditure position; balance sheet and cash and CIP. There was a significant amount of detail in the reports both in terms of the main body and the appendices. This meant that committee had all relevant information, but it may be difficult to identify the key issues. The focus needed to be on exceptions, risks and analysing the drivers for variances and the actions being taken to improve.

The pharmacy team were integrated into the trust governance structure. We saw evidence of information flow both up and down the risk and governance structure. The ICP was able to describe how the safe medicines group reported monthly to the medicines management group who were responsible for overseeing that safety alerts were disseminated widely throughout the trust. The ICP attended regular meetings with the local Clinical Commissioning Groups (CCGs), area Prescribing Committee and local community pharmacy network link meetings.

Board Assurance Framework

The board assurance framework lacked clarity of strategic risks. This had been identified, with the board well engaged with plans to secure its development.

The trust provided their Board Assurance Framework, which details six strategic objectives within each and accompanying risks. A summary of these is below.

- Objective 1: Deliver a great patient experience
- Objective 2: Safe and caring services

- Objective 3: Drive service improvement, innovation and transformation
- Objective 4: Be the place people choose to work
- Objective 5: Make the best of what we have
- Objective 6: Deliver a viable future.

(Source: Trust Board Assurance Framework – October 2018)

The BAF was reviewed at regular intervals and took account of some key risks across the trust which matched with the findings of CQC inspections. However, a number of risks had deteriorated over time including some risks around the emergency care service.

There were some formatting and factual accuracy issues within the BAF itself. For example, the BAF refers to CQC placing restrictions on its licence around 'e obs' in August 2018. CQC does not issue licences. Where the CQC had placed conditions upon registration, this was not in relation to 'e obs'. This showed a lack of knowledge around CQC's role and misinformed risk oversight.

The BAF did not present concerns regarding the diagnostics service. CQC inspectors found significant safety and leadership issues within this service during the inspection. These appear not to have been sighted by the board and this shows a lack of ward to board risk identification and management. In relation to the maternity service there was one risk identified as 'midwifery staffing'. There have been concerns raised by the CCG, CQC, staff and NHSE around the increase in serious and other adverse incidents in maternity. Despite this and other prominent cases the issue of providing safe care and treatment did not appear in the BAF. This case and the increase in concern could have an impact on the trust ability to deliver a great patient experience and affect the trusts reputation.

The BAF did reference the addition of a risk to the corporate risk register titled "Governance arrangements from floor to board through divisional structures do not provide information on developing risks." This was added in September 2018. Details of impact, controls and gaps in control are listed in the corporate risk register, but no detail on how to act on this is included.

There were several areas of intolerable risks remaining static for extended periods within risk registers and the BAF without reasonable justification. An example of this was the stream to maintain high performance in national operational performance standards in relation to Urgent Care to ensure robust triage, environment, working models and escalation and clinical pathways. This had remained at risk score 20 from May 2018 to August 2018. As was the stream of maintaining high performance in national operational performance standards in relation to key cancer targets which had also remained at 20 for the same period. The assurance rating for the board had also worsened between June and August 2018. We reviewed board minutes and it did not appear that these risks were challenged during these periods and there did not appear to have been any robust evidence requested or provided to the board meeting.

The assurance area on the BAF provided measures that were qualitative such as 'education programme to be implemented', with little support of quantitative factual data. We found no challenge to this and no further assurance was given. For example, the content of the education programme, how many staff it would include and how it would be measured and fed back into the board.

The BAF and risk register did not fully reflect all key areas of risk between them. For example, the corporate risk register and BAF failed to highlight some risks and tended to capture concerns after they have occurred, presenting a reactive approach to managing risk. This demonstrated a lack of

challenge and oversight by senior leaders. There was a tendency to rely on reassurance rather than evidence to provide assurance to the Board.

An example of this was the risk 'ability to provide a safe, caring and effective service within the emergency department inclusive of immediate assessment area'. This risk was only added to the BAF in July 2018 this was despite two previous critical reports which detailed significant safety concerns in the emergency department dating back to December 2017. This risk was not placed on the corporate risk register. There was no risk on the corporate register relating to urgent care services despite significant patient safety concerns, multiple regulatory actions and adverse press interest. A further example was the risk 'the Trust's reputation for high quality, safe and effective care is damaged'. This was also added in July 2018 despite there being significant negative press coverage locally and nationally throughout 2018. This was not present on the corporate risk register. Where we identified risks were not recorded via the corporate risk register, we did see some oversight of the risks via the board assurance framework. However, this did not provide assurance of the risks owned at divisional or local level.

There were numerous gaps in controls for many of the risks on the register, and there were no plans attached or mitigation for these gaps. We saw within Audit Committee meeting minutes that they had challenged the scores contained in the BAF as they felt they did not reflect the serious nature of the risks that had been discussed by the committee. They also felt the BAF was not being used dynamically to reflect the live position.

Management of risk, issues and performance

The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the detail of controls and assurance of mitigations at board level were not always evident.

Financial overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2016/17)	**Last Financial Year (2017/18)**	**This Financial Year (2018/19)**	**Next Financial Year (2019/20)**
Income	£351.7m	£352.6m	£363.7m	Not available
Surplus (deficit)	£11.6m	(£7.1m)	(£11.5m)	Not available
Full Costs	(£340.1m)	(£359.7m)	(£375.2m)	Not available
Budget (or budget deficit)	£9.8m	£11.1m	£8.2m	Not available

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The forecast for the 2018/19 was £11.5m

The Trust had historically over-achieved against the agreed control total/planned position. In 2015/16, the Trust had a small deficit plan of £3.7m but achieved an improved outturn by just under £0.8m. 2016/17 was further influenced by the receipt of STF funds subject to delivery of finance and performance targets. The trust was required to deliver a £0.726m deficit which yielded £10.5m STF income. However, the Trust posted an improved performance resulting in an additional £1.445m STF incentive/bonus funds.

The 2017/18 performance fell short of the control total and included an impairment of £1.428m and the loss of two quarters of STF. The 2018/19 position used the base forecast following September information. It assumed the loss of two quarters STF. A recovery plan was subject to debate to reduce the deficit to £4.843m.

Plans were to develop the 19/20 plan in conjunction with the new planning guidance and operating framework. Discussions with the chair of the Finance Committee demonstrated that there was a good understanding of the key financial risks. The trust had a cost improvement plan (CIP) in place and from review of the financial plan and Finance Committee in October 2018 there were a number of issues affecting the trusts financial position. The trusts forecast for following the CIP were closely met by their actual performance. All cost improvement plans had a quality impact assessment completed prior to it being approved.

The trust strategy had two relevant financial strategic objectives; Making the best use of what we have; and Deliver a viable future. There are several risks to the achievement of the objectives that have been identified. The Trust was a member of the NHSI Improvement Programme, the Dudley Improvement Practice. The programme aim was to embed this throughout the organisation and through this reduce waste, improve flow and patient experience and deliver financial savings. It was recognised that savings may not be realised for at least two years.

Trust corporate risk register

The trust provided their corporate risk register which included their eight highest profile risks. Each of these have a current risk score of 15 or higher as of October 2018:

ID	Description	Risk score (current)	Risk level (target)
COR241	Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate due to the capacity and capability of the subcontractors estates function.	20	8
COR485	Failure of the Trust to remain liquid in 2018-19 and beyond. The cash flow forecast based on the current Income and Expenditure plans and capital plans shows that there is a risk that the Trust will run out of cash in November 2018.	20	8
COR616	Failure to remain financially sustainable in 2018-19 and beyond	20	16
COR421 (DS709)	Lack of paediatric follow up capacity resulting in delayed follow up appointments for the children.	20	12
COR616	Failure to remain financially sustainable in 2018-19 and beyond.	20	16
COR748	Governance arrangements from floor to board through the divisional structure do not provide information on developing risks.	16	8
COR632	Gaps in leadership development has led to capability issues for middle and senior managers in the trust.	16	6
COR111	The risk of a cyberthreat exploiting a vulnerability that could threaten confidentiality, availability or integrity of data services required to support business operations.	16	4
COR621	Compliance to statutory Safeguarding processes, systems and practice.	15	10

(Source: Trust Corporate Risk Register, October 2018)

The trust had a risk management strategy which outlined approach to and tolerance of risk, supported by a risk assessment practical development and reviewing guideline. The strategy outlined individual, committee and board responsibility regarding managing risk through the use of departmental, divisional and corporate risk registers as well as horizon scanning.

Since our last inspection two further risk managers had been appointed to address risk register improvement at service level and to support divisional teams. A consultant from the critical care team told us his had helped to ensure ongoing monitoring of risks, with the risk manager being responsible for following up long standing risks. Risks from divisional meetings were escalated to the Risk and Assurance Group if needed, which fed into the quality and safety team. This new structure aimed to ensure that a member of the corporate risk team was available to attend all risk

meetings. We were told that the risk register and BAF had been moved up the agenda for board meetings to ensure the right amount of time and attention was allocated. We were told of examples where risks had been escalated up the governance framework and had been resolved as a consequence. However, we also heard examples of where safety issues had been escalated from staff to management and these had not been escalated up through the governance system.

The corporate risk register lacked necessary detail to serve as effective risk oversight at trust level. Critical information, such as risk entry dates, review dates, risk descriptions, controls and mitigations were either missing or poorly described. An example of this was risk COR632 which centred on gaps in the trusts middle management resulting in capability issues. This risk contained no information in the cause and effect, impact, controls and gaps in controls. The risk was given a high rating of 16. There was no information regarding the date added, review date or completion target date. Along with the BAF the corporate risk register had been identified as requiring refinement to ensure it was functional. This management capacity was highlighted as a concern throughout our inspections. Some of the mitigations for controls in place were not due to commence until April 2019.

Pharmacy had a clear system in place to manage alerts and recalls. There was a departmental risk register which fed into the trust risk register for those areas that have a significant impact on trust performance. During the core service inspection, issues around the storage of medicines had been highlighted. The ICP described a complex way of ensuring the risk was due to be mitigated but the risk had not been handled in a simplified or timely way.

Executives were well sighted and knowledgeable around operational risks within most departments of the trust. However, this was due to reaching down through services to directly understand and seek assurance around operational issues, rather than presenting effectiveness of trust risk management and oversight systems. Issues raised to the senior team from our inspection of diagnostics services had not been highlighted through any of the trusts internal risk management or escalation processes.

The trust had an Audit Committee and we reviewed minutes from these meetings. A programme of clinical audit was outlined and monitored. In 2017/2018 all but three audits detailed on the clinical audit plan had been completed. A clinical Audit annual report had been produced detailing learning, improvements and changes made following audits. The Risk and Assurance Group met monthly, however was inconsistently attended by most members. Incidents, coroner's report and finance were also discussed.

We were told the trust was working with local ambulance providers to look at intelligent conveyancing with a system wide approach to ensure the trust only receive appropriate conveyances to their emergency department.

During our inspection we spoke to the estates lead and the lead health and safety officer. They were members of a small team. Both were suitably qualified and proactive in their roles and reported they had good support from their line management.

The trust was run under a private finance initiative (PFI) which in turn subcontracts out maintenance and cleaning. A programme of internal audit was completed across the hospital by the estates team, with the lead nurse or matron for the area encouraged to attend and contribute. Audit information was electronically collated and used to inform contract monitoring with the external providers. All staff had access to a help line and an online portal to report maintenance issues. The trust and PFI provider had two meetings per month to monitor performance.

We heard an example of a serious incident that had occurred due to a lack of maintenance of the sites facilities. The learning had included advancements to the monitoring of contracts. We also

heard how improvements had been made to the food menu after feedback from patients which had been discussed with the external provider for catering.

The estates team took a multi-disciplinary approach and engaged a range of clinicians in their work. Examples included working with nutritionists with menu changes, clinicians with clinical environment redevelopment and microbiologists with the water safety group. The estates and health and safety team were also proactive in escalating to and monitoring items on the risk register. We saw some of these issues, for example the number of staff trained in the Control of Substances Hazardous to Health (COSHH) assessments had been discussed at board level. We were provided examples where actions to long standing risks had been changed to lower the overall risk score. The health and safety manager had worked hard to ensure a focus on fire safety at the community sites and not just the main hospital sites, including assessments and review cycles.

Information management

The trust collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards. The trust recognised where further improvement was needed to ensure accurate and reliable data sources.

The trust had a Chief Information Officer (CIO) whose role was to oversee the digital transformation of the trust, ensure IT and IT support for the trust was maintained and to oversee the commercial arm of the trust IT services.

The digital transformation project was a strategic priority for the CIO. A programme of work for the next two years had been outlined and was overseen by the Digital Trust Programme Committee. The digital trust programme aimed to introduce a full electronic patient records system, ensuring the trust be paper free at the point of care, improve communication between the trust and organisations caring for the patient, reduce repetition and duplication on the patient journey and to increase near real-time monitoring to reduce clinical risk from near misses.

The trust IT system had been recognised as outdated and not user friendly. A replacement programme was planned for April 2018 but had been delayed and was not completed by our inspection in February 2019. Clinicians had also contributed to requirements of the system, ensuring it would be fit for purpose once delivered. The CIO was actively engaging clinicians in the IT developments to help it be adopted across the trust. However, some parts of the digital transformation had been brought forward in response to quality concerns. The implementation of electronic observations and sepsis recording had been deployed in the emergency department in September 2018 in response to concerns around the reporting of those metrics. The trust was also undergoing a PC/Device replacement programme to be completed in March 2019.

The data security and protection toolkit is an online self-assessment tool that all organisations must use if they have access to NHS patient data and systems, this replaces the previous Information Governance toolkit and has been in place since April 2018. At the time of inspection, the trust was moving to the new toolkit and preparing the annual submission required by March 2019.

Cyber security was a high priority and managed well by the trust. A cyber security manager was appointed three years ago and the trust invested in robust firewalls, responding to daily threats.

Information was used to generate performance dashboards at ward, executive and board level. Performance dashboards allow ward managers to see performance live. The dashboard contained key information and was available for staff and patients to review. Finance and information

management staff could work with the directorates to provide accurate figures and information to be used to inform reports and planning. We saw examples of this in papers presented to board. However, we were also told that more analysis and triangulation of data needed to occur for it to be used to make accurate judgements and to be used effectively as assurance.

The trust has sought external assurance in relation to information it has gathered when needed. For example, two external agencies provided assurance on coding changes and the impact that it had upon mortality reporting at the trust.

The trust had a named Caldicott Guardian and Information Governance lead. Information governance was also included in yearly mandatory training requirements for all staff.

Engagement

The trust engaged with patients, staff, the public and local organisations to plan and manage services. There had been a focus on increasing engagement with staff over the past 12 months however, some staff still felt they were not listened to.

At the time of our inspection the patient experience and engagement strategy was being rewritten and was in the consultation stage. We reviewed minutes from the patient experience group which met quarterly, representatives from the CCG and health watch and chair of governors also attended the meeting. Feedback was collected from patients in a variety of forms. These included friends and family test, community and inpatient patient experience surveys, Patient-Led Assessment of the Care Environment (PLACE) assessments in addition to specific maternity and cancer patient surveys. We also observed patient stories were presented to the group. We saw that digital ways of collecting and reporting Friends and family Test (FFT) results were discussed to try to increase response rates to surveys. We noted community groups were represented in surveys and we were told some executives had visited the Corbett and guest hospitals to ensure feedback from staff at these sites was also heard.

We consistently heard of efforts made by executive and non-executive members to engage with staff and patients. The chief executive told us she and the other executives had been working as a board to offer opportunities for staff to engage and ask questions by supporting and leading on make it happen events, which focused on engaging staff in improvements. Methods included monthly live web chats, coffee conversations and patient safety walkabouts. The medical director had also worked on medical engagement through channels such as medical leader's meetings, a new consultants' group and a newsletter to the medics. This had been welcomed by many consultants we spoke with. Most staff felt that there had been an effort to increase staff engagement throughout the year.

Governors had been engaged in the development of the new strategy and were represented at high level committees such as strategy and patient experience. We also heard governors had been actively engaged in key issues for the trust. For example, Consultants had given a presentation to governors on sepsis and the trusts response to concerns raised.

The trust actively engaged with local partners to improve services and patient experience. The clinical strategy was established in partnership with the CCG.MCP meetings covered system wide issues and developments. The trust also had a social services staff member based onsite who attended board rounds to ensure social services were actively involved with care and discharge of patients.

Learning, continuous improvement and innovation

The trust was committed to improving services and learning from when things went well and when they went wrong. Training, research and innovation was actively promoted.

Learning from deaths

National guidance on learning from deaths was published in March 2017, NHS trusts were required to publish an updated policy by September 2017 on how their organisation responds to and learns from deaths of patient who die under their management and care. A learning from deaths policy was in place and was last updated in July 2018. The policy stated that all trust deaths would be reviewed. However, it was unclear from meeting minutes whether that was the case. The policy addressed the need to ensure clear documented evidence of deaths of patients with a learning disability and the need to involve the liaison nurse for learning disabilities within the review. However, the guidance did not set out the requirements for the process in place to respond to the deaths of patients suffering with severe mental illness. This was highlighted at our last well led inspection. In the learning from deaths report to the board dated 6 February 2019, 120 second death reviews were reflected upon but this was not representative of all the trust deaths which was approximately 400 being reviewed as per policy. Elements of the policy were clear. However, it was not always comprehensive. For example, it was unclear how and when bereaved relatives were involved in review and learning. The trust had a named lead for learning from deaths, however they were not allocated any additional time to complete this role.

We reviewed four sets of minutes from the mortality surveillance group, we found three meetings were poorly attended, as 8/19, 4/19 and 5/19 attendees. We found that minutes were poorly recorded and incomplete in parts. The detail in the minutes was descriptive of process with minimal evidence of learning, outcomes, analysis or change to practice being presented. The group had identified that issues in accessing notes could sometimes delay reviews and hinder learning. There was also a large backlog of deaths that required a second review.

The trust had a deteriorating patient group that linked into the surveillance group. The trust lead for learning from deaths lead was confident the group would recover from the backlog and told us how the group was focused on learning but the process needed further refinement and embedding.

The trust had an electronic mortality tracking system on which all deaths were recorded. The review process for deaths in ED had also been strengthened since our last visit, with all deaths in the department reviewed daily by another consultant than the one responsible for the patients care. Weekly review of deaths at the departmental governance meeting had also been initiated and any cases identified as needing level 2 having a structured judgement review. The trust had started training for staff members in the structured review process from October 2018.

Learning from incidents

A thematic review of 37 pressure ulcer related serious incidents was undertaken between May and June 2018 in agreement with the Dudley Clinical Commissioning Group (CCG). The review was requested in order to address the 37-outstanding root cause analysis (RCA) reports outstanding at the trust. The thematic review was conducted to identify common themes and develop an action plan. Common care and service delivery problems were identified as poor skin bundle documentation, poor water low completion and delays in ordering appropriate equipment. Most common reported root causes related to inappropriate assessment of skin damage, inaccurate water low assessments and repositioning delays. The improvement plan included the creation of a pressure ulcer task and finish group, to appoint a permanent senior tissue viability nurse to lead

the integrated tissue viability service and to participate in NHS improvements pressure ulcer 90 day improvement programme. A further desktop review into serious incident management was conducted by the Quality Governance Team which is part of NHS improvements Nursing directorate in response to concerns around RCA reports submitted by the trust. This review provided the trust with a list of recommendations in order to improve their management of serious incidents.

During our inspection we reviewed four serious incidents. We saw that in one of these the lead nurse for the ward on which the incident occurred had been the lead investigator which is not best practice. Terms of reference for the investigations were not evident for those we reviewed. We did see that one RCA in relation to MRSA had been investigated thoroughly and robustly. Not all investigations had evidence of feedback sought from the patient, family or carers and one initially looked to attribute blame rather than have a focus on learning from the incident. All four RCAs has clear conclusions and recommendations for further action highlighted.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	100.0%
What is your target for completing a complaint	40	45.7%
If you have a slightly longer target for complex complaints please indicate what that is here	n/a	n/a
Number of complaints resolved without formal process in the last 12 months?	1,738 (October 2017 to September 2018)	n/a

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

The trust received 483 complaints from October 2017 to September 2018. Urgent and emergency services received the most complaints with 133 (27.1% of all complaints received trust wide).

A breakdown by core service can be seen in the table below:

Core Service	Number of complaints	Percentage of total
AC - Urgent and emergency services	133	27.5%
AC - Medical care	99	20.5%
AC - Surgery	89	18.4%
AC - Outpatients	60	12.4%
AC - Maternity	22	4.6%
AC - Services for children and young people	23	4.8%
Other	15	3.1%
AC - Gynaecology	10	2.0%
CHS - Adults community	9	1.9%
AC - Diagnostics	9	1.9%
AC - Critical care	7	1.5%

	2	0.4%
AC - End of life care	2	0.4%
CHS - Sexual health	1	0.2%
Trust wide	**483**	**100.0%**

The most common subject of the complaints was patient care which accounted for 163 complaints (33.3%).

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

A complaints policy was in place detailing staff responsibilities and organisational time frames for answering complaints. We interviewed a complaints officer who recognised that the trust position in regard to complaints was 'not good' and the department had capacity issues, as well as capacity issues at divisional levels. A new complaints officer had recently started with a view to ease pressure. However, we were informed that the current complaints officer had no formal training in complaints management. We saw in meeting minutes that the chief executive acknowledged that the current complaints process is not sustainable and work needed to be done to target investment in the right area of the complaints team.

The trust had a complaints review and learning group that was chaired by the chief executive. We reviewed the meeting minutes from December 2018 and found these to contain information on numbers of complaints and backlogs and although communication was highlighted as a key theme very little learning from complaints was discussed.

During the inspection we reviewed five complaint files. Those reviewed presented a lack of holistic consideration of the patient at the centre of their care. We were also not assured of NED complaints reviews of the robustness of complaints management systems.

Compliments

From October 2017 to September 2018, the trust received a total of 6,894 compliments. Medical care received the most compliments with 2,691 (39.0% of all compliments received trust wide). A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
AC - Medical care (including older people's care)	2,691	39.0%
CHS - Adults community	1,438	20.9%
AC - Maternity	908	13.2%
AC - Surgery	712	10.3%
AC - Critical care	311	4.5%
AC - Outpatients	234	3.4%
AC - Services for children and young people	202	2.9%
AC - Urgent and emergency services	154	2.2%
Other	102	1.5%
AC - End of life care	62	0.9%
AC - Diagnostics	38	0.6%
CHS - End of life care	35	0.5%
AC - Gynaecology	7	0.1%
CHS - Sexual health	0	0.0%
Trust wide	**6,894**	**100.0%**

The trust reported that key themes emerging from the compliments support the information found in other surveys that have been undertaken and include care and treatment (medical, nursing,

other, general nursing care) and staffing (medical/nursing, general nursing/care).

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows the trust's services awarded an accreditation.

Accreditation scheme name	Service accredited
Joint Advisory Group on Endoscopy (JAG)	Endoscopy - August 2018
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	Biochemistry - September 2017 Cellular Pathology and Mortuary - May 2016 Haematology - October 2017 Immunology - March 2018 Microbiology - March 2018

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

Learning and innovation

Research and development was actively promoted with an appointed research and development director and research manager. A trust consultant had also won a research impact award at a regional awards ceremony. Research activity at the trust had grown by 4.1% from 2016/17 to 2017/18.

We heard about an innovative approach to generate income. The trust had developed a commercial IT company, which outsourced its products and data management capabilities to other organisations.

The trust had launched the Dudley Improvement Practice, which would be used to drive forward improvement in services. The approach would be clinically led.

Improvement tools and standardised improvement methodologies were in place. The trust was using two recognised improvement tools and was currently taking the first few cohorts through the improvement methodology training.

The trust facilitated a patient safety summit in September 2018 which was open to all staff to share information and learning across the trust.

The emergency department and medical division had developed a specialist chest pain unit and frailty ward to ease flow into and out of the emergency department. The imaging department had won a Gold standard award for diagnosing osteoporosis and other related conditions using Dual Energy X-ray Absorptiometry (DEXA) scanning. Staff within the end of life services were empowered to find innovative ways to meet people's individual needs and wishes.

A surgical ambulatory assessment unit had been set up as part of the surgical assessment unit to aid patient flow and patient experience. These enabled patients referred for acute symptoms requiring urgent triage and surgical assessment who could sit to attend for their pre- assessments without being admitted. Following triage and assessments, patients, where appropriate, could return home until their operation the following day rather than be admitted overnight prior to surgery if required. This initiative supported a better access of inpatient beds for patients who required them; and enabled a quicker turnaround time for patients.

Acute services

Russells Hall Hospital

Pensnett Road
Dudley
West Midlands
DY1 2HQ

Tel: 01384 456111

www.dgoh.nhs.uk

Urgent and emergency care

Facts and data about this service

Details of emergency departments and other urgent and emergency care services

The emergency department at Russells Hall Hospital is a consultant led department, with a separate paediatric unit, both of which provide care 24 hours a day, seven days a week. The trust also runs an Ambulatory Emergency Care (AEC) from the same site. Consultant cover is provided across the department 16 hours a day, seven days a week. There is a nurse led minor injuries service in addition to the Urgent Care Centre (UCC). The onsite UCC is run by a separate provider.

The AEC provides same day emergency care to patients in a hospital setting. Patients are assessed, diagnosed, treated and can go home the same day without being admitted overnight. It is a consultant led service supported by nursing, diagnostic and community teams and is the first point of contact for most medical patients.

(Source: Routine Provider Information Request (RPIR) – Sites tab; Acute RPIR – Context tab)

The emergency department is divided into different treatment areas including paediatrics, major and minor injuries, resuscitation, ambulance assessment area and the ambulatory emergency care unit.

A streaming nurse is located at the entrance to the emergency department and directs patients to either the emergency department or the UCC.

The emergency department was last fully inspected in December 2017 and was rated inadequate overall. Further responsive inspections in relation to specific concerns were conducted in January, March, June and August 2018, these inspections were not rated.

The trust currently has conditions on its registration concerning triage, management of the deteriorating patient, staffing and clinical oversight.

We visited the emergency department on the 15, 16, 30 January and 4 February 2019. We spoke with approximately 24 staff members, including matrons, consultants, doctors, nurses, health care assistants and administration staff. We reviewed 28 set of patient records and observed the care being given to patients.

**Activity and patient throughput**

Total number of urgent and emergency care attendances at The Dudley Group NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018
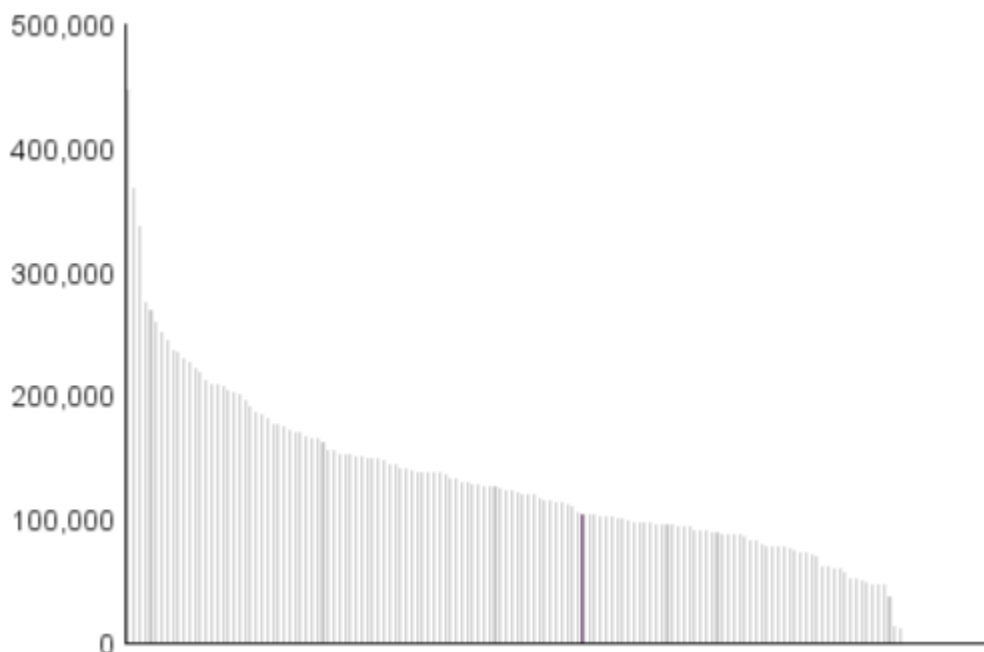
From July 2017 to June 2018 there were 103,275 attendances at the trust's urgent and emergency care services as indicated in the chart above.

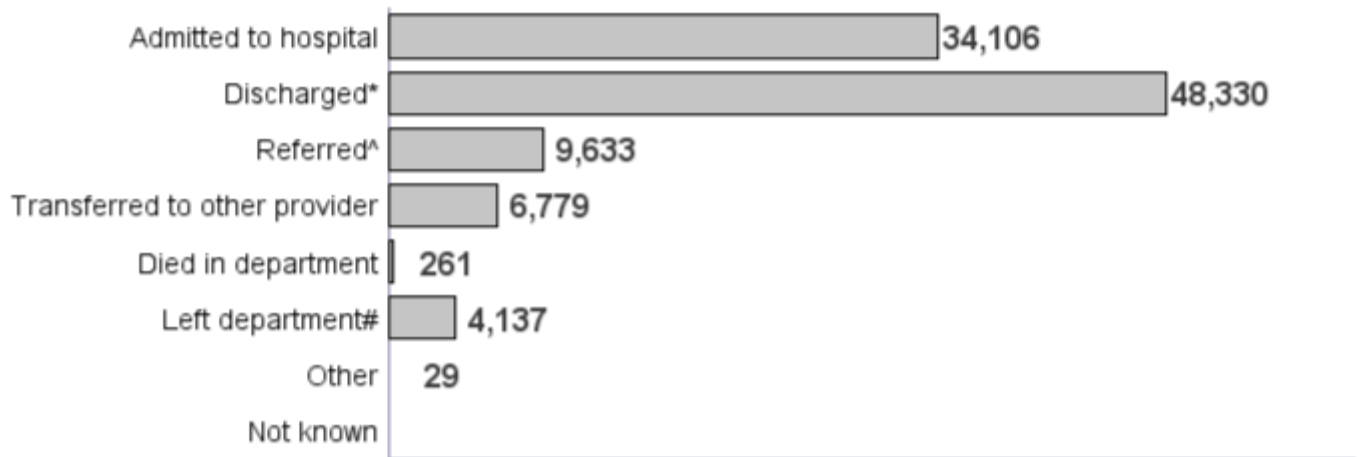*(Source: Hospital Episode Statistics)*

Urgent and emergency care attendances resulting in an admission
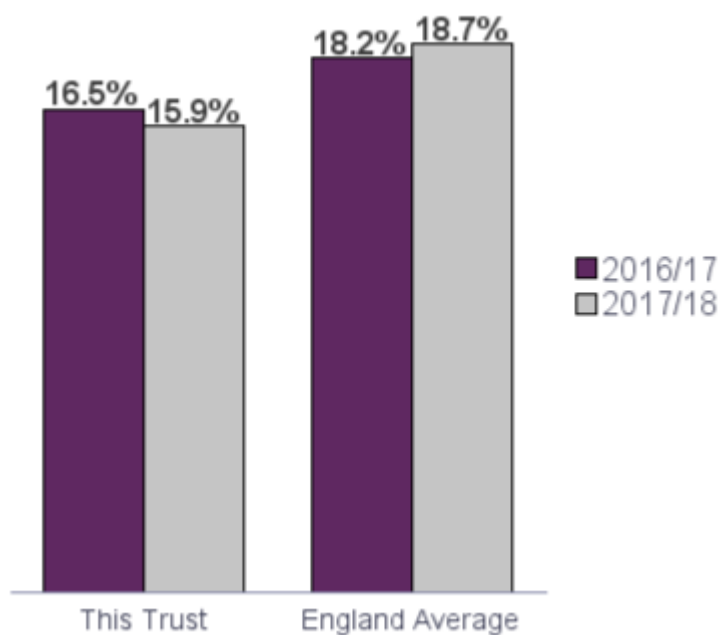
The percentage of A&E attendances at this trust that resulted in an admission remained similar in the most recent year compared to the previous year. In both years, the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2017 to June 2018

Disposal method	Attendances
Admitted to hospital	34,106
Discharged*	48,330
Referred^	9,633
Transferred to other provider	6,779
Died in department	261
Left department#	4,137
Other	29
Not known	

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to all staff however, they did not make sure that everyone completed it. The trust's mandatory training target was met by nurses for five out of ten modules while doctors only reached compliance for one.

Managers had a system to monitor staff compliance with mandatory training. A central trust database of training completion identified staff who were not up to date with training.

The matron had overall responsibility for mandatory compliance for nursing staff. Band 7 nurses in the department had a team of nurses for which they were responsible for monitoring training compliance. The practice development nurse also sent individual staff members emails to remind them to complete training.

Bank nurses completed mandatory training. The professional development team monitored mandatory training compliance for clinical bank workers. Where staff were non-compliant they were suspended from working until the required training had been completed.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in urgent and emergency care is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	117	122	95.9%	90.0%	Yes
Equality & diversity (including autism awareness)	113	122	92.6%	90.0%	Yes
Information governance	112	122	91.8%	90.0%	Yes
Conflict resolution - level 1	112	122	91.8%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	111	122	91.0%	90.0%	Yes
Resus - adult	106	122	86.9%	90.0%	No
Infection control - clinical	105	122	86.1%	90.0%	No
Fire	103	122	84.4%	90.0%	No
Manual handling (patient) / slips, trips & falls	97	122	79.5%	90.0%	No
Resus - paediatric	59	78	75.6%	90.0%	No

In urgent and emergency care the trust had an overall mandatory training compliance rate of 88.0% for qualified nursing staff. The 90% target was met for five of the 10 mandatory training modules for which qualified nursing staff were eligible.

We were told a mandatory training session had been completed two days before our inspection and that further mandatory training days were planned to enable staff to complete their training. We requested this information however, overall compliance had only increased to 89% with still only five of the 10 mandatory training levels being complaint overall. We requested an action plan that showed plans were in place to reach compliance with mandatory training levels for nurses.

A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in urgent and emergency care is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	36	40	90.0%	90.0%	Yes
Equality & diversity (including autism awareness)	33	40	82.5%	90.0%	No
Information governance	32	40	80.0%	90.0%	No
Clinical governance (including incidents, complaints & claims investigations)	31	40	77.5%	90.0%	No
Resus - paediatric	19	25	76.0%	90.0%	No
Conflict resolution - level 1	30	40	75.0%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	29	40	72.5%	90.0%	No
Fire	27	40	67.5%	90.0%	No
Resus - adult	26	40	65.0%	90.0%	No
Infection control - clinical	26	40	65.0%	90.0%	No

(Source: Routine Provider Information Request (RPIR) – P38 Training tab)

In urgent and emergency care the trust had an overall mandatory training compliance rate of 75.1% for medical staff. The 90% target was met for one of the 10 mandatory training modules for which medical staff were eligible. More up to date information at the time of inspection showed training figures had increased in two modules with still only one reaching 90% compliance. Completion rates for other modules had deteriorated. We requested the department's action plan to increase medical staff mandatory training rates, this contained no detail on how staff were going to be facilitated to complete training, progress or assurance information. Therefore, we were not assured this action plan was robust and would be effective in increasing mandatory training rates for medical staff.

Nursing staff told us they did not always have time to complete mandatory training. We were told how staffing shortages and demand within the department meant that planned training could be cancelled at short notice

Clinical staff received mandatory training on how to recognise and provide a first response to patients with mental health needs, learning disabilities, autism or dementia. All mental health training was delivered in-house and was not accessed through the local psychiatric liaison team or other areas of the local mental health trust. As at 21 December 2018, 86% of nursing staff had received training in mental health law. This was a mandatory training course that nursing staff completed every three years and included the Mental Capacity Act, Deprivation of Liberty and the Mental Health Act.

Training sessions in learning disabilities and dementia were provided although staff were not required to attend these training sessions. At the time of inspection 85% of staff had completed training in dementia and learning disabilities awareness. The provider offered de-escalation and

breakaway training and encouraged staff to become dementia friends. The trust's mental health lead had completed a course in mental health first aid.

A sepsis policy was in place and annual training in sepsis management was provided. New starters in the department received a half-day sepsis education programme as a part of their induction. All clinical staff completed annual training in sepsis management as a part of the mandatory resuscitation training. However, neither doctors or nurses were fully complaint with resuscitation training. Nurses recorded a 87% compliance rate with doctors achieving 65% compliance therefore, we could not be assured that all staff had the same minimum level of knowledge around sepsis.

Safeguarding

Staff we spoke to understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse. Weekly data provided by the trust showed that paediatric liaison forms and multi-agency referral forms were not always completed where appropriate so we were not assured that safeguarding knowledge was applied correctly at all times. and they knew how to apply it. Staff we spoke with could demonstrate the safeguarding principles and knew who to escalate their concerns to.

The interim named doctor for safeguarding interviewed as part of the inspection process was not trained to the appropriate level to provide expert knowledge and advice on issues related to child safeguarding.

There was a safeguarding policy for both adults and children that reflected best practice and national guidance.

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules for qualified nursing staff in urgent and emergency care is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	121	122	99.2%	90.0%	Yes
Safeguarding children level 1 & 2	116	122	95.1%	90.0%	Yes
Safeguarding adults	115	122	94.3%	90.0%	Yes
Safeguarding children level 3	71	78	91.0%	90.0%	Yes
W R A P	111	122	91.0%	90.0%	Yes

Data received before the inspection showed that in urgent and emergency care the trust had an overall safeguarding training compliance rate of 94.3% for qualified nursing staff. The 90% target was met for all five of the safeguarding training modules for which qualified nursing staff were eligible. However, at the time of inspection we saw that training compliance had fallen with nursing staff completion rate for Safeguarding Children – Level 3 at 82% and Workshop to Raise the Awareness of Prevent (WRAP) at 89%. Nurses assigned to the paediatric level had safeguarding children level three training.

Staff competency in safeguarding was kept updated. Named nurses within the trust were trained in providing supervision. Safeguarding leads told us of plans to train more supervisors staff to enable more staff to access support and in a more structured format.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in urgent and emergency care is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	36	40	90.0%	90.0%	Yes
Safeguarding children level 3	22	25	88.0%	90.0%	No
Safeguarding children level 1 & 2	34	40	85.0%	90.0%	No
Safeguarding adults	31	40	77.5%	90.0%	No
W R A P	28	40	70.0%	90.0%	No

(Source: Routine Provider Information Request (RPIR) – P38 Training tab)

In urgent and emergency care the trust had an overall safeguarding training compliance rate of 81.6% for medical staff. The 90% target was met for one of the five safeguarding training modules for which medical staff were eligible.

We requested current training compliance rates on inspection and saw that medical staff were still only compliant with one safeguarding module which was safeguarding children level one and two. We noted that safeguarding level three compliance had fallen to 78%.

Volunteers that worked within the trust were provided with safeguarding children level one and two training.

Leaders trained to safeguarding level four could be accessed by staff. The trust had two named children nurses, one named adult nurse, one paediatric liaison nurse and an overarching head of safeguarding. The trust had recently appointed a paediatric consultant to the interim named doctor for safeguarding; however, they were yet to complete level four training.

We saw improvements had been made to safeguarding practices since our last inspection. The trust safeguarding team supported staff within emergency department with the recognition and referral of potential safeguarding cases. The paediatric liaison nurse reviewed all paediatric admissions to ensure the correct safeguarding actions had been completed. However, these reviews highlighted that paediatric liaison forms and multi-agency referral forms were still not being consistently completed and there was a reliance on the paediatric liaison nurse to ensure these had been completed.

Further safeguarding information was available to staff on how to fill out safeguarding referral forms. We saw instructions on how to thoroughly fill out a Multi-Agency Referral Form (MARF) that ensured the correct information was captured. Further prompts were available when clinicians suspected child sexual exploitation.

There was a process to identify any children with a child protection or a safeguarding concern on admission to the department. The Child Protection – Information Sharing (CP-IS) system was checked for all children attending the department. Children who were known to social services, looked after children or those on a child protection plan were recorded on this database. This system was used when a child was booked into the department and a note made on the system to alert clinicians to any necessary information. During the inspection we saw this system being used and relevant safeguarding questions were being considered in patient records.

A new children's safeguarding screening questionnaire was in development. Service leads had worked with the IT department to design a bespoke safeguarding screening tool. Once completed the aim was the tool would prompt staff to perform specific actions such as admission to the

paediatric ward or completing a paediatric liaison form. However, the implementation of the new electronic patient record that this was to be contained within had been postponed.

The trust employed a vulnerable adult's liaison nurse. The head of safeguarding told us how 104 staff from high risk areas across the trust, including the emergency department, had attended face to face training sessions in domestic abuse awareness. The department had entered a bid to an external agency to fund an Independent Domestic Abuse Advisor.

Cleanliness, infection control and hygiene

The service controlled infection risk. Staff kept themselves and equipment clean, most areas visited during the inspection were clean and tidy. Control measures were in place to prevent the spread of infection however, these were not always followed.

Most areas we visited were visibly clean and tidy. The medical equipment we looked at was clean. We saw cleaning schedules prominently displayed in each department for daily and weekly cleaning tasks.

Cleanliness of the department was audited monthly. An environmental audit was conducted monthly, which assessed all areas of the department including clinical and store areas. We were provided with November 2018's audit which scored 85% compliance, with shortfalls being noted as dusty shelving and equipment. In response to this result we saw the action plan included a daily walk round of the department of the nurse in charge to assess cleaning levels. During the inspection we noted that high level cleaning within the resuscitation area had not been completed, we raised this with the lead nurse and saw it had been completed later that day. Hand hygiene audits were completed monthly. We saw results for October, November and December 2018 were all at 100%.

Not all staff had completed mandatory training in infection prevention and control. At the time of inspection mandatory training levels for nurses was 86.1% and doctors 65%.

Link nurses with an interest in infection prevention and control were in place. Link workers met bi-monthly to discuss best practice and to share their leaning and experience.

Staff could describe infection prevention and control measures. Members of the trust's infection prevention and control team supported the emergency department. We saw that the emergency department had a named contact for a clinical nurse specialist, nurse and matron from the infection prevention and control team.

Infection control validation audit results were displayed in the department. We saw the audit results and action plan from November 2018. The department scored 81% overall, actions identified included ensuring infection control was a standard agenda item for ward meetings and to increase mandatory training levels. However, we reviewed meeting minutes after this audit had been conducted and infection control discussions were not mentioned. We saw January 2019's audit results displayed in the department as 90.95%.

An Influenza (Flu) management policy was in place. This document highlighted individual responsibilities, screening methods and isolation. Control measures were in place to prevent the spread of communicable diseases and infection however, these were not always adhered to. In the majors department we saw one cubicle had a barrier nursing station and an infection control poster had been placed on the curtain however, the curtain had been left open allowing staff and visitors to walk into the cubicle without attention being drawn to the risk. A further cubicle had all the appropriate infection control barriers and signage in place however, we observed a doctor and medical student entering this cubicle wearing no protective equipment. When approached by inspectors they said they were aware infection precautions were in place but they were 'just putting up fluids'. We saw a patient with confirmed flu in the resuscitation area, although staff

were wearing personal protective equipment no signage or barrier nursing trolley had been set up to highlight this to other staff coming in and out of the area. Not all curtains around cubicles had the dates of when they were last changed.

Personal protective equipment in a range of sizes and hand sanitizer was prominently available in all areas that we visited. We observed staff members washing their hands between patient contacts and most staff were bare below the elbows. We observed staff deep cleaning bays between patients.

Environment and equipment

Not all environments within the department were suitable for their use. At the time of inspection ligature points remained across the department.

The adult's emergency department and urgent care centre (UCC) which was run by an independent provider shared a reception area. Paediatric patients would be booked in at the same emergency department reception but then sent to a separate dedicated paediatric waiting room.

The Paediatric emergency department had moved into a new area the week before our inspection. A full standard operating procedure had been put in place to cover the care and treatment provided within this area. This move was before the planned date due to the high volume of paediatric patients the trust had been receiving. The paediatric area was secure. Buzzer entry was in place to the paediatric department, the waiting area also had high handles on the door so small children could not leave unaided. During our inspection the area was not yet fully fit for purpose with electrical and decorating work still ongoing. Child friendly areas were in development. The paediatric emergency department had a separate waiting area with toys and books for children and child friendly decoration was underway.

Paediatric resuscitation equipment was available in the paediatric department and was checked daily. The paediatric crash bell sounded during our inspection and we saw a good response from all staff grades. We saw resuscitation equipment was also available in the ambulance assessment, major's, triage and resuscitation areas.

The resuscitation area of the department was small and did not promote dignity for patients. Improvements had been made to the area since our last inspection by changing the storage system to create more space however, this area remained a cramped environment. The main drugs store was within one of the four bays so needed to be constantly accessed by staff treating all patients.

The ambulance triage area was constrained by its building. We have previously raised this area as inappropriate for patients to stay in for long periods. The cubicles were small with brick walls on three sides. The size of the cubicles would make it difficult to use resuscitation and lifting equipment if needed. Leaders recognised the constraints to this area and its was intended to house patients for only a short period of time however, flow issues within the hospital meant patients could be in these cubicles for a long time. During our inspection there were a number of patients in the ambulance assessment area who had been there for up to eight hours.

The emergency department had a mental health assessment room. This room had not been accredited by the Psychiatric Liaison Accreditation Network. The room had no blind spots and was minimally furnished in line with best practice however, only one of the viewing panels had frosted glass and there was nothing in place to cover the other viewing panel to protect patients' dignity. Staff told us they used a pillow case to cover this observation panel when it was safe and appropriate to do so however, this could pose further risks. The door handles in the mental health assessment room presented a ligature risk. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Patients who

were assessed or supported in this room had access to a toilet next to the room which contained several ligature points. Staff we spoke with were unclear on how this risk was managed and one staff member reported that patient's unsupervised access to this toilet was based on an individual's clinical judgement, rather than the initial triage risk assessment process. This presented a risk that staff may not be clear on whether patients with a mental health need would be given unsupervised access to a room containing several ligature points which they could use to harm themselves.

The trust maintained equipment in a way that kept patients safe. The trust had an asset management system in place which automatically scheduled emergency department equipment for maintenance and auto generated the preventative maintenance request for each item. We observed equipment to be in good working order.

Systems were in place for the segregation and correct disposal of waste materials such as sharp items and those contaminated by bodily fluids. This included secure sharps containers with temporary closure ability for the safe disposal of needles. Clinical waste was appropriately separated before disposal with all bins being labelled appropriately.

Assessing and responding to patient risk

Risks were not always identified and escalated appropriately.

The trust did not score better than other trusts for any of the five Emergency Department Survey questions relevant to safety. The trust scored worse than other trusts for one question and about the same as other trusts for the remaining four questions.

Question	Score	RAG
Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.7	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	5.0	Worse than other trusts
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	5.9	About the same as other trusts
Q33. In your opinion, how clean was the emergency department?	8.4	About the same as other trusts
Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?	9.7	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

The median time from arrival to initial assessment was better than the overall England median in 11 months over the 12-month period from September 2017 to August 2018.

In November 2017 the median time to initial assessment at the trust was the same as the England average.

Ambulance – Time to initial assessment from September 2017 to August 2018 at The Dudley Group NHS Foundation Trust
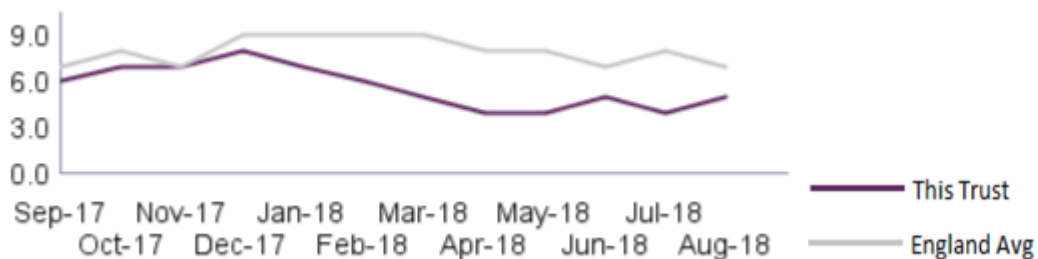

(Source: NHS Digital - A&E quality indicators)

Russells Hall Hospital

From October 2017 to September 2018 the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Russells Hall Hospital was quite stable.

From October 2017 to January 2018 there was an upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Russells Hall. As this is over the winter months, it is expected.

The percentage increased from 68.6% in April 2018 to 81.0% in July 2018 but improved again to 67.3% in September 2018.

Ambulance: Number of journeys with turnaround times over 30 minutes - Russells Hall Hospital
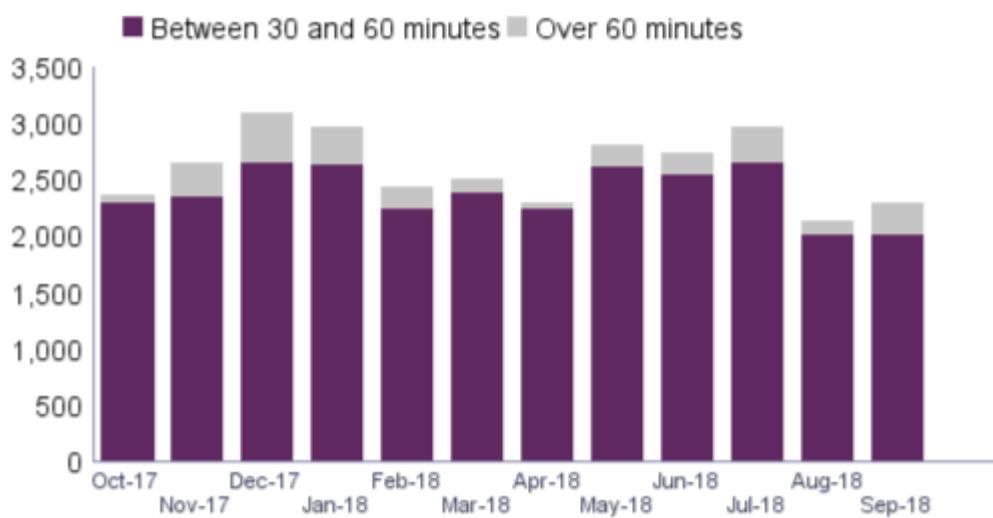
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Russells Hall Hospital
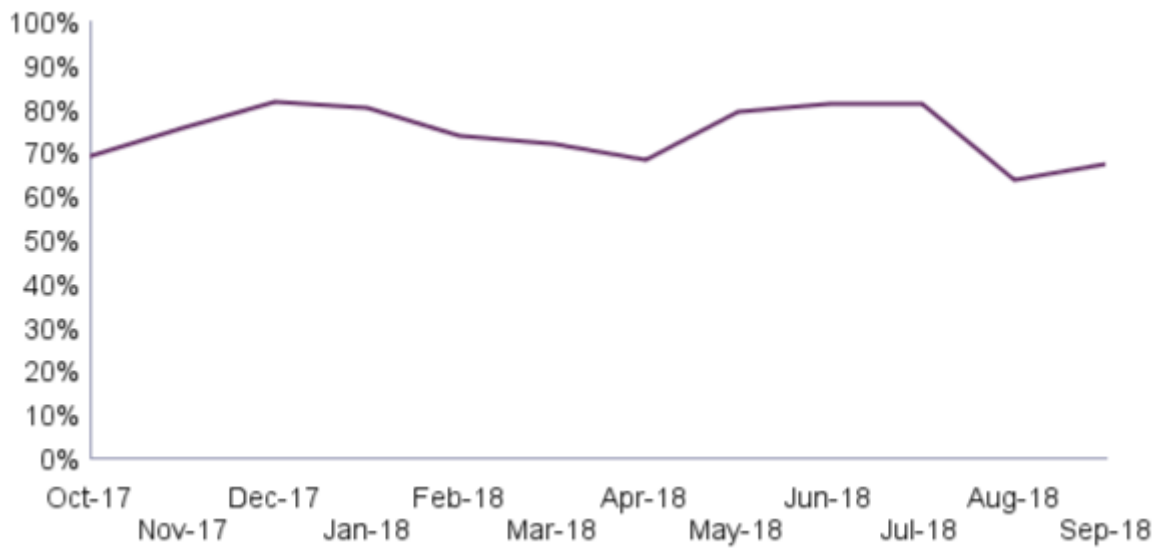

(Source: National Ambulance Information Group)

A "black breach" occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From September 2017 to September 2018 the trust reported 906 "black breaches". The largest number of black breaches occurred in December 2017 (152) and January 2018 (138). There were also high numbers reported in July 2018 (128) and September 2018 (118).

Reasons ascribed by the trust in December 2017 and January 2018 included bad weather conditions, high volume of attendances and ambulances and over predicted activity.
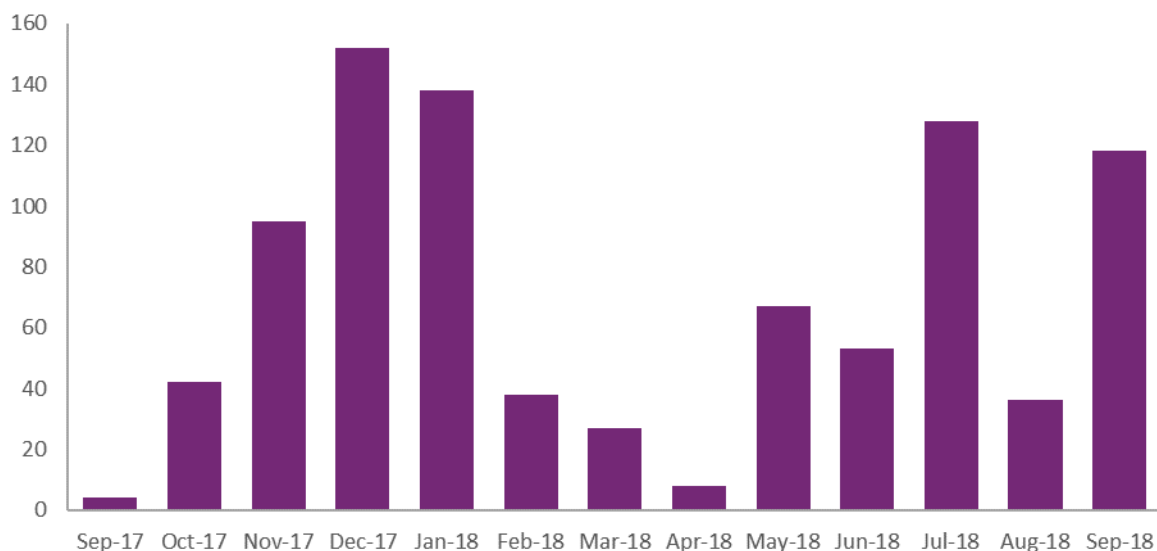
(Source: Routine Provider Information Request (RPIR) - Acute – AC13 Black Breaches tab)

A front door policy was in place. This document outlined the pathway of patients from the time they presented at the department by ambulance or self-present.

Patients self-presenting to the emergency department were seen by a streaming nurse in line with recommendations from the Royal College of Emergency Medicine. The streaming nurse was a

senior nurse from the Urgent Care Centre. An experienced nurse would have a brief conversation with each patient as they arrived and would decide whether they could be treated in the urgent care centre or the emergency department. There was a glass screen between the patient and the nurse which made the conversation difficult. Patients had to speak loudly in order to be heard. There were waiting patients in chairs very close to the nurse's desk who could overhear the conversations.

Staff told us how referrals from the UCC were not always appropriate and sometimes sick patients were not highlighted to the emergency department to be fast tracked. One child was found to be making additional effort to breathe normally and had a high temperature. Although they were sent to the children's emergency department staff were not alerted to the arrival of a small child with breathing difficulties by staff from the UCC. Trust documentation states that all children who need to be seen in the department will be booked in at the main emergency reception desk with the receptionist informing the paediatric emergency department by telephone of the arrival of a child. However, the process was unclear for children sent straight from the streaming nurse.

The department appointed an Emergency Practitioner in Charge (EPIC) daily. This position was a senior consultant or doctor who provided clinical oversight of the patients in the department. The EPIC was available to answer questions or to review any patients that staff were concerned about. Nurses and doctors approached the EPIC to discuss complicated patients and to seek agreement to discharge patients from the department.

The trust currently has a condition on its registration for the treatment of disease, disorder and injury to ensure that an effective system is in place to robustly clinically assess all patients who present to the emergency department in line with relevant clinical guidelines within 15 minutes of arrival. We found that patients were triaged using a clinically recognised model and staff were confident with the triage process. However, not all patients were triaged within 15 minutes of their arrival at the emergency department.

Initial assessment (triage) of patients was carried out in accordance with guidance from the Royal College of Emergency Medicine and the Royal College of Nursing. The triaging of patients on entry to the emergency department had improved from our previous inspections. The department used the Emergency Severity Index (ESI) triage scoring system. The ESI scoring system is used electronically and calculates a patient's triage category. The triage process placed patients into one of five categories, category one 'immediate' needing lifesaving intervention to five 'Redirect' with the patient being sent to a more appropriate care provider.

Triage nurses were able to describe the ESI system. Specifically, trained nurses performed the triage role and could explain the triage process to us. A dedicated ambulance triage nurse assessed ambulance patients on their arrival to the department to assess the priority of each patient and in which area of the department or hospital they should be seen. The trust had recently trained more ESI nurses so that they could have more flexibility in times of high pressure however, these staff were still gaining confidence in the role and not triaging as quickly as other staff members. We saw flow charts of the triage process displayed on the walls in the triage assessment rooms. Action cards were available which set out the triage nurse and clinical support workers roles and responsibilities in relation to triage.

The department performed hourly audits of the number of patients waiting longer than 15 minutes for triage. This is in line with the internal escalation level protocol. We reviewed the manual records of this audit and saw there was variation in the monitoring and escalation provided in response.

During our inspection we observed the triage of 14 paediatric patients, all triaged within 15 minutes of their arrival at the department. We observed five complex adult patients being triaged, all of which were completed in a timely manner with the correct risk assessments being performed.

We observed a triage nurse enter the main department to query a condition and triage category with the EPIC. We saw during the triage process allergies were documented and red wrist bands placed onto patients who needed it to alert staff to their allergy.

National guidance recommends that 95% of patients should be triaged within 15 minutes of their arrival at an emergency department. For the week of our inspection data showed that 90% of patients who presented to the emergency department were triaged within 15 minutes. The ambulance triage attained the highest percentage of 99.4%, majors area 78.2% and paediatrics 88.5%. Post inspection we reviewed 23 sets of patient records, 21 of these had been triaged within the 15-minute standard. However, triage time has been highly variable throughout the year for majors and paediatrics with large differences in performance being seen week on week.

The ambulance service would alert the department if they were about to arrive with a critically ill patient. We observed this process for a patient with a stroke. It is important that patients who have just had a stoke are treated as quickly as possible. National Institute for Health and Care Excellence (NICE) guidance (NG128) recommends suspected stroke patients have immediate access to imaging, for his to happen a senior doctor needs to be resent to assess and refer the patient. However, there was no doctor waiting for the patient when they arrived in the resuscitation room. A nurse had to leave the patient to find a doctor. The patient did not receive a brain scan in a timely manner and was not reviewed by a specialist stroke team for more than two hours. Therefore, the risk to the patient of permanent damage was not reduced as much as it could have been.

Risks were not always identified and escalated appropriately. We were not assured that all patients allocated to wait on the corridor were safe.

Ambulance patients' experienced corridor waits after triage due to poor flow through the department. During our inspection the department was working under high demand with significant bed pressures across the hospital, this caused stacking of ambulance patients. Triage nurses had to decide whether a patient needed immediate further assessment or if they could wait in the corridor until a cubicle became free. Nurses told us they did not enjoy making this decision but that they tried to do it as safely as possible. However, we saw patients that were deteriorating or that were potentially unstable on the corridor waiting for treatment.

Although patients had been assessed as safe to wait in the corridor they had no privacy and little dignity. They were subject to constant traffic of hospital staff and ambulance crews with their patients. In an emergency it would have been difficult to wheel the patient back down the corridor to the resuscitation room. The corridor was cold at night and poorly lit. We spoke with one patient who said that staff had explained the reasons for waiting in the corridor but that it was not a pleasant experience.

Staff were not clear on the safety arrangements for corridor nursing. A corridor nurse was in place to continue to take observations and to monitor the patients in this area. One staff told us that the corridor nurse would care for up to eight patients and when numbers went over this ambulance crews would be required to stay with their patients however, the Hospital Ambulance Liaison Officer (HALO) told us this figure was 11 with a further nurse told us this figure was seven patients. After the inspection we requested a copy of the standard operating procedure (SOP) for corridor care, we were provided with a copy of the 'Care of the Emergency Department Patients on the Corridor Standard Operating Procedure' this was a new document created in April 2019 therefore, at the time of inspection there was not a (SOP) in place for corridor nursing, further documentation provided outlining corridor care actions was dated February 2019. Therefore, no guidance was in place at the time of our January inspection. The document we were provided with stated that once patients were on the corridor a ratio of one nurse to four patients should be maintained where possible with immediate escalation to the site co-ordinator where this was not

met. The 'Care of the Emergency Department Patients on the Corridor Standard Operating Procedure' document and the 'Front Door Emergency Department Assessment Policy' both contained different documents for escalation capacity issues within the ambulance assessment area however, these were based on different criteria so would be confusing for staff in knowing which one to follow.

Nurses responsible for looking after patients in the corridor told us they felt supported and not isolated from the department. We saw the ambulance triage nurse ordering the allocation of bays to the patients with the highest clinical priority.

During our inspection on the 15 and 16 January 2019 we reviewed seven patients on the corridor, staff were able to explain what each patient had been brought in with and could show us that observations had been recorded for each. The corridor nurse and a clinical support worker completed observations of patients waiting and ensured identity wrist tags were distributed. We saw a patient who was severely hyper ventilating on the corridor escalated straight into a major's cubicle for treatment.

During our inspection on the 30 January 2019 we reviewed two patients with potential cardiac symptoms who had been placed on the corridor without the relevant reviews to ensure their condition was stable. During our inspection on the 4 February 2019 we were concerned about one elderly patient who had been in the corridor for almost three hours. We discussed their condition with the nurse who was in charge of the ambulance assessment area and the patient was brought into a cubicle to be seen by a doctor and treatment for a serious infection was commenced.

The local ambulance service had assigned a HALO to the emergency department. There was no written protocol for HALOs to follow when looking after patients in the corridor and trust staff we spoke to were unclear about their exact responsibilities. Trust documentation provided to us around the care of patients on the corridor did not mention the role of the HALO in specific situations. We observed the HALO checking patients' vital signs such as pulse, blood pressure and respirations. However, they did not have access to the department's computer system and so could not make a permanent record of these observations. Instead, they were recorded in a blank space on the patient safety checklist. We saw a batch of checklists being given to a nurse in the ambulance triage area so that the observations could be entered on to the computer retrospectively. We could not be assured that this system would result in any deterioration in NEWS2 scores being quickly escalated or recorded in real time. The Standard operating procedure that we were supplied with post inspection did not outline who took responsibility it was to upload any manually recorded observations and when this should be done.

The HALO often had to leave the corridor to liaise with ambulance crews and hospital staff in the main department. The corridor nurse also had to leave on occasions to fetch items such as blankets for patients. There was no handover process between the HALO and the nurse and so they did not know the condition of each other's patients. If a patient had needed help while one person was absent the correct response may not have been given.

We visited the corridor outside the emergency department at 9:40pm on the 4 February when the number of patients had increased to nine. There was no member of staff present. We observed the corridor for five minutes until the nurse returned carrying a drink of water for one of the patients. If a patient's condition had deteriorated in that time there would have been no-one to help them. During this inspection we also saw the HALO had to leave the area leaving the corridor nurse in charge of 11 patients with no assistance.

The trust currently has a condition on its registration for the treatment of disease, disorder and injury to ensure there is an effective system to identify, escalate and manage patients who may present with sepsis or a deteriorating medical condition in line with the relevant national clinical guidelines, which applies to all areas of the emergency department. During our inspection we found that repeat patient observations were more complaint with being performed within set time frames and were escalated to senior staff within the department. We saw that the trust, emergency department leaders and staff had worked hard on their sepsis recognition and treatment throughout the year. Although we did see improvements around sepsis care and treatment we could not be assured that sepsis documentation and treatment was completed in line with best practice and the designated timeframes.

An adult observational policy was in place. This outlined the use and escalation points of National Early Warning Scores NEWS and had been updated to reflect the new NEWS2 guidance. NEWS2 is a quick and systematic way of identifying patients who are at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations were recorded and contributed to a total score. Once a certain score was reached a clear escalation of treatment was outlined.

We saw nurses performing and escalating NEWS2 scores. We observed a greater focus on the timely completion of NEWS2 scores than in our previous inspections and saw that nursing staff had movable computer stations they took into bays to record vital signs live on the electronic observation system. During the inspection we saw that nurses were more empowered to escalate their concerns than on our previous inspections. We saw nurses ensuring that their concerns had been heard and saw in documentation who they had escalated their concerns to. We looked at the records of nine patients in the major treatment area on the 15 January 2019, all had had an early warning score calculated when they arrived and repeat observations performed within or close to the designated time frame. Where capacity allowed we saw that patients with a NEWS2 score of seven or greater were allocated a resuscitation bay for continual monitoring.

Paediatric patients had repeat observations performed. We saw a child with a paediatric early warning score (PEWS) of four had their observation frequency increased and were escalated to a doctor for review. An escalation process was in place, agreed between paediatric emergency department and the ward, any child with a PEWS of 5 or greater was escalated to the ward for specialist input and management. Transfer documentation was used between the emergency departments and the ward.

The trust and emergency department leaders and staff had worked hard on their sepsis recognition and treatment throughout the year. Staff were more engaged with sepsis recognition and treatment. We saw improvements in sepsis care and documentation since our previous inspection however, some evidence of poor and inconsistent practice remained. Leaders told us how they had worked on their antibiotic administration time for septic patients however, further work was needed on the delivery and recording of the other five parts of the sepsis 6.

The trust was working to promote sepsis awareness within the department. Monthly 'sepsis stars' newsletters were distributed across the trust, these contained important reminders as well as training dates for staff and sepsis link nurses. The emergency department had a dedicated sepsis trolley containing all items needed to screen for and treat sepsis. Managers told us a business case had been approved for a band 6 sepsis nurse to be placed within the department.

A sepsis policy was in place and reflected national guidance. The sepsis policy stated, 'If sepsis is suspected as a potential diagnosis by the presence of any one or more Red Flags on the appropriate Sepsis Screening tool; initiate all the 'Sepsis Six Pathway' on the reverse of the screening tool or on the eSepsis within 60 minutes of this time (time zero). The eSepsis or paper Sepsis Screening & Action Tool must be completed by any healthcare professional undertaking

any element of the Sepsis Six as well as the variances documented, if deescalated at any point this must be documented on the pathway and be filed in the medical notes as a record of the period of care.'

An electronic sepsis screening tool (eSepsis) had been in use in the department since September 2018. This tool automatically triggered when a 'red flag' was present from NEWS2 scores, clinicians could also start the tool if they had concerns about a patient's condition. If sepsis was suspected or confirmed the form guided clinicians through the delivery of the Sepsis 6 care bundle. However, leaders told us the current e-sepsis tool in use by the trust was too long and did not function how they wanted it to within the department. This had been raised as an issue through the deteriorating patient group to look at amending the questionnaire in use.

We saw a coloured dot appeared on the patient tracking board to highlight were a patient was on the sepsis pathway. A red dot indicated sepsis screening was needed, amber that this was part complete and green that the pathway was completed or deescalated. Although we saw examples of good practice in regard to sepsis management where patients were appropriately screened and deescalated by a clinician, we noted cases where these pathways had been discontinued and not deescalated on the system by an appropriate clinician so amber marks remained by patients' names. Staff told us if a patient was deescalated from the sepsis pathway this would not be automatically triggered again from their NEWS2 score during that admission and it would be the responsibility of the nurse to recognise and escalate the trigger. After the inspection the trust confirmed that this is not the case and once a patient was deescalated from the sepsis pathway the electronic system would trigger again if their condition deteriorated.

Staff were not consistently and accurately completing sepsis documentation. We saw in two patient notes they had been described as confused/lethargic and unwell however the 'looks sick' question on the screening form has been marked as no and 'alert' marked as yes. This meant there was potential for sepsis red flags to be missed delaying treatment. We saw an example where a child was documented as having a potential teething infection, however 'no' had been ticked on the screening form next to 'potential infection?'. A further patient had triggered a sepsis screen by having a NEWS2 score of 6 at 10:20am, we visited the patient at 11:05am as they were having blood cultures done however the nurse told us they were yet to start and document any of their sepsis screening or pathway on the system. Although we would not wish for treatment to be delayed we could not be assured that documentation of these time critical steps would be correct and allow the hospital to continually improve their sepsis performance.

Time zero is when the first sign of potential sepsis is highlighted, which can be a NEWS2 score of three in a single category, a NEWS2 score of 5 overall, or a clinician thinks the patient may have sepsis, at this point a full sepsis screen should be conducted. Time zero is important in the treatment of sepsis to ensure quick treatment to treat the infection with the time to complete the sepsis 6 bundle measured from this point. Inaccurate recording of time zero also poses a risk for tracking treatment, investigation and auditing of results as multiple computer systems need to be navigated in order to get a true reflection of someone's sepsis treatment. Time zero was not correctly or consistently recorded for a high number of sepsis patients.

One patient was brought in by ambulance with paramedics handing over as a potential sepsis case at 1.43pm, the time zero on the sepsis paper work was 2.10pm. A further patient considered as having sepsis due to having a single NEWS2 score of 3 at 3.27pm, time zero on the sepsis screening documentation was noted as being 3:56pm. A further patient had a single NEWS2 score of 3 at 9:13pm, a nurse questioned potential sepsis in their records at 10.31pm, time zero was documented as 11.27pm, the patient was later deescalated from the sepsis pathway with a

different diagnosis. This delay posed a potential risk to the timely and safe treatment of sepsis patients.

Not all patients received sepsis treatment in a timely manner. It is important that antibiotics for the treatment of sepsis are given within the first hour of sepsis being suspected. During our inspection visits on 15, 16 and 30 January we saw occasions where treatment had taken longer. In the case described above a patient had triggered as potential sepsis at 3.27pm, the screening tool was started at 3.56pm, antibiotics were ordered at 5.10pm and administered at 6.24pm therefore being administered one hour and fifty-eight minutes after the initial hour was over. A further patient was brought in by ambulance at 7.15am and highlighted as potential sepsis by ambulance crew, they were not reviewed by a Doctor until 9.09am with antibiotics being administered at 9.40am. Therefore antibiotics were not prescribed until one hour and twenty-five minutes after the initial hour had ended, it was not clear from the documentation what time these were administered.

Data the trust provides to the CQC weekly has shown an inconsistent picture in regard to sepsis treatment although screening of patients appears to consistently be better we are not assured that all sepsis patients receive treatment in a timely manner.

A clinical support worker competent in obtaining vital signs maintained oversight of the patients in the main waiting area. Their role was to escalate any patients of concern to the triage nurse or nurse in charge of the department. Their responsibilities were clearly defined in the waiting room care support worker role document. Posters in the waiting room asked patients to make themselves known to staff if they felt their condition was worsening or if they were experiencing any chest pain. During the inspection we saw a patient become increasingly unwell in the waiting area, this patient was quickly escalated to the triage nurse and moved into the majors.

The criteria for patients eligible for the fit to sit area were clearly displayed. These criteria were: Patient should be self-caring and ambulant or easily transferable; a NEWS2 of three or less across more than one parameter; a pain score of three or less; if cardiac chest pain they should have no new electrocardiogram (ECG) changes and be pain free; have no oxygen requirement; no confusion and if attending with vaginal bleeding this should be less than a normal menstrual cycle.

However, we saw occasions where patients' who did not meet the criteria had been allocated to the fit to sit area. During our inspection on the 15 and 16 January a patient with chest pain was in fit to sit, despite having no ECG performed to assess for changes or any observations performed in the department to attain their NEWS2 score. We visited the department again during a period of high demand and two patients had been offloaded from ambulances into this area without having observations recorded in the hospital, the nurse in charge of the area told us she was not aware what their NEWS2 score was or if they should be in that area. When we raised this with management they agreed that this was outside of process however, were under capacity demands. This raised a risk that potentially unstable patients were placed in an area which had reduced staffing.

During a further unannounced visit on the 30 January a patient who appeared pale, frail and elderly who was vomiting blood was placed in fit to sit. We escalated this to staff and were advised they would be moved. The patient was not moved for nearly three hours at which point they had deteriorated. They had in this time received IV therapy for clotting while in fit to sit in a chair. The nurse supervising this patient was alone in the area so was unable to locate help and was assisted by CQC staff. A doctor and matron then moved the patient urgently to a high dependency cubicle as there were no spaces in the resuscitation area.

We again visited the fit to sit area during our inspection on the 4 February 2019. We saw that patients had been assessed before being transferred to the area and this risk assessment took place throughout our inspection. However, the area was closed at 8pm as there was not enough registered nurses to staff it safely.

The nurse in charge held safety huddles throughout the day. All nurses on shift were called to the nurses' station where the nurse in charge would reiterate important issues for the shift, we saw issues discussed included sepsis screening de-escalation, allergy wrist bands and the escalation of NEWS2 scores. Nurses who were working in the waiting room were asked if they had any concerns over any patients waiting outside the main department.

A system was in place to notify staff to aggressive or difficult patients. We saw that an abusive patient had a note in their record reminding staff to attend to the patient in twos.

In the paediatric emergency department, patients with a mental health need were nursed in the two bays closest to the nursing station to support increased observations. Staff told us patients at risk of self-harm were managed through one to one observations and by removing all obvious ligature risks from the bays. However, this did not include removing collapsible bed rails and this remained a serious ligature risk for young people presenting at the emergency department in a mental health crisis. We reviewed the departments ligature point identification assessment, this only took into account toilet areas and no other areas of departments where patients could potentially come to harm such as, within treatment bays with curtains drawn.

Staff did or arranged psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Patients presenting with a mental health need were automatically prioritised as a category two case, which meant they required priority care and treatment. Upon admission to the emergency department, staff asked any patient who presented with a mental health need three questions as part of their initial triage of the patient. These questions assessed whether the patient had suicidal or self-harming intent and whether the patient appeared agitated. These triage questions determined whether the patient required one to one observation to keep them safe whilst in the emergency department. This was a direct result of learning from an incident in which a patient with mental health needs was not appropriately observed in the department and came to harm.

We reviewed the competency documentation for well-being workers who were responsible for providing one to one observations. This explored the need to supervise those with confusion and dementia with reference to level 4 observations. Level 4 observation is the need for continual observation with the patient within arms-length. No specific reference was made as to how to supervise those experiencing a mental health crisis and considering self-harm or suicide. We could therefore not be assured that the wellbeing workers had received all the training they needed in order to protect patients and themselves in this type of situation.

There were clear pathways for as and when patients would be referred and assessed by the psychiatric liaison team. For example, the psychiatric liaison team would not assess patients with a suspected mental health need until they were medically fit. The psychiatric liaison team aimed for a four-hour response time from referral to assessment in the emergency department. However, this time was not audited by the department.

All staff we spoke with knew how to make a referral to the psychiatric liaison team based at the local mental health hospital. Some staff said that there were delays in the psychiatric liaison team assessing patients in the emergency department. The psychiatric liaison team used the local crisis

resolution team to assist them in their workload as and when required. In the three months before our inspection the psychiatric liaison team had received 482 referrals.

During our inspection we observed and tracked the care of an adult who presented experiencing a mental health crisis. We saw that this patient was appropriately managed, risk assessed and referred to the psychiatric liaison team.

Nurses in the department used a patient safety checklist. This was aimed at reminding nursing staff to undertake hourly safety checks of all patients in the major treatment area or those waiting to go into the area. Although, most patients in the major treatment area had been checked hourly, those waiting in the ambulance corridor had not. At 9pm we checked the patient safety checklists of three patients in the corridor. Two were aged over 80 years and all had potentially serious conditions. The amount of time they had spent in the corridor varied from two and a half hours to three and a half hours. All them had only had one set of safety checks carried out. At the time, patients were being care for by a temporary nurse from an agency. The nurse was unfamiliar with this system of safety checks and did not realise that they needed to be carried out every hour.

Nurse staffing

The trust currently has a condition on its registration for the treatment of disease, disorder and injury to ensure there are sufficient numbers of suitably qualified skilled, competent and experienced clinical staff at all times to meet the needs of patients within all areas of the emergency department, including any area where patients are waiting to be seen. We found the service did not always have enough staff with the right qualifications, skills, training and experience to keep people safe and to provide the right care and treatment.

The trust reported the following qualified nursing staff numbers for the two periods below for urgent and emergency care:

Site	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Russells Hall Hospital emergency department	124.0	122.0	98.4%	144.7	124.5	86.0%

(Source: Routine Provider Information Request (RPIR) – P16 Total staffing tab)

The trust reported a qualified nursing staffing level of 98.4% in urgent and emergency care in March 2018 which dropped to 86.0% in September 2018.

As at September 2018, there were 20.2 fewer whole time equivalent (WTE) staff in post than planned for and 2.5 more WTE staff in post than in March 2018. There was an increase of 20.7 WTE planned posts between the two time periods.

From October 2017 to September 2018, the trust reported a vacancy rate of 10.2% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 6.3%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From October 2017 to September 2018, the trust reported a turnover rate of 12.7% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 8.5%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the trust reported a sickness rate of 6.6% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 3.5%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From October 2017 to September 2018 the trust reported 85,763.0 of the 412,016.0 available hours were filled by bank staff (20.8%) and 58,947.0 hours were filled by agency staff (14.3%) in urgent and emergency care. There were 852.0 hours that needed to be covered by bank or agency staff but were left unfilled (0.2%).

None of the qualified nursing hours were left unfilled. The trust gave the reason of 'vacancies' for the usage of bank and agency staff

A breakdown of bank and agency usage by staff type is shown below:

Staff type	October 2017 to September 2018						
	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	25,990.0	10.0%	57,756.0	22.1%	0.0	0.0%	261,202.0

| Non-qualified | 59,773.0 | 39.6% | 1,191.0 | 0.8% | 852.0 | 0.6% | 150,814.0 |
| Total | 85,763.0 | 20.8% | 58,947.0 | 14.3% | 852.0 | 0.2% | 412,016.0 |

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)

Management completed a staffing review in 2018 however, levels were again being revised during our inspection. The planned nursing levels for the emergency department was 14 registered nurses for days shifts, 12 for night shifts and one on a twilight shift to provide extra cover early evening. During our inspection and months leading up to it, extra staff had been allocated due to the increased demand of the paediatric area, the opening of additional assessment cubicles and to facilitate corridor care.

The trust's internal target was to have over 75% substantive Dudley Group staff on each shift within the emergency department. However, this was not consistently met due to the demand of increased staffing levels. For the week of our inspection the trust reported that on average 72.9% of staff working in the emergency department were substantive.

An agency staff approval process guideline was in place. This detailed the timescales in which agencies could be approached and the approval process. Local induction paper work for substantive and agency staff was not consistently completed to a high standard. We reviewed three sets of induction paper work, two did not have the competency sections completed fully, one was not signed by the staff member to confirm their competencies or to confirm that had received their induction to the area.

We saw that staffing levels were discussed at leadership meetings. At the time of inspection, the department had 20 registered nurse vacancies across bands 5 and 6 and had been conducting continual recruitment exercises throughout the year. The trust had been successful in recruiting graduate nurses and had ensured a practice development nurse was available to be proactive with the training and development of the new recruits.

Medical staffing

The service did not always have enough medical staff with the right qualifications, skills, training and experience to keep people safe and to provide the right care and treatment.

The trust currently has a condition on its registration for the treatment of disease, disorder and injury to ensure that specialist clinical expertise is secured to ensure expertise across the emergency department. We saw that working relationships and communication across the specialist departments had improved however, some patients still experienced long waits for speciality review.
The Royal College of Emergency Medicine recommends emergency departments have 16 hours of consultant cover per day. Management had strengthened the consultant rota since our last inspection and had achieved this standard consistently, any shortfalls seen were due to short notice sickness absence. The service aimed to provide a minimum of 14 hours consultant cover when staff shortages were experienced.

There were 10 whole time equivalent (WTE) consultants in the department, eight of them on the specialist register of the General Medical Council. Two were Paediatric Emergency Medicine (PEM) trained. There was always a consultant present from 8am to midnight. We noted that locum

(temporary) consultants always worked the 4pm to midnight shift. As a result, it was possible that senior consultants were not familiar with the issues that arose out-of-hours. There was also a consultant on-call at night from home.

Medical staffing rotas showed that planned staffing for the department included one lead consultant, supported by three other consultants. However, for the seven days over our January inspection visit we saw that the department was short of one 'other consultant' on five days and short of two 'other consultants' on two days. These days were then overstaffed with junior and registrar level doctors. We therefore could not be assured that the right skill mix of medical staff and amount of consultants per attendees to the emergency department was appropriate.

We looked at the rota for the month before our inspection and saw that, when there were no consultants in the department, there was always a senior middle grade doctor or above on duty, supported by another middle grade doctor and two junior doctors. The senior middle grade doctor was the only one at night who had the knowledge and experience to treat children. They spent a large part of the night in the children's treatment area which had recently moved to the far end of the department. This left more junior doctors to treat people in the resuscitation room and the major treatment area.

The department had been conducting continual recruitment activity throughout the year and had appointed two further consultants due to start early 2019 a further advertisement had been approved for a further emergency consultant.

The trust's Human Resources (HR) department had also been supporting work into retention activities for both medics and nurses. The HR project manager engaged with staff within the department, the exit interview process had been strengthened and unions and union reps were being engaged with.

Junior doctors felt well supported. Junior doctors told us they received good supervision and senior support. There was a strong culture around the importance of informal and formal teaching within the department. Trainees reported the provision of, and their attendance at teaching was not compromised by service delivery. Despite the pressures within the department, the feedback from junior doctors was positive in relation to staff morale, teamwork and enjoyment. Most doctors told us that they could take meal breaks and usually finished their shifts on time.

The trust reported the following medical staffing numbers as of March and September 2018 for urgent and emergency care:

Site	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Russells Hall Hospital emergency department	66.7	50.5	75.6%	66.8	53.2	79.6%

The trust reported a staffing level of 79.6% for medical staff in urgent and emergency care in September 2018 which had increased from 75.6% in March 2018. There were 16.2 less WTE staff in post than planned for in March 2018 and 13.6 less WTE staff in post than planned for in September 2018.
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

From October 2017 to September 2018, the trust reported a vacancy rate of 23.4% for medical staff in urgent and emergency care. This was higher than the trust target of 6.3%.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

From October 2017 to September 2018, the trust reported a turnover rate of 18.3% for medical staff in urgent and emergency care. This was higher than the trust target of 8.5%.
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the trust reported a sickness rate of 0.7% for medical staff in urgent and emergency care. This was lower than the trust target of 3.5%.
*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

From October 2017 to September 2018 the trust reported that 5.0% of medical staff hours in urgent and emergency care at Russells Hall Hospital were filled by bank staff and 12.2% were filled by locum staff. In addition, 8.1% of hours were not filled by bank and locum staff to cover staff absence.

| Site | October 2017 to September 2018 | | | | | | |
| | Bank | | Locum | | Unfilled | | Total Hours |
	Hours	%	Hours	%	Hours	%	
Russells Hall Hospital emergency department	5,961.8	5.0%	14,632.8	12.2%	9,638.0	8.1%	119,661.0

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

As of July 2018, the proportion of consultant staff reported to be working in urgent and emergency care at the trust was similar to the England average. Over the same time period, the proportion of junior (foundation year 1-2) staff was lower than the England average.

Staffing skill mix for the 34-whole time equivalent staff working in urgent and emergency care at The Dudley Group NHS Foundation Trust.
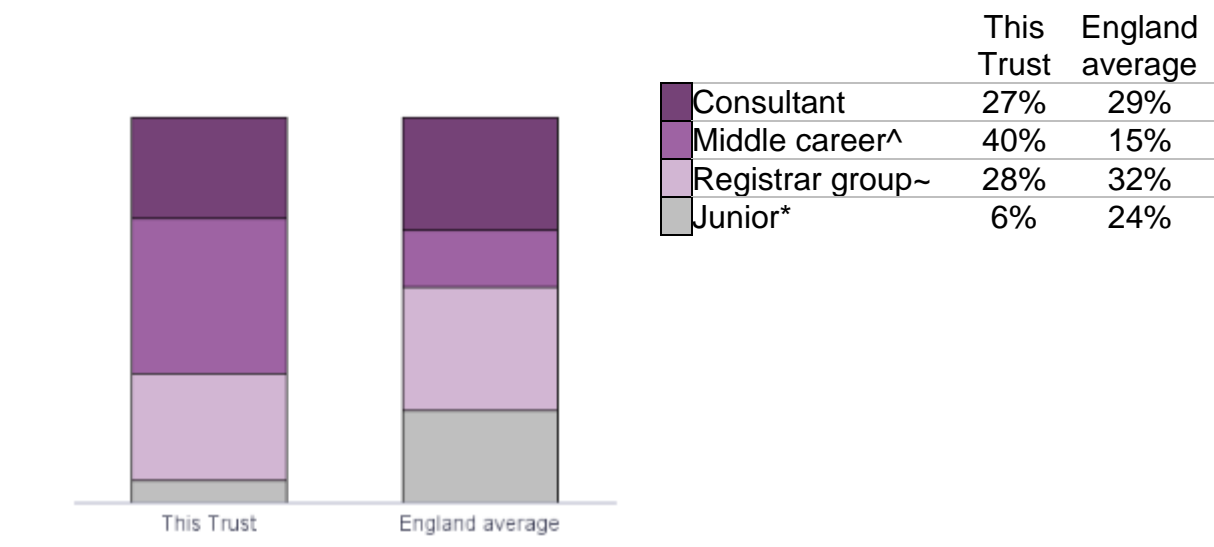
	This Trust	England average
Consultant	27%	29%
Middle career^	40%	15%
Registrar group~	28%	32%
Junior*	6%	24%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept records of patients' care and treatment. However, these could sometimes be difficult to navigate.

Most of the records we reviewed were clear and documented treatment and medication given clearly. However, not all documentation was completed contemporaneously making patients treatment difficult to track in real time. Not all records were stored securely. We saw that four patient safety checklists containing patient details from the day before our 15 January inspection had been left in the waiting area.

Managers completed monthly record keeping audits. We reviewed October and November 2018's audit with results of 92% and 90%. Records were reviewed for documented evidence of pain management, medication, risk assessment score and patient observations. Action plans were generated following audits. Actions included to ensure pain scope is documented on initial assessment and to ensure batch numbers are recorded of medications.

Staff from the emergency department and the psychiatric liaison team reported issues with not being able to access each other's clinical note taking and care records system. Although the psychiatric liaison team documented their assessments on the provider's electronic system, staff reported issues with access to patient information such as previous mental health inpatient admissions and risk assessments.

Medicines

The service did not always follow best practice when prescribing, giving, recording and storing medicines.

Not all medicines were stored securely. The resuscitation trolley within the ambulance assessment area had a seal on it however, the draws could be opened without breaking the seal, the trolley contained emergency medications. This posed a risk that drugs could be taken or tampered with without staff knowledge. We raised this with the matron and this was secured immediately. We also found this trolley to have out of date blood culture bottles within it.

Intravenous (IV) fluids were not secured during one of our inspection days. The room in which IV fluids were kept was accessible by swipe card however, this system was broken allowing free access. We escalated this to the matron who advised us this had been highlighted as an urgent 30 minute priority fix to the estates team that morning and it was yet to be fixed. No action had been taken in the short term to secure these items. When we returned to the department that evening the swipe card access had been fixed.

Staff stored medicines related stationary securely. Prescription pads were stored in a locked cupboard behind a swipe card access door.

Staff did not always store medicines appropriately. We found a 28 pack of digoxin had 42 tablets within it and five ampule pack of tranexamic acid was found to have six ampules inside it, this is not in line with best practice recommendations. A sheet of prednisolone was loose on the side within the drugs room. We raised this with the nurse in charge during the inspection and saw that storage of drugs had been improved the next day. We checked controlled drugs against stock levels and saw that these had been reconciled accurately.

IV fluids were stored in boxes on shelves, often stacked on top of each other. Some IV fluids had been put into boxes where the batch numbers and expiry dates were not what was stated on the outside of the box. For example, a bag of glucose 20% with an expiry of 06/2020 and Lot number of 18578004B in a box of expiry date 01/2020 lot number 18578002B. We saw that a bag of Hartmans solution and a bottle of potassium chloride were loose on the floor. We saw that storage in this room had been raised repeatedly as an issue in medicine management audits from September 2018 however no action was evident during our inspection as issues remained.

Staff recorded the temperature of the drug storage room daily however, actions were not consistently taken or recorded when they went out of range. The temperature of the drugs storage room was above 25 degrees on 24 occasions in the five months before our inspection. Staff had only documented actions to correct this on three actions. We raised this issue with the matron, the next day an air conditioning unit had been fitted in the room to allow staff to control the temperature. The IV drugs room had its temperature recorded 13 out of 16 days in January 2019. We saw that this had also been raised as an issue in the November 2018 medicines management audit.

Not all drugs and emergency medications were within their expiry dates. Within the drugs storage room two bottles of sodium bicarbonate were out of date and within the resuscitation trolley in ambulance assessment area we saw that one bottle of aerobic and one of anaerobic culture bottles went out of date in October 2018. Staff removed these from the department when we highlighted them.

Patient Group Directives (PGDs) were in place. We reviewed all the PGDs under the adult emergency department section of the intranet, all were within their review and expiry dates.

Most staff administered drugs in line with best practice, we saw nurses checking and double signing for medications before administration. However, on the first day of inspection we had concerns about the administration of medicines within the paediatric emergency department. Nurses prepared drugs in a separate room without the electronic drugs chart for the patient present. The drugs were then checked with the prescription outside the room. After discussions around this practice on the first day of our inspection we saw that a computer was placed in this room to allow access to the prescription whilst preparing medication.

We reviewed the safe medicines practice group meeting minutes from May, June and July 2018. These minutes were limited in detail with little documentation of discussion, learning or actions taken.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents however, these investigations were not always completed in a timely manner.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as never events for urgent and emergency care.
(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported 17 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from December 2017 to November 2018.

One incident which occurred in March 2018 took over 90 days to be reported.

A breakdown of the incident types reported is in the table below:

Type of incident	Number of incidents	Percentage of total
Treatment delay meeting SI criteria	8	47.1%
Sub-optimal care of the deteriorating patient meeting SI criteria	6	35.3%
Abuse/alleged abuse of adult patient by staff	1	5.9%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	5.9%
Slips/trips/falls meeting SI criteria	1	5.9%
Total	17	100.0%

(Source: Strategic Executive Information System (STEIS))

An electronic incident reporting system was in place. Staff were knowledgeable about this system and knew how to report an incident. Staff told us they received feedback after they had reported an incident. Staff told us that they would receive feedback by email for incidents they had entered onto the system. We saw feedback from incidents was displayed on the staff room walls and that incidents we discussed and documented in operational meetings. Serious incidents were not always recognised at the time they occurred but were declared after reviewing records in light of patient complaints.

The matron for the department oversaw all incidents for the emergency department. They were supported by another staff member who tracked incidents being reported on the electronic system.

Seventy-two-hour reviews were completed for all serious incidents. We saw documented evidence of these meetings occurring and saw that route cause analysis investigations were completed. The trust was in the process of reviewing their serious incident management process with support from NHSI and the clinical commissioning group (CCG). The CCG had also been working with the trust to ensure a better working relationship in managing the timely completion and sign off of route cause analysis investigations after serious incidents had occurred.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. However, this guidance was not always consistently followed in relation to sepsis management.

Staff could access clinical guidelines and local policies on the emergency department section of the trust intranet. Doctors had access to best practice guidelines from external websites operated by organisations such as the National Institute for Health and Care Excellence and the Royal College of Emergency Medicine.

A clinical audit programme was in place including mandatory and optional data collections. A named consultant was allocated to each audit.

We reviewed the admission assessment for three patients who presented at the emergency department with a mental health need. The assessment record clearly documented the patient's mental health needs, psychiatric history and previous mental health crises where applicable and demonstrated that the patients were seen within the four-hour target team by the psychiatric liaison team once deemed medically fit. Although the patient records demonstrated the requirement for all three of these patients to be allocated a wellbeing worker upon assessment, there was no evidence in the emergency department clinical recording system that this had been allocated.

At handover meeting, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff used a separate room to handover sensitive information to avoid causing distress to the patient and to protect the patient's privacy and dignity. Staff referred patients for a mental health assessment who were suspected to be experiencing depression, including post-natal depression.

The department had a sepsis policy which followed best practice guidelines in relation to sepsis recognition and management. However, we found that this was inconsistently applied to patients. Time zero is defined as when the first sign of potential sepsis is highlighted and is the point from which sepsis treatment time is measured. We saw that time zero was not always accurately recorded within patient records.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

In the CQC Emergency Department Survey, the trust scored 6.0 for the question "Were you able to get suitable food or drinks when you were in the emergency department?" This was the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Volunteers and staff provided patients with food and drink while they were in the department. Volunteers brought food down to the department in the evening so patients had access to food overnight. Water fountains and café facilities were available for visitors.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

In the CQC Emergency Department Survey, the trust scored 4.3 for the question "How many minutes after you requested pain relief medication did it take before you got it?" This was worse than other trusts.

The trust scored 6.9 for the question "Do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

Question – Effective	Score	RAG
Q31. How many minutes after you requested pain relief medication did it take before you got it?	4.3	Worse than other trusts
Q32. Do you think the hospital staff did everything they could to help control your pain?	6.9	About the same as other trusts
Q35. Were you able to get suitable food or drinks when you were in the emergency department?	6.0	About the same as other trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Staff administered pain relief to patients and asked if they were in pain when completing quality rounds. We observed staff discussing patients pain levels in handovers. We saw staff in the paediatric department rechecked patients pain levels 30 minutes after medication had been administered.

The learning disability nurse had introduced a hospital communication book that contained pictures and signs to help patients with a learning disability to communicate with hospital staff, including to rate their pain using pictures.

Patient outcomes

Managers monitored the effectiveness of care and treatment however, results were not always used to improve patient care. The department had failed to meet any of the national standards in the 2016/17 Royal College of Emergency Medicine (RCEM) audits.

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Russells Hall Hospital emergency department failed to meet any of the national standards.

The department was not in the upper UK quartile for any standards.

The department was in the lower UK quartile for two standards:

- Standard 4 (fundamental): Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy. This department: 66%; UK: 77%.

- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

This department: 0%; UK: 52%.

The department's results for the remaining five standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Consultant sign-off audit, Russells Hall Hospital emergency department failed to meet any of the national standards.

The department was not in the upper UK quartile for any standards.

The department was in the lower UK quartile for one standard:

- Standard 4 (developmental): Consultant reviewed: abdominal pain in patients aged 70 years and over. This department: 0.0%; UK: 10%.

The department's results for the remaining three standards were all within the middle 50% of results.

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 15.0%; UK: 11%.

- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 12.0%; UK: 8%.

- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 11.8%; UK: 12%.

(Source: Royal College of Emergency Medicine)

In the 2016/17 Severe sepsis and septic shock audit, Russells Hall Hospital emergency department failed to meet any of the national standards.

The department's results for all eight standards were all within the middle 50% of results.

- Standard 1: Respiratory rate, oxygen saturations (SaO_2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 64.2%; UK: 69.1%.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 61.2%; UK: 64.6%.

- Standard 3: O_2 was initiated to maintain $SaO_2 > 94\%$ (unless there is a documented reason not to) within one hour of arrival. This department: 49.0%; UK: 30.4%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 51.6%; UK: 60.0%.

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 44.8%; UK: 44.9%.

- Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given within one hour of arrival. This department: 54.0%; UK: 43.2%.

- Standard 7: Antibiotics administered: Within one hour of arrival. This department: 47.0%; UK: 44.4%.

- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 12.1%; UK: 18.4%.

(Source: Royal College of Emergency Medicine)

The lead consultant told us that the Royal College of Emergency Medicine (RCEM) audit results had not been a focus over the past 12 months, we requested action plans around the audit results but these were not provided. We were told safety aspects raised in our previous inspections had been the focus of improvements within the department.

From September 2017 to August 2018, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% in all 12 months. However, the trust's performance was consistently better than the England average.

There was a deterioration in trust performance overall, from 6.2% in September 2017 (compared to the England average of 7.7%) to 7.0% in August 2018 (compared to the England average of 8.1%).

Unplanned re-attendance rate within seven days - The Dudley Group NHS Foundation Trust
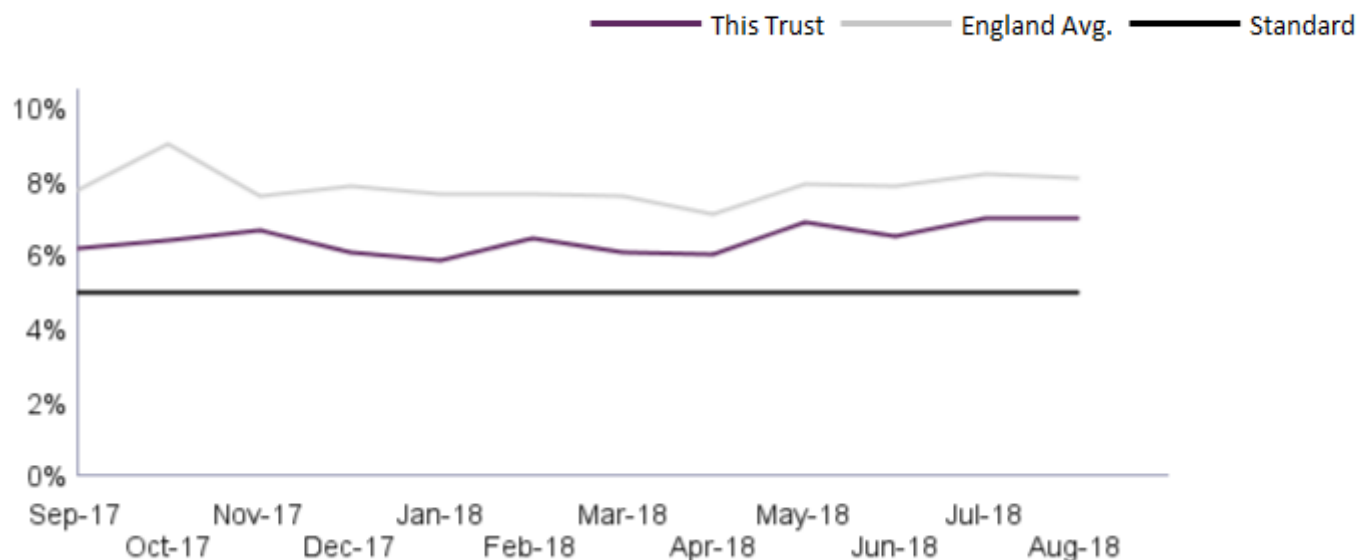
(Source: NHS Digital - A&E quality indicators)

Competent staff

Most staff were competent for their roles. However, mandatory training compliance was low and some staff did not have full understanding of key areas of their role.

For year to date, April to September 2018, 89.1% of required staff within urgent and emergency care received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
NHS infrastructure support	7	7	100.0%	90%	Yes
Support to doctors and nursing staff	90	95	94.7%	90%	Yes
Support to ST&T staff	7	8	87.5%	90%	No
Qualified ambulance service staff	6	7	85.7%	90%	No
Qualified nursing & health visiting staff (Qualified nurses)	103	122	84.4%	90%	No

The appraisal data provided by the trust for medical staff was only provided at trust level, so could not be broken down by core service. For year to date, April to September 2018, 98.5% of medical staff trust wide received an appraisal compared to the trust target of 90%. Data provided after our inspection showed that as at 13 February 2019 100% of medical staff in the emergency department had received an appraisal.

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

Staff within the paediatric department had the appropriate level of life support training. All qualified nursing staff had completed Paediatric Life Support (PILS). Some paediatric staff had also completed Acute Illness Management (AIM) training.

The paediatric department had a minimum of two registered children's nurses at all times. Rotations between the paediatric ward and emergency department were in place. However, staff we spoke to had mixed feelings about this, with some reporting that they did not feel they had the competencies or experience to work in an emergency department setting. Paediatric staff had escalated their concerns and management were aware however, staffing levels meant that some staff who did not feel confident were still placed within the paediatric department.

Triage nurses were trained in the use of the Emergency Severity Index (ESI) triage tool. Triage nurses needed to have been a qualified nurse for two years or more and to have worked in the emergency department for at least six months. The ESI training involved the completion of an online training course, six weeks of shadowing and ten observed triage sessions at the front door and ambulance assessment areas.

A practice development nurse was in place. This nurse helped to facilitate ongoing training for nurses within the emergency department.

Staff we spoke with were unclear on how their responsibilities when supervising mental health patients and decision making around supervision levels was unclear. This presented a risk that patients with a mental health need may not be supervised correctly and cause harm to themselves.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other.

The paediatric departments worked well together. Staff and management from the paediatric emergency department and wards worked well together to care for and manage paediatric patients within the hospital. The paediatric departments had good links with the local children's critical care retrieval team.

Senior emergency department doctors and nursing staff collaborated and communicated well together. A senior nurse led a departmental ward round attended by consultants and junior doctors, potential patient risks, issues and outstanding tasks were highlighted.

We saw examples of good multidisciplinary working in the department and specialities external to the department. We saw speciality consultants attending the department to review patients who could not yet be transferred to wards. Staff told us that they felt these relationships had been strengthened over the past year. We were told how the medicine consultants had a rota in place to provide in reach to the emergency department and that extra surgical staff had been recruited to allow surgical patients to be reviewed in a more timely manner. An area of the department had been cleared to provide a work space for speciality doctors.

Staff were provided with emotional support after distressing incidents or deaths within the department. Debriefs after incidents were usually held by the consultant in charge, staff were offered ongoing support if needed.

We saw that monthly meetings had started between the emergency department and Acute Medical Unit (AMU) consultants. These meetings aimed to increase joint working between the two departments and to encourage joint working on clinical pathways and operational issues.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff reported close working relationships with the psychiatric liaison team, local community mental health teams, child and adolescent mental health services and dementia gateways. However, staff did not have access to an older people's psychiatrist and said this resulted in delays in seeking clinical support. The provider worked closely with a local drug and alcohol team to support patients who required this support.

Seven-day services

Both the emergency department and paediatric emergency department provided care for the local population 24 hours a day, seven days per week.

The streaming nurse service in the main reception to the emergency department was provided 24 hours per day, seven days per week to guide patients to the most appropriate area for their level of clinical need.

The service had arrangements, known to all staff on duty, to meet patients' urgent or emergency mental health care needs at all times, including outside office hours and in an emergency. The service included round the clock access to psychiatric liaison (covering the age range of the ward/clinic) and/or other specialist mental health support if staff were concerned about risks associated with a patient's mental health. Staff in the emergency department had access to the psychiatric liaison team 24 hours seven days a week (for all patients aged 18 – 65), the child and adolescent mental health service (for children under the age of 18) specialist older people's mental health nurses (for those aged 65 and over) and learning disability nurses employed by the trust and other specialist clinicians outside of the trust to support patients with mental health needs.

Health promotion

Health promotion materials were available and staff knew which services to signpost patients to.

The department had access to alcohol liaison nurses for patients who presented with alcohol misuse to provide advice and support. The provider worked closely with a local drug and alcohol team to support patients who required this support.

Support for mental health conditions, dementia and learning disabilities was available from within the department and across the trust. Staff referred patients for a mental health assessment who were suspected to be experiencing depression, including post-natal depression.

The trust employed patient wellbeing workers to support patients living with dementia and their families. They offered distraction and support for the patient as well as gathering useful information to help in their care.

We saw flu injection information advertised around the department for patients. The emergency department monthly newsletter also told staff how they could claim their free flu jab.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. However, the service did not monitor or audit the treatment or interventions that mental health patients received while in the emergency department.

Deprivation of Liberty Safeguards training was delivered within the mental health awareness training module. For year to date, April to September 2018, the trust reported that mental health awareness training was completed by 80.5% of all staff in urgent and emergency care compared to the trust target of 90%. The completion rate for qualified nursing staff was 88.5% in urgent and emergency care. The trust did not provide any data for medical staff completion rates of mental health awareness training in urgent and emergency care.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)
Staff we spoke with (one band 5) were able to discuss the principles of the mental capacity act.

The trust had an in date mental capacity protocol. Staff were aware of how to access mental capacity policies upon the trusts intranet page. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Staff used the expertise of the mental health team to seek clarification around issues related to patients' mental capacity or deprivation of liberty.

The trust had clear processes around when a person was deprived of their liberty, such as when a person had been on one to one observations for more than 48 hours. The provider had 20 patients detained under Section 5(2) from Nov 2017 to October 2018. The Emergency Department could be used as a 136 facility, providing a place of safety for those experiencing a mental health crisis, however, the trust had no formal process for recording these incidents within the department as all information was collated by the police. Any incidents where patients were brought to emergency

department under Section 136 would be recorded in their notes individually making any themes and trends hard to track.

Is the service caring?

Compassionate care

Staff cared for patients with compassion however, patient dignity was sometimes compromised.

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was consistently worse than the England average from September 2017 to August 2018. There was little variation in the trust's performance over this period aside from slight peaks in performance in October 2017 and April 2018. In October 2017 the trust's performance was 83.7% compared to the England average of 86.6%. In April 2018 the trust's performance was 81.9% compared to the England average of 86.7%.

A&E Friends and Family Test performance - The Dudley Group NHS Foundation Trust
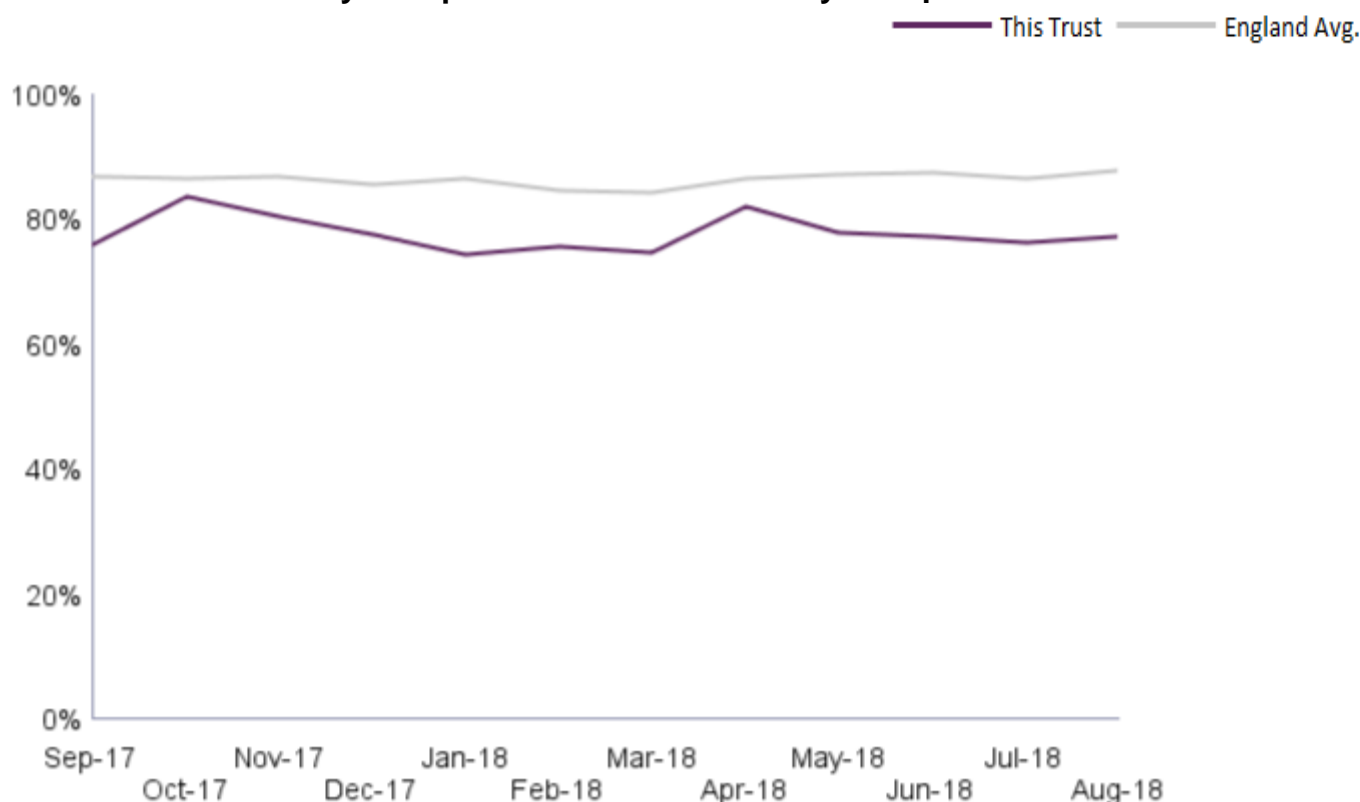
(Source: NHS England Friends and Family Test)

The service displayed their friends and family test results within the department. Results from December 2018 showed 78.9% of respondents would recommended the department. The response rate to the survey was low with 499/3884 providing feedback.

Staff did not always respect patient's privacy and dignity while they were in the department. Patients dignity was not always observed within the waiting room. We saw clinical support workers performing observations in the waiting room in front of all the other waiting patients in a busy corridor where people were walking through. We raised this with the matron for the department who told us these observations should be performed in a side room off the main waiting area. When we returned to the department on the 30 January the support worker was doing the observations in the designated side room but was still able to provide oversight of these patients.

Ambulance patients who had been assessed as safe to wait in the corridor had no privacy and little dignity. They were subject to constant traffic of hospital staff and ambulance crews with their patients.

We saw staff providing kind and compassionate care to patients. We observed staff introducing themselves to patients. We observed both doctors and nurses ensuring patients were comfortable and providing reassurance and support when mobilising elderly patients. Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia.

One parent we spoke with in the paediatric emergency department said they had no complaints about the treatment and had been sent straight through to the department from the main reception and were seen quickly.

We saw staff show compassion towards a patient identified as being end of life. The patient was fast tracked through the triage process to be made comfortable within the department.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We observed staff providing emotional support to patients and their loved ones. We saw staff reassuring patients throughout their time within the department.

Families and loved ones were supported after the loss of a patient. We were told how following a death in the department the consultant or lead doctor for that patient would break the news to the family. There was a viewing room within the emergency department that relatives could use.

Further emotional support was available for patients and parents. Bereavement and chaplaincy services were accessible through the trust. A bereavement pack had been developed explaining the next steps in the process after someone had died in the hospital and provided advice and contact numbers for local funeral, counselling and support services.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

During our inspection we saw staff keeping patient's families informed of their condition and treatment and doing their best to answer any questions that they had.

The trust scored about the same as other trusts for any of the 24 Emergency Department Survey questions relevant to the caring domain.

The trust scored about the same as other trusts for all 24 questions.

Question	Trust 2016	2016 RAG
Q10. Were you told how long you would have to wait to be examined?	3.7	About the same as other trusts
Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.3	About the same as other trusts
Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?	7.7	About the same as other trusts

Question	Trust 2016	2016 RAG
Q14. Did the doctors and nurses listen to what you had to say?	8.5	About the same as other trusts
Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.5	About the same as other trusts
Q17. Did doctors or nurses talk to each other about you as if you weren't there?	9.3	About the same as other trusts
Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	7.4	About the same as other trusts
Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?	8.4	About the same as other trusts
Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.1	About the same as other trusts
Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?	8.7	About the same as other trusts
Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.8	About the same as other trusts
Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?	8.9	About the same as other trusts
Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	6.7	About the same as other trusts
Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?	5.6	About the same as other trusts
Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.5	About the same as other trusts
Q27. Before you left the emergency department, did you get the results of your tests?	7.9	About the same as other trusts
Q28. Did a member of staff explain the results of the tests in a way you could understand?	8.6	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	8.9	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	5.1	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	4.9	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?	5.0	About the same as other trusts
Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	5.7	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?	7.4	About the same as other trusts
Q45. Overall... (please circle a number)	7.8	About the same as other

Question	Trust 2016	2016 RAG
		trusts

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people. However, limited information was available to those whose first language was not English.

An urgent care centre was co-located to the emergency department. A streaming nurse was provided by this service to stream patients to the appropriate place for the treatment they required.

Since our last full inspection of the department the trust had opened a 24-hour paediatric emergency department. The paediatric emergency department was co-located to the adults' emergency department. From February 2018 to January 2019 paediatric admissions accounted for 19.3% of all emergency department admissions.

The department had undertaken the NHS 15 steps challenge with the help of a local primary school. Children had evaluated the paediatric areas across the trust and provided feedback. The emergency department developed an action plan which included, to ensure signage was clear, improve the decoration and to make sure that child friendly and suitable toys were available for all ages. Child friendly signage was in place. Although not finished the paediatric emergency department had marked the path to the department with large Bear footprints to guide children and their families from the main reception to the paediatric area. The department had not completed or had plans to complete a 'You're Welcome' audit, the department of Health's quality criteria for young people friendly health services

The adult department had a large waiting room. There were chairs available and space to accommodate wheelchairs. This waiting room was often near capacity during times of high demand. A child friendly waiting area had been created in the new paediatric emergency department with games and toys to keep children waiting for treatment and any siblings occupied.

Staff had access to interpreters to aid communication with patients who could not speak English as a first language or for people with a hearing difficulty. We saw that Patient Advice and Liaison Service (PALS) posters were displayed in different languages. However, we saw no other information available in different languages.

The department had access to alcohol liaison nurses for patients who presented with alcohol misuse to provide advice and support. Support for mental health conditions, dementia and learning disabilities was available from within the department and across the trust.

Meeting people's individual needs

The service took account of patients' individual needs.

The trust scored about the same as other trusts for the all three questions relevant to the responsive domain in the emergency department survey 2016.

Question – Responsive	Score	RAG
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.0	About the same as other trusts
Q11. Overall, how long did your visit to the emergency department last?	6.8	About the same as other trusts
Q20. Were you given enough privacy when being examined or treated?	9.0	About the same as other trusts

Staff and the care systems they followed helped to provide good care to patients in need of additional support. Staff developed care plans in collaboration with patients who frequently attended the emergency department with mental health needs. These care plans were person-centred, contained the patient's own views and wishes and were holistic and recovery-focused. Staff in the emergency department worked closely with the psychiatric liaison team to discuss frequent attenders to improve their care and treatment.

The trust had an electronic flagging system which identified patients over the age of 18 years who were known to the local council's learning disability system. The sharing of this information was supported by the use of a Purpose Specific Information Sharing Protocol. Staff reported challenges remained where patients with a learning disability who were not from the local area attended the emergency department. Staff addressed this challenge by asking for the person's learning disability passport, which is a nationally recognised support tool for people with a learning disability to use when accessing hospital.

Staff were supported by a Learning Disability (LD) nurse who worked Monday to Friday 8am to 4pm. The trust was in the process of recruiting an additional Band 6 specialist learning disability nurse. The LD nurse had an email alert when any patient from the Dudley Borough was admitted. There was also a prompt on all adult admission documentation to refer any patients with a learning disability to the LD nurse.

The LD nurse assessed patients with a learning disability for any reasonable adjustment which may be needed to ensure that individual needs were met. There was also a learning disability checklist for staff to utilise which supported staff to consider all aspects of the patient's learning disability needs. The provider ensured reasonable adjustments were made to support people with a learning disability. For example, consultants had met with patients in the car park of the hospital when they had been anxious about coming into hospital and the learning disability nurse had introduced 'Makaton Monday' on the paediatric emergency department to encourage people to learn and use Makaton. Makaton uses signs and symbols to help people communicate. It is designed to support the development of spoken language. The learning disability nurse had introduced a hospital communication book that contained pictures and signs to help patients with a learning disability to communicate with hospital staff, including to rate their pain using pictures. The learning disability nurse reported that the staff in the emergency departments had been receptive to introducing tools to support people with learning disabilities and regularly contacted them for support and advice.

The Trust did not have a specific nurse for dementia but had a team of mental health nurses who assessed and reviewed older people with mental health needs.

Where emergency department staff identified patients potentially living with dementia, patients had access to a full physical, memory assessment using recognised tools. Patients with a pre-existing diagnosis of dementia were reviewed by the mental health team and care planned according to individual needs.

The trust had a Dementia Strategy in place. The emergency department was identified as an area where high numbers of patients living with dementia may move through and so was highlighted to ensure dementia adaptations and a dementia friendly environment was adopted. We did not see any of these adaptations on inspection and when asked staff were unable to show them to us.

The department had access to a Reminiscence Interactive Therapy Activity (RITA) computer. This was used for patients who were living for dementia or who were frightened to watch old videos and to listen to music. It could also be used for younger visitors with learning disabilities to play games.

The service had appropriate discharge arrangements for people with complex health and social care needs however the local health economy was struggling to accommodate discharges from the hospital in a timely manner.

Access and flow

People could not always access the service when they needed it. Waiting times for treatment and arrangements to admit, treat and discharge were not in line with best practice. Key documentation for the running of an emergency department was difficult to locate and not updated to reflect the current model of the department.

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for 10 months of the 12-month period from September 2017 to August 2018.

Performance against this standard showed improvement from February 2018 and was better than the standard and the England average in April 2018. Performance then dipped but recovered in August 2018.

In April 2018 the trust's median time to treatment was 50 minutes compared to the England average of 60 minutes. In the most recent month, August 2018 the trust's median time to treatment was 51 minutes compared to the England average of 56 minutes.

Median time from arrival to treatment from September 2017 to August 2018 at The Dudley Group NHS Foundation Trust
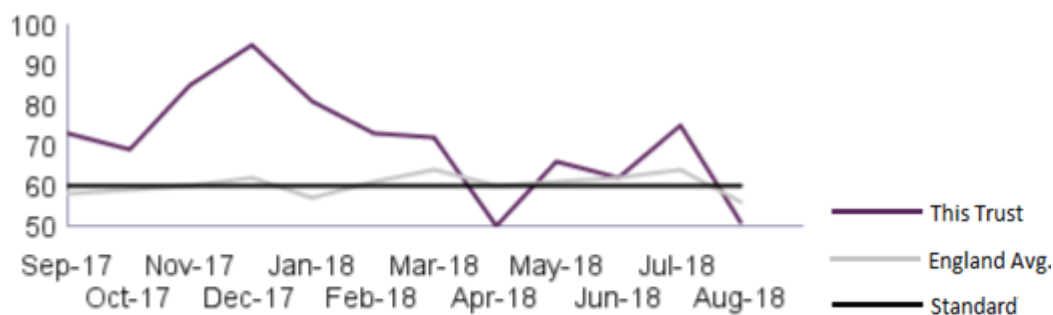
(Source: NHS Digital - A&E quality indicators)

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2017 to September 2018 the trust consistently failed to meet the standard and performed worse than the England average for the 12-month time period.

From October 2017 to September 2018 the trust's performance mirrored the England average.

Although overall performance deteriorated from 90.0% in October 2017 to 85.0% in September 2018, the rate has remained above 85.0% since April 2018.

Four hour target performance - The Dudley Group NHS Foundation Trust
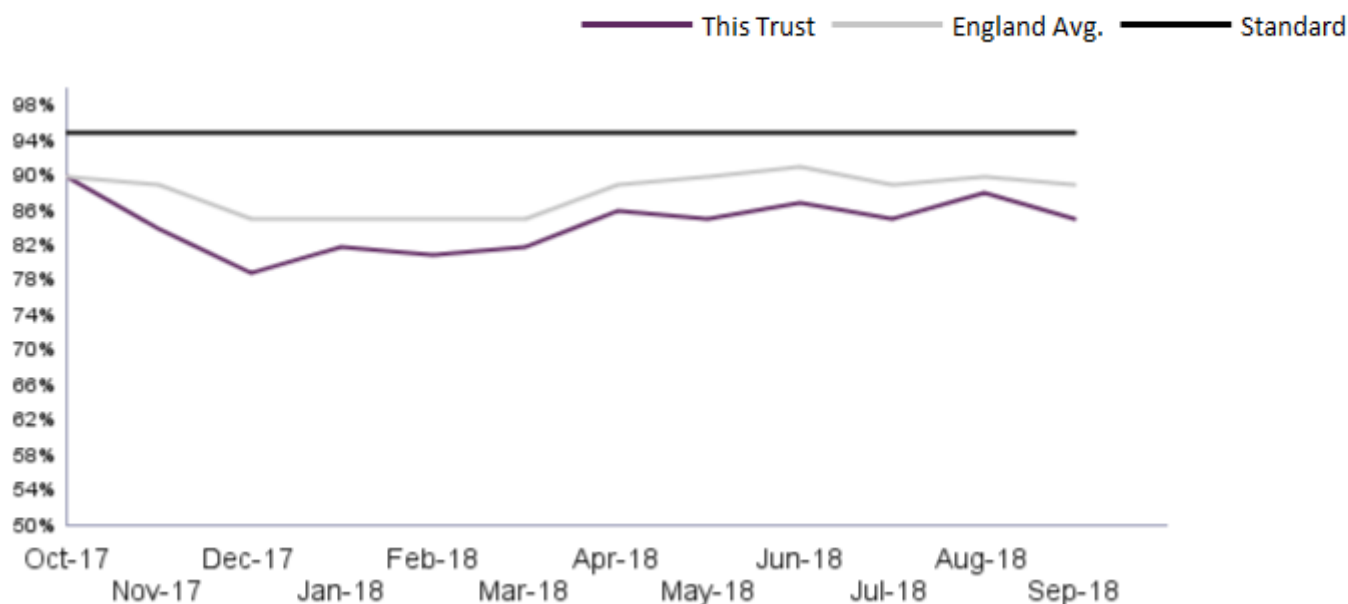
(Source: NHS England - A&E Waiting times)

From October 2017 to September 2018 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was worse than the England average apart from in October 2017 and November 2017.

Over these 12 months the trust's performance against this metric showed improvement from a high of 50.0% in February 2018 to just over 12.0% in August 2018.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - The Dudley Group NHS Foundation Trust
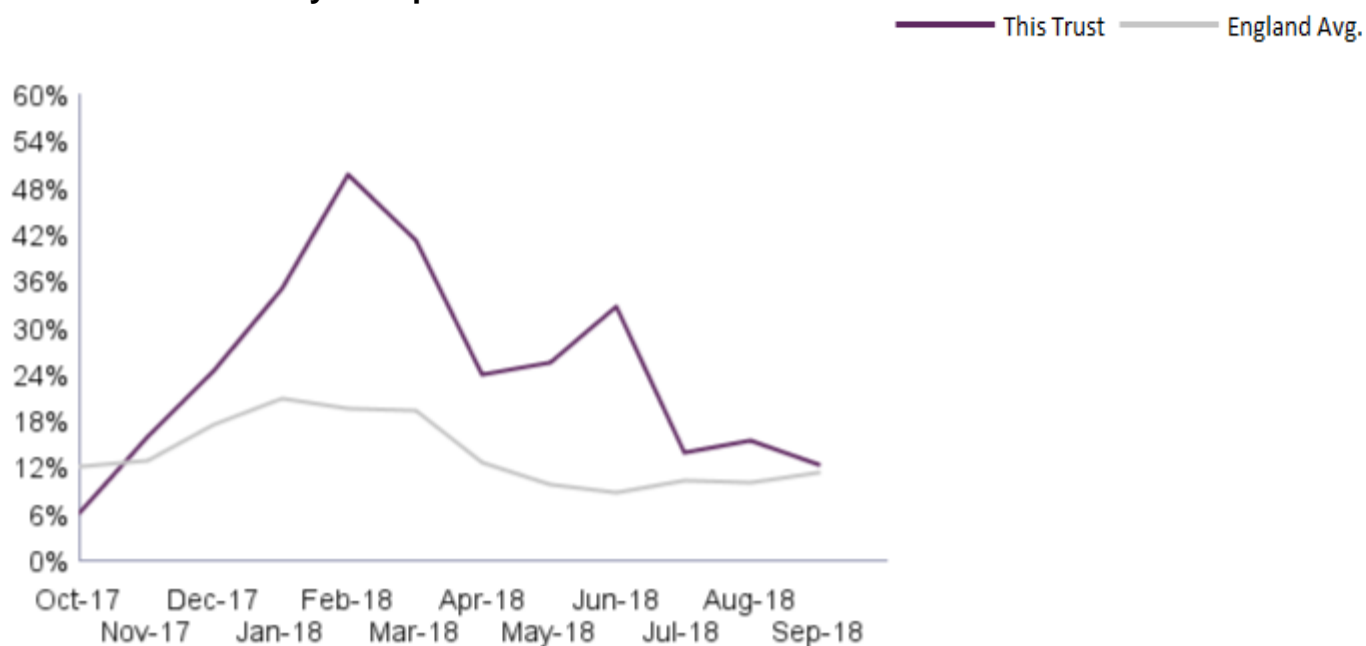
(Source: NHS England - A&E SitReps).

Over the 12 months from October 2017 to September 2018, 10 patients waited more than 12 hours from the decision to admit until being admitted.

The highest numbers of patients waiting over 12 hours were in January 2018 (four), December 2017 (three) and February 2018 (two).

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
October 2017	143	0
November 2017	314	0
December 2017	535	3
January 2018	850	4
February 2018	973	2
March 2018	802	0
April 2018	462	0
May 2018	538	1
June 2018	708	0
July 2018	316	0
August 2018	355	0
September 2018	257	0

(Source: NHS England - A&E Waiting times)

From September 2017 to August 2018 the monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was similar to the England average.

In September 2017 the percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was 3.0%, compared to the England average which was 3.1%.

In March 2018 the trust's performance for this metric improved to 1.7%, while the England average was 3.3%.

Percentage of patient that left the trust's urgent and emergency care services without being seen - The Dudley Group NHS Foundation Trust
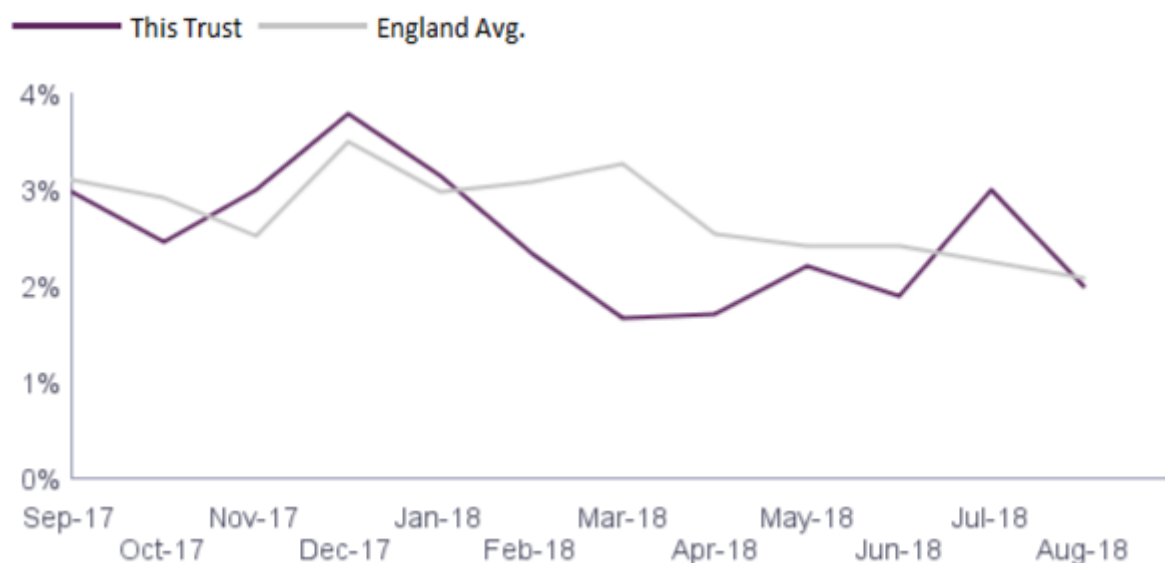
(Source: NHS Digital - A&E quality indicators)

From October 2017 to September 2018 the trust's monthly median total time in A&E for all patients was similar the England average.

In December 2017 the trust's monthly median total time in A&E for all patients was 196 minutes compared to the England average of 159 minutes.

Median total time in A&E per patient - The Dudley Group NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

During all our inspection visits the emergency department was challenged with high attendances and limited flow within the hospital. Staff of all grades told us that flow and capacity remained a significant challenge for the department and the trust.

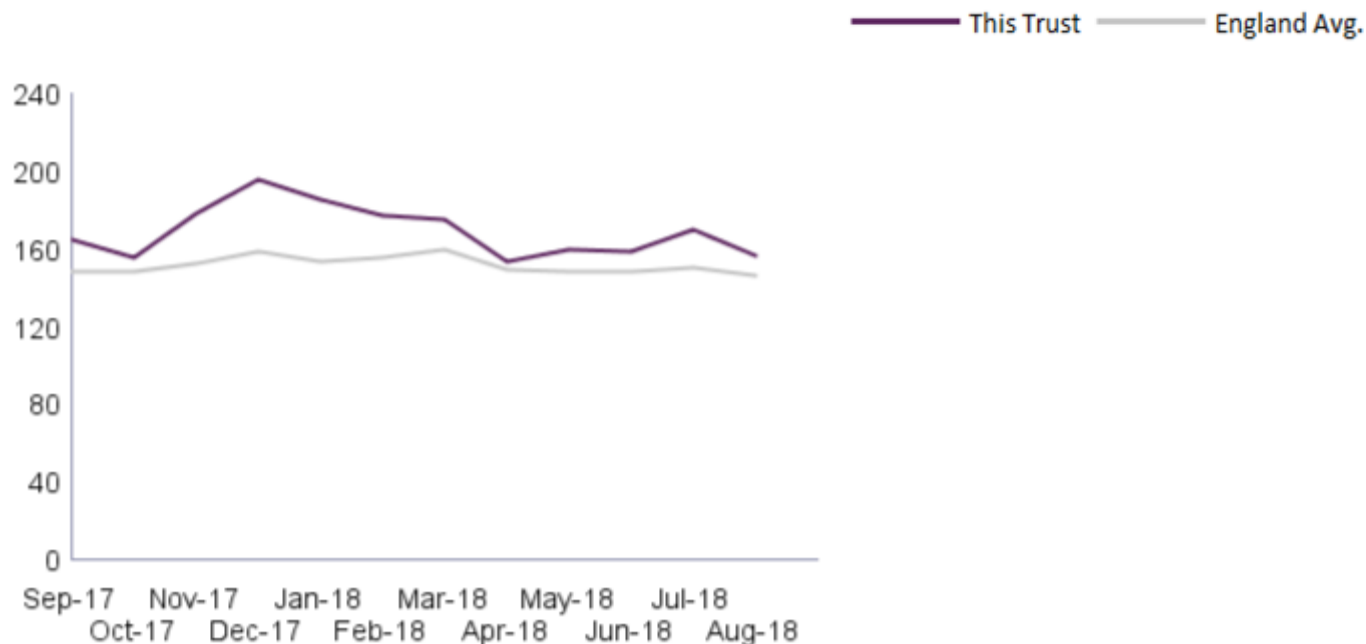A streaming nurse was in place is at the entrance to the emergency department and directed patients to either the emergency department or the UCC. to ensure the most appropriate department for each patient was used and to limit the number of patients entering the emergency department.

Staff were clear about the situations that they needed to escalate to hospital managers. However, we were told conflicting levels at which corridor care would be escalated. They told us that they usually received a courteous response when they escalated issues but that action to resolve issues did not always take place. However, we saw corporate nursing staff assisting with bed moves and transfers from the department.

In times of high activity, it was difficult for those in charge of the department to keep track of patient referrals. It was difficult for the nurse and doctor in charge of the department to keep track of the progress of all the patients who had been referred to specialist teams, or those needing to be admitted to a ward. This difficulty had been recognised and a new role of patient flow nurse had been created. This was an experienced nurse who could liaise with all the on-call doctors, the diagnostic teams, the bed management team and wards accepting emergency admissions. The nurse helped to ensure there were no delays in diagnosis or in the decision to admit.

Patients experienced delays in being seen by speciality doctors. This impacted the amount of time that they spent within the department. During our visit on the 4 February there were thirteen patients waiting to be seen by the on-call physicians by 3.30pm. We observed one patient who had waited two hours to be seen by an on-call physician. The trust has had conditions on its

registration since August 2018 concerning the oversight of specialist clinical expertise in the emergency department.

The emergency department was crowded at the beginning of our inspection on 4 February 2019 and became severely crowded during the evening. There were not enough available beds in the hospital to allow emergency patients to be admitted to a ward as soon as a bed was required. At 4.15pm one patient had been waiting to be admitted to a ward for eight hours and two for four hours. All had breathing difficulties. Their need for a bed on a ward had been discussed by senior hospital managers at a 4pm bed management meeting but no empty beds had been found for them.

A further bed management meeting took place at 6.15pm. By this time there were 25 patients in the emergency department who needed to be admitted to a ward. Two of them were extremely ill and were being treated in the resuscitation room. One patient in the major treatment area had been waiting to be admitted to a ward for 10 hours. They had spent a total of 15 hours in the emergency department. There were eight patients waiting in the ambulance corridor because there was no space in any of the treatment areas. Links with the ambulance service showed that there were five more ambulances on their way to the hospital at this point.

Managers took action to create capacity across the hospital where possible. The on-call director decided to convert the hospital's discharge lounge to a ward for 10 patients. The plan was to move patients in the hospital who were due for discharge the next day and move them to the temporary ward. This would provide empty beds for sicker patients waiting in the emergency department. We observed that the lack of appropriate space to examine recently arrived patients led to delays in assessment and intimate procedures such as catheterisation.

Communication between the bed management team and the emergency department was not always effective. During our inspection visit on 4 February 2019 the hospital site co-ordinator had been told at 8pm that one of the patients in the resuscitation room was about to be admitted to the medical high dependency unit. The site co-Ordinator was surprised to find the patient remaining in the resuscitation room at 10pm. The nurse-in-charge of the emergency department had not been told about the empty bed and so the patient had not been admitted.

The hospitals escalation policy was difficult to locate and the copy we were shown was out of date. On our inspection on the 4 February we asked two senior managers for a copy of the hospital's full capacity protocol. It was possible that the hospital had deteriorated to OPEL 4 level (No capacity across the trust, severe ambulance handover delays, emergency care pathway significantly compromised). We wanted to know what options were available to staff when this happened. It proved difficult to find a copy of the full capacity protocol but we were eventually shown the hospital's Escalation Policy. This was dated 2014 and had not been reviewed since the NHS OPEL framework had been published in 2016.

By 10pm the doctor in charge of the ED told us there were 36 patients waiting to be admitted to a ward. 28 needed to go to medical wards and eight to a surgical ward. The number of patients waiting in the corridor had increased to 15. Only two patients had been moved to the temporary ward and so the additional 14 beds that had been identified at 6.15pm had not yet been made available for patients in the emergency department. At 10.55pm there were 17 patients waiting in the ambulance corridor. However, the nurse in charge of the ED was optimistic that the actions taking to create more beds for emergency admissions would soon start to work.

The escalation policy contained actions cards for individual hospital leaders, describing the actions to take when the hospital was under prolonged pressure and extreme pressure. However, the actions described were mainly related to the communication with other organisations. They did not give guidance regarding the practical measures to be taken. We were told that that the OPEL framework did not apply to the hospital at night and so the escalation policy was not used.

We were provided with an in date digital copy of the surge and escalation policy which was ratified in 2018 and did reference OPEL levels and had the full capacity protocol included as an appendix. The policy described the six criteria that needed to be met in order for the full capacity protocol to be activated, one being 'The Emergency Department escalation status is RED which is defined through the ED Crowding tool, applied every 2 hours'. We requested to see a copy of the ED crowding tool and were told one was not used. Therefore, we could not be assured that a robust escalation protocol was in place and steps to avoid severe overcrowding within the department was being performed in line with trust policy.

We were told a new internal escalation tool was being developed at the time of inspection with the help of NHS Improvement. Leaders were redesigning this so escalation levels were integrated with professional standards and actions identified for staff at all levels.

The hospital had implemented some innovative patient assessment and flow methods aimed at preventing unnecessary admissions to the wards and easing pressure upon the emergency department.

The trust had opened a cardiac assessment unit next to the emergency department. Patients with symptoms that were potential heart problems could be directed to the unit where they would be assessed and treated by a specialist doctor however, this service stopped accepting patients at 5pm. A standard operating procedure and admission and discharge criteria were in place for this unit. The department was in the process of preparing a business case to extend the opening hours of the unit due to the positive impact on patient flow and experience it had had.

The hospital's 'Impact' team assessed vulnerable patients who had been declared medically fit to go home. This team consisted of an occupational therapist and a social worker with close links to community services. They could rapidly access mobility aids or social support to maintain patients' safety when they returned home.

There was an ambulatory emergency centre aimed at providing rapid, day case medical treatment for emergency patients. Although it was open seven days a week it closed at 6pm with no new patients accepted after 5pm.

The trust was supporting a minor eye conditions service. Nurses were knowledgeable of and information was available explaining the local minor eye conditions service as an alternative service instead of the minor injuries department.

Flow out of the department had been increased by being able to refer to a rapid assessment and treatment bay on the acute medical unit (AMU), with the AMU team then being responsible for onward referrals into the hospital.

Learning from complaints and concerns

The service treated concerns and complaints seriously however, complaints were not always responded to within appropriate time frames or learning effectively shared.

From October 2017 to September 2018 the trust received 133 complaints about urgent and emergency care services.

For the 83 complaints that had been closed at the time of data submission, the trust took an average of 84.5 working days to investigate and close these complaints. This is not in line with the trusts' complaints policy, which states complaints should be closed within 40 working days. The 50 complaints that had not yet been closed had been open for an average of 68.7 working days at the time of data submission.

Patients and their families had contacted the local CQC inspectors throughout the year to complain about how their complaints about care received in the emergency department were being handled.

Department leaders told us they struggled to reply to complaints within set time frames and to ensure that learning was always shared. We were told how leaders often struggled to find time to investigate and answer complaints in a timely way with the demands of running the department. We were told how the medical division of the hospital had employed two staff members to help with complaint responses which had had a beneficial effect on easing some workload for the emergency department staff.

We saw that complaints and feedback from investigations were discussed at monthly emergency department operational meetings. We saw examples of where complaints had led to improvements in practice such as developing a Dementia action plan for the service and starting to utilise play specialists within the paediatric emergency department.

Posters containing the contact details for the Patient Advice and Liaison Service were on display in a range of languages throughout the department and waiting areas.

The breakdown by subject can be seen in the table below.

Subject	Number of complaints
Patient care	42
Other (specify in comments)	28
Values & behaviours (staff)	19
Communications	13
Admissions and discharges (excluding delayed discharge due to absence of care package)	11
Waiting times	4
Access to treatment or drugs	4
Prescribing	4
Privacy, dignity & well being	4
Appointments	1
Facilities	2
Restraint	1
Total	133

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

From October 2017 to September 2018 the trust received 154 compliments about urgent and emergency care (2.2% of all received trust wide).

The trust did not provide a breakdown by subject for compliments received.

The trust reported key themes emerging from the compliments supported the information found in other surveys that had been undertaken and included care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The emergency department distributed a monthly newsletter to its staff and we saw that compliments and positive feedback from patients was included. One comment stated 'The emergency department were absolutely fabulous, faultless and saved my life'.

Is the service well-led?

Leadership

Managers of the department had the right skills and abilities to run the service.

Senior staff and management within the department had a grasp on key risks such as flow, staffing and environment and were open and honest about the journey the department had been on. Leaders told us that the external support they had received over the past six months had been invaluable in helping the department to improve.

The paediatric emergency department had recently been brought back under the management of urgent and emergency care, it was previously managed by the children and young people directorate. We were told that this had made lines of accountability and escalation clearer for both clinical and operational issues within the emergency departments. Staff within the department were happier with this arrangement.

Managers recognised their limitations. The Matron for the emergency department was not a paediatric nurse by background so had advertised a band 7 management post for the paediatric department to be responsible for the day to day and ongoing management of this area, reporting into the matron and lead nurse.

Nurses told us they felt supported by the matron and lead nurses and they were visible and accessible. During our inspection we saw the matron and lead nurse were highly visible in the clinical environment, supporting junior staff, leading the treatment of the sickest patients and dealing with the more complex situations that arose. Junior Doctors told us they felt supported within their roles.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The Trust had a vision for its service "Trusted to provide safe, caring and effective services because people matter", which was underpinned by the three values: Care; Respect and Responsibility.

An overarching quality improvement plan had been put in place across the emergency department to enable leaders to systematically work towards improving standards in response to our previous inspections and other action plans that the department were already working to. We saw this was reviewed and updated with named leads assigned to each action.

The service had a mental health strategy appropriate for patients with mental illness that the trust board approved and reviewed annually.

The trust board included a clinical lead responsible for the mental health strategy and developing clear, measurable health outcomes. The trust had oversight of the number of patients within the trust with a mental health need and the use of the Mental Health Act. However, staff said they felt mental health was not always taken seriously within the trust and gave examples of how changes to the wellbeing workers' management structure would negatively impact on their ability to directly support patients with mental health needs.

A large sum of money had recently been awarded to the trust to invest into improving the emergency and urgent care services. Leaders were in the early stages of thinking of how best to use this morning to redesign the environment and services to provide the best care and treatment.

Culture

Managers promoted a positive culture that supported and valued staff. Most staff we spoke with were happy working in the department. However, some staff felt there was a lack of trust wide ownership to the problems faced by the emergency department.

All staff we spoke with were confident they could get support from other staff members and department leadership when required. We observed easy, effective and courteous communication between all grades and disciplines of staff within the department. There was strong teamwork between all emergency department staff.

We observed that nurses seemed more empowered in their role. The culture of the service felt happier and more open than on our previous visits in 2018. Most staff we spoke with told us that morale was good and they felt supported by senior staff. However, some nurses described working at night as "depressing". This was because it was very difficult to admit patients to a ward at night and sick patients had to stay in a noisy emergency department where it was difficult to sleep or rest. Nurses found themselves constantly apologising to patients and their families about the situation. However, during the inspection we observed cheerful and professional interaction between nurses and patients.

The emergency department had started a breakfast club. This took place every morning and was a chance for staff from the morning and night shifts to meet and discuss any issues. Staff meetings for each nursing band took place and were recorded. Issues were discussed and nurses could voice concerns to senior team. We saw that messages were shared from wider trust meetings and updates on strategic developments were shared.

Staff reported a lack of trust wide ownership and action to address the problems faced by the department. They also said a lack of responsiveness from some specialities to provide patient input hindered flow and they had experienced deliberate obstruction upon referring patients.

There was a concern about the hospital culture around 'corridor care'. At the time of inspection there appeared to be a lack of presence of the senior management team in the department to address the serious crowding issue. Staff reported that the hospital's senior management team made decisions without proper discussion with emergency department team.

Governance

The services approach to continually improving and monitoring the service it provided was not always robust. Key documents for the running of an emergency department were not accessible or not up to date.

Important documents for the running of an emergency department and hospital were out of date or did not contain the most up to date information or were inaccessible to staff.

For example, the surge and escalation policy that was shown to us when requested on site was out of date and did not reference key national guidance documents. We were provided with an up to date copy through the data request process, this meant staff had not been able to access the most up to date version of the document when it was needed within the department. The in date version we were supplied with referenced areas of the department no longer in use such as the intermediate medical assessment area and key documents mentioned within the policy to decide on escalation levels such as the ED crowding tool were not being used.

Monthly emergency department governance meetings were held and recorded. We reviewed the minutes from October to December 2018. We saw good attendance at these by both medical and nursing staff. Issues discussed included current risks, compliments, complaints and that incidents

and resulting actions were discussed. We saw that data submissions provided to the CQC as part of the conditions of the trust's registration were discussed at the departments operational meetings.

However, emergency department staff meeting minutes lacked a standardized format and detail into issues discussed. The medicines practice group meeting minutes were limited in detail with little documentation of discussion, learning or actions taken.

The department had not met any of the standards of the RCEM audits, at the time of the inspection these were not being proactively improved on with no action in place to increase compliance.

An Urgent Care Service Improvement Group had been in place since July 2018in place . This groups focus was to bring together action plans to meet CQC requirements and the Emergency Access Standard (EAS) performance targets into one overarching meeting.

Joint governance meetings were held between the emergency department and the urgent care centre. We were told how the Emergency department operational and governance meeting was attended by staff from the urgent care centre and issues such as inappropriate referrals to the emergency department were discussed.

Managers distributed monthly newsletters to staff. These detailed updates of current events in the trust and developments that staff needed to be aware of. Patient safety alerts and newly approved policies were also listed.

A safeguarding report was generated each quarter and presented at board level. We saw that key issues were highlighted and a summary of current safeguarding risk register updates were presented. The number of female genital Mutilation (FGM) cases per month were also included.

The trust had a Service Level Agreement with a mental health trust for mental health liaison and Mental Health Act management.

We were not assured that mental health treatment was proactively tracked and audited within the emergency department. We were told that the service did not track: the number of patients seen in the department who were detained under the mental health act; the number who were restrained or had rapid tranquilisation administered and although response times were tracked did not have a key performance indicator for referral to treatment time with the psychiatric liaison team. There was no key performance indicator for waiting time for referral to the psychiatric liaison team. We were told the average waiting time between October and December 2018 was 1.82 hours.

A restrictive intervention for adult patient's policy was in place. This stated that type and frequency of restrictive intervention should be monitored using the hospitals electronic incident reporting system and reported through the internal safeguarding board meeting minutes. We asked the provider to provide the number of restraints or restrictive interventions used and were told that all patient notes would need to be looked at to provide this number, we were then later told that zero restrictive interventions had been used within quarter three. We were not assured that the department were consistently and accurately tracking these forms of interventions.

Management of risk, issues and performance

The department did not always have effective systems for identifying risks.

We reviewed the risk register for the emergency department, extracted from the trusts system in October 2018. The detail of the risk register was not up to date and therefore did not reflect the key risks for the department at that time. The first risk held the description of 'paediatric area not open 24/7. The area is open from midday to midnight' this did not reflect the most up to date picture as it been open 24 hours a day for some time. Gaps in control for this risk noted that paediatric and adult patients were mixed from midnight to midday, this was also not the case at the time of inspection. This risk remained open on the risk register. A further risk in relation to the paediatric emergency department had been added as 'a decision has been made to open the paediatric ED 24/7 without established appropriate nursing and medical workforce so to ensure the department meets the national guidance.' This was no longer applicable as it had been open 24 hours a day for some time and had not been removed from the register. One risk description also referred to having no fully trained ESI triage nurses in the department, despite this now not being the case.

However, the risk of not being able to provide more staff when the ambulance assessment area exceeded 12 patients was highlighted, medical and nurse staffing in general, sepsis and a backlog in complaints were recorded as departmental risks amongst others.

Leaders highlighted that a lot of end of life patients were being inappropriately conveyed to the department which was undignified for the patient but also created flow problems within the hospital. Work was ongoing with the local ambulance services, care homes and community end of life teams to tackle this problem and to ease pressure upon the department.

All issues we highlighted during the inspection were quickly rectified where possible or improvement and action plans were put in place.

A major incident plan was in place. The hospital had a major incident and mass casualty plan policy and conducted major incident exercise in line with national guidance. NHS trusts are mandated to perform a live major incident practice every three years. The hospital last participated in one in September 2016. Debrief sessions were held after and lessons learned formulated into action plans to improve responses should a real situation occur.

Information management

The department collected, analysed, managed and used information to support all its activities.

Leaders of the department had access to the information they needed in order to manage the department well. We saw that over the year various dashboards had been developed and electronic systems had been implemented to provide an easier overview of patients in the department.

Matrons worked with nursing staff to receive and give regular handover of patients and updates of their conditions. Bed meetings were held throughout the day so leaders of the department were informed of the capacity and flow through the organisation.

Engagement

Since our last full inspection leaders in the department had improved their engagement with staff. The service also engaged with patients, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

A trust engagement lead was in place. The trust appointed a staff engagement lead in May 2018 to focus on listening to staff and working on plans to improve staff engagement. This staff member had made initial recommendations for the next staff survey to improve the ownership of survey outcomes by local managers as well as other themes to add into engagement exercises that were not necessarily found from the survey.

Team engagement was included on the department's improvement plan. Leaders had an action plan to increase engagement within the department with agreed actions and timescales recorded. Action included, monthly newsletters, breakfast clubs, MDT meetings, a written communication book and recognising those who had gone 'the extra mile' within their role weekly.

Staff were involved with service developments. The new paediatric department had been developed in consultation with staff. Staff were given a tour of the area for the new facility and asked to send the matron ideas for its development and design before it had opened.

Learning, continuous improvement and innovation

The department was committed to improving its services.

Trust executives, department leaders and staff were committed to improving the care delivered within the emergency department and a lot of change had occurred over the 12 months before our inspection.

The department had formulated an overarching improvement plan cover areas of triage, deteriorating patient, children's care, clinical expertise, team engagement and risk management in order to continually assess and drive improvement in the emergency department.

We saw more focus on fundamental aspects of safety and a more considered approach to actions and changes within the department. However, not all changes to process and policies were fully embedded at the time of our inspections.

Surgery

Facts and data about this service

The core service of surgery at Russells Hall Hospital, Dudley Group NHS Foundation Trust has 214 surgical inpatient beds across eight inpatient wards:

Ward/unit	Speciality or description	Inpatient beds
East B2 - Trauma	Trauma and orthopaedics	24
East B2 - Hip fracture	Orthopaedic trauma and hip suite	30
East B1 - Elective	Elective orthopaedics	26
East B3	Vascular and general surgery ward	42
West B4	General and colorectal surgery / elective surgery	48
West B5	General surgery and gynaecology	12
Surgical Assessment Unit (SAU)	Surgical assessment and surgical ambulatory emergency care unit	12
West C6	Urology and general surgery	20

The service's theatre suite comprises 10 main operating theatres, including one dedicated emergency theatre and one dedicated trauma theatre, four-day case theatres on the Russells Hall Hospital Site, and a day case theatre on the Corbett Hospital site.

The service also has a dedicated day surgery unit on the Russells Hall Hospital site.

A surgical ambulatory assessment unit has been set up as part of the surgical assessment unit. This enables patients who are referred for acute symptoms requiring urgent triage and surgical assessment, who could sit, to attend for their pre- assessments without being admitted. Following triage and assessments, patients, where appropriate, return home until their operation the following day rather than be admitted overnight prior to surgery if required. The aim of this service is to achieve a 12-hour turnaround time from patient arrival to returning home. Referrals are received for this service from GPs, urgent care centres, accident and emergency department and community nursing. For certain specialities, such as vascular surgery, referrals can be received from other West Midlands hospitals. There is capacity to accommodate patients who required a longer assessment period, with four beds allocated for up to 48 hours per patient.

On the vascular ward (B3), two surgical high dependency beds are located (SHDU) to support patients who need level two care (higher level of care than on a general surgical ward). This is staffed by one nurse to two patients. Each bed is located within a separate side room.

The trust also has a specialist operating theatre in the x-ray department where certain vascular operations are performed.

The main surgical specialities provided are:

- General surgery
- Vascular surgery

- Orthopaedics and trauma
- Gynaecology
- Urology
- Plastic surgery
- Ear, nose and throat surgery
- Maxillofacial surgery

The trust also provides paediatric surgery in general surgery, trauma and orthopaedics, ear, nose and throat, oral and maxillofacial surgery, plastics, ophthalmology and orthodontics.

(Source: Routine Provider Information Request (RPIR) Sites tab, acute RPIR context acute tab and trust website)

The trust had 33,662 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 9,366 (27.8%), 20,496 (60.9%) were day case, and the remaining 3,800 (11.3%) were elective.

(Source: Hospital Episode Statistics)

During our inspection, we spoke with 55 members of staff. This number included consultants, medical staff, nurses with a range of seniority, therapy staff, clinical support workers, wellbeing workers, ward clerks, and other staff outside of the surgical division but who supported the work such as nurses within the mental health team and pharmacy staff.

We spoke with 10 patients and three relatives; and observed a number of staff and patient interactions.

Additionally, we checked a total of 26 patient records, which included medicine charts, nurse records and medical notes.

We visited every ward at Russells Hall Hospital and visited the operating theatres. We also spoke with the Hospital at Home team who worked with urology patients within the community and in the hospital.

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to all staff. Following the inspection the trust provided evidence that nursing staff compliance to mandatory training was satisfactory; however medical staff compliance was below the trust target.

Trust wide

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for qualified **nursing** staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual handling (non-patient) / slips, trips & falls	5	5	100.0%	90.0%	Yes
Health & safety	300	307	97.7%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	288	307	93.8%	90.0%	Yes
Equality & diversity (including autism awareness)	285	307	92.8%	90.0%	Yes
Conflict resolution - level 1	279	306	91.2%	90.0%	Yes
Infection control - clinical	268	307	87.3%	90.0%	No
Resus - adult	262	306	85.6%	90.0%	No
Information governance	259	307	84.4%	90.0%	No
Fire	253	307	82.4%	90.0%	No
Resus - paediatric	33	41	80.5%	90.0%	No
Manual handling (patient) / slips, trips & falls	232	302	76.8%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 87.9% for qualified nursing staff. The 90% target was met for five of the 11 mandatory training modules for which qualified nursing staff were eligible.

Manual handling (non-patient) / slips, trips & falls was the only training module with a completion rate of 100.0% although the data only relates to five eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

Manual handling was the only training topic to have less than 80% compliance; at 76.8% for qualified nursing staff.

Data from the trust showed that sepsis training was included within resus training. We asked for figures for January 2019 which showed that 85.7% nursing staff had completed this (570 staff had completed out of an eligible 665).

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for **medical** staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	132	140	94.3%	90.0%	Yes
Equality & diversity (including autism awareness)	127	140	90.7%	90.0%	Yes
Information governance	122	140	87.1%	90.0%	No
Clinical governance (including incidents, complaints & claims investigations)	118	140	84.3%	90.0%	No
Fire	113	140	80.7%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	111	140	79.3%	90.0%	No
Resus - adult	110	140	78.6%	90.0%	No
Resus - paediatric	39	50	78.0%	90.0%	No
Conflict resolution - level 1	109	140	77.9%	90.0%	No
Infection control - clinical	101	140	72.1%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 82.6% for medical staff. The 90% target was met for two of the 10 mandatory training modules for which medical staff were eligible.

Mandatory training compliance was under 80% for five of the 10 modules. These included manual handling (79.3%), resus – adults (78.6%), resus – paediatrics (78%), conflict resolution (77.9%) and infection control (72.1%).

Data from the trust showed that sepsis training was included within resus training. We asked for figures for January 2019 which showed that 75.9% medical staff had completed this (186 staff had completed out of an eligible 245).

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital

A breakdown of compliance for mandatory training courses from April to September 2018 at Russells Hall Hospital for qualified **nursing** staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual handling (non-patient) / slips, trips & falls	3	3	100.0%	90.0%	Yes
Health & safety	289	296	97.6%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	277	296	93.6%	90.0%	Yes
Equality & diversity (including autism awareness)	275	296	92.9%	90.0%	Yes
Conflict resolution - level 1	268	295	90.8%	90.0%	Yes
Infection control - clinical	257	296	86.8%	90.0%	No
Resus – adult	251	295	85.1%	90.0%	No
Information governance	248	296	83.8%	90.0%	No
Fire	243	296	82.1%	90.0%	No
Resus – paediatric	33	41	80.5%	90.0%	No
Manual handling (patient) / slips, trips & falls	225	293	76.8%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 87.6% for qualified nursing staff at Russells Hall Hospital. The 90% target was met for five of the 11 mandatory training modules for which qualified nursing staff at the hospital were eligible.

Manual handling (non-patient) / slips, trips & falls was the only training module with a completion rate of 100.0% although the data only relates to three eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 at Russells Hall Hospital for **medical** staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	126	132	95.5%	90.0%	Yes
Equality & diversity (including autism awareness)	121	132	91.7%	90.0%	Yes
Information governance	116	132	87.9%	90.0%	No
Clinical governance (including incidents, complaints & claims investigations)	112	132	84.8%	90.0%	No
Fire	107	132	81.1%	90.0%	No

Manual handling (non-patient) / slips, trips & falls	105	132	79.5%	90.0%	No
Resus – adult	105	132	79.5%	90.0%	No
Conflict resolution - level 1	103	132	78.0%	90.0%	No
Resus – paediatric	35	45	77.8%	90.0%	No
Infection control - clinical	95	132	72.0%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 83.1% for medical staff at Russells Hall Hospital. The 90% target was met for two of the 11 mandatory training modules for which medical staff at the hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital: Hospital at Home Team (Urology speciality)

A breakdown of compliance for mandatory training courses from April to September 2018 at Russells Hall Hospital / Community for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual handling (non-patient) / slips, trips & falls	2	2	100.0%	90.0%	Yes
Information governance	2	2	100.0%	90.0%	Yes
Fire	2	2	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	2	2	100.0%	90.0%	Yes
Infection control - clinical	2	2	100.0%	90.0%	Yes
Conflict resolution - level 1	2	2	100.0%	90.0%	Yes
Resus – adult	2	2	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	2	2	100.0%	90.0%	Yes
Health & safety	2	2	100.0%	90.0%	Yes

In surgery the 90% target was met for all of the nine mandatory training modules for which qualified nursing staff at Russells Hall Hospital / Community were eligible. All training modules had completion rates of 100.0%.

It should be noted that the data for nursing staff refers to two eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff. These staff were all within the Hospital at Home team and data for no other staff group was provided.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection in January 2019, we spoke with ward managers, staff and viewed training

completion records. We found that nursing staff were undertaking mandatory training regularly and this was recorded and monitored well. Where staff were not compliant with mandatory training, this was highlighted in ward meetings and daily huddles.

However, despite the above activity observed on site during the inspection, we requested more recent figures; from October 2018 to December 2018. We found that qualified nurses now met the trust target of 90% compliance for five of the 10 modules; showing a decline in compliance. For medical staff, compliance had also declined with none of the 10 training targets being met. We asked the trust for evidence of an action plan to address training rates. The response to this request was that "Divisional mandatory training rates are good so there is no bespoke action plan. Evidence of actions associated with improving Mandatory Training compliance in individual specialties and Directorates is contained within the Divisional Management Team Directorate Performance Review meetings action logs".

(Source: Data Request DR116 and DR177)

Following the inspection, we requested training figures for both nursing and medical staff. The trust sent us data which demonstrated nursing staff compliance to mandatory training was satisfactory and met the trust target of 90% in February 2019. Whilst medical staff compliance was below the trust target; this was much improved and was 84% in February 2019.

Staff received updates on sepsis as part of their ongoing training and as a result were able to describe the process of responding to a patient who triggered a sepsis pathway.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

Trust wide

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules for qualified **nursing** staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	301	307	98.0%	90.0%	Yes
Safeguarding children level 1 & 2	273	292	93.5%	90.0%	Yes
Safeguarding adults	278	307	90.6%	90.0%	Yes
W R A P	277	307	90.2%	90.0%	Yes
Safeguarding children level 3	20	24	83.3%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 92.9% for qualified

nursing staff. The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training modules from April to September 2018 for **medical** staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding children level 3	69	73	94.5%	90.0%	Yes
Prevent	131	140	93.6%	90.0%	Yes
Safeguarding children level 1 & 2	127	140	90.7%	90.0%	Yes
Safeguarding adults	125	140	89.3%	90.0%	No
W R A P	108	140	77.1%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 88.5% for medical staff. The 90% target was met for three of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital

A breakdown of compliance for safeguarding training courses for qualified **nursing** staff in surgery at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	290	296	98.0%	90.0%	Yes
Safeguarding children level 1 & 2	262	281	93.2%	90.0%	Yes
Safeguarding adults	268	296	90.5%	90.0%	Yes
W R A P	266	296	89.9%	90.0%	No
Safeguarding children level 3	20	24	83.3%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 92.7% for qualified nursing staff at Russells Hall Hospital. The 90% target was met for three of the five safeguarding training modules for which qualified nursing staff at Russells Hall Hospital were eligible.

A breakdown of compliance for safeguarding training courses from April to September 2018 for **medical** staff in surgery at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)

Safeguarding children level 3	64	66	97.0%	90.0%	Yes
Prevent	125	132	94.7%	90.0%	Yes
Safeguarding children level 1 & 2	121	132	91.7%	90.0%	Yes
Safeguarding adults	119	132	90.2%	90.0%	Yes
W R A P	102	132	77.3%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 89.4% for medical staff at Russells Hall Hospital. The 90% target was met for four of the five safeguarding training modules for which medical staff at Russells Hall Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital: Hospital at Home Team (Urology speciality)

A breakdown of compliance for safeguarding training courses for qualified nursing staff in surgery at Russells Hall Hospital / Community is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	2	2	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	2	2	100.0%	90.0%	Yes
Prevent	2	2	100.0%	90.0%	Yes
Safeguarding adults	2	2	100.0%	90.0%	Yes

In surgery the 90% target was met for all of the four safeguarding training modules for which qualified nursing staff at Russells Hall Hospital / Community were eligible. All safeguarding training modules had completion rates of 100.0%.

It should be noted that the data for nursing staff refers to two eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff. These staff were all within the Hospital at Home team and data for no other staff group was provided.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Post inspection we requested more up to date training data from October 2018 to December 2018. This showed that whilst nursing staff at Russells Hall Hospital met the trust training target for all required safeguarding modules; medical staff now only met the training target for two out of five modules (Prevent and WRAP). Safeguarding adults was met by 80.3% of medical staff, safeguarding children level 1&2 was 81.7% compliant, and safeguarding children level 3 compliance had dropped from 97% compliant to 75.6% compliant.

Staff told us about the safeguarding processes and were aware of how to make a referral. Staff provided examples of when they had made a safeguarding referral or raised concerns and identified action taken as a result. The trust had a safeguarding lead; and staff were aware of who to approach if they could not access their immediate manager.

Staff told us their safeguarding training included specialised areas of protecting vulnerable people such as WRAP training (Workshop to Raise Awareness of Prevent – Prevent is a national

strategy aimed at protecting vulnerable individuals from becoming involved in, or supporting, terrorist activity). We saw information boards and leaflets about child sexual exploitation (CSE) and staff we spoke with were aware of how to work with patients experiencing or at risk of domestic abuse.

Patients could request a chaperone to be present during care and treatment. Staff were aware of how to respond if a patient requested a chaperone.

Data from the trust showed that from October 2017 to September 2018; 26 referrals were made to adult safeguarding services by surgery services.

Data from the trust indicated that patients under the age of 18 did not reside on surgical wards. Instead they were admitted or seen in the paediatric wards. Within theatres; there were separate areas and lists for paediatric patients. Please see the core service report for 'Children and Young People' for further details.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Wards presented as visibly clean. We noted that updated 'I am Clean' stickers were placed on equipment and facilities, including antibacterial hand gel dispensers. Domestic cleaning was undertaken twice per day. We saw checklists which confirmed this had been undertaken. Sluice rooms we visited were tidy and clean.

Antibacterial hand gel was readily available including on and around patient bed areas. Personal protective equipment such as aprons and gloves was located at convenient points and we saw staff using this when working directly with patients.

We observed all staff to be 'bare below the elbows' in keeping with good handwashing practice, and noted all uniforms looked clean and in good condition.

A recent audit conducted within theatres showed staff compliance to hand hygiene was 100%. We saw hand hygiene audits for ward B5 and the surgical assessment unit (located all on the same overall ward) had achieved 94% in December 2018. However, within the same month an infection prevention and control audit showed 82% compliance. We saw actions were clearly visible to all staff to improve this score.

We observed on some wards, sachets of antibacterial wipes for patient use prior to eating meals.

Curtains used for privacy around beds were not single use; however, we sample checked a number of these and found they were all visibly clean and were dated as to when they needed to be changed. All were within the correct date for changeover.

We saw the trust had an in date policy for the decontamination of medical devices which covered surgical instruments.

We requested data about surgical site infections. Data was submitted for the specialities of obstetrics and gynaecology, orthopaedics and vascular surgery from November 2016 to October 2017. For obstetrics and gynaecology, we saw the trust had an average infection rate of 0.3% which was in line with the mean national rate of 0.4%. For orthopaedics, we saw that the trust had 0.4% surgical site infection rate compared to a mean of 0.7 (data drawn from 29 trusts). For vascular surgery, the trust were in line with other trusts (out of nine trusts who submitted data) with an average 2.2% reported infection rate as opposed to 2.5%.

Data from the trust showed audit results from April 2018 to December 2018 for the insertion and care of vascular access devices to ensure the risk of infection from this is minimised. Results showed that for peripheral vascular devices; all insertions achieved 100% compliance against set standards. For the ongoing care of peripheral vascular access devices, with the exception of two wards all areas showed 100% compliance. The two exceptions were ward B1 during the time frame of April 2018 to June 2018 where 90% compliance was achieved. We saw that the six months after this showed improvement of 100% compliance. The other exception was ward B5 which achieved 91% compliance from July to September 2018. Where central venous access devices were used with patients; we saw that audits demonstrated 100% compliance from April to December 2018 in all applicable locations.

Environment and equipment

The service had suitable premises and equipment and looked after them well. However, storage of flammable liquids was not compliant with current legislation at the time of inspection.

We sample checked medical equipment on wards and within theatres to see if these had been serviced and tested to ensure safety and effectiveness. We found all equipment checked was within date for servicing and maintenance. Equipment was managed internally by a medical devices team who also managed broken or damaged equipment. Consumable products were in date and securely stored. We noted one catheter which had been partially opened but replaced back with the unused stock. We passed this to the relevant ward manager who immediately disposed of it.

Clinical waste was disposed of as per best practice, and was stored in locked cupboards on wards and in theatres whilst awaiting collection. Sharps bins were used appropriately and were managed as per best practice guidance.

We sample checked resuscitation trolleys across wards and within theatres. We found that daily and weekly checks were completed; and the trolleys were secure. Oxygen cannisters were in date and had sufficient gas. Suction equipment was checked and appropriate for emergency use. The automatic defibrillators were maintained; and emergency kits for diabetic emergencies and anaphylaxis were present. Emergency drugs were in date.

The ward environments were suitable to meet the needs of patients. We saw there was enough room between beds on bay areas for staff to manoeuvre; and the corridors were tidy and uncluttered. Toilets were suitable for patients who had cognitive impairments, or were partially sighted. Grab rails were situated within toilets to aid patients and help reduce the risk of falls.

However, the overall physical size of the surgical assessment unit had been identified as a risk, due to be added to the divisional risk register. This was due to patient need outstripping the resources available. The surgical ambulatory assessment unit had been introduced in this area to aid patient flow however this was also over capacity at times.

We saw the theatres were maintained well; and the environment was clean and tidy. There were adequate facilities for staff to prepare for their work.

We noted on one ward, a high number of easily accessible ligature points. We discussed this with the ward manager who told us of plans to remove hooks in patient and visitor accessible rooms, bathrooms and bed areas, and to change rails in bathrooms to collapsible versions. We were told

of changes to reduce risk that had already happened, such as the removal of falls 'grab bags' from patient toilets.

Within theatres, we saw that flammable substances under Control of Substances Hazardous to Health (COSHH) were stored in a locked cupboard. However, all substances were located together and within a wooden cupboard which could pose as a fire risk. The use of wooden storage cupboards did not comply with COSHH storage requirements. The Approved Code of Practice L138 (2013) for COSHH provide general guidance and details of the performance requirements for fire resisting cupboards and bins. It is important to recognise that these do not specify an absolute test or standard for the cupboard or bin itself, rather they relate to nominal construction principles. Namely: that the materials used to form the sides, top, bottom, door(s) and lid are capable of providing the required fire resistance (i.e. 30 minutes integrity) and reaction to fire (i.e. minimal risk); that the joints between the sides, top and bottom of cupboards and bins should be free from openings or gaps; that the lid / doors should be close fitting against the frame of the bin/cupboard, such that there is a nominal overlap between the frame and lid/doors in their closed position; that the supports and fastenings should be of a material with a melting point greater than 750°C. These criteria represent the minimum performance requirements for compliance with the current legislation. We raised this during inspection and the trust responded by saying the wooden cupboards would be replaced by fire-proof ones. The trust later told us they had chosen to remove the cupboards entirely to reduce the risk of fire.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. However, staff did not record venous thromboembolism risk 24 hours post admission; and did not have staff trained to acute life support (ALS) level in the recovery area of theatres; although an ALS trained anaesthetist was located in the operating theatre.

The trust had introduced the use of electronic observations to monitor patients' health and to identify any deteriorating patients. The staff used the National Early Warning Score 2 (NEWS2) which produced a score after vital signs tests were done, including temperature check, blood pressure and oxygen saturations. Depending on the score generated; staff were prompted as to how often to repeat observations or when to alert medical staff to a deteriorating patient. NEWS2 scores were recorded and stored electronically; although staff updated a patient whiteboard with scores after each check for a more visible view. We saw that observations were completed as prompted by the electronic system. Staff could either use a hand-held device to record the observations; or alternatively a 'computer on wheels' could be taken round the patients' bedsides.

We noted that within the vascular surgery ward (B3), a small bay was dedicated for the use of pre and post-operative vascular patients who required a higher level of care, but did not need a high dependency unit bed at this stage. This bay had four beds, and due to the needs of the patients was mixed sex; although curtains could be drawn around beds. Observations within this bay were recorded on a paper chart for easy viewing for the medical team and it was staffed at a rate of one nurse per two patients.

Where patients' NEWS2 scores escalated; staff were automatically prompted to undertake a screen for more serious conditions such as sepsis. We saw examples of where this had been completed. Where required staff would then initiate a 'sepsis six' bundle which aimed to ensure patients at high risk of sepsis were treated quickly to prevent death or very serious complications. We saw examples where a patient prompted a sepsis screen, but did not require the sepsis care package as the symptoms were indicative of another cause such as head injury. However, a trust audit from September 2018 to January 2019 showed that compliance within the surgical division was below target. This audit measured against two targets. These were that 90% of eligible patients were screened for sepsis and that of those who screened positive; 90% received antibiotics within 60 minutes. Results showed that compliance for screening was significantly below 90% for all months; although this figure increased in December 2018 and January 2019. Compliance for antibiotics administration within 60 minutes was also under the 90% trust target and the national mean of 80% (ranging from 77.5% in October 2018 to 51.4% in September 2018).

The trust critical care outreach team were available 24 hours per day, seven days a week to respond to medical emergencies.

All clinical staff within theatres were trained to a minimum of intermediate life support (ILS). All anaesthetists were trained in acute life support (ALS). However, there were no surgical staff specifically within recovery that had up to date ALS or paediatric advanced life support (PALS). According to The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Immediate Post-Anaesthesia Recovery 2013 guidance states 'At all times, at least one member of staff present should be a certified Acute Life Support (ALS) provider and, for children, hold an appropriate paediatric life support qualification. All staff should be encouraged to attain and maintain at least one such life support qualification.' The service was not fully compliant with meeting these guidelines during the inspection. The trust was made aware of this issue whilst we were on site. The trust provided a risk assessment reporting that an ALS trained anaesthetist was always available within the operating theatre area. Following the inspection; the trust provided further information from the AAGBI which clarified that having a 'floating' ALS trained anaesthetist within five minutes of recovery areas was acceptable if all recovery staff are trained to a minimum of ILS. Therefore, the trust met this requirement.

The trust used a surgical safety checklist based on the World Health Organisation (WHO) version. The completion of this checklist pre, during and post procedures kept patients safe from avoidable harm or errors. During our inspection we observed staff following this process and checked completed checklists in patients' records. We found that all theatre staff were involved in the completion of the checklist and it was done collaboratively and to a high standard. We saw the results of an observation audit conducted in December 2018 had scored 100%.

Staff checked patients' allergies and ensured red wristbands were given to patients with any specific allergies.

Where patients were referred with acute conditions to the new surgical ambulatory assessment unit, contained within the surgical assessment unit, a target was to triage them within 30 minutes. We spoke to staff about this. At the time of our inspection; whilst times were written on a patient whiteboard of initial observations and full nurse triages undertaken; there was no formal way to monitor or record this. Therefore, there may have been a risk that some patients were not being seen within the target time slot.

Staff completed initial assessments for venous thromboembolism (VTE) however we noted in patient records that staff did not always record if this was reviewed after 24 hours post admission. We discussed this with ward staff who told us they encouraged medical staff to complete and

record the reviews. We saw that staff undertook preventative measures, such as using compression stockings during surgical procedures, where indicated.

Staff were aware of how to conduct a falls risk assessment and what to do in the event of a fall. Falls assessments were undertaken on all admissions; and if triggered, a falls 'bundle' (care pathway) was followed. If patients were at risk of falling, this was highlighted on their prescription chart, at a board behind patients' beds and on the overall patient whiteboard. We observed staff responding quickly to alarms linked with potential patient falls; for example, is a pressure pad alarmed to indicate a patient was getting out of bed unaided.

All patients received a skin assessment upon admission; and we saw these were reviewed as required. Staff were aware of what to do in the event of discovering tissue damage, including requesting medical photography and the tissue viability team, and ordering specialist equipment. We saw where patients were non-compliant with interventions such as skin checks and re-positioning; staff recorded this clearly and encouraged the patients to engage.

Patients told us that staff mostly answered call bells in a timely way, and were not kept waiting. However, one patient told us they had been required to wait for over quarter of an hour for a response.

We saw the trust had an in-date blood transfusion policy which provided links to a separate policy regarding patients who may refuse a transfusion for themselves or their children. We also saw an in date standard operating procedure for 'massive bleeds' for staff to follow in the event of an emergency haemorrhage.

Nurse staffing

Due to an increase in the whole time equivalent allocation of nursing staff numbers in 2018 following a staffing review; some wards were not fully recruited to at the time of inspection. However, shifts were staffed safely and recruitment was active.

Total staffing: planned vs. actual

The trust reported the following qualified nursing staff numbers for the two periods below for surgery:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Nursing	319.6	272.7	85.3%	378.1	267.8	70.8%

The trust reported a qualified nursing staffing level of 85.3% in surgery in March 2018 which dropped to 70.8% in September 2018.

As at September 2018, there were 110.3 fewer WTE staff in post than planned for and 4.9 fewer WTE staff in post than in March 2018. There was an increase of 58.5 WTE planned posts between the two time periods.

 (Source: Routine Provider Information Request (RPIR) –Total staff tab)
Following the inspection, the trust provided additional information; the planned WTE staff in March 2018 did not reflect the adjusted establishment following the staffing review. This is reflected in the September 2018 data and accounts for the lower fill rate.

We also requested more up to date data from the time of the inspection which is represented here:

The trust provided the following data showing the monthly nursing staffing fill rate for surgery at Russells Hall Hospital:

Staff Group	Day			Night		
	Planned hours	Actual hours	Fill rate	Planned hours	Actual hours	Fill rate
Qualified nursing staff	14,706	11,575	78.7%	11,568	9,596	83.0%

The trust reported an overall monthly fill rate for qualified nursing staff in surgery of 80.6%, this rose from 78.7% for day hours to 83.0% for night hours. Therefore, an improvement in the fill rate was noted by the time of inspection.

(Source: Data Request DR117)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 21.2% for qualified nursing staff in surgery. This was greater than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

More up to date data from the trust showed the staffing fil rate broken down by ward/ area for end of December 2018.

Surgery Wards/Theatres Establishment as of 31.12.18		
Ward/Theatre	**WTE Establishment**	**WTE Contracted Staff**
Ward B1	30.25	24.60
Ward B2 (H)	59.00	50.28
Ward B2 (T)	38.31	30.10
Ward B3	73.88	47.12
Ward B4	41.27	32.34
Ward B4b	38.27	30.28
Ward B5	62.52	61.65
Ward C6	29.94	28.00
Main Theatres	139.74	117.24
Daycase Theatres RHH	71.86	52.18

This showed the overall vacancy rate for nursing staff at Russells Hall Hospital within surgery

was 19.1% as of December 2018 so a slight improvement on previously supplied figures. However, the table shows that two areas had a much higher vacancy rate; ward B3 (vacancy rate of 36.3%) and day case theatres (vacancy rate of 27.4%). Conversely two wards met, or nearly met the trust target for vacancy rate. These were B5 with a vacancy rate of 1.4%, and C6 with a vacancy rate of 6.5%.

(Source: Data Request DR174)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 8.2% for qualified nursing staff in surgery. This was lower than the trust target of 8.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 8.2%
- Russells Hall Hospital / Community: 0.0%
- Russells Hall Hospital / Corbett Hospital: 7.6%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 4.7% for qualified nursing staff in surgery. This was greater than the trust target for sickness of 3.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 4.8%
- Russells Hall Hospital / Community: 0.0%
- Russells Hall Hospital / Corbett Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

During our inspection, we discussed the sickness rate with ward managers who described the process in place for managing this; particularly periods of short term sickness. Managers demonstrated how sickness rates had improved through following the trust process, and supporting staff where necessary to facilitate a return to work.

Bank and agency staff usage

Trust wide

From October 2017 to September 2018 the trust reported 131,646.0 of the 1,059,009.0 available hours in surgery were filled by bank staff (12.4%) and 46,229.0 hours filled by agency staff (4.4%). In addition, there were 90,024.0 hours that needed to be covered by bank or agency staff but were unfilled (8.5%).

A breakdown of bank and agency usage by staff type is shown below:

Staff type	October 2017 to September 2018

	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	54,378.0	8.4%	45,707.0	7.1%	77,604.0	12.0%	644,200.0
Non-qualified	77,268.0	18.6%	522.0	0.1%	12,420.0	3.0%	414,809.0
Total	131,646.0	12.4%	46,229.0	4.4%	90,024.0	8.5%	1,059,009.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The nursing staff vacancy rate, as described above, was linked to a recent staffing review which had resulted in more positions being made available. As a result, all ward areas were actively recruiting on an ongoing basis to fill the new roles, and to replace natural turnover. During our inspection we saw that there was variation between how fully staffed the wards were. Despite this, all wards had the required ratio of nursing staff to patients, and staff reported feeling able to complete their work. Staff told us, and we saw, that where required provision for 1-1 patient care was enabled. The trust used the Safer Nursing Care Tool (SNCT) to calculate safe nursing staff numbers required per shift.

Staff told us that night shifts were more heavily reliant on bank and agency staff to manage and keep the wards safe. We spoke with ward managers who were aware of this as a risk, and had plans and ongoing actions to mitigate this, such as ensuring a substantive member of staff was allocated to each night shift.

Similarly, theatre staffing was adequate to safely meet the needs of the patients and was per the Association for Perioperative Practice (AfPP) guidelines.

Ward staff attended daily huddles and 'board rounds' which enabled nursing and other staff to be updated on each patients' progress and needs. Important safety messages were disseminated at these times; such as relevant learning from incidents or complaints.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below for surgery:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical	226.0	212.0	93.8%	232.8	217.5	93.4%

Staff fill rates for medical staff in September 2018 remained similar to March 2018 with fill rates of 93.4% and 93.8%. There were 14.0 less WTE staff in post than planned for in March 2018 and 15.3 less WTE staff in post than planned for in September 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 7.6% for medical staff in surgery. This was greater that the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 7.6% for medical staff in surgery. This was lower than the trust target of 8.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 8.0%
- Russells Hall Hospital / Corbett Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 1.5% for medical staff in surgery. This was lower than the trust target for sickness of 3.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 1.4%
- Russells Hall Hospital / Corbett Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From September 2017 to August 2018, the trust reported 12,607.5 of the 463,695.0 available medical staff hours in surgery were filled by bank staff (2.7%) and 9,447.3 hours were filled by locum staff (2.0%). In addition, 2.4% of medical staff hours available were not filled by either bank or locum staff to cover staff absence.

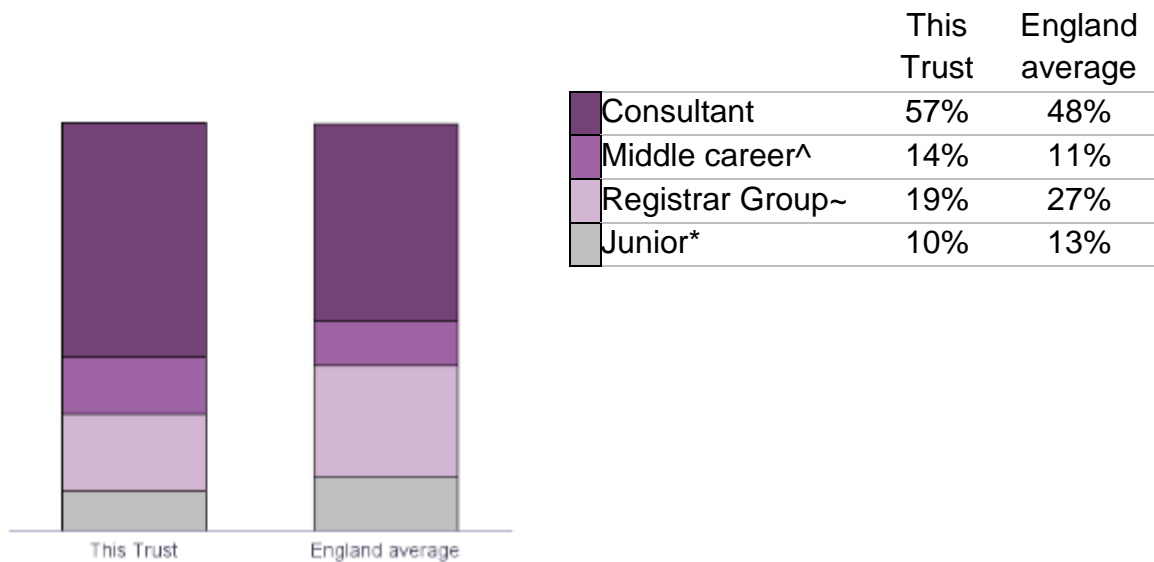| Core service	September 2017 to August 2018						
	Bank		Locum		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
AC -Surgery	12,607.5	2.7%	9,447.3	2.0%	11,029.0	2.4%	463,695.0

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at The Dudley Group NHS Foundation Trust

	This Trust	England average
Consultant	57%	48%
Middle career^	14%	11%
Registrar Group~	19%	27%
Junior*	10%	13%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

A consultant led ward round occurred daily on all surgical wards. We were told of pilot trials 'ideal two weeks' where consultant led ward rounds had been held twice daily to assess the impact upon patients. A business case was being constructed to support the implementation of this initiative full time on certain wards.

Registrars and trainee doctors provided support to the consultant over a 24-hour period. Advanced nurse practitioners and clinical nurse specialists worked in some areas to provide further support to the medical team.

When consultants were not on site; such as overnight and weekends, an on-call rota was in place to ensure cover.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

During the inspection we checked 26 patient records, including prescription charts, nursing records and medical notes.

Records of observations of patients' vital signs were electronic; however, all other patient records were paper based. The trust were implementing an electronic records system at the time of the inspection.

We found nursing records contained completed risk assessments to help keep patients safe, including falls and pressure ulcer risk assessments. These were regularly reviewed. Where appropriate we saw care bundles had been initiated and kept within the patient nursing notes; such as catheter care and high risk of falls care plans. Preoperative assessments were consistently completed to a good standard.

We saw nurses kept records of intentional rounding; where they had checked on patients every two hours in addition to other observations.

Medical records checked all showed evidence of patients being seen within 12 hours of admission, and being further reviewed daily by a senior clinician.

In addition to individual patient records, patients' names were recorded on a whiteboard located in the ward area in which the patient was located. These boards included details such as the patient's named consultant, any risk factors, bed number, the last National Early Warning Score 2 (NEWS2), readiness for discharge, therapy involvement, and any other salient details such as whether the patient was nil by mouth. These boards enabled a quick overview of all patients within a set area of a ward; and were updated by nursing staff regularly throughout the day.

Where relevant, patient records contained 'passports'. For example, patients with learning difficulties had a document which provided easy to access information about their particular additional needs. We saw that additional needs were clearly record, such as patients with dementia.

Discharge documents were clearly recorded and contained relevant information to keep the patient safe. The patient received copies of certain documents to take with them; for example, medications which were given to the patient to take home. A GP letter was sent upon discharge, with a copy kept in the patient records.

Patient records, when not actively in use, were kept offsite at a third party location. Staff told us they were able to request and obtain records within a timely manner seven days a week; for example should a patient be acutely admitted.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

We checked seven prescription charts during our inspection. We found that these were clearly completed and appropriate reviews of medicines had been conducted. All prescriptions were signed and dated by clinicians responsible for the patient.

We sample checked medicine storage within wards and theatres. We found that medicines were stored at set temperatures. Medicines contained within fridges sent automatic alerts if the

temperature went out of range; following which an engineer attended to address the problem. Intravenous fluids were kept in locked cupboards.

We observed controlled drugs were checked by staff as per best practice; and we saw two nurses attend to administer a controlled drug to a patient along with the controlled drugs recording book. Within theatres, controlled drugs were checked twice daily. When administered; both the person administering the drug and the witness signed to confirm this had happened.

We observed non-controlled medicines being collected and administered. This was completed in line with best practice requirements; and quantities used recorded at the point of taking medicine from storage; and recorded on the patient's prescription chart.

Keys for the controlled drugs storage were kept separate from non-controlled drugs storage keys to ensure safety. All drug cupboards we saw were locked and keys were help by qualified clinical practitioners.

We saw improvements to the recordings of oxygen prescriptions after this had been identified as a concern.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and some of the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported one incident classified as never events for surgery. This related to a retained foreign object post procedure in October 2017, this was not reported until February 2018.

We looked at the investigation report for this incident and saw it contained an action plan specific to the root causes of the incident.

(Source: Strategic Executive Information System (STEIS))

Staff told us of a never event which was downgraded to a serious incident following investigation. This was due to the incident (initially classified as a retained swab) occurring due to a faulty swab which was immediately identified, rather than through non-compliance with safety measures. Following never events, or potential never events, the trust made action plans which included the completion of human factors training to be completed annually by all theatre staff.

Although theatre staff were well versed in never events, and serious incidents within the theatre setting we found that not all ward staff had the same level of awareness. Some ward staff were not aware of any theatre based never events, and therefore were unable to identify learning.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

Type of incident	Number of incidents	Percentage of total
Pressure ulcer meeting SI criteria	6	27.3%
Slips/trips/falls meeting SI criteria	4	18.2%
Treatment delay meeting SI criteria	4	18.2%
Surgical/invasive procedure incident meeting SI criteria	2	9.1%
Medication incident meeting SI criteria	1	4.5%
Environmental incident meeting SI criteria	1	4.5%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	4.5%
HCAI/Infection control incident meeting SI criteria	1	4.5%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	4.5%
Pending review (a category must be selected before incident is closed)	1	4.5%
Total	22	100.0%

One incident has not yet had a category assigned as it is pending review.

(Source: Strategic Executive Information System (STEIS))
We were told of an example of a serious incident whereby a patient suffered serious harm followed a missed diagnosis. Following this, the patient came to speak with staff at the trust to raise awareness. As a result, a similar condition was quickly identified and managed in such a way to avoid significant patient harm.

As a response to a higher number of patient falls occurring; the trust introduced strategies to manage this including nominating a ward representative to act as a falls facilitator.

Staff we spoke with knew the process for reporting incidents; and all staff told us they were encouraged to do so. Following the submission of an incident on the electronic reporting system, staff received an email to confirm receipt.

Staff received feedback and learning following incidents, and managers used an 'incident of the week' to encourage local learning.

Staff were able to explain the duty of candour, and give examples of when this had been applied.

The duty of candour is a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Data from the trust showed that from October 2017 to September 2018; the duty of candour had been applied 25 times within surgery.

A major incident box was stored within theatres containing protocols and staff details. Staff we spoke with were aware of the box, and what to do if a major incident was declared.

Morbidity and mortality was reviewed as part of six weekly teaching and training sessions by medical staff. Staff told us this was a learning exercise whereby presentations would be given and each presented case discussed. Data from the trust demonstrated that morbidity and mortality was discussed in this way.

Safety thermometer

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, three falls with harm and seven new catheter urinary tract infections from September 2017 to September 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at The Dudley Group NHS Foundation Trust

Total Pressure ulcers (23) [1]

Total Falls (3) [2]

Total CUTIs (7) [3]

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

During our inspection we saw safety thermometer results were displayed on huddle boards on every ward. These were ward specific. Staff we spoke with told us what their objectives to ensure harm free care were in each area.

Where a patient fall, pressure ulcer or catheter/ urinary tract infection had occurred, staff submitted an incident report. We saw that quick action was taken; for example, if staff identified new tissue damage; they made referrals to the tissue viability team and medical photography as required.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We saw that within theatres and on every ward, various notice boards containing up to date, evidence based, information for staff, patients and visitors were clearly displayed. These boards included information on sepsis, falls, food and nutrition including how to order meals, pressure ulcers, dementia and boards about palliative care at the trust. Staff also told us the trust intranet was an excellent source of information to enable best practice.

We saw that best practice procedures were followed within theatres with regards to pre, peri and post-operative actions. For example, staff followed guidance with regards to checking and documenting accountable items including disposable surgical instruments as per the Association of Perioperative Practice (AfPP). However, we did observe that The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Immediate Post-Anaesthesia Recovery 2013 guidance was not fully being followed as referenced in 'Safe'. Specifically, this guidance states 'At all times, at least one member of staff present should be a certified Acute Life Support (ALS) provider and, for children, hold an appropriate paediatric life support qualification. All staff should be encouraged to attain and maintain at least one such life support qualification.' We found within the recovery area of theatres; staff were not trained to ALS level. However, the trust provided a risk assessment reporting that an ALS trained anaesthetist was always available within the operating theatre.

We saw that patients were assessed for their risk of venous thromboembolism (VTE), and where a risk was identified, staff offered prophylaxis and specialist equipment in line with National Institute of Health and Care Excellence (NICE) guidance.

We noted within the risk register specific to surgery services provided in October 2018; that not all surgery staff were adhering to NICE guidelines which meant patients may not receive evidence based care. As a result, an action had been set to monitor this through monthly clinical governance meetings.

Where patients triggered a need to be screened for sepsis, we found that staff had clear prompts and processes to enable effective management. All staff we spoke with were aware of the process. However, as discussed in 'Safe' a trust audit from September 2018 to January 2019 showed that compliance within the surgical division was below target. This audit measured against two targets. These were that 90% of eligible patients were screened for sepsis and that of those who screened positive; 90% received antibiotics within 60 minutes. Results showed that compliance for screening was significantly below 90% for all months; although this figure increased in December 2018 and January 2019. Compliance for antibiotics administration within 60 minutes was also under the 90% trust target and the national mean of 80% (ranging from 77.5% in October 2018 to 51.4% in September 2018). We saw that the 'Sepsis Six' (six actions that should be taken if a patient screens positive for sepsis, including antibiotics within 60 minutes) were also below target for every month the audit took place. We saw that as a result of this audit specific actions were set including daily checks; staff awareness raising sessions and monthly reviews at the 'Deteriorating Patient Group'.

Patients were discharged as per national guidelines following the specific procedure they had undergone. Please see 'patient outcomes' for details on patient length of stay.

We saw a 'hospital to home' service was available to urology patients (both surgical and medical) whose service matched NICE guidelines regarding patients being provided with the opportunity to have a trial without a catheter in their own home.

We saw that staff within the trust contributed to research which promoted development of best practice and evidence based procedures. Please see 'Well Led' for further details.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences. However, audits showed that some patients fasted too long prior to their procedure.

Data provided from the trust prior to our inspection showed that most surgery patients were fasting too long prior to their surgery. An audit conducted in October 2018 identified specific concerns such as some patients waiting up to 17 hours and 29 minutes without fluids and up to 24 hours without food. Other concerns were only 23% of patients having fluids within four hours of surgery, and 13% patients eating within 12 hours of surgery. However, it was found that no patients reviewed received food inappropriately. A re-audit was scheduled for April 2019 to assess compliance with action plans.

A fasting policy had been updated during February 2018, and we saw the 'safer steps to surgery' theatre checklist included a section about any changes to the theatre list which may impact upon patients' waiting times. Where it was identified that a patient had longer to wait for their surgery and therefore could continue to eat or drink; the process was for a member of the theatre team to contact the relevant ward to inform them. We observed theatre teams discussing this issue in order to identify patients who could have fluids. The policy also specified a responsibility of ward staff to contact theatres about any patients who had been fasting overnight.

We explored this during our inspection and found that actions were being taken to address these audit results and patient complaints that had been received. However, the trust were not formally monitoring these at this time therefore could not assure themselves that all patients were fasted for appropriate periods of time. Nor were wards using a standardised approach to ensure patients were not starved excessively such as when surgery was delayed; although we saw ward staff were taking positive steps to minimise patient discomfort. We discussed this with ward managers, who as a result put in interim measures to better assure themselves that fasting patients were monitored. We also spoke with senior management who reported that they planned to share information and learning about this process via the next divisional newsletter. Post inspection the trust informed us this newsletter had been shared.

The Malnutrition Universal Screening Tool (MUST) was completed on patients upon admission. This assessed whether a patient was at risk of malnutrition. We found appropriately completed fluid and food intake charts which were updated regularly. Staff told us that not all MUST assessments had been completed fully however, and that as a result this had been addressed on daily huddles to ensure the risk assessment score was correctly calculated. Furthermore, MUST information had been added to skin assessments to reinforce the importance of identifying nutritional requirements.

Patients generally reported the food to be of a good quality, and with sufficient variation. We saw patients were able to access specialist meals such as low fat, halal, vegan, a variety of soft food diets and vegetarian.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Some nursing staff on wards had been trained in specific 'patient group directives'. This enabled them to administer specific pain relief without having to wait for a consultant; which provided a quicker response to patients who reported pain.

Patients we spoke with told us that should they experience pain, it was well managed and the nurses responded quickly. We saw within nursing records that staff regularly asked about pain levels. We also observed staff to do so during our inspection.

The specialist pain team saw surgical patients with pain management devices as standard practice, but any patient could be referred for specialist support. The pain team were using methods to manage post-operative pain which had been shown to reduce length of stay within clinical trials; for example, rectus sheath catheters. Furthermore, medical staff at the trust were involved in developing and implementing national guidelines for pain management such as for patients undergoing lower limb amputation, as published in the British Journal of Pain, April 2018. Please see 'seven-day services' for opening hours of the pain team.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Data provided by the trust showed that patients had a similar to expected risk of readmission for both elective and non-elective admissions when compared to the England average. Please see below for specific data.

Data received during the inspection showed that patient length of stay following procedures for hip fractures had reduced since 2017. Other data submitted to the National Hip Fracture Database showed the number of patients documented to not have a pressure ulcer rose to 98.2% in 2018, and the percentage of patients receiving a perioperative medical assessment rose from 98.5% in 2017 to 99.4% in 2018. Both of these results compared favourably to the national average. Results which indicated the trust was performing worse than the national average in 2018 were against the measure of patients being admitted to an orthopaedic ward within four hours and patients being mobilised out of bed the day after surgery. Please see below for specific data.

From July 2017 to June 2018, the average length of stay for surgical elective patients at Russells Hall Hospital was lower than the England average and for surgical non-elective patients, the average length of stay was similar to the England average. We requested more recent data and received length of stay figures from October to December 2018. We saw the trust compared favourably to the national average in all specialities for elective and non-elective patients with one exception. The exception was urology for both elective and non-elective patients where the trust length of stay on average was longer than the national average.

The trust had introduced a 'Hospital at Home' team to specifically support urology patients including those post-surgery. One objective of this area of work was to reduce length of stay

however other benefits had been observed. Data from the trust showed day case rates for endoscopic resection of prostate (TUR) and endoscopic resection/ destruction of lesion of bladder were consistent with national average (3.6% and 31.8% respectively, based on the last 12 months pre-inspection). At the time of inspection, the 30-day emergency crude average readmission rates (related and un-related to index admission) for all elective urology patients was 8.12%.

The risk of mortality for the 90-day and two year postoperative figures were in line with the national average for data submitted to the Bowel Cancer Audit. The 30-day unplanned readmission rate was as expected. However; 18-month temporary stoma rate in rectal cancer patients undergoing major resection was worse than expected for 2017. Please see below for specific data.

Data from the 2017 National Vascular Registry Audit and National Oesophago-Gastric Cancer Audit 2016 showed the trust either performed better than, or in line with, the England average. Please see below for specific data for comparable results.

The National Emergency Laparotomy Audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%. Data from the trust for four indicators from 2016 showed two were rated 'amber' and two were rated 'green'. The risk-adjusted 30-day mortality for the site was within the expected range. Please see below for specific data. A more recent National Emergency Laparotomy Audit (2017) indicated that the trust had six domains rated as green and two rated as amber.

The 2016/17 Patient Reported Outcomes Measures (PROMS) survey showed that patients reported that hip replacements they felt worse post procedure than they England average. However, for knee replacements; results showed patients felt about the same as the England average. Please see below for specific data.

Data provided by the trust prior to the inspection showed internal audits were undertaken to monitor performance to identify actions where required. For example, in October 2016, an audit was conducted on pre-operative airway assessment compliance. This found that although several measures were being fully met, the airway assessment part of the anaesthetic assessment was not always fully completed. Neither was this always recorded when the assessment had been completed. Therefore, actions to remedy this included ensuring that airway assessments were fully documented; and for a re-audit to take place in April 2019 to check compliance.

At the time of inspection; the trust were seeking to be accredited by the Anaesthesia Clinical Services Accreditation Scheme.

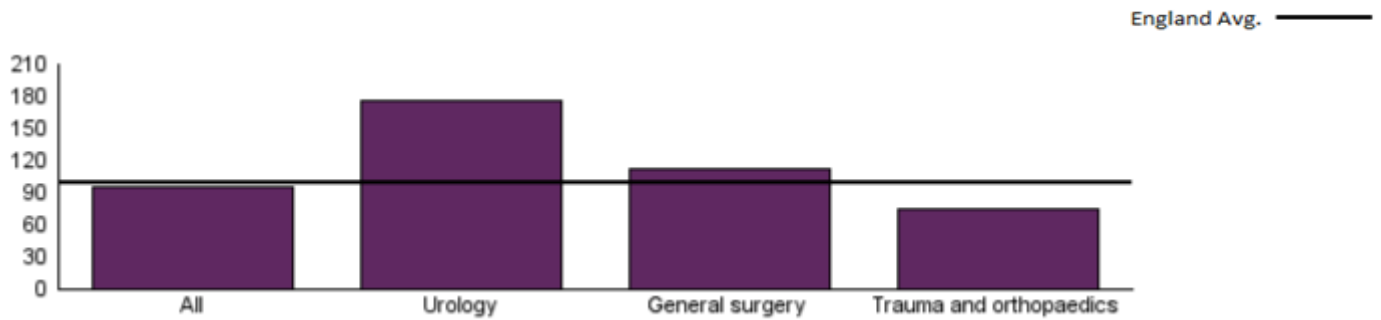**Relative risk of readmission**

Russells Hall Hospital

From June 2017 to May 2018, patients at Russells Hall Hospital had a similar to expected risk of readmission for elective and non-elective admissions when compared to the England average.

The chart below shows the risk of readmission for the top three specialties, based on count of activity for elective admissions:

Elective Admissions - Russells Hall Hospital

England Avg. ——

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

- Patients in urology and general surgery at Russells Hall Hospital had a higher than expected risk of readmission for elective admissions.

- Patients in trauma and orthopaedics at Russells Hall Hospital had a lower than expected risk of readmission for elective admissions.

Non-Elective Admissions - Russells Hall Hospital
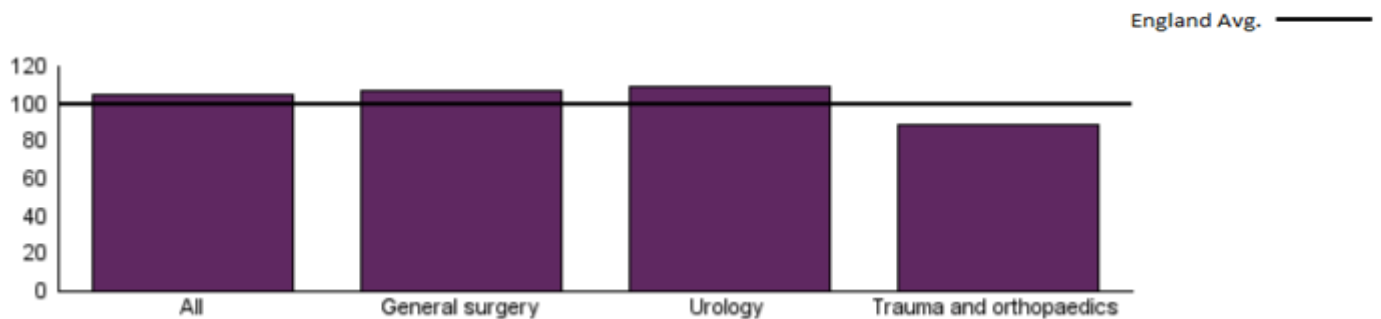
England Avg. ——

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

- Patients in general surgery and urology at Russells Hall Hospital had a higher than expected risk of readmission for non-elective admissions.

- Patients in trauma and orthopaedics at Russells Hall Hospital had a lower than expected risk of readmission for non-elective admissions.

(Source: Hospital Episode Statistics – HES- Readmissions (June 2017 to May 2018))

National Hip Fracture Database

Russells Hall Hospital

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 7.3% which was within the expected range. The 2016 figure was 11.4%.

The proportion of patients having surgery on the day of or day after admission was 80.0%, which failed to meet the national standard of 85%. This was within the middle 50% of trusts. The 2016 figure was 71.8%.

The perioperative medical assessment rate was 98.4%, which failed to meet the national standard of 100%. This was within the top 25% of trusts. The 2016 figure was 93.3%.

The proportion of patients not developing pressure ulcers was 97.3%, which failed to meet the national standard of 100%. This was within the middle 50% of trusts. The 2016 figure was 98.9%.

(Source: National Hip Fracture Database 2017)

During the inspection we received some updated figures from the 2018 submission of data to the National Hip Fracture Database. We saw that the average length of stay was 16.6 days for acute patients, and 16.5 days for overall hospital length of stay. This compared favourably to the previous year when the figures were 19.5 and 19.8 days respectively.

We also saw results such as patients documented to not have a pressure ulcer rise to 98.2% in 2018, and the percentage of patients receiving a perioperative medical assessment rose from 98.5% in 2017 to 99.4% in 2018. Both of these results compared favourably to the national average.

Results which indicated the trust was performing worse than the national average in 2018 were against the measure of patients being admitted to an orthopaedic ward within four hours (17.7% reported) and patients being mobilised out of bed the day after surgery (66.1% of patients). However, this percentage of patients being mobilised the day after surgery had increased since 2017 when 60.9% of patients was reported.

Data showed that from March 2018 to August 2018; 30-day mortality was declining and by August had come into line with the national average.

Bowel Cancer Audit

The Dudley Group NHS Foundation Trust participated in the 2017 Bowel Cancer Audit.

In the 2017 Bowel Cancer Audit, 69.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 72.1%. However, due to changes in the methodology, performance against this metric should not be compared between reports.

The risk-adjusted 90-day post-operative mortality rate was 1.9% which was within the expected

range. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 13.9% which was within the expected range. The 2016 figure was 22.1%.

The risk-adjusted 30-day unplanned readmission rate was 11.9% which was within the expected range. The 2016 figure was 6.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 64.1% which was worse than expected. The 2016 figure was 59.3%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The Dudley Group NHS Foundation Trust participated in the 2017 National Vascular Registry Audit.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.4% for Abdominal Aortic Aneurysms. The 2016 figure was 0.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 11 days, better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 3.3%, this was within the expected range.

(Source: National Vascular Registry)

Oesophago-Gastric Cancer National Audit

The Dudley Group NHS Foundation Trust participated in the National Oesophago-Gastric Cancer Audit 2016, as a part of the West Midlands Strategic Clinical Network.

In the 2016 National Oesophago-Gastric Cancer Audit (NOGCA), the age and sex adjusted proportion of patients diagnosed after an emergency admission was 0.0%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2015 figure was 0.0%.

The 90-day post-operative mortality rate was not eligible.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 34.7%. This was similar to the national aggregate.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results

National Emergency Laparotomy Audit

Russells Hall Hospital

The national Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2017 National Emergency Laparotomy Audit (NELA), Russells Hall Hospital achieved an amber rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 190 cases.

The site achieved a green rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 148 cases.

The site achieved a green rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 124 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 86 cases.

The risk-adjusted 30-day mortality for the site was within the expected range based on 190 cases.

(Source: National Emergency Laparotomy Audit)

<u>Patient Reported Outcome Measures</u>

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

Legend: % Trust improved | % Trust worsened | % England improved | % England worsened

In 2016/17, for groin hernias, the trust's performance was worse than the England average for both the EQ VAS and EQ-5D Index indicators.

For hip replacements, the trust's performance was worse than the England average for the EQ VAS indicator but about the same as the England average for the EQ-5D and Oxford Hip Score.

For knee replacements, the trust's performance was about the same as the England average for EQ-5D score and Oxford knee score but worse than the England average for EQ VAS score.

For varicose veins, the trust's performance was worse than the England average for the EQ VAS score but about the same as the England average for the EQ-5D Index.

(Source: NHS Digital)

After inspection the trust commented that they did not undertake groin hernias as these are deemed as a procedure of limited clinical priority.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

<u>Appraisal rates</u>

For year to date, April to September 2018, 90.8% of required staff in surgery received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified nursing midwifery staff	1	1	100.0%	90.0%	Yes

Qualified healthcare scientists	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	235	250	94.0%	90.%	Yes
Qualified nursing & health visiting staff	275	306	89.9%	90.0%	No
Other qualified scientific, therapeutic & technical staff	28	32	87.5%	90.0%	No
NHS infrastructure support	11	13	84.6%	90.0%	No
Qualified allied health professionals	14	17	82.4%	90.0%	No
Support to scientific, therapeutic & technical staff	15	19	78.9%	90.0%	No
Total	**580**	**639**	**90.8%**	**90.0%**	Yes

Russells Hall Hospital

For year to date, April to September 2018, 90.8% of required staff within surgery at Russells Hall Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified nursing midwifery staff	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	232	247	93.9%	90.0%	Yes
Other qualified scientific, therapeutic & technical staff	27	30	90.0%	90.0%	Yes
Qualified nursing & health visiting staff	265	295	89.8%	90.0%	No
NHS infrastructure support	11	13	84.6%	90.0%	No
Qualified allied health professionals	14	17	82.4%	90.0%	No
Support to scientific, therapeutic & technical staff	14	18	77.8%	90.0%	No
Total	**564**	**621**	**90.8%**	**90.0%**	Yes

Russells Hall Hospital: Hospital at Home Team (Urology speciality)

For year to date, April to September 2018, 100.0% of required staff within surgery at Russells Hall Hospital / Community received an appraisal compared to the trust target of 90%. These staff were all within the Hospital at Home team.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified nursing & health visiting staff	2	2	100.0%	90.0%	Yes

It should be noted the data only refers to two staff so the performance should be taken in context when dealing with small numbers of eligible staff. No other staff groups were reported for this team.

Staff told us that there were good opportunities to continue with professional development within the division. Staff told us of examples of where they had been supported to attend additional training in order to gain further qualifications and competencies relevant to their role. In addition, several staff gave examples of where they had been encouraged to attend other trust locations or other trusts in order to learn more widely. Staff also told us of teaching from peers and medical staff which enabled them to gain a wider view of surgery as a whole.

New staff underwent a preceptorship programme. A post registration lead supported newly qualified nurses, and nurses new to surgery into the post. This included a six week supernumerary period which could be extended if needed. The induction was supported by clinical supervision sessions with the education department. Ward managers developed induction packs or workbooks specific to the speciality of the ward for new staff to work through.

Theatre staff attended 'audit days' every six weeks. These were half day sessions whereby planned procedures were not scheduled to allow staff to attend and undertake mandatory and competency training and updates.

Staff undertook clinical supervision to ensure clinical competency was upheld.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff told us they could access details of all specialist teams quickly via the trust intranet system; and reported that specialist teams attended quickly following a referral or request. In particular the palliative care team were highlighted as a team which provided an excellent service as part of the multidisciplinary approach within surgery wards.

A specialist pain team supported patients between 8.30am and 4.30pm, Monday to Friday for both acute and chronic pain. Nursing or medical staff could make a referral to the team as necessary. Out of hours pain services were delivered by the outreach team.

Wards such as the trauma and orthopaedic, and hip fracture ward had dedicated therapy staff which included physiotherapists, occupational therapists and therapy assistants. Speech and language therapists were situated separately in the trust, but staff could make referrals as necessary. Podiatrists attended ward rounds daily on the vascular ward.

A learning disability nurse worked within the trust to support patients. Staff told us they had good relationships with the team who responded quickly upon request.

A trust wide mental health team were readily available to provide assessments relevant care and interventions, review records and to provide advice and guidance. We observed staff working

effectively as part of a team to ensure patients with a mental health condition, and/ or a neurological condition such as dementia were cared for safely and effectively.

Staff fostered positive links with other departments to support patients where necessary. For example, staff on the surgical assessment unit could access staff in the ophthalmology department to support with blind or partially sighted patients.

Discharge co-ordinators worked across all wards. We saw they worked effectively with all staff; and staff of any grade were open to facilitating discharges in the best interests of the patients. For example, we saw staff from the therapy service liaising with social services to enable financial support post discharge.

Seven-day services

Surgical services were provided seven days per week, every day of the year.

The hospital ran operating lists seven days a week; and provided inpatient services every day. Consultants were available and on-site daily during core hours. Out of hours, such as overnight and at weekends; consultants worked on an on-call rota to ensure constant oversight.

During the inspection we reviewed patient records which showed that Russells Hall Hospital met the NHS England standard around time to first consultant review. We saw all patients received an initial review; and a follow up review within the required timeframe.

The therapy teams including physiotherapists and occupational therapists (OT) worked between 8am to 4pm during week days, and one physiotherapist and one OT working 8am until 12pm on each weekend day. A pilot had recently been undertaken to increase weekend cover to aid a quicker patient recovery time. Following this pilot, funding had been agreed to staff additional posts until the end of March 2019. Following this a business case was planned for submission for permanent changes.

As above, the specialist pain team were available between 8.30 am to 4.30pm on week days. Outside of these hours, staff could request support from the outreach team.

Pharmacy opening hours were 9am to 7pm Monday to Friday and 9.30am to 5pm on weekends and bank holidays. In addition, 24 hour cover was provided by a resident pharmacist and supported by a backup on-call senior pharmacist.

(Source; Data request DR179)

Health promotion

Staff worked to promote the health of patients both before and after procedures, to optimise patient outcomes.

During our inspection we found that a 'one-stop' pre-operative assessment and consultation also including an anaesthetist project had been started that week. The aim of this was to optimise patient health prior to surgery and to reduce cancellations. Although this way of working was in its infancy at the time of inspection; therefore, no audit results were available; consultants involved were confident this would encourage patients to manage their health better in preparation for surgery.

We found health promotion materials displayed on wall wards; for example, relating to healthier eating. Mobility and exercise were promoted and supported where possible. Patients were encouraged to mobilise as soon as possible post-procedure in order to aid recovery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 82.4% of eligible nursing staff and 60.9% of eligible medical staff in surgery. The medical and nursing staff groups did not meet the target.

A breakdown of compliance by site for qualified **nursing** staff in surgery is shown below:

Site	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Russells Hall Hospital / Community	2	2	100.0%	90.0%	Yes
Russells Hall Hospital	158	194	81.4%	90.0%	No

In surgery the 90% target was met for the mental health law training module for which qualified nursing staff at Russells Hall Hospital / Community were eligible. The 90% target was not met for the mental health law training module for which qualified nursing staff at Russells Hall Hospital were eligible.

It should be noted that the data for nursing staff refers to two eligible staff Russells Hall Hospital / Community and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for **medical** staff in surgery at Russells Hall Hospital is shown below:

Site	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Russells Hall Hospital	14	23	60.9%	90.0%	No

In surgery the 90% target was not met for the mental health law training module for which medical staff at Russells Hall Hospital were eligible. The trust did not provide any data for medical staff completion rates of mental health law training at any other sites.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We requested a more up to date overview of mental health training compliance post inspection. We found that nursing staff compliance had risen and was now at 90% however, medical staff compliance had dropped to 40.6%.

Staff we spoke with demonstrated a good understanding of mental capacity and when this may need to be further assessed. Patients were screened as part of admission pathways, for example for dementia. All patients over 65 received an automatic screening. If it was felt at this stage that a patient may lack capacity to consent to care and treatment; medical staff undertook capacity assessments prior to gaining consent.

We saw separate consent forms for patients who lacked capacity to make informed decisions at the point of care. These were well completed with family input collated where it was identified that a patient did lack the capacity to make decisions.

Staff from the trust wide mental health team attended wards and reviewed patient notes where it had been identified that a patient had lacked capacity to make a decision about clinical care or treatment. This provided additional oversight of the legal process as per the Mental Capacity Act.

Where it was identified that a patient would benefit from being deprived of their liberty in their best interests (for example being located within a ward and not being permitted to wander round the hospital to prevent further harm or injury); staff knew to make a referral for a Deprivation of Liberty Safeguards (DoLS) application. These referrals were sent to the mental health team who sent the requests to the relevant local authority. Staff told us that the mental health team keep them updated on review or expiry dates for any DoLS applied. Data from the trust showed that from October 2017 to October 2018; 19 applications were granted to deprive patients of their liberty. The mental health team were also informed of any patient having one to one care.

Where a patient had a 'do not attempt cardio-pulmonary resuscitation' (DNACPR) order in place; this was respected. Staff told us many patients with this attended the hospital with such an order already in place from community settings. These forms were reviewed at admission. Where a patient arrived without an original copy; medical staff completed a new form in line with trust policy.

Where patients were detained under the Mental Health Act, either long or short term, staff were aware of how to refer such patients to the mental health team for review.

Staff asked patients if they understood the procedure to be undertaken prior to being given anaesthetic in theatre in order to double check consent.

Is the service caring?

Compassionate care

Staff consistently cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Patients told us that staff provided an excellent level of patient care. They told us that staff regularly checked on their care and wellbeing and that staff respected privacy and dignity. Patients spoke of kindness and compassion when describing the ward staff and reported they felt safe.

We observed patient and staff interactions with staff from all grades including medical staff. We saw staff spoke to patients with respect and took time to listen to patient's responses. Staff showed a genuine interest in patients including their personal life history as well as their medical and care needs. For example, a patient had been sourced a book which was particular to their own specific interests for them to keep. We saw staff were non-judgemental in their interactions and treated all patients as individuals.

Within theatres we observed staff treated patients with care and compassion. Staff ensured patients retained dignity at all times; for example, only uncovering body parts as necessary and when needed.

We received feedback that physical aspects of patients' care could sometimes be delayed on weekends when services such as fresh linen provision was not as readily available. However, staff reported making effect to provide the best level of care for patients despite this.

Staff working on the gynaecological ward showed us how they provided compassionate care to patients who had undergone termination of pregnancies due to foetal abnormalities. Documentation and competency packs had been created to make it easier for staff to support patients; and services such as burials and cremations could be organised. Staff were able to provide a certificate of life, photos in a frame, hand and foot prints and a candle for patients that wished for this.

Patients told us they were offered clean clothes, underwear and shower or bed bath opportunities each day; and were encouraged to maintain cleanliness which aided dignity.

Staff told us where a patient requested to see a member of staff of a specific gender, this would be facilitated in order to provide a dignified and respectful service. Staff could request a chaperone where required.

Friends and Family test performance

From October 2017 to September 2018 the Friends and Family Test (FFT) response rate for surgery at Russells Hall Hospital was 35.5%. This was based on 21,345 responses.

The data showed that the percentage of patients that would recommend the service to their friends or family varied from an average of 87% to 96% across the 12 month period.

A breakdown of FFT performance by ward for surgical wards at this hospital with total responses over 100 for the period from October 2017 to September 2018 is shown below.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at The Dudley Group NHS Foundation Trust, by site.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
Day case	16,039	33%	97%	96%	96%	95%	96%	95%	97%	95%	95%	95%	95%	95%	96%
Ward B4	1,079	46%	89%	87%	85%	94%	88%	86%	94%	90%	93%	90%	85%	87%	89%
Ward B5	938	48%	90%	90%	97%	87%	90%	78%	74%	89%	86%	87%	69%	79%	87%
Ward B1	851	54%	96%	98%	97%	96%	89%	94%	94%	88%	93%	86%	91%	93%	93%
Ward C6	817	45%	88%	91%	76%	91%	94%	93%	92%	92%	98%	94%	83%	91%	91%
Ward B3	681	35%	93%	90%	85%	85%	88%	86%	92%	88%	91%	96%	78%	90%	89%
Ward B2 (Trauma)	481	86%	90%	97%	93%	100%	100%	98%	97%	90%	94%	94%	94%	92%	95%
Ward B2 (Hip suite)	322	37%	96%	100%	92%	95%	97%	97%	100%	91%	100%	100%	93%	89%	96%
Ward B6	128	36%	100%						86%		86%	96%	95%	100%	95%

Key — Highest score to lowest score: 100% | 50% | 0%

[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

[3] The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

We saw FFT data was displayed on all wards along with the number of compliments and complaints per week.

Emotional support

Staff provided emotional support to patients to minimise their distress.

The trust employed wellbeing workers who worked closely with patients; particularly patients with additional needs such as advanced dementia, learning disabilities, and impaired cognitive functioning. We observed wellbeing workers interacting with patients and saw they spent quality periods of time engaging with patients; ensuring that patients' emotional and psychological needs were met. Other staff based on the ward spoke of the added value of having wellbeing workers to dedicate time to patients. They highlighted that this ensured patients had high levels of compassionate care even when staff were too busy to spend more time with individual patients over and above clinical care needs.

Staff enabled Pets as Therapy dogs to attend wards where possible to provide additional care. We were given examples of where staff had enabled patients, particularly patients at the end of life, to see their own pets in a private space.

We saw specific rooms which had been nicely decorated and were used to break bad news to patients or families; where patients could be supported in privacy. Where patients were at the end of life they were provided with a side room, and given privacy to receive their care. Staff told us the palliative care team provided an excellent level of care for patients at the end of life;

including emotional support.

The chaplaincy team were available to offer emotional and spiritual support. Staff told us the team visited wards daily; and could also be requested out of hours. The chaplaincy team also offered patients the opportunity to visit the chapel.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff involved patients and those close to them in decisions about their care and treatment. We saw this behaviour displayed by all staff including consultants; who prioritised speaking with patients and keeping them up to date with progress and information. We saw that staff worked over and above requirements to ensure patients care and treatment was at the forefront; and that patients had confidence in staff. We saw staff worked together to improve and provide care; and a collaborative approach was observed.

Staff gave information and reassurance to patients undertaking surgical procedures. We observed staff explain what they were going to do to the patient before doing it. We saw that when dealing with patients who may have less understanding of information; staff still made an effort to directly communicate with the patient and keep them informed.

Patients told us they felt fully informed about their care and described both medical and nursing staff positively in respect of keeping them up to date with information and updates.

Patients we spoke with told us they felt fully informed to consent to any care or treatment and felt involved in decisions made.

We observed a member of staff provide discharge information. This was very clear, and enabled opportunity for the patient and family to ask further questions and clarify information.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

We saw that services were planned around the needs of the local population.

The trust provided teams to enable patients with additional needs to receive treatment as per the Equality Act (2010). Please see 'meeting people's individual needs' section for more details.

Two surgical high dependency beds were available to provide level two care post operatively. In addition; a four bedded bay was located within the vascular ward to provide additional support to patients who did not meet criteria for level two care; but still required more support than on a general ward.

From the Monday of the week of our inspection visit; the trust had made changes to the pre-operative assessment pathway to better meet the needs of elective patients. This involved including an anaesthetist, and other colleagues where required, as part of the pre-assessment consultation. Therefore, the patient could experience a 'one stop' appointment which enabled less journeys to the trust, and more time between first consultation and surgery to enable health optimisation. The aims including increasing theatre productivity, reducing on the day cancellations and improving the patient experience. Due to the infancy of this process at the time of our inspection, it was not possible to gather any data around this. However, a meeting was scheduled with the relevant Clinical Commissioning Group (CCG) in February 2019 to discuss long term funding.

Meeting people's individual needs

The service took account of patients' individual needs.

Staff could book face to face interpretations for patients who did not speak English to a level to be able to give informed consent to treatment and care. For emergency procedures where there wasn't time to get an interpreter in person; a telephone interpreter service was available. Staff also had access to communication cards which showed images of commonly used items, or words in order to assist communication; for example, with Deaf patients prior to an interpreter arriving. Trust leaflets could be translated into a variety of languages.

All wards had link nurses who had received additional training and support to work with patients with specific needs. For example, wards had link nurses for dementia and for patients with learning difficulties and disabilities. However, we noted within the trust risk register submitted in October 2018 that patients with autism may have a compromised experience due to a lack of staff training and awareness. Plans to reduce the impact of this were in place; however, no dates of progress were set. Conversely; the trust reported in their pre-inspection information that staff were up to date with most recent mandatory training figures which included autism awareness.

Patients living with learning disabilities or dementia received a hospital 'passport' which communicated vital information about the patient should they change wards or travel into different areas of the hospital.

A trust wide mental health team was available to support patients with symptoms and/ or diagnoses of mental health conditions, learning difficulties, brain damage including dementia and

patients with learning difficulties and disabilities. The staff within this team primarily focussed on the needs of older adults however supported younger patients on a referral basis.

Wellbeing workers provided specific support to older patients with dementia, or other cognitive functioning related needs. This included playing games on a 1-1 basis, reading with patients, enabling use of a specialist individual television which showed and played films and music from early decades to promote positive memories. We saw in some bays where all patients were elderly; a communal television was set up to show films, and a CD player played familiar songs. We saw a patient who had been unhappy during the morning, but after listening to music for a while, they became visibly more relaxed and settled.

Data from the trust showed how the surgery service complied with the Accessible Information Standard. The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand and is now a legal requirement. However, we saw a poster which clearly outlined how the trust met the AIS but provided only a landline phone number as a way to communicate about AIS needs which may have been a barrier to some patients.

Hospital volunteers were available daily to provide additional support to patients, for example with escorting patients around the hospital for therapeutic walks, or to bring books. Pets as Therapy dogs, and their owners, visited patients in the hospital. We were told of examples where the dog had accompanied patients to therapy sessions within the hospital gym.

Provision for bariatric patients was available. The trust had one bariatric bed within the trust which could be requested. Alternatively, a third party provider could deliver specialised equipment within the same day as a request being made. Bariatric commodes were available on different wards.

Within the pre-assessment and admission ward area, a large and bright waiting room was available. The waiting room contained a tv, papers and leaflets and offered information in large print and braille. There was room for family members to stay with the patient whilst awaiting theatre. Patients could also be given a pager if they did not wish to wait in the lounge.

Patients could access chaplaincy services at any time of day or night where required.

On ward B4, we saw a relative's room had been decorated to create a welcoming environment. This room was used to support patients, visitors and staff; for example, when breaking bad news or following an incident.

Staff told us, and we saw, that where appropriate patients were encouraged to take walks both on and off the ward. We saw different types of staff accompanying patients.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit and treat patients were in line with good practice.

We saw referral to treatment times (within 18 weeks) was good for admitted patients being better than the England average. When looked at per specialty we saw that seven of nine specialities performed better than the England average; two performed worse. More specific details can be found below.

A surgical ambulatory assessment unit had been set up as part of the surgical assessment unit to aid patient flow and patient experience. These enabled patients referred for acute symptoms requiring urgent triage and surgical assessment who could sit to attend for their pre-assessments without being admitted. Following triage and assessments, patients, where

appropriate, could return home until their operation the following day rather than be admitted overnight prior to surgery if required. The aim of this service was to achieve a 12 hour turnaround time from patient arrival to returning home. Referrals were received for this service from GPs, urgent care centres, accident and emergency department and community nursing. For certain specialities, such as vascular surgery, referrals could be received from other West Midlands hospitals. This initiative supported a better access of inpatient beds for patients who required them; and enabled a quicker turnaround time for patients. There was scope for patients who required a longer assessment period with four beds allocated for up to 48 hours per patient. Due to this service being open for a short time only at the time of our inspection; there were no audit results present to measure the anticipated goals of an increased discharge rate and a reduced need for admission. Staff told us anecdotally of successes. Senior leadership reported that since May 2018 when the unit opened; same day discharge rates varied between 32% to 39%.

The surgical assessment unit (SAU) had 12 beds which could take short stay inpatients. At the time of inspection; two medical outliers were located in the SAU ward. Criteria was in place for medical patients outlying surgical wards. The requirement stipulated that patients had to be medically fit, or very near to this, for discharge. On ward B4 (general surgery and colorectal surgery), where 12 beds were dedicated to medical outliers as a short-term measure to help the overall hospital flow; a dedicated medical team had been allocated.

Whilst surgical outliers did not get located on medical wards, we saw some speciality surgical patients outlying on other speciality wards. We saw these patients were reviewed by the relevant medical team on a daily basis. We found the vascular ward The vascular ward had allocated 6 beds to trauma and orthopaedics. Then a further 6 beds were used for vascular or surgery outliers. These beds were situated just past the end of the trauma and orthopaedic/ hip fracture ward and were well serviced by medical and nursing staff from that speciality. A surgical clinical co-ordinator managed bed placement, and outliers.

Outliers

The data was for surgical main ward bed occupancy from 1st – 24th January 2019. The following data shows a count of overnight bed stays, and not a count of patients. The count has been taken at midnight for each day within the period, therefore if 1 patient stays in a bed for 2 nights then they will be counted twice in the table below.

NB One station on B4 has been formally designated for medicine patients, which is why B4 has the highest count in the data.

Surgical Main Ward	Medical Outlier (Overnight Bed Stay Count)	Total Available Ward Capacity (No. Beds x Days in period)	Percentage Ward Capacity Occupied by a Medial Outlier
B1	1	624	0.2%
B2	81	1296	6.3%
B3	0	1008	0.0%
B4	299	1152	26.0%
B5	44	576	7.6%
C6	13	480	2.7%
Total	438	5136	8.5%

Outliers were reviewed and managed by the appropriate speciality.

Data from the trust showed that from October 2017 to September 2018; there were 12,108 delayed transfers of care (DTOC: discharges). We saw the highest numbers fell on ward west B5 (general surgery and gynaecology) with 2160 DTOC, and the east half of ward B3 (vascular and general surgery ward) who had the same number of DTOC.

Patient discharges were regularly discussed in order to manage access and flow of the surgical wards. We saw this was discussed at ward rounds, board rounds and staff huddles. Meetings around patient discharge included a discharge co-ordinator and therapy staff such as an occupational therapist and physiotherapist. Staff told us the biggest barriers to discharging patients who were fit were consultant reviews and medicine delays. In addition, discharges could be delayed due to awaiting social services packages of care in the community. We saw increased pharmacy presence on surgical wards to try to address the concerns around delays in medicine to take home.

Staff told us that patients were not discharged from longer stay wards after 8.30pm, and ward or bed moves were avoided after 10pm where possible. However, data from the trust showed that from October 2017 to September 2018; 1,899 bed moves happened between 10pm and 8am. The wards with the highest number of night moves were B4 (general surgery and colorectal surgery; 616 moves) and B3 (vascular and general surgery ward; 539 moves). However, we did note that the data showed a reduction in moves per month from June to September 2018 which was more positive.

We requested more up to date information from the trust. This showed that from October to December 2018; 783 patients were discharged between 10pm and 7am. This figure excludes children and young people figures. The highest figure was from the day surgery unit which had 56 late discharges.

Data for the same timeframe of October to December 2018 showed that 683 patients were moved bed or ward between 10pm and 7am. However; 408 moved from the surgical ambulatory assessment unit (from a chair or trolley to a bed) and 132 moved from the surgical assessment unit.

During the inspection we saw data which showed theatre utilisation was 76.8% the week prior to our visit.

A trust 'hospital to home' service was available to urology patients (both surgical and medical) with the purpose of reducing hospital length of stay; to prevent re-admissions, to help recovery and improve the patient experience. The service was generally for patients discharged with a catheter; who would then be provided with specialist support and help at home.

Average length of stay

Russells Hall Hospital

From July 2017 to June 2018, the average length of stay for surgical elective patients at Russells Hall Hospital was 3.3 days, which is lower than the England average of 3.9 days. For surgical non-elective patients, the average length of stay was 5.2 days, which is similar to the England average of 4.9 days.

The chart below shows the average length of stay for the top three specialties, based on count of activity for elective admissions:

Elective Average Length of Stay - Russells Hall Hospital
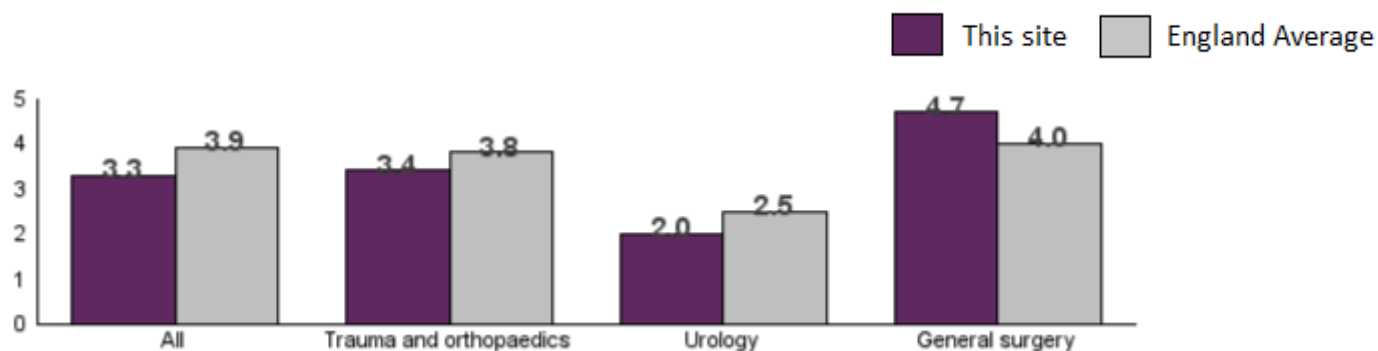
Note: Top three specialties for specific site based on count of activity.

- Average length of stay for elective patients in trauma and orthopaedics was 3.4 days, which is lower than the England average of 3.8 days.

- Average length of stay for elective patients in urology elective 2.0 days, which is lower than the England average of 2.5 days.

- Average length of stay for elective patients in general surgery was 4.7 days, which is higher than the England average of 4.0 days.

The chart below shows the average length of stay for the top three specialties, based on count of activity for non-elective admissions:

Non-Elective Average Length of Stay - Russells Hall Hospital

Note: Top three specialties for specific site based on count of activity.

- Average length of stay for non-elective patients in general surgery was 4.0 days, which is similar to the England average of 3.8 days.

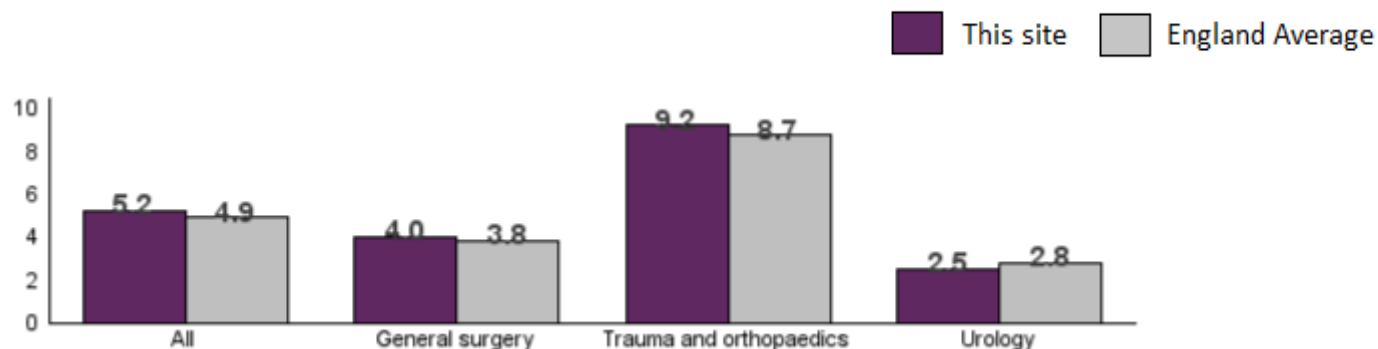- Average length of stay for non-elective patients in trauma and orthopaedics was 9.2 days, which is similar to the England average of 8.7 days.

- Average length of stay for non-elective patients in urology was 2.5 days, which is similar to the England average of 2.8 days.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average. It ranged from 78.3% to 85.2%, compared to the England average of 64.6% to 71.5%.

In the latest period, August 2018, 85.2% of this group of patients were treated within 18 weeks compared to the England average of 68.5%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Trauma & orthopaedics	92.3%	60.0%
Plastic surgery	86.0%	81.1%
General surgery	80.7%	72.6%
Urology	80.3%	76.7%
Oral surgery	80.2%	59.4%
ENT	79.5%	63.1%
Ophthalmology	70.6%	68.2%

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two-year period from quarter 2 (Q2) of 2016/17 to Q1 2018/19, the percentage of last-minute cancellations at the trust where the patient was not treated within 28 days was consistently lower than the England average.

In Q4 2017/18, this trust cancelled 150 surgeries. Of the 150 cancellations 6% weren't treated within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - The Dudley Group NHS Foundation Trust

Cancelled Operations as a percentage of elective admissions - The Dudley Group NHS Foundation Trust

Over the two-year period, the percentage of cancelled operations at the trust was in the most part, worse than the England average. There was an improvement in the trust's performance in Q2 2017/18.

Cancelled operations as a percentage of elective admissions only includes short notice

cancellations.

(Source: NHS England)

We requested more up to date data regarding cancelled operations; specifically from April to December 2018. The trust reported that out of 19, 276 elective main and day case procedures were performed in this timeframe. The number cancelled at the last minute for non-clinical reasons was 410 which equated to 2.1%. Out of these cancelled operations; the number of patients not treated or offered a procedure date within 28 days was 16, which equated to 0.1% compared to the number of performed procedures.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of complaints

From October 2017 to September 2018 the trust received 89 complaints in relation to surgery (18.2% of total complaints received by the trust). The main subjects of complaints were patient care (29) and communications (19).

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient care	29
Communications	19
Admissions and discharges (excluding delayed discharge due to absence of care package)	9
Values & behaviours (staff)	9
Other (specify in comments)	8
Appointments	5
Access to treatment or drugs	4
Waiting times	3
Admin/policies/procedures (inc patient record)	1
Privacy, dignity & well being	1
Facilities	1
Total	**89**

For the 46 complaints that had been closed at the time of data submission, the trust took an average of 83.4 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

The 43 complaints that had not yet been closed had been open for an average of 80.8 working

days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 there were 712 compliments received for surgery (10.3% of all received trust wide).

Compliments were received in all 12 months of the period. November 2017 was the month where the most compliments were received (99).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Recent learning from complaints and 'you said; we did' comments were displayed on all wards. In addition, the number of complaints and compliments received each month were displayed.

Staff told us, and we saw, that they received feedback following complaints and that learning was embedded.

Complaints information was displayed for patients to read; and leaflets containing details of how to make a complaint were readily available.

Patients told us they knew how to make a complaint if they wished to.

During the inspection we discussed the length of time taken to respond to complaints being outside of the trust target. Please see 'Well-Led' for more details.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

A triumvirate senior management team oversaw the division of surgery, women and children under which surgical services fell. They supported matrons to deliver the objectives and work of the surgery service.

Matrons oversaw at least two wards within the surgical division. Under them, ward managers (band 7 senior nurses) ran each surgical ward. Ward managers were supported by a nurse in charge (band 6 nurses). The surgical assessment unit also had a clinical lead nurse to provide additional management and development support.

Matrons held regular meetings with ward managers; who then cascaded information down to the remainder of the ward and theatre staff via daily huddles, team meetings, email or notices up in staff areas. We saw evidence of information sharing, and staff told us they regularly received updates from local management. Other staff, such as therapy staff, told us they could attend ward team meetings if they wanted to; otherwise they were regularly updated on new information by the ward managers.

We saw how each ward/ theatre manager individualised their approach to supporting their team as per the ward they worked on. For example, some managers created ward newsletters, or put special notices up. Other managers made displays in staff areas and created healthy competitions between staff to encourage more effective working.

Staff also told us about how they had been enabled to generate and follow through on ideas. For example; a member of staff who did not speak English as a first language generated a language aid with translations for common words used; in a variety of languages. This supported both staff and patients to have better communication.

Staff told us local management were visible, supportive and willing to help out with day to day clinical duties over and above their management roles. Staff told us that management allowed flexibility towards working patterns where possible, for example to accommodate childcare needs.

Staff on some wards told us about senior management visiting the wards and being available for conversation or support. Some staff told us they had not seen the senior management visit their working area.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff could articulate the general trust vision and strategy and emphasised that providing an excellent level of care was at the centre of this. The trust vision centred around providing safe, caring and effective services which kept patients at the heart of work undertaken.

Staff were aware of their roles within the trust vision; and were able to articulate current ongoing priorities to achieve this. Local management shared goals and ways to achieve these; and enabled staff to contribute to this process.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

All staff we spoke with spoke of a culture of team work and continuous learning. Staff told us they felt supported, respected and valued within their teams and within the wider organisation.

Staff at all levels presented as included in the wider business of the division; staff were aware of risks and challenges to the areas in which they worked and presented as keen to improve standards where possible for patients. Staff told us of a 'non-hierarchical' approach where they felt that they could approach any colleague of any grade to receive support or share ideas. Staff also told us where they had been involved in specific projects or new practices, for example being part of interview panels for new staff. Staff told us this helped them feel valued by the trust and the senior management teams.

We saw evidence of 'positive incident reporting' where excellent standards of work were reported on. Staff told us this promoted a positive working environment. Staff told us they would be happy to raise concerns without fear of recrimination further enabling a more secure working environment. Staff were aware of the duty of candour (The duty of candour is a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology); and were open and transparent when interacting with patient.

Some wards had processes to recognise excellent work. For example, on Ward B3 an 'employee of the month' system had been set up. Staff told us that receiving feedback via nominations provided a morale boost to both individual staff members, and the team as a whole.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Clinical governance meetings were held monthly, which included the triumvirate leadership team and matrons from within the division. Through these meetings, a variety of topics were monitored and discussed including incidents, the risk register, complaints, patient falls and general concerns. This was a forum to raise any ongoing or new issues from ward level; as well as having information cascaded down from the senior management level and above. As these were division level meetings, matrons told us they gained a good overview of areas outside of surgery.

Matrons conducted monthly meetings with their ward managers/ lead nurses in order to ensure that information was cascaded down from clinical governance and up from ward meetings.

Ward managers held staff meetings, daily huddles and provided updates as necessary based on information passed to them. Ward managers were responsible for raising any concerns noted on a daily basis, such as bed shortages, to the matron to ensure correct processes were followed. All staff we spoke with told us they felt information was shared both up throughout management streams, and back through to ward level staff effectively.

We saw each ward, and within theatres, had a quality board displayed which provided information to staff, patients and visitors. This contained updates on local risks, shared learning following incidents and complaints and any urgent messages. These boards were tailored to individual wards as necessary.

Quality audits were compiled on the wards, such as hand hygiene, and infection prevention and control. The results of each wards monthly audit were fed up to the matron and divisional chief nurse via monthly meetings where results were challenged and action plans created.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Staff could access policies, procedures and updates via the trust intranet; 'The Hub'. All staff we spoke with were familiar with this and could demonstrate how to long on and access information.

Updates following any changes or updates to national guidelines were discussed and ratified via clinical governance meetings. Any changes were implemented in a timely way in order to be introduced within patient care quickly. Senior management told us, and we saw, that medical staff monitored outcomes closely in order to take a proactive approach to improving performance where necessary.

We observed matrons conducting board rounds on the ward to ensure a 'hands on' approach was taken to mitigating any immediate risks or concerns.

Staff we spoke with told us of the local risks, and those of the wider division relating to surgery. For example, within theatres staff highlighted a lack of time at the end of one theatre list to fully prepare for the next list, including cleaning the theatre was a risk.

Actions were in place to reduce risks to the division. For example, patient complaint response times had been identified as significantly outside of the trust target. A structured plan to reduce the backlog of complaints, and deal proactively with any new complaints had been set. This also included arranging more face to face and telephone conversations to resolve complaints in a more 'human' way.

We reviewed the risk register sent to us in October 2018; prior to our inspection visit in addition to a surgery specific risk register sent in January 2019. We saw risks recorded aligned with those raised during inspection; such as oxygen not being routinely prescribed. We saw other risks had been identified; for example, the use of non CE marked surgical instruments; and mitigating actions set to reduce the risk.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Ward clerks provided support to ensure that patient records were stored securely in line with data protection requirements.

We saw that patient records were stored in key-coded lockable cabinets. Where these were not functioning; we saw staff took immediate action to remedy this.

Information technology systems were used effectively to provide patient care.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

We saw that matrons provided a dedicated weekly slot, which was displayed on wards, for patients and visitors to come and speak with them.

Staff provided examples of public and patient engagement. For example, following a complaint, a campaign was initiated on a social media site for the public to donate unwanted working televisions. As a result, the ward involved received a large number of donations from members of the public and the local community. The ward were in the process of safety testing these during our inspection; but intended to share out the extra televisions with other wards once ready.

We were told about a staff experience task force which had been set up to improve staff experience; this included funded ongoing training. The task force included staff from all grades within the trust. A peer sub group had been set up to assess the applications for funding for additional training.

We saw evidence of staff engagement at local level and at trust level. For example, we saw regular communications such as the Trust Safety and Experience bulletin being circulated and pinned up in staff areas. Messages and team meeting minutes were distributed to all relevant staff members.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Staff told us, and we saw evidence of ongoing improvement to clinical practice. For example, staff identified that oxygen was not being routinely prescribed as a medicine despite being given to patients. This was identified and actions were undertaking including daily management checks. As a result, compliance improved. Within theatres, opening times for day surgery had been extended to enable those with a longer recovery time to still go home rather than be admitted.

Staff including nursing, medical and therapy staff, told us of visits to other trusts, conferences and events whereby learning was shared and brought back to Russells Hall for implementation if appropriate.

During our inspection, we were provided with evidence of numerous research projects that staff had completed or were working on. For example, a consultant and physiotherapist had produced a paper in September 2017 on measuring basic mobility pre and early post-operatively in patients with hip fractures in order to assess outcomes. This paper used the Cumulated Ambulatory Score (CAS); and was presented at national and international conferences. More recent research in the process of submission to medical journals included research into the complications associated with providing bone strengthening treatments in orthopaedic patients.

Research into better pain management strategies was ongoing as referenced in the 'Effective' section of this report. For example, medical staff at the trust were involved in developing and implementing national guidelines for pain management such as for patients undergoing lower limb amputation, as published in the British Journal of Pain, April 2018.

All research described to us by staff involved was aimed at improving the patient journey, ensuring better patient outcomes and providing the best care possible. Staff all presented as passionate about these aims and told us of how they were willing to undertake research in their own time where necessary to ensure a good level of continuous innovation.

Other innovative practice was the 'golden patient' initiative. This involved ensuring selected patients were ready for 8am on the morning of the theatre lists; therefore, could be in theatre ready for their procedure to begin at the time of the theatre team brief. The aim was to improve the average start time of theatre lists; enabling a more efficient service.

Staff told us about new patient pathways including the surgical ambulatory assessment unit, as previously discussed in 'Responsive'. A further example was a mastectomy pathway which enabled patients to return home the same day as their operation due to employing a clinical nurse specialist who could see the patient the next day for a post-operative review.

We were told about a change to recruitment processes whereby interview candidates were interviewed by a panel which included a peer from the same banding, and a member of staff from the relevant area of work. Senior managers told us they had received positive feedback from people who had taken part; and members of staff involved told us they felt this was a valuable and worthwhile strategy to help recruit new staff.

As referenced under 'Responsive'; a trust 'hospital to home' service was available to urology patients (both surgical and medical) with the purpose of reducing hospital length of stay; to prevent re-admissions, to help recovery and improve the patient experience. This service was staffed by two nurses who undertook the same role, working with patients on a one to one basis, to ensure best practice care for patients discharged with a catheter.

Critical care

## Facts and data about this service

The Dudley Group NHS Foundation Trust had 41 critical care beds as of July 2018. These consisted of 23 adult critical care beds (52.6%) and 18 neonatal critical care beds (47.4%). A comparison of this breakdown by bed type to the overall England breakdown by bed type can be seen below.

Breakdown of critical care beds by type, The Dudley Group NHS Foundation Trust and England.

This trust

Neonat... 47.4%   Adult, 52.6%

England

Paediatric, 7.8%
Neonatal, 23.9%
Adult, 68.3%
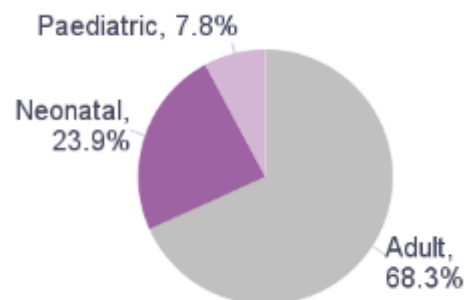
(Source: NHS England)

The Dudley Group NHS Foundation Trust has 23 adult critical care beds which consists of high dependency (level 2) and intensive care (level 3) beds.

At Russells Hall Hospital, critical care services are delivered across three units: Intensive care unit (ICU) with seven level 3 beds with the capacity to increase to nine, the surgical high dependency unit (SHDU) with eight level 2 beds, and the medical high dependency unit (MHDU) with eight level 2 beds with capacity to increase to 10 beds. The ICU and SHDU are located on the first floor, east wing and the MHDU is located on the second floor, west wing of the hospital.

The ICU and SHDU was part of the Surgery, Women and Children's division and came under the Theatres, Anaesthetics, Critical Care and Pain (TACP) directorate.

The MHDU was part of the Medicine and Integrated Care division and came under the gastroenterology, GI unit, Respiratory, Renal, Endocrine and MHDU directorate.

The trust is part of the West Midlands Critical Care Network.

The trust provides critical care outreach services 24 hours a day, seven days a week to support the management of unwell patients outside of the critical care unit. The unit also supports a rehabilitation programme for patients post ICU, but this is minimal and a business case is in development to expand this.

There were a total of 227 admissions to the service during the period April to June 2018.

During the inspection we visited the ICU, SHDU and the MHDU. We spoke with 16 staff including health care assistants, doctors, nurses, allied health professionals and ancillary staff. We also spoke with the leadership team. We spoke with 7 patients and relatives. We reviewed 13 patient records and 10 medication administration records. We attended three handovers, this included a doctors' handover and two nurses handovers from day to night staff. We made observations and looked at documentary information accessible within the department and provided by the trust.

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for qualified nursing staff in the intensive care unit (ICU) and surgical high dependency Unit (SHDU) is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - adult	88	88	100.0%	90.0%	Yes
Health & safety	88	88	100.0%	90.0%	Yes
Conflict resolution - level 1	87	88	98.9%	90.0%	Yes
Equality & diversity (including autism awareness)	87	88	98.9%	90.0%	Yes
Fire	85	88	96.6%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	85	88	96.6%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	83	88	94.3%	90.0%	Yes
Resus - paediatric	56	62	90.3%	90.0%	Yes
Infection control - clinical	79	88	89.8%	90.0%	No
Information governance	78	88	88.6%	90.0%	No

The trust had an overall mandatory training compliance rate of 95.6% for qualified nursing staff in the intensive care unit (ICU) and surgical high dependency unit (SHDU). The 90% target was met for eight of the 10 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following the inspection, the trust provided details of the mandatory training undertaken by medical staff working in critical care. This is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - adult			96.0%	90.0%	Yes
Health & safety			94.1%	90.0%	Yes
Information governance			94.1%	90.0%	Yes
Equality & diversity (including autism awareness)			94.1%	90.0%	Yes
Infection control - clinical			94.1%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)			88.2%	90.0%	Yes
Manual handling (patient) / slips, trips & falls			88.2%	90.0%	Yes
Resus - paediatric			89.8%	90.0%	No
Conflict resolution - level 1			84.3%	90.0%	No
Fire			84.2%	90.0%	No

The overall mandatory training rate for medical staff working within critical care had an overall compliance rate of 90.7%. The 90% target was met for seven of the 10 mandatory training modules for which medical staff were eligible.

Mandatory training rates for nursing staff was displayed on information boards. Compliance for January 2019 was 95.8% for nursing staff working on the ICU / SHDU and 95.7% for nursing staff working on the MHDU. Staff told us they could access their annual and mandatory training on line and they received a reminder before it was due to expire to complete their training.

The trust advised training for sepsis was incorporated in the mandatory annual training of the management of deteriorating patient which also includes, primary assessment, track and trigger (NEWS) and specialist requirements for individual areas, for example anaphylaxis.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had access to safeguarding leads who were available Monday to Friday 9.00am to 5.00pm. The critical care service made seven safeguarding referrals for adults during the period October 2017 to September 2018.

Staff we spoke with were aware of their responsibility to protect vulnerable children and adults. Staff demonstrated a good understanding and knowledge of the types of abuse patients may experience. Staff could give us an example of a recent safeguarding concern, they were knowledgeable about what happened after a referral was made.

Nursing staff on the MHDU were still working towards the trust target of 90% for safeguarding children level 3. The completion rate at the time of the inspection was 70% with a further three

staff booked on to safeguarding level 3 training in March 2019 which was the next available date. The safeguarding level 3 completion rate for consultants working on the MHDU was 100%.

Children were not generally admitted to the units, the service told us 13 children under the age of 18 year olds, requiring level 3 and level 2 care, were admitted to the unit in the past 12 months. The trust advised two of the admissions were babies and one was admitted to the ICU for three hours whilst waiting for the kids intensive care and decision support (KIDS) team to transfer the patients to the paediatric intensive care unit (PICU) and the other had a paediatric nurse in attendance at all times.

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules for qualified nursing staff on ICU and SHDU critical care is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	88	88	100.0%	90.0%	Yes
Prevent	88	88	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	88	88	100.0%	90.0%	Yes
W R A P (workshop to raise awareness of prevent)	87	88	98.9%	90.0%	Yes
Safeguarding children level 3	20	22	90.9%	90.0%	Yes

In the ICU and SHDU the overall safeguarding training compliance rate was 99.2% for qualified nursing staff. The 90% target was met for all five safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Following the inspection, the trust provided details of the safeguarding training undertaken by medical staff working in critical care. This is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent			98.0%	90.0%	Yes
Safeguarding children level 3			91.4%	90.0%	Yes
Safeguarding adults			90.2%	90.0%	Yes
Safeguarding children level 1 & 2			90.2%	90.0%	Yes
W R A P (workshop to raise awareness of prevent)			88.2%	90.0%	No

In the critical care the overall safeguarding training compliance rate was 91.6% for qualified nursing staff. The 90% target was met in four of the five safeguarding training modules for which medical staff were eligible.

In discussion, staff we spoke with told us they had access to the psychiatric liaison team. Patients held on the unit under section of MHA were cared for with 1:1 support of a registered mental health nurse. One emergency Deprivation of Liberty Safeguards (DoLS) application was made between October 2017 and October 2018.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. However, monthly hand hygiene audits did not include a large enough sample to provide assurance.

The ICU had one isolation glass pod, the SHDU had two side rooms and the MHDU had 3 side rooms and an isolation glass pod for infection control purposes. Patient who had infections were nursed in side rooms. Infection control guidance was displayed on the doors and during the inspection we observed staff taking the appropriate precautions, wearing personal protective equipment (PPE) which included masks, gloves and aprons when entering the rooms and disposing of the PPE appropriately.

We observed doctors and nursing staff washing their hands and using hand cleansing gel in line with infection prevention and control guidelines. All staff were bare below the elbow and used (PPE) as appropriate. There were adequate hand washing facilities in all clinical areas and we observed that staff washed their hands or used hand cleansing gel appropriately. The cleansing gel bottles we used during our inspection were all functioning. Visitors were asked to use sanitising gel when arriving on the unit and this was freely available.

Monthly observational hand hygiene audits demonstrated a compliance of 100% on the ICU and SHDU for the period April to December 2018 and 100% in December on the MHDU. However, only four samples were undertaken in December across the ICU and SHDU, which is less than 4.5% of nursing staff. The infection control link nurse was responsible for the audits.

During inspection, we found the units appeared clean, tidy and well maintained. Housekeeping staff were observed cleaning on the wards. 'I am clean' stickers had been dated and were visible to indicate the equipment had been cleaned and was ready for use.

Monthly environmental cleaning audits for the period April to December 2018 showed the ICU/SHDU scored between 93.2% (which was below the trust target of 95%) and 99.3%. Cleaning dropped below 95% compliance for a three month period from June 93.2%, July 93.7% and August 94.8%. The MHDU compliance was 96.2% in December 2018.

The service submitted data to the Intensive Care National Audit and Research Centre (ICNARC) showed the unit was well within expected limits for unit acquired infections. There was no hospital acquired blood stream infections such as MRSA in the ICU, SHDU and MHDU in the period April to June 2018. Data provided by the trust demonstrates that 100% of elective patients on the SHDU and 95.3% of emergency patients on the ICU were screened for MRSA during the period April to December 2018.

The trust reported one case of methicillin-susceptible Staphylococcus aureus (MSSA) and E coli and four cases of *clostridium difficle* (*C. Diff*) in the critical cares services in twelve month period January to December 2018.

There were regular audits of the standards in the use of invasive devices such as catheters, peripheral lines. For the period April to December 2018, compliance was 100%.

The ICU had a dedicated microbiology service. This included a trust anti-microbial pharmacist attending the ICU ward round Monday to Friday and a consultant microbiologist reviewing ICU patients three times per week with the ICU Consultant.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. But not all patients had venous thromboembolism (VTE) assessments.

The critical care outreach team were available 24 hours a day, seven days per week to follow up on patients who had been stepped down from critical care. They also reviewed and assessed patients who showed signs of deterioration across the hospital. The team was led by a lead band 7 nurse and with band 6 nurses who worked on rotation from the ICU and SHDU. The team worked closely with critical care consultants.

Members of the critical care outreach team are part of the trusts medical emergency team (METs) and assist with all emergencies and instigate the process of making decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR) when required.

The National Early Warning Score (NEWS) was used within the critical care services and across the trust for detecting the deteriorating patient, along with a sepsis care bundle for identifying and manging sepsis. ICNARC quarter one 2018/2019 data showed there was a higher number of high sepsis admissions to the units when compared nationally.

Data provided showed for the 3 month period September to November 2018 there were 110 admissions to the ICU. Time of decision to admit was recorded on 62.7% (69) records, with 98.5% (68) of patient admitted within 4 hours of decision to admit. This was higher than the standard for 54% to be admitted within 4 hours of decision to admit.

Consultant review on admission was within the 12 hours for 93% (99) of patients for the period September to November 2018. The trust advised that for the same period in 2017 this was 83%.

Patients ward rounds were held twice a day 7 days a week on the ICU and twice a day Monday to Friday on the SHDU and MHDU. On the ICU, treatment plans were recorded on the electronic patient record, specifically designed for use with critical care patients. A paper proforma for level 2 patients was in use on the SHDU and MHDU which recorded the treatment plan following the ward round and was used for the medical handover of patients.

A range of risk assessments were in place for each patient admitted into the critical care services. The ICU used an electronic patient record system. The system alerted both nursing and medical staff if any assessments and ongoing reviews were not completed, as well as highlighting variations in patient condition. The SHDU and MHDU used paper records. Nursing risk assessments included pressure areas, moving and handling, nutrition, venous thromboembolism (VTE) and falls. Data provided recorded 77.4% of patients were VTE assessed in the period January 2018 to December 2018.

Staff had access to tissue viability nurse specialist as well access to more specialist pressure relieving equipment if needed. Patients were weighed weekly this helped to determine appropriate care such as pressure mattress settings and dosage of medicines.

Environment and equipment

The service had suitable premises and equipment and looked after them well. But the SHDU did not have a resuscitation trolley based on the unit.

The critical care services were delivered across three units. The ICU and the SHDU were next door to each other and the MHDU was in another part of the hospital.

Concerns raised during the last inspection concerning the environment of the SHDU being cramped and staff not having sufficient space to care for patients had been partially addressed by reducing the number of bed spaces in the bays from eight to six and utilising two adjacent side rooms from another ward. Whilst still not complying with Department of Health, Health Building Note 04-02: Critical Care Units: for a Critical Care bed space to be 25m^2 this had improved space on main SHDU area allowing easier access to patients. Senior staff told us that plans had been drawn up to remodel the SHDU incorporating additional space from an adjacent ward.

During the inspection we observed that fire doors between the main SHDU and the two adjacent side rooms had been propped open. There was no fire risk assessment in place. This was raised as a concern at the time of the inspection and we were later advised the trust's health and safety officer had inspected and recommend that automatic door closures be fitted so in the event of a fire the doors would close automatically. We were given assurances that this was being escalated to be addressed.

Emergency equipment for resuscitation and difficult airway management was kept in tamper evident tagged trolleys. Resuscitation trolleys were located on the ICU and MHDU. We saw they were checked daily and the contents of drawers were checked weekly. The seal was changed when medicines and stock were checked. However, the SHDU shared the ICU resuscitation trolley with the ICU which meant it was not within easy reach. This was raised with senior staff at the time of the inspection and they advised this would be addressed. Emergency and difficult airway equipment was stored on a shelf in the clinical room which staff accessed by using a keypad, this was also not easily accessible.

Electrical medical equipment (EME) had a registration label affixed. Portable Appliance Testing (PAT) labels were attached to medical equipment showing they had been inspected and were safe to use. Medical Engineering had an asset management system in place which had a predefined schedule of maintenance each calendar year which included critical care and this covered all medical equipment within the area. As part of the annual maintenance programme, critical care was last visited in November 2018.

There was sufficient equipment available to meet the requirements of the numbers of level 3 patients; for example, the unit had nine ventilators for the allocated seven level 3 patients and a portable transfer ventilator.

The ICU used rehabilitation chairs on the unit so patients could be transferred laterally from the bed to chair without the use of a hoist.

There were arrangements for appropriate segregation and management of waste. Single use items were disposed of appropriately in either clinical waste or sharp bins.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

The trust reported the following qualified nursing staff numbers for the two periods below for critical care:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing staff	88.0	85.0	96.5%	102.4	83.7	81.7%

The trust reported a qualified nursing staffing level of 96.5% in critical care in March 2018 which dropped to 81.7% in September 2018.

As at September 2018, there were 18.7 fewer WTE staff in post than planned for and 1.3 fewer whole time equivalent (WTE) staff in post than in March 2018. There was an increase of 14.4 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The information above does not include the fill rates for the MHDU. Fill rates for the ICU and the SHDU provided following the inspection for the period January 2018 to December 2018 for qualified nursing night staff was 85.3% and qualified nursing day staff was 87.9%.

The nursing establishment was based on the acuity of seven level 3 patients on the ICU and 16 level two patients on the SHDU and MHDU. The MHDU had an additional two bed spaces that that the ICU and MHDU consultant could authorise to open providing additional staff could be found. At the time of the inspection the MHDU had eight beds in use which was the level the unit was funded for.

Nurse staffing was sufficient to meet professional standards of 1:1 registered nurse to level 3 patients and 1:2 registered nurse to level 2 patients. Supernumerary band 6 nurse shift-leads were on each unit every shift.

The ICU and SHDU staffing allocation included 2 whole-time equivalent (WTE) band 7 (sister for the ICU and SHDU, critical care outreach lead), 17.33. WTE band 6, 44.20 WTE band 5, and 4.99 WTE band 2 nurses. Nurses rotated across the ICU and SHDU. The matron worked across the Theatres, Anaesthetics, Critical Care and Pain (TACP) directorate. A deputy matron band 8 had been appointed to the critical care service and had just started. The MHDU staffing allocation was 1 WTE band 7, 8.84 WTE band 6, 17.56 WTE band 5, 2.88 band 2. Staff told us that the band 5 establishment in the MHDU had recently been increased and they had put in for an additional 0.33 WTE band 2 post.

The critical care outreach team was staffed by band 6 nurses from the ICU and SHDU. 16 to 19 band 6's worked on rotation to provide one outreach nurse 24 hours a day, seven days per week in addition to a clinical band 7.

Staff rotas were planned by the band 7 nurses supported by administrators who helped cover gaps and swaps in shift for example contacting staff for extra shifts using mobile phone apps. On the MHDU there was a four week roster, with no set night or days but a minimum of two weeks days in four weeks or flexible working. Staff told us there had previously been no flexible working and many staff had been working permanent nights.

From October 2017 to September 2018, the trust reported an overall vacancy rate of 13.3% for qualified nursing staff in critical care. This was greater than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

At the time of the inspection there were no staff vacancies on the MHDU and 10 WTE vacancies for band 5 nurses on the SHDU and ICU. Senior staff told there was ongoing recruitment with the trust recruitment team, with rolling adverts every two weeks. The trust had recently held an open day for theatres and critical care, and further were planned. Trust nursing staff were also able to transfer between directorates.

From October 2017 to September 2018, the trust reported an overall turnover rate of 6.9% for qualified nursing staff in critical care. This was better than the trust target of 8.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

From October 2017 to September 2018, the trust reported an overall sickness rate of 4.8% for qualified nursing staff in critical care. This was greater than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

From October 2017 to September 2018, the trust reported 12,471 of the 203,105 available hours in critical care were filled by bank staff (6.1%) and 18,073 hours filled by agency staff (8.9%). In addition, there were 5,308 hours that needed to be covered by bank or agency staff but were unfilled (2.6%).

A breakdown of bank and agency usage by staff type is shown below:

Staff type	October 2017 to September 2018						
	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	11,161.0	6.0%	18,025.0	9.7%	4,677.0	2.5%	186,306.0
Non-qualified	1,310.0	7.8%	48.0	0.3%	631.0	3.8%	16,799.0
Total	12,471.0	6.1%	18,073.00	8.9%	5,308.00	2.6%	203,105.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Staff told us they would escalate staffing if staffing levels did not meet the levels required. Bank staff would be contacted before agency to fill the posts. The critical care service employed bank nurses who were known to the units. During the inspection were observed handovers from day to

night staff on the ICU and MHDU. On the MHDU 3 agency staff had been booked. To ensure that the skills mix was as required, one of the agency staff was swapped with a nurse from the SHDU.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Patient care was led by a consultant in intensive care medicine. Ten consultants covered the rota across seven days per week from 8am to 6pm on the ICU and SHDU. There were two consultants on duty each shift. They had a dedicated job plan which meant they had no other responsibilities when allocated to the ICU and SHDU. At weekends there was one consultant from 8am to 6pm. Out of hours, one consultant was on call from home for 15 beds 6pm-8am, able to attend the hospital within 30 minutes. This was within the guidelines for provision of intensive care services (GPICS) standard of a range of 1:8 -1:15 consultant to patient ratio.

On the MHDU there were four WTE consultants, one of whom also worked across the ICU and SHDU. On the MHDU a consultant covered Monday to Friday between 8.00am and 6.00pm. Out of hours cover was provided by the medical registrar. Consultant cover was provided by the medical speciality teams.

Weekend ward rounds on the SHDU and MHDU were once daily. A medical registrar reviewed patients on the medical high dependency unit at the weekend, with telephone support from an ICU consultant if needed. The ICU consultant would also provide face-to-face support if required.

Junior medical staff we met had no concerns about safety or clinical care and they felt consultants were approachable and they felt supported by their consultants. Teaching sessions for junior doctors included attendance at ward rounds, board rounds, attendance at weekly training meeting, morbidity and mortality meeting, and grand rounds for the whole hospital. A grand round is an educational meeting for all medical and non-medical staff. It is a chance for different disciplines to meet to discuss important cases and recent advances in treatment.

The trust included ICU and SHDU consultants within the surgical, theatre and critical care numbers. The trust counted MHDU consultants within the wider medical consultant numbers.

The trust did not provide data for medical staff in critical care covering total staffing, vacancy, turnover, sickness and temporary staffing as part of the RPIR request.

(Source: Routine Provider Information Request (RPIR) – total staffing, vacancy, turnover, sickness and medical bank and locum staffing data tabs)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

On the ICU, patient records were recorded in the electronic patient record (EPR), specifically designed for use with critical care patients. Medical transfer documentation was completed

electronically and the nursing discharge summary was done electronically and printed for hand over to ward staff. On the SHDU and MHDU paper records were still in use

All records we reviewed were clear, up to date, legible, dated and signed. On the EPR, records were electronically signed. Paper records were stored securely and easily available to all staff providing care on the units. The EPR could only be accessed by staff password so the system was protected. This meant that patient information and records were stored securely. On the ICU there were enough computers available for staff, this meant records could be updated immediately.

Records were shared by doctors, nurses and other healthcare professionals. This meant that all professionals involved in a patient's care could access the records as required. Medical staff were also able to access results from investigations electronically.

We looked at 13 records and found that assessments for VTE, pressure areas, nutrition and pain had been completed using national risk assessment tools. Sepsis bundles were in place where appropriate. The records also included evidence of the twice daily ward round reviews and completed care plans.

Data provided for critical care inpatient documentation analysis showed across the 8 standards audited documentation was mostly fully compliant. Two areas were identified as being an organisational priority. These were against standard 8, decisions making: not having the responsible lead indicated (3%); and standard 12, advance decisions: decision maker not identified for advance decisions (32%).

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

A senior pharmacist was worked on the ICU for 3.5 hours a day and the SHDU for 1.5 hours a day Monday to Friday. On the MHDU a senior pharmacist was available for 1.0 hour a day Monday to Friday. On the ICU and the SHDU they also attended the multi- disciplinary meeting and ward rounds. Data provided showed that pharmacist would attend MHDU ward rounds from February 2019. Medicines advice was available from the hospital wide pharmacy team on a Saturday and Sunday between 9.00am to 5.00pm and out of hours 24/7.

The pharmacist undertook reconciliation and review of medicines. Medicines (including controlled drugs) were stored securely. Medicines and equipment for use in emergencies were accessible to staff and were checked regularly. Emergency medicines were stored in tamper evident boxes.

Medicine fridge temperatures were checked regularly and found to be up to date. The SHDU used the fridge on the ICU to store medication.

Ambient temperatures of medicines storage areas were monitored. On the MHDU the ambient temperatures were high, regularly reading above 25^C which could affect the efficacy and expiry dates. Staff advised pharmacy was aware and they had fans in the summer to mitigate the risk.

We saw controlled drugs (CD) were generally well managed, safely stored with regular stock checks. On the ICU, electronic patient records (EPR) were counter signed electronically. Staff told us they signed both the CD register and the EPR. On the SHDU and MHDU, these were recorded signed on the MAR chart and the CD register. Data provided showed that CD's were audited by

pharmacy on the ICU and SHDU in September 2018, there were three actions remaining outstanding.

Patients own drugs were stored in cupboards at patient's bedside which staff could access with keys.

Pharmacy staff visited wards each day and conducted medicines reconciliation. Medicines reconciliation is the process of ensuring that the list of medicines a person is taking is correct. Staff could access medicines supplies and advice out of hours. Data provided showed the ICU and SHDU scored 85% for medicine storage in March 2018. An action plan was in place which showed these had all been completed by June 2018.

We checked 10 prescription charts and saw that information on patient demographics and allergy status were complete.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The trust used an electronic incident reporting system widely used in the NHS to report incidents. During the 12 month period January 2018 to December 2018, a total of 271 incidents were reported across the critical care services. The top three being single sex accommodation breaches (25), pressure sores grade 2 hospital acquired (23), patient skin tear (18). Staff we spoke with were aware of how to report incidents and had used the reporting system. They received feedback on outcomes of investigation and learning across the unit and wider trust was shared during handover safety briefings. There was a monthly briefing document, 'Incidentally' which was shared to all clinical staff in anaesthetic's and critical care which senior staff used to share learning. Incidents were also reviewed as part of the two weekly review of critical care clinical incident meeting, which were escalated through to the critical care quality and professional development team (QPDT)and governance meetings.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as a never event for critical care.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in critical care which met the reporting criteria set by NHS England from December 2017 to November 2018. This related to a pressure ulcer meeting SI criteria in January 2018.

(Source: Strategic Executive Information System (STEIS))

There was one serious incident on critical care which was a pressure ulcer (PU). We requested details of the investigation but this was not provided. However, the trust provided the thematic review which was requested by the Dudley Clinical Commissioning Group (CCG) following a

meeting with the trust to address the 37 PU serious incidents (SIs) root cause analysis (RCA) reports that remained outstanding from across the trust. The SI in critical was reviewed as part of the thematic review. An action plan was developed in response to the thematic review with 19 actions identified. Data provided indicated that as of December 2018 10 action points were still in progress.

Through investigation and learning from pressure damage incidents senior staff told us the tissue viability nurse would review any pressure damage. There had also been changes to equipment used as the critical care services had sourced different equipment such as full face masks to reduce sores across a patient's nose, reviewed mouth care bundles to increase checks of a patient mouth and endotracheal tube (ET Tube) placement, and sourced different types of fastening to secure tubes. Training had also been implemented on the new equipment to reduce pressure damage.

From November 2014, NHS providers are required to comply with the duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of their responsibility to apologise and be open and honest and share the information with the patient and their carer's. At the last inspection, it was found that staff did not undertake duty of candour in line with requirements of the duty of candour regulations. Data provided showed targeted training had been put in place for all nursing and medical staff to be completed by July 2018.

Learning from Morbidity and Mortality reviews reported on all deaths within the critical care services. Minutes and power point presentations detailed the learning from the reviews and highlighted areas of good practice.

Safety thermometer

Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported nine new pressure ulcers, no falls with harm and no new catheter urinary tract infections from September 2017 to September 2018 for critical care.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Dudley Group NHS Foundation Trust

Total Pressure ulcers (9) [1]

1 Pressure ulcers levels 2, 3 and 4

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges, the Intensive Care Society, the Faculty of Intensive Care Medicine and other relevant bodies.

Policies, procedures and guidelines were available to all staff via the trust intranet system and staff demonstrated they knew how to access them.

The critical care service participated in the ICNARC database for England Wales and Northern Ireland, so care delivered and patient outcomes were benchmarked against similar units nationally.

The ICU followed NICE guidance CG135 by promoting and participating in a programme of organ and tissue donation.

The critical care service participated in the Midlands Critical Care and Trauma Networks peer review self-assessment audit 2018 to assess how the service was meeting the Guidelines for the Provision of Intensive Care Services (GPICS).

In quality and professional development team meetings (QPDT) audit results were reported back. Local audits have been used to improve practice, examples being: Vancomycin prescribing, propofol infusion, anti-microbial prescribing, prescribing in renal impairment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. However, the service did not have a dedicated dietitian and was not meeting the Guidelines for the Provision of Intensive Care Services (GPICS) for dietician's staff.

Nursing staff completed assessments in nutrition and hydration. Staff used the Malnutrition Universal Scoring Tool (MUST) on admission and at regular intervals to assess patients at risk of malnutrition. Staff weighed patients weekly to assess patient nutritional needs. These were seen to be completed on the electronic record system along with fluid balance checks.

Patients who could take oral nutrition were offered a menu with a wide range of dietary requirement food, and healthy choices. There was access to meals for different dietary requirements religious or cultural needs.

The ICU did not have a dedicated dietitian and was not meeting the Guidelines for the Provision of Intensive Care Services (GPICS) for dietician's staff providing between 0.05 - 0.1 WTE per bed space. Dieticians attended critical care daily Monday to Friday.

Speech and language therapist (SALT) were available Monday to Friday following individual referral. Critical care nurses were not trained to undertake swallow assessments.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used verbal and nonverbal assessments to assess and manage pain. The communication tools were available on the ICU and SHDU used to assess pain in patients who were unable to communicate. On the MHDU staff did not have access to pain tools, but we saw that new patient observation charts had prompts in place to assist staff to recognise if a patient was in pain. The new patient observation charts were in the process of being printed.

Pain levels were regularly reviewed and discussed at ward rounds; this was recorded in the electronic patient record.

Consultants on the units managed pain relief, with input from the specialist pain team available on request. Staff told us that the pain team included a psychologist if needed.

Staff competency assessment included patient controlled analgesia (PCA) for patients able to use it. Nurses told us there was a new policy and procedure developed following a few near miss incidents, and this was much clearer to use.

Patients we spoke with told us that pain had been dealt with immediately.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The trust had three units which contributed to the Intensive Care National Audit Research Centre (ICNARC) in 2017/18, which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 Annual Report. Any available quarterly data should be considered alongside this annual data. Please note: The surgical HDU (SHDU) only submitted data for Q3 and Q4 2017/18.
(Source: Intensive Care National Audit Research Centre (ICNARC))

The trust submitted two ICNARC submissions, one which covered the ICU and the SHDU and another for the MHDU. Information from the ICNARC quarter one 2018/2019 was provided by the trust and is referenced below.

For the MHDU at Russells Hall Hospital, the risk adjusted hospital mortality ratio was 1.4 in 2017/18. This was higher than expected. The figure in the 2016/17 annual report was 1.3.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
493 admissions	Risk-adjusted hospital mortality ratio (all patients)	1.3	1.4	1.0	none	Higher than expected

For the ICU at Russells Hall Hospital, the risk adjusted hospital mortality ratio was 1.0 in 2017/18. This was within the expected range. The figure in the 2016/17 annual report was 0.9.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
344 admissions	Risk-adjusted hospital mortality ratio (all patients)	0.9	1.0	1.0	none	Within expected range

For the SHDU at Russells Hall Hospital, the risk adjusted hospital mortality ratio was 1.1 in 2017/18. This was within the expected range.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
347 admissions	Risk-adjusted hospital mortality ratio (all patients)	n/a	1.1	1.0	none	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC data from quarter 1 April to June 2018 report showed the risk adjusted mortality ratio was 1.41 for the ITU and SHDU, and for the MHDU 1.48, which was within the expected range.

For the MDHU at Russells Hall Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 2.1. This was higher than expected. The figure in the 2016/17 annual report was 1.3.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
311 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	1.3	2.1	1.0	none	Higher than expected

For the ICU at Russells Hall Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 1.2. This was within the expected range. The figure in the 2016/17 annual report was 0.6.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
181 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	0.6	1.2	1.0	none	Within expected range

For the SHDU at Russells Hall Hospital, the risk adjusted hospital mortality ratio for patients with a predicted risk of death of less than 20% was 0.9. This was within the expected range.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
305 admissions	Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	n/a	0.9	1.0	none	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC data from quarter 1 April to June 2018 report showed the risk adjusted mortality rate was 1.41 for the ITU and SHDU, and for the MHDU 1.48, which was within the expected range.

The trust advised the clinical service lead would undertake a review of the data submitted in the ICNARC reports and review data which was significantly away from the national average. In the past this had included analysis of patients being discharged out-of-hours that demonstrated these were predominantly very stable patients. Other indicators of concern have included delayed discharges from MHDU which was added to the risk register with actions.

The trust provided evidence of an audit calendar of 13 local and national audits planned and undertaken. The calendar showed that eight had been completed and six were awaiting national publication, two audits were yet to commence and three had been removed from the plan. Recently published studies included research in to psychological sequalae following ICU admission. The study demonstrated that 14 – 15% of the ICU's patients had issues, which reinforced the need for an ICU rehabilitation clinic as these numbers were higher than anecdotally thought for the patient population in ICU.

As part of the Midlands Critical Care and Trauma Network the unit participated in peer review. The latest report 2018 found the unit met the 65% of standards with 28% partially achieved. At inspection we found some steps had been taken to address areas for improvement such as including a rehabilitation clinic as part of the proposed redevelopment of the rehabilitation service in critical care and the percentage of nurses with post graduate qualification in critical care. However, out of hours discharges continued and the provision of sufficient pharmacist cover was still an issue.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and monitor the effectiveness of the service.

On the ICU and SHDU 40% of nursing staff had the post registration critical care award. The trust forecast this would be 46% by May 2019. This did not meet the Guidelines for the Provision of Intensive Care Services (GPICS) 2015 which suggests a minimum of 50% of registered nurses on the units should hold a post postgraduate critical care qualification. The trust advised they had four staff identified to undertake the next course and were reviewing if a further two places could be supported.

All new qualified staff working on the MHDU were supernumerary for six weeks and would be required to complete their step 1 competencies for high dependency unit (HDU) care, before undertaking their HDU training. At the time of the inspection, nine band 6, three band 5 had completed the course and two band 5 staff were working towards the course. 13 band 5 nurses still needed to complete the course.

Staff told us they had access to ongoing specialities training on the ICU and SHDU supported by a band 7 clinical practice educator nurse (PDN). The MHDU had a 0.5 WTE vacancy for a PDN.

ICU and SHDU staff had opportunities to develop and progress. All band 6 nurses rotated across the critical care outreach team to gain skills in patient assessment and treatment. All nurses and HCAs in ICU and SHDU rotated between the two units gaining skills in the treatment of critically ill patients in ICU and surgical patients in SHDU. Across all the units, more experienced band 5 nurses had the opportunity to 'act up' in the role of a sister or nurse in charge to gain management experience before applying for the role. Senior staff told us it had been agreed that staffing across the ICU, SHDU and MHDU should be aligned to manage the medical and nursing staff cover.

For year to date, April to September 2018, 93.1% of required staff in critical care received an appraisal compared to the trust target of 90%.

The breakdown by staff group for the ICU and SHDU can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
NHS infrastructure support	1	1	100.0%	90%	Yes
Support to doctors and nursing staff	13	13	100.0%	90%	Yes
Qualified nursing & health visiting staff	81	88	92.0%	90%	Yes
Total	**95**	**102**	**93.1%**	**90%**	**Yes**

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Appraisal rates for MHDU nursing staff was displayed on information boards. Compliance for January 2019 was 100% for nursing staff. The trust advised qualified nurses revalidation across the critical care service was 100%.

Appraisal rates for medical staff working across the critical services was 100% and that revalidations were all current with non - deferred.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

In addition to doctors and nurses, the critical care service was supported by other allied health professionals. A dietitian who attended the service Monday to Friday and 2.5 WTE physiotherapists. This did not meet the GPIC standards for dietitian and physiotherapy WTE requirements. A business case was being developed to improve the rehab service. The lead nurses were band 7, and the deputy matron who had recently been appointed for the critical care services was band 8 which met the GPIC standard.

The ICU and SHDU had a practice development nurse (PDN) responsible for co ordinating training and development for nursing staff. The MHDU did not have a PDN in post. This did not meet the GPIC standards for WTE.

Dedicated senior pharmacist services were available 5 hours per day Monday to Friday on the ICU and the SHDU. Senior pharmacists were available 1 hour per day on the MHDU and they also supported other wards. A microbiologist attended the unit Monday to Friday and attended ward rounds on a Monday, Wednesday and Friday on the ICU and SHDU. The trust advised the microbiologist would start attending the MHDU wards round three days per week from February 2019.

Speech and language services were available Monday to Friday.

The critical care operation policy detailed the patient admission criteria for the unit. The final decision to admit rested with the consultant on the day.

The multidisciplinary team worked well together and attended or contributed to the morning consultant led ward round. There were weekly multidisciplinary meetings including doctors, nurses, pharmacists and physiotherapists.

The physiotherapists worked with medical and nursing staff to plan and implement ventilator weaning programmes, for patients starting to breathe more on their own.

The critical care outreach team followed up patients discharged to the wards.

Seven-day services

On the ICU and SHDU, a critical care consultant covered seven days a week between 8.00am and 6.00pm on site. There were consultant led ward rounds twice every day, including weekends and bank holidays on the ICU. Consultants worked an on call rota, they were accessible 24/7 and able to attend within 30 minutes.

On the MHDU a consultant covered Monday to Friday between 8.00am and 6.00pm. There were consultant led ward rounds twice a day Monday to Friday. Out of hours cover was provided by the medical registrar. Consultant cover was provided by the medical speciality teams.

Junior doctors confirmed they were encouraged to call consultants if needed and they were always accessible.

A critical care pharmacist was based on the ICU and the SHDU Monday to Friday. On the MHDU had access to a pharmacist who also covered the wards Monday to Friday. Medicines advice was available from the hospital wide pharmacy team on a Saturday and Sunday between 9.00am to 5.00pm and out of hours 24/7.

Physiotherapist staff covered seven days per week 8.00am to 4.00pm providing a reduce service at the weekends for patients who require respiratory reviews. They also provided a 24/7 on-call service for deteriorating respiratory patients.

The ICU had a dedicated microbiology service Monday to Friday.

The critical care outreach team were available 24 hours a day, seven days per week to follow up on patients who had been stepped down from critical care. They also reviewed and assessed patient who showed signs of deterioration.

The trusts palliative care team provided a five day a week service, they took referrals and attended the critical care services as needed.

Health promotion

Staff identified patients who may need additional support and had long term conditions following their critical care. They referred patients to specialist teams as needed, for example the diabetes team and pain team.

Patient menus included meals labelled as healthy choices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care, but compliance for mental health law training for medical staff was below the trust target of 90%.

The trust reported that from April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 96.9% of staff in critical care compared to the trust target of 90%. This included 85 out of 87 qualified nursing staff in critical care (96.6%).

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Following the inspection, the trust provided details of the mental health law training undertaken by medical staff working in critical care which showed 28% of medical staff had completed the training which was below the trust target of 90%.

Staff demonstrated a good knowledge and understanding the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Staff told us they would contact the psychiatric liaison team if they had any concerns or needed support.

Staff told us that an independent mental capacity advocate (IMCA) was needed on occasions. At the time of the inspection there were no patients in the critical care service subject to DoLS.

Staff told us they always asked a patient before they provided any care, where patients had capacity they would seek verbal consent. On the MHDU, staff told us that they would ask patients consent to display their initials on the white board as this was visible to people accessing the unit. We saw this was documented on the front of admission documentation.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff were passionate about providing compassionate care to patients and those close to them. Staff described how they supported patients who were anxious or distressed, they were non-judgmental in their attitudes. We observed staff treating patients and relatives with compassion, dignity and respect.

All the patients and relatives we spoke with told us they were very happy with their treatment which they felt was excellent and were very positive about the staff who provided their care and treatment across all three units. On the intensive care unit (ICU), surgical high dependency unit (SHDU) and medical high dependency unit (MHDU) staff were seen to be considerate and empathetic towards patients and their relatives. We observed staff providing reassurance to patients and ensured they were comfortable. Patients told us that staff would introduce themselves when delivering care.

Visiting times across the three units varied, on the ICU there was open visiting with quiet time between 1.00pm and 3.00pm. On the MHDU the visiting times had recently changed to allow relatives to visit from 11.00am to 8.00pm. Staff told us this had been positive change for patients as it meant relatives could support their loved ones at meals times if required and that relatives came at different times of the day. On the SHDU visiting was restricted. Relatives could visit from 11.30 to 1.00pm and from 5.00pm to 8.00pm. Staff explained this was due to patients on the unit having been to theatre and needing time to recover after their surgery.

Messages from relative and patients were displayed on notice boards outside the units. The cards displayed thanked the staff for their caring and kindness. Senior staff told us that they would update the board each month with cards they had received from grateful relatives and patients.

In the communication book on the MHDU, we saw an entry to ask staff to say, 'happy birthday' to a patient.

The units all participated in the NHS Friends and Family test (FFT). On the ICU, the response rate for the period January to December 2018 was 45% which was higher than the critical care services target of 35%. The SHDU had a response rate of 84.8% and on the MHDU it was 78% over the same period. On the ICU and SHDU, 100% of patients recorded they would recommend the service and on the MHDU 99% of patients recorded they would recommend the service.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw staff providing emotional support to patients and relatives. Patient's individual concerns were identified and responded to in a positive and reassuring way.

A multi-faith hospital chaplaincy team was available to provide support to patients and relatives.

Patients, and their families, who received life changing diagnosis were provided with support from staff and were referred to other services as needed. The specialist palliative care team was accessible and provided supportive care for complex social, emotional and spiritual matters. They

worked with staff to support patients and families at the end of life and withdrawal of treatment. Medical staff told us they would try to move patients who were end of like care to side rooms.

Staff could also refer patients to the liaison psychiatric team for review if needed.

Patient diaries were in place for families and members of the multidisciplinary team to write in to keep a record of what had happened whilst the patient was receiving treatment.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients and relatives told us that staff took time to explain the care and treatment, and they had good communication from the medical staff.

The entrance to the units had photo boards of all the staff, and friends and family were encouraged to speak to staff if they had any concerns or questions.

On the units we observed staff speaking to relatives in relative's rooms to protect their privacy and to provide support to relatives. Relatives rooms were available on the units where relatives could spend time and staff could meet with families for discussions and break bad news. Camp beds were also available so family members could stay overnight and be close by their loved ones.

Treatment plans and rehabilitation goals were discussed with patients and family where possible. The rehabilitation plan for each patient was discussed with their families throughout their stay and when they moved to the ward.

Staff could access the Specialist Nurse for Organ Donations (SN-OD). Staff told us they would normally involve the SN-OD early in the process to speak sensitively to relatives of patients about organ donation when treatment was being withdrawn. The consultant and SN-OD would approach families together. Families would receive a letter from the SN-OD to thank them. We saw one relative commented "How can you make it any worst by asking – positive outcome'.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

At Russells Hall Hospital, critical care services are delivered across three units: Intensive care unit (ICU), with seven level 3 beds and two level 2 beds, the surgical high dependency unit (SHDU) with eight level 2 beds, and the medical high dependency unit (MHDU) with eight level 2 beds and two additional flexible beds.

The trust managed patients with weaning difficulties using the protocol from the BREATHE trial which was consultant led. Guidelines were in place for ventilator weaning. Patients with long term ventilation were transferred to another hospital which was centrally funded by NHS England. Staff told us the last long term difficult patient was transferred to another hospital for long term ventilation over 12 months ago

Renal dialysis facilities were available on the ICU, SHDU, and MHDU, with access seven days a week to renal physicians.

The ICU, SHDU and MHDU all had access to a relative room within the units. The rooms provided a quiet and private place for family members, friends or carers of patients with life threatening illness, or recently bereaved. They were used by next of kin if they had a difficult decision to make or if they had received bad news.

Camp beds were available if a family member wanted to stay overnight with access to toilet facilities. Although there were no kitchen facilities on either unit for families or relatives to make a hot drink or heat meals, relatives could purchase hot drinks from a vending machine in the waiting area of ICU.

Meeting people's individual needs

The service took account of patients' individual needs.

Whilst the ICU did not have a rehabilitation follow up clinic. Data provided showed that in 2018 that a total of 57 patients were indicated for ICU rehabilitation and started the rehabilitation pathway. With 45 patients reviewed at least once on the in-patient fortnightly multi-disciplinary ward round. 12 patients were discharged from hospital between being discharged from the ICU and an ICU rehabilitation ward round. Telephone follow up calls were made to three patients who were identified as high risk whilst in-patients.

There were a high number of mixed sex breaches on the unit over the year. A mixed sex breach occurs when level one or level zero patients are accommodated in an open ward area with a member of the opposite sex. Mixed sex breaches should occur infrequently on critical care as patients are transferred to a ward once they reach level 1.

Communication aids were available to assist staff with nonverbal cues. Staff also had access to two iPads on the ICU with communication applications (apps) for patients with tracheostomy. The iPads could also be used by patients for entertainment purposes. Staff advised they would also encourage patients have their own devices brought in. Often there isn't enough band-width to meet the demands of all the patients, visitors and staff. Following the last inspection, the trust had installed free Wi-Fi in the ICU and SHDU and television screens on the MHDU.

Call bells for two side rooms on the adjacent ward did not ring in the nurse's station on the SHDU but rang on the adjacent ward. Senior staff advised this was being addressed and had plans in place to mitigate the risk. At the time of the inspection one patient was in a side room.

Equipment for bariatric patients was stored and available in the hospital and additional equipment could be hired.

Whilst the trust did not flag patients with dementia, the ICU made changes to their electronic patient record which prompted staff to undertake delirium assessments.

The trust had learning disability nurses who were able to offer support and advice when patients with a learning disability were admitted to any of the critical care wards. There were also learning disability specific care plans. These contained important information about patient needs and wishes, likes and dislikes and how best to communicate and interact with them. Staff had access to communication tools. Staff also relied on families to help support patients through their admission.

The liaison psychiatric team were available for staff to refer patients for specialist support and assessment.

Staff also worked closely with the hospital palliative care team who were very responsive to referrals for life limiting illness, and end of life care.

A translation service was available for patients and families. The main service was by telephone but face to face translation could be arranged.

Access and flow

People could access the service when they needed it. However, patients discharged on the MHDU were delayed more than 8 hours, this was worse than other similar units.

From September 2017 to August 2018, The Dudley Group NHS Foundation Trust has had a relatively stable adult bed occupancy. Levels were above or the same as the England average for most months in the period except for September 2017 when they were less than the England average.

Adult critical care Bed occupancy rates, The Dudley Group NHS Foundation Trust.
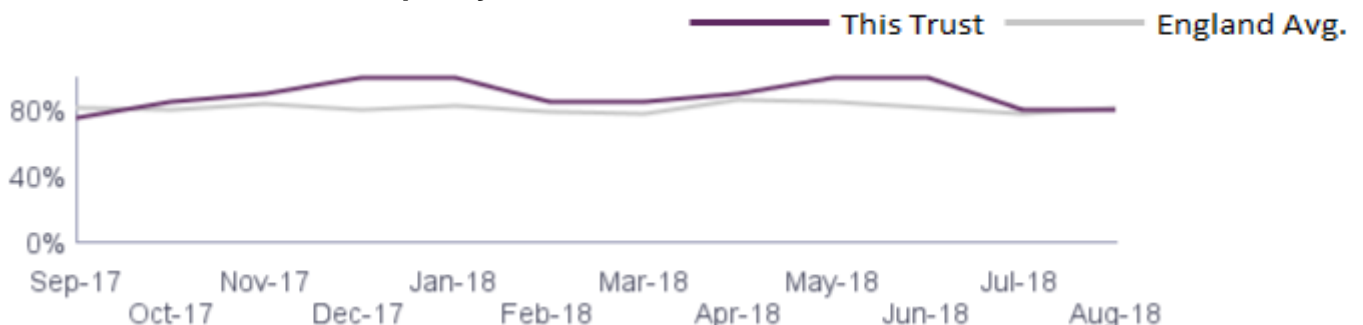
Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

The critical care operational policy set out the patient pathways for admitting patients to the ICU and the SHDU. ICNARC data for the ICU and SHDU from quarter 1 April to June 2018 report

showed that 26.7% of admissions were unplanned from emergency or urgent surgery. Elective surgery was 14.9% and non-surgery was 58.4% of admissions. On the MHDU all the admissions were non-surgical.

The trust told us there were 30 patients (ICU x 6, SHDU x 11, MHDU x13), between October 2017 and September 2018 who could be transferred to wards but had to wait more than 4 hours to be moved due to the capacity on general wards in the hospital.

The trust told us they never ventilated patients outside of critical care owing to bed pressures. Over the 12 month period December 2017 to November 2018, there were 78 elective cases for surgery admitted to the ICU and 354 admitted to the SHDU. Over the same period, eleven patients had their operations cancelled, this was 6.4% (5) on the ICU and 1.7% (6) on the SHDU.

ICNARC data from quarter 1 April to June 2018 report showed there were no out of hour discharges to the wards or unplanned readmissions within 48 hours on the ITU, SHDU and MHDU.

For the MHDU at Russells Hall Hospital, there were 3,650 available bed-days in 2017/18. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 22.8%. This compares to the national aggregate of 4.6%. This meant that the unit was within the worst 5% of units. The figure in the 2016/17 annual report was 20.7%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
3,650 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	20.7%	22.8%	4.6%	0%	Within the worst 5% of units

For the ICU at Russells Hall Hospital, there were 2,920 available bed-days in 2017/18. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 0.9%. This compares to the national aggregate of 4.6%. This meant that the unit was not within the worst 5% of units. The figure in the 2016/17 annual report was 1.7%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
2,920 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	1.7%	0.9%	4.6%	0%	Not within the worst 5% of units

For the SHDU at Russells Hall Hospital, there were 1,456 available bed-days in 2017/18. The percentage of bed days occupied by patients with discharge delayed more than eight hours was 1.5%. This compares to the national aggregate of 4.6%. This meant that the unit was not within the worst 5% of units.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
1,456 available critical care bed days	Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	n/a	1.5%	4.6%	0%	Not within the worst 5% of units

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC data from quarter 1 April to June 2018 report showed the percentage bed-days occupied by patients with discharge delayed greater than 8 hours was 1.00% for the ITU and SHDU which was better than similar units and for the MHDU was 20.6% which was worse than other units.

For the MHDU at Russells Hall Hospital, there were 519 admissions in 2017/18, of which 0.0% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2016/17 annual report was also 0.0%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
519 admissions	Crude non-clinical transfers	0.0%	0.0%	0.3%	0.0%	Within expected range

For the ICU at Russells Hall Hospital, there were 359 admissions in 2017/18, of which 0.3% had a non-clinical transfer out of the unit. This was within the expected range. The figure in the 2016/17 annual report was 0.5%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
359 admissions	Crude non-clinical transfers	0.5%	0.3%	0.3%	0.0%	Within expected range

For the SHDU at Russells Hall Hospital, there were 363 admissions in 2017/18, of which 0.0% had a non-clinical transfer out of the unit. This was within the expected range.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
363 admissions	Crude non-clinical transfers	n/a	0.0%	0.3%	0.0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC data from quarter 1 April to June 2018 report showed the non clinical transfers to another unit was 0.00% for the ITU and SHDU and for the MHDU was 0.0%.

For the MHDU at Russells Hall Hospital, 0.4% of admissions were non delayed, out-of-hours discharges to the ward in 2017/18. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range. The figure in the 2016/17 annual report was 0.3%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
276 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	0.3%	0.4%	2.0%	0%	Within expected range

For the ICU at Russells Hall Hospital, 2.9% of admissions were non delayed, out-of-hours discharges to the ward in 2017/18. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range. The figure in the 2016/17 annual report was 1.9%.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
140 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	1.9%	2.9%	2.0%	0%	Within expected range

For the SHDU at Russells Hall Hospital, 4.0% of admissions were non delayed, out-of-hours discharges to the ward in 2017/18. These are discharges which took place between 10:00pm and 6:59am. This was within the expected range.

Number of cases	Metric	2016/17	2017/18	National aggregate	Asp Standard	Comparison
323 admissions	Crude, non-delayed, out-of-hours discharge to ward proportion	n/a	4.0%	2.0%	0%	Within expected range

(Source: Intensive Care National Audit Research Centre (ICNARC))

Data provided for the critical outreach team for the period January 2018 to December 2018, showed the team carried out 3932 assessments, with 65% (2559) patients being reviewed, 11.4% (4490) patient had been stepped down from critical care.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. However, complaints were not managed in line with the trusts complaints policy.

From October 2017 to September 2018, the trust received seven complaints in relation to critical care (1.4% of total complaints received by the trust). Patient care was the subject of three of these complaints.

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient care	3
Other (specify in comments)	2
Values & behaviours (staff)	2
Communications	1
Total	**7**

For the five complaints that had been closed at the time of data submission, the trust took an average of 52.8 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

The two complaints for the critical care services that had not yet been closed had been open for an average of 61.5 working days at the time of data submission. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

From October 2017 to September 2018, there were 311 compliments received for critical care (4.5% of all received trust wide).

Compliments were received in all 12 months of the period. December 2017 was the month where the most compliments were received (46).

The trust reported key themes emerging from the compliments, supporting the information found in other surveys that had been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Compliments received in the 12 month period January to December 2018 the total compliments received were 344 across the critical care services.

The trust advised because of positive feedback from a patient they purchased four rehabilitation chairs from charitable funds for use within the ICU. This enabled patients to be transferred laterally from bed to chair within out the use of a hoist.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Critical care services were managed through two different directorates. The ICU and SHDU was part of the Surgery, Women and Children's division and came under the Theatres, Anaesthetics, Critical Care and Pain (TACP) directorate. The MHDU was part of the Medicine and Integrated Care division and came under the gastroenterology, GI unit, Respiratory, Renal, Endocrine and MHDU directorate. Each division was overseen by a clinical director and a nursing and directorate manager. At a local level the ICU and SHDU were supported by a clinical service lead and matron. The MHDU was supported by the lead clinician for the MHDU and matron.

The trust had two band 7 lead nurses to oversee nursing on the ICU, SHDU and MHDU. A matron for intensive care and theatres supported the lead nurse for ICU and SHDU and a matron for medicine supported the MHDU lead nurse. On the unit's shifts were led by the nurse in charge (NIC) who was a band 6. The NIC was rostered as supernumerary

Since the last inspection plans were being developed to bring the MHDU under the TACP division so all the critical care services sat in the one division. A band 8 deputy matron had very recently commenced to work across all the critical care services to provide more leadership oversight and oversee the reorganisation of the critical care services.

Vision and strategy

The service had a vision and strategy for the critical care services reflected the trusts vision and strategy to provide the best possible patient experience and workable plans to turn it into action.

The priority of the critical care services was to become integrated with accountability within one clinical division with one clinical team overseeing the service. To achieve this the critical care service was undertaking demand and capacity modelling of the three units to understand the required level of demand for level 3 beds and level 2 beds; working towards the integration of the clinical management of ICU, SHDU and MHDU in 2019/20 and developing plans to co-locate the service so all the level 3 and level 2 beds were together.

Data provided demonstrated that discussions had commenced, these included the clinical director, ICU clinical service lead, MHDU lead clinician, matron and the lead nurse for the ICU and SHDU and the lead nurse for the MHDU. The critical care service had started the scoping exercise looking at how many beds would be required and future proofing to match the increasing demand for critical Care beds, particularly Level 2 beds.

Whilst the plans were in the initial stages, during the inspection staff we spoke with were aware of the plans to bring the services together under one clinical division. The lead nurses had started reviewing documentation across the SHDU and MHDU so these were consistent and sharing best practice between the units.

A business case was in the process of being developed to expand the post ICU rehabilitation service to offer post discharge outpatient clinics and improve the allied health professional inpatient service offered.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

The multidisciplinary team in the critical care services worked together to provide high quality patient care. The trust values of 'Trusted to provide safe, caring and effective services because people matter' was reflected by staff at all levels in the way they went about their work.

There was a culture of honesty, openness and transparency. Staff were encouraged to report incidents and learning from incidents was discussed at safety huddles, handovers and through critical care and MHDU newsletters to staff.

Clinical staff felt valued and supported. Staff told us there was good team work and very good working relationships. Staff told us 'it's a nice place to work'. Staff were committed to delivering a good service.

Staff were proud to work for the hospital; they were enthusiastic about the care and services they provided for patients. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work. One nurse told us there was a different culture in critical care to the wards, as there was better communication and they felt supported to provide high quality care. Staff were proud of the units they worked on and the positive feedback they received from patients and families.

Junior doctors told us they were supported well by consultants and they had access to teaching. There were opportunities for further learning and development, nursing staff told us there were opportunities for them to progress.

Governance

The service used a systematic approach to continually improve the quality of its services.

There were effective structures and process of accountability to support the services within the critical care services. Clinical governance structures were in place and staff felt these were effective.

Critical care consultants, MHDU consultants, matrons and lead nurses for the critical care and MHDU, pharmacist, allied health professionals, operational managers, clinical nurse specialist and practice development nurse attended the critical care quality and professional development team (QPDT) meetings which was chaired by the clinical director for critical care. QPDT meetings were six weekly, there was a standing agenda which included a review of directorate risks, audits, complaints, compliance to National Institute for Health and Care Excellence (NICE) guidance, NHS Improvement patient safety alerts, learning from deaths and finance. An action log points identified actions to be addressed, by whom, target date for completion, progress and comments. The action sheet showed there were six action points outstanding, three of which were in progress and three from the meeting in January 2019 to be progressed. The clinical director for critical care also attended the monthly trust wide Risk and Assurance Group meetings.

Staff understood their role and function within the service and how their performance enabled the organisation to reach its objectives.

We spoke with the lead nurses who demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting, and undertaking audits.

Nursing staff had regular handovers and safety huddles to escalate and share information from incidents. Critical care staff meeting and band 6 nurse's meetings were also held.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them. However, the service risk register did not clearly document the date of entry for risks or when they had last been reviewed.

The ICU/SHDU risk register had 10 risks identified on it. The risk register included all the concerns we found during the inspection. The trust had a clear process for identifying and managing risks, this included a two weekly review of the critical care reported incident meeting which were escalated to the critical care QPDT and governance meeting. The top two risks identified on the risk register were lack of junior doctors on the SHDU during the week, and not complying with NICE requirements QS158 for rehabilitation after critical care illness for adults. Data provided demonstrated that controls were in place to manage the risks, however it was not clear when the risks had been added to the risk register as they entries were not dated and it was not clear from the risk register when they had last been reviewed or updated as again there was not date.

Activity dashboards were in place to monitor key performance indicators on the ICU and SHDU which included performance measures including hand hygiene performance and pain scores. The ICU and SHDU also undertook a range of local audits these included nutritional audits and pressure ulcers monitoring.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The critical care services used electronic paper records on the ICU and paper records on the SHDU and MHDU. Staff were aware of their responsibilities in relation to confidentiality and data security. Staff had password access to electronic patient records, and paper records were held in trolleys with a digital lock to ensure they were held securely. All the records were accessible to the multidisciplinary team. On the MHDU and SHDU, clinical staff had access to diagnostic results such as blood results and imaging to support them to care safely for patients.

Critical care service performance data was reported to the Intensive Care National Audit and Research Centre (ICNARC). The data for quarter one April to June 2018 was submitted within the expected timescales. Quality key performance indicators (KPI's) for the ICU and SHDU were monitored and reported using the quality dashboard or balanced scorecard.

Staff had secure access to the trust intranet. This held a wider range of information including the trust news, policies and procedures and their training and personal development records. The units had several information boards for staff, patients and visitors.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Patients participated in the friends and family test to provide feedback on their experience whilst in the ICU, SHDU and MHDU. Data provided showed that the service used patient feedback to enhance patients' experience. For example, the critical care service purchased with assistance of charitable funds rehabilitation chairs that enabled patients to be laterally transferred from bed to chair without the use of a hoist on the ICU. The unit no longer used hoists to transfer patients. Patients who had been in critical care were invited to be an "expert patient" as part of the services rehabilitation programme.

The critical care monthly newsletter 'On the critical list' and MHDU newsletter was available to staff, this included updates on the services audit performance, team announcements, feedback from incidents, and highlighting the team's achievements and areas of practice for improvement.

In the staff room there were information boards advertising training and education, opportunities for development, governance and social events. The staff room on the ICU and SHDU also had an idea's board to encourage staff to feedback. There were also regular staff meetings for nursing and medical staff.

The critical care service was part of the Black Country Critical Care Network (BCCCN). The lead nurse and ICU Consultant attended these meetings which were held quarterly and the Tri-network events. The BCCCN lead nurse was also invited to attend the critical care QPDT meetings.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service was part of the local adult critical care network and attended meetings for sharing learning, for example from serious incidents.

The critical care lead had presented at national Intensive Care Society renal symposium on citrate for renal replacement therapy (RRT). The trust was the first critical care unit in Midlands to use Procalcitonin, Citrate for RRT and Dexmedetomidine for sedation.

To address concerns raised by patients concerning the noise levels in the ICU the critical care service purchased a noise monitor (as used in industry). This was installed on the wall by the ICU nursing station. If the set sound threshold was exceeded a visible alarm was activated.

The trust had introduced 1-way valves for arterial lines in ICU and SHDU as part of the national NHS Innovation Accelerator initiative.

A bespoke electronic bed booking system was developed to reduce instances of critical care beds not being booked prior to elective surgery.

A positive incident reporting system was introduced into theatres and critical care to allow any staff member to report any incidence of excellence in healthcare to allow review of why things went well and learn from them.

Critical care had introduced in-situ simulation training for multi-disciplinary staff on tracheostomy emergencies.

Critical Care introduced an 'Anaesthetic Code Red' system as a separate 2222 call in the event of any airway emergency either on the ICU or across the hospital.

The critical care service was currently involved with 65 clinical trials. These included Breathe trial which was looking at the effect of protocolized weaning; and the Stress – L randomized trial to assess whether the addition of a beta blocker infusion to standard treatment in patients with septic shock improved organ failure.

Maternity

Facts and data about this service

The Dudley Group NHS Foundation Trust has 49 maternity beds. Inpatient services include delivery suite midwifery led unit, maternity triage, antenatal and postnatal ward with maternity theatres.

(Source: Routine Provider Information Request – Sites tab)

The trust provided the following statement regarding the maternity service at The Dudley Group NHS Foundation Trust:

'The trust provides a full maternity service incorporating community services, antenatal services, midwife and obstetric-led delivery services and postnatal care. Facilities include a dedicated midwifery led unit, delivery suite, day assessment unit, two dedicated obstetric operating theatres and a women's outpatients department. Antenatal clinics include joint diabetic/obstetric clinic and joint haematology/obstetric clinic.

During our inspection, we spoke with 18 members of staff including maternity service leaders, matrons, midwives and administrative staff. We also spoke with nine women and two partners and reviewed information displayed on huddle boards and noticeboards located in the maternity department.

The trust is part of the Staffordshire, Shropshire & Black Country Newborn and Maternity Network. The trust is also actively part of the Black Country and West Birmingham Local Maternity System delivering the Maternity Transformation Programme.

(Source: Acute Routine Provider Information Request – Context acute tab)

From July 2017 to June 2018 there were 4,250 deliveries at the trust.

A comparison of the number of deliveries at the trust and the national totals during this period is shown below.

Number of babies delivered at The Dudley Group NHS Foundation Trust – Comparison with other trusts in England.
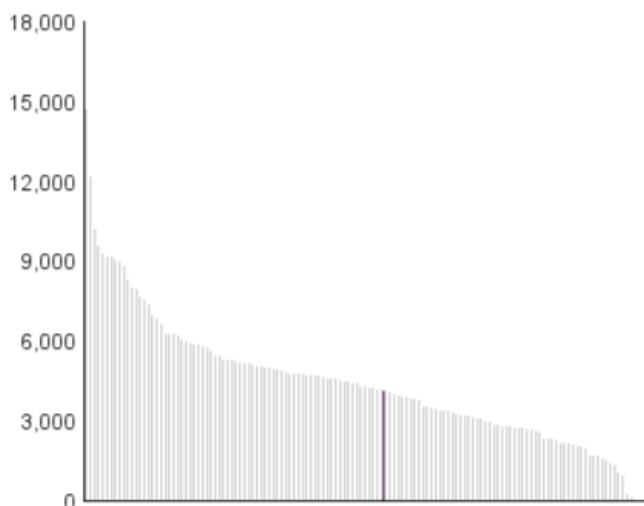
A profile of all deliveries and gestation periods from April 2017 to March 2018 can be seen in the tables below. Please note, this excludes any deliveries where the delivery method is 'other' or 'unrecorded'.

Profile of all deliveries (April 2017 to March 2018)			
	THE DUDLEY GROUP NHS FOUNDATION TRUST		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Single or multiple births			
Single	4,036	98.6%	98.6%
Multiple	59	1.4%	1.4%
Mother's age			
Under 20	181	4.4%	3.1%
20-34	3,255	79.5%	74.9%
35-39	554	13.5%	18.1%
40+	105	2.6%	4.0%
Total number of deliveries			
Total	4,250		596,828

Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

The trust has a similar profile of deliveries in terms of single or multiple births when compared to the England average.

The number of births for mothers aged 20-34 is higher at the trust than the England average. During the reporting period, 79.5% of mothers were aged 20-34 compared to an England average of 74.9%.

The number of births for mothers aged 35 and over is lower at the trust than the England average. During the reporting period, 16.1% of mothers were aged 35 and over compared to an England average of 22.1%.

Gestation periods (April 2017 to March 2018)			
	THE DUDLEY GROUP NHS FOUNDATION TRUST		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Gestation period			
Pre term 24-36 weeks	236	5.8%	7.9%
Term 37-42 weeks	3,838	94.2%	92.1%
Total number of deliveries with a valid gestation period recorded (24 - 42 weeks only)			
Total	4,074		497,291

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.

This table includes deliveries with a gestation period of 24 - 42 weeks only. Deliveries with a valid recorded gestation period of under 24 weeks or over 42 weeks have been excluded from this table due to low numbers.

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.

Number of deliveries at The Dudley Group NHS Foundation Trust by quarter
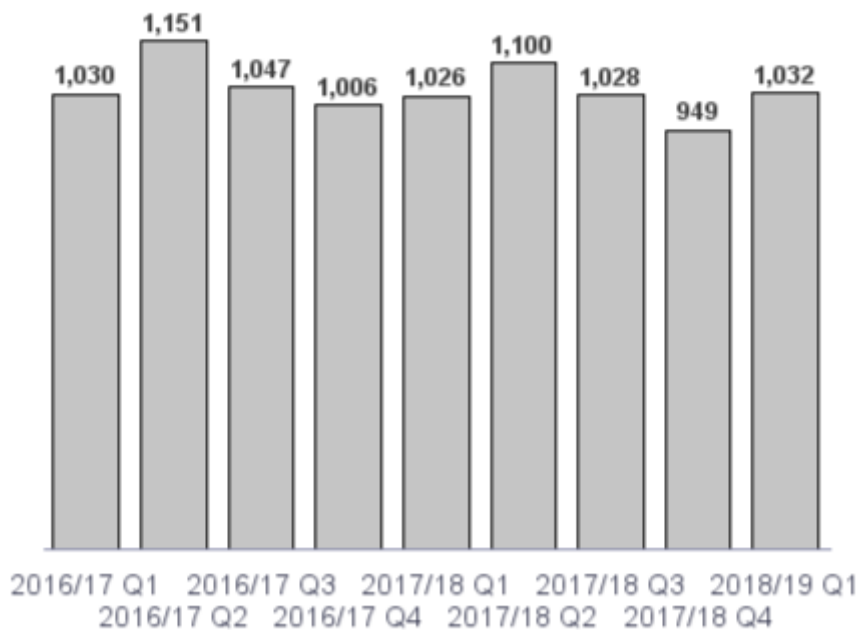
The number of deliveries at the trust fluctuates between 949 and 1,151 per quarter during the reporting period.

(Source: Hospital Episode Statistics - HES Deliveries (July 2017 - June 2018))

Is the service safe?

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.

Mandatory training

The trust target for mandatory training compliance was not all met for midwives or medical staff in some subjects. However, the service had action plans in place, these were monitored regularly, and the trust had set a high percentage target of 90%. Lowest compliance rate was fire at 78% and Infection Prevention and Control at 60.6%.

We discussed low training compliance rates for some modules with leaders of the service during the inspection. The department had processes in place to ensure staff conducted mandatory training in a timely manner. The process was to put on bespoke mandatory training sessions for staff that are not compliant, dates were set for three days in February 2019, including evening sessions to tailor around staff availabilities.

Staff told us that they could access mandatory training when they required it.

Staff within the maternity service conducted skills drills training that was available every month to ensure staff could conduct the training each year, as recommended by national guidance. As of January 2019, 91% staff had completed maternity skills drills training in the simulation laboratory at the trust.

Cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph. All midwives and doctors are required to complete training and competency checks. The unit completion, interpretation, and escalation training for medical staff was at 83.3% compliance and at 92% for midwives against a trust target of 90%.

Mandatory training completion rates

Trust wide

The trust set a target of 90% for completion of mandatory training. Please note that the following analysis includes medical staff working across both maternity and gynaecology.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for midwifery staff in maternity is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Conflict resolution - level 1	160	164	97.6%	90.0%	Yes
Health & safety	159	164	97.0%	90.0%	Yes
Resus - neonatal	151	160	94.4%	90.0%	Yes
Equality & diversity (including autism awareness)	154	164	93.9%	90.0%	Yes

Clinical governance (including incidents, complaints & claims investigations)	153	164	93.3%	90.0%	Yes
Information governance	147	164	90.44%	90.0%	Yes
Fire	146	164	91.71%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	145	164	92.51%	90.0%	Yes
Resus - adult	144	164	91.83%	90.0%	Yes
Infection control - clinical	139	164	84.8%	90.0%	No

In maternity the trust had an overall mandatory training compliance rate of 91.6% midwifery staff. The 90% target was met for five of the 10 mandatory training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for medical staff in maternity (and gynaecology in some cases) is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality & diversity (including autism awareness)	23	23	100.0%	90.0%	Yes
Information governance	23	23	100.0%	90.0%	Yes
Health & safety	23	23	100.0%	90.0%	Yes
Manual handling (non-patient) / slips, trips & falls	22	23	95.7%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	22	23	95.7%	90.0%	Yes
Resus - neonatal	22	23	95.7%	90.0%	Yes
Conflict resolution - level 1	22	23	95.7%	90.0%	Yes
Infection control - clinical	22	23	95.7%	90.0%	Yes
Resus - adult	21	23	91.3%	90.0%	Yes
Fire	18	23	78.3%	90.0%	No

In maternity the trust had an overall mandatory training compliance rate of 94.8% for medical staff. The 90% target was met for nine of the 10 mandatory training modules for which medical staff were eligible.

Please note, all medical staff in maternity are at Russell's Hall Hospital / Corbett Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russell's Hall Hospital

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified midwifery staff in maternity at Russell's Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Conflict resolution - level 1	128	131	97.7%	90.0%	Yes
Health & safety	128	131	97.7%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	126	131	96.2%	90.0%	Yes
Equality & diversity (including autism awareness)	126	131	96.2%	90.0%	Yes
Resus - neonatal	119	127	93.7%	90.0%	Yes
Infection control - clinical	119	131	90.8%	90.0%	Yes
Resus - adult	117	131	89.3%	90.0%	No
Information governance	116	131	90.44%	90.0%	Yes
Fire	115	131	91.71%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	114	131	92.51%	90.0%	Yes

In maternity the trust had an overall mandatory training compliance rate of 92.5% for qualified midwifery staff at Russell's Hall Hospital. The 90% target was met for six of the 10 mandatory training modules for which qualified nursing and midwifery staff at Russell's Hall Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russell's Hall Hospital / Community

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified midwifery staff in maternity at Russell's Hall Hospital / Community is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - neonatal	32	33	97.0%	90.0%	Yes
Conflict resolution - level 1	32	33	97.0%	90.0%	Yes
Information governance	31	33	93.9%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	31	33	93.9%	90.0%	Yes
Fire	31	33	93.9%	90.0%	Yes
Health & safety	31	33	93.9%	90.0%	Yes
Equality & diversity (including autism awareness)	28	33	90%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	27	33	81.8%	90.0%	No
Resus - adult	27	33	81.8%	90.0%	No
Infection control - clinical	20	33	60.6%	90.0%	No

In maternity the trust had an overall mandatory training compliance rate of 87.9% for qualified midwifery staff at Russell's Hall Hospital / Community. The 90% target was met for six of the 10 mandatory training modules for which qualified midwifery staff at Russell's Hall Hospital / Community were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russell's Hall Hospital / Corbett Hospital

As all medical staff in maternity at the trust are at Russell's Hall Hospital / Corbett Hospital, the training data table is identical to the trust wide table for medical staff above.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. All midwifery staff had received the required level of safeguarding training, only some medical staff had completed safeguarding children level 3, this was due to only three eligible staff not having completed the training.

The maternity department did not have a named safeguarding midwife, however would seek advice from the vulnerable women's midwife that was level three trained for both adults and children. When we spoke with senior staff they informed us that this job role is currently being recruited. The head of midwifery (HoM) also supported safeguarding role if needed. Supervision for safeguarding was informal but staff told us they would always speak with their colleagues if they required additional support.

The trust told us low compliance rate for safeguarding training level three for medical staff, were because the two doctors identified were transferring their safeguarding training details from their previous trust's, if this was not in date it was planned they would attend the trust's safeguarding training session by the end of March 2019. Trust informed us that all 12 consultants had completed level three training prior to the inspection. This is now at 100%.

Staff were aware of their role and responsibilities in making safeguarding referrals. Staff showed us their clear safeguarding guidance on the trust internet and told us this was easy to follow. Staff we spoke with demonstrated good understanding around safeguarding and knew whom to contact within the safeguarding team.

The maternity department had a system in place for recording and reporting female genital mutilation (FGM). Staff followed the trust's maternity care of the woman subjected to FGM and to safeguard baby guideline. The guideline discussed the FGM mandatory reporting process and care for pregnant women who have undergone FGM.

FGM training for maternity staff was provided within the vulnerable women's workshop and was also available as an E- learning package at the trust. The trust children's safeguarding team and the appropriate children's services were informed of any unborn and new-born whose mother had been subjected to FGM.

The maternity department had a system in place for recording and reporting cases of sexual exploitation. Where sexual exploitation was suspected, these cases would be initially referred to social services via the Multi Agency Referral Form (MARF). Midwives informed one of the specialist midwives responsible for safeguarding when a MARF was completed. The Specialist Midwives would inform the named nurse for safeguarding children as the trust lead for child sexual exploitation.

Senior staff worked closely with the practice development midwife to put measures in place in respond where safeguarding training compliance did not meet the trust target, this also included other subjects within trust mandatory training. Staff were being allocated training days on their off duty to attend training and the planning for training were booked months in advance to ensure staff could complete training. A process had also been implemented to notify staff members and their line manager if they have had two non-attendances to training.

We reviewed the trust's abduction policy. This would be followed in the event of an unplanned removal of a baby or child up to 16 years of age from the maternity unit. Staff we spoke to were aware and knowledgeable about the process and were able to explain the policy.

Security staff-controlled access to the maternity department 24 hours a day, seven days a week.

The department had close links with the other trusts mental health team who would provide support if a woman was deemed to be at risk of self-harm or also harm to others. This was to ensure measures were put into place to maintain the safety of the women and others.

Maternity services had systems in place to check if families were subject to a child protection or child in need plan. This included the specialist midwives receiving copies of all child protection plans sent from the local social services. An electronic flag was placed on the hospital womens management system and recorded in paper documentation once a notification of a child protection plan was received to alert staff.

Community midwives held monthly meetings with the health visitor who covered the same caseload of women. These meetings allowed for information regarding safeguarding or other concerns to be shared, meeting minutes were then shared with the acute team.

Specialist Midwives led the unborn baby network monthly. This was attended by representatives from all agencies across acute and community. This allowed all concerns relating to child protection to be highlighted and ensured that appropriate actions were carried out by the relevant agency. It also ensured communication between acute and community were maintained.

We saw that staff were actively reminded to participate in WRAP (Workshop to raise awareness of PREVENT) and PREVENT training (training to enable staff to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves) as part of their mandatory training schedule.

Safeguarding training completion rates

Trust wide

The trust set a target of 90% for completion of safeguarding training. Please note that the following analysis includes medical staff working across both maternity and gynaecology.

A breakdown of compliance for safeguarding training modules from April to September 2018 at trust level for midwifery staff in maternity is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	162	163	99.4%	90.0%	Yes
Safeguarding children level 1 & 2	160	164	97.6%	90.0%	Yes
Safeguarding adults	158	164	96.3%	90.0%	Yes
Safeguarding children level 3	155	164	94.5%	90.0%	Yes
W R A P	152	163	93.3%	90.0%	Yes

In maternity the trust had an overall safeguarding training compliance rate of 96.2% for qualified midwifery staff. The 90% target was met for all five safeguarding training modules for which qualified midwifery staff were eligible.

A breakdown of compliance for safeguarding training modules from April to September 2018 at trust level for medical staff in maternity is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	23	23	100.0%	90.0%	Yes
Prevent	23	23	100.0%	90.0%	Yes
Safeguarding adults	22	23	95.7%	90.0%	Yes
Safeguarding children level 1 & 2	22	23	95.7%	90.0%	Yes
Safeguarding children level 3	20	23	87.0%	90.0%	No

In maternity the trust had an overall safeguarding training compliance rate of 95.7% for medical staff. The 90% target was met for four of the five safeguarding training modules for which medical staff were eligible.

It should be noted that for the one safeguarding training module that did not meet the target, this is due to only three eligible staff not having completed the training, so the performance should be taken in context when dealing with small numbers of eligible staff.

Please note, all medical staff in maternity are at Russell's Hall Hospital.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russell's Hall Hospital

A breakdown of compliance for safeguarding training modules from April to September 2018 for midwifery staff in maternity at Russell's Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	129	130	99.2%	90.0%	Yes
Safeguarding children level 1 & 2	128	131	97.7%	90.0%	Yes
Safeguarding adults	127	131	96.9%	90.0%	Yes
Safeguarding children level 3	124	131	94.7%	90.0%	Yes
W R A P	122	130	93.8%	90.0%	Yes

In maternity the trust had an overall safeguarding training compliance rate of 96.5% for qualified midwifery staff at Russell's Hall Hospital. The 90% target was met for all five safeguarding training modules for which midwifery staff at Russell's Hall Hospital were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russell's Hall Hospital / Community

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified midwifery staff in maternity at Russell's Hall Hospital / Community is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	33	33	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	32	33	97.0%	90.0%	Yes
Safeguarding adults	31	33	93.9%	90.0%	Yes
Safeguarding children level 3	31	33	93.9%	90.0%	Yes
W R A P	30	33	90.9%	90.0%	Yes

In maternity the trust had an overall safeguarding training compliance rate of 95.2% for qualified midwifery staff at Russell's Hall Hospital / Community. The 90% target was met for all five safeguarding training modules for which midwifery staff at Russell's Hall Hospital / Community were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russell's Hall Hospital / Corbett Hospital

As all medical staff in maternity at the trust are at Russell's Hall Hospital, the training data table is identical to the trust wide training table for medical staff above.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service-controlled infection risks within the department. Staff kept equipment and premises visibly clean. However, staff sometimes used appropriate control measures to prevent the spread of infections.

We saw all areas in the department were visibly clean and tidy and staff adhered to regular cleaning schedules.

Infection prevention and control (IPC) measures were in place to ensure women were protected against healthcare-acquired infections whilst in the department. Staff received infection control training as part of their mandatory training. As of April 2018, to January 2019 100% of staff were compliant with hand hygiene audit.

Trust IPC policies and guidance were based on national guidance and best practice. However, on one occasion, we saw one example of a staff member re-using face masks and kept the mask around their neck walking to different areas in the department. Clinical face masks are required for barrier nursing, to prevent contamination between staff and the women. We raised our concerns with senior managers and within few hours the department had responded, we saw the trust IPC lead in the department, posters were put on display to remind staff the importance of IPC.

We saw staff across the maternity department were bare below the elbows. This enabled effective hand cleansing.

We saw staff wearing Personal Protective Equipment (PPE) such as gloves and aprons. Staff used hand I sanitizers and washed hands between any clinical intervention. There were sufficient hand sanitising gel dispensers in use, which were well maintained.

During our inspection we saw domiciliary staff were visible throughout the department, we observed staff requesting areas to be cleaned. Staff used appropriate clinical waste bags which was stored appropriately.

Domiciliary staff told us they follow cleaning schedules for each department at the hospital, this included deep cleaning; Once cleaning had been completed staff would sign and date to say areas had been cleaned.

Staff used 'I am clean' stickers to show equipment were clean and ready to be used.

Staff we spoke with in MLU explained their cleaning schedule for the birthing pool and how often they cleaned the area. This was part of their daily schedule to check the birthing pool before any women were admitted to the unit.

Environment and equipment

The service had suitable premises and equipment and these were well maintained, there was adequate availability of emergency and specialist equipment for women.

The maternity unit had the necessary medical equipment in place in accordance with the Royal College of Obstetricians and Gynaecologists Safer Childbirth: '*Minimum Standards for the Organisation and Delivery of Care in Labour'* recommendations. All equipment we checked was in good working order and equipment was up-to-date with electrical testing.

We checked the departments' resuscitation trolleys for both adults and children and found they were well maintained and easily accessible. Staff had signed to verify they completed daily checks. We found one paediatric butterfly needle that was out of date, this was raised and replaced immediately.

All staff we spoke with said that they had access to the equipment they needed but if equipment broke they would report this to their matron who then organised a replacement.

Medical engineering at the trust had an asset management system in place which had a predefined schedule of maintenance for all equipment on each calendar year, this meant that all of maternity's medical equipment had a schedule, that sat on asset management database. The system auto generated the work order for maternity and this covers all medical equipment within maternity unit, the work order auto drops off the system and was assigned to the team to visit and carry out servicing.

The midwifery led unit is located next to our obstetric delivery suite; this allows quick access to labour suite if required. The midwifery led unit (MLU) is a dedicated unit for women with low risk pregnancy. The unit is run by midwives. The birthing rooms have equipment that encourages women to mobilise such as a multi-track couch, birthing balls and bean bags. If women attend MLU but are not in established labour the midwife can provide a TENS machine and pain relief, until in established labour, women have the option to go home.

The unit has three postnatal bays each having four beds allocated to them, labour care was provided in a single en suite room with one to one midwife care. There were two obstetric theatres with a recovery area with staff available 24 hours a day to assist with operative delivery and other surgical obstetric procedures.

Assessing and responding to patient risk

The service had systems in place to recognise and respond to deteriorating women' needs and clinical risks. Observations of women were recorded using the Modified Early Obstetric Warning Score (MEOWS) system, staff demonstrated good understanding of how and when to escalate when a woman deteriorates.

Women's needs were assessed on arrival at the unit through triage, which was open 24 hours a day, seven days a week. Staff told us if women arrived at the unit in established labour, even if they had not booked they would be admitted for observation on to the maternity ward or admitted to the delivery suite.

We saw staff appropriately using the sepsis six pathway through their electronic system called the e-sepsis to assess women for sepsis. Staff told us this was recently introduced to the maternity department and was a work in progress. Staff went on to tell us that the system was not always suitable for maternity services and this was something the trust was currently reviewing to adapt electronic documentation for maternity services.

Staff on duty had a good understanding on recognising signs and symptoms for sepsis and what to do if they had a woman with pyrexia and tachycardia. The sepsis compliance rate for midwives (excluding medics) was at 98%, January 2019.

We observed both obstetric theatres, all staff followed the 'WHO' surgical safety checklist. We reviewed the 'WHO' audit and found 100% were completed for November 2018, December 2018 and January 2019. This was supported from the records we reviewed and found all 'WHO' surgical safety checklists were completed in the maternity surgery records.

Medical Staff told us there was a clear communication antenatally with obstetric anaesthetists through the anaesthetic high risk women database. All midwives, obstetric registrars and consultants had access to the database and could communicate with the anaesthetic team in advance to escalate concerns on high risk pregnant women who required anaesthetic assessment If there is an urgent referral requirement a face to face discussion will always take place.

Staff used the Modified Early Obstetric Warning Score (MEOWS) system for all women. This was recorded electronically apart from those women who were placed in the high dependency unit beds, MEOWS were recorded in women's written record notes. The department did not currently complete MEOWS audits; however, this is something that will be added to their 2020 audit plan.

We reviewed 20 records specifically to review risk assessments, we found that staff did not always complete risk assessments. We raised this with senior managers who said they will act on our concerns. We revisited the department unannounced on 7 February 2019, and we reviewed another eight records and found all risk assessment in the records were completed.

We requested the maternity unit Venous Thromboembolism (VTE) assessment, the unit audited 50 case notes at random, and found 100% of women had their VTE assessed at booking appointment, 94% of women were assessed correctly during antenatal booking, four women were referred appropriately and correctly that scored four or more in their pregnancy, and one woman was not referred at booking;

We saw that 95% of women were VTE assessed on admission, 84% were correctly assessed, 92% of women were VTE assessed postnatally and 93% were assessed correctly, 97% of women were appropriately treated postnatally, 96% of women were assessed prior to being discharged from the unit with correct treatment.

We found numerous issues around cardiotocography (CTG) monitoring and documentation. We reviewed 19 and 11 were not completed accurately. According to NHS England 2016 guidelines, RCOG, RCM and NICE guidelines 2019, accurate record keeping and monitoring cardiotocography must include mother's name, date, time, hospital number and maternal pulse at

the start of monitoring, maternal pulse was not always documented, information must either be recorded electronically or documented on the actual CTG paper. Intrapartum events that may affect a CTG should be recorded on the CTG paper and in the medical records and any ongoing intervention for example vaginal examination, fetal blood sample or epidural siting.

Staff providing an opinion on the CTG also known as 'fresh eyes' should complete a CTG interpretation sticker in the medical records and sign the CTG paper including date and time that they are reviewed. Following birth, CTG should be signed, record the date, time and mode of delivery, or if the trace was discontinued at any time prior to delivery. Storage of traces for all CTGs should be folded in sequence and securely stored in date order in an identifiable CTG envelope and placed within the medical files and ensure that the patient's name and hospital number (or personal ID label) is on the envelope.

We received some Cardiotocography (CTG) monitoring audit dated December 2018. The audit showed variable results of compliance. We also received an additional response that stated, "due to overall unsatisfactory compliance" and "the delays in the electronic patient record, the unit will continue to monitor and re-do audits in six-month time". We received further data for January 2019, following CQC concerns that were raised around lack of documentation completion and the understanding of 'fresh eyes', that showed 90% of staff of had completed accurate documentation and 'two hourly fresh eyes', this was taken from a sample of 10 patient records. We re-visited the unit 7 February 2019 unannounced and we reviewed further eight patient records including CTG monitoring and we found them all to be completed.

Midwifery staffing

The service employed midwives and medical staff with the right qualifications and skills to keep people safe from avoidable harm and to provide the right care and treatment. However, we reviewed staffing rotas that showed on regular basis the unit was short on most days. When we revisited the unit unannounced we found the department staffing levels had improved.

The maternity department monitored required and actual staffing on a continual basis. On a day-to-day basis lead nurses and midwives, escalated staffing issues to matrons who made decisions about how best to resolve any problems. The lead midwives completed actual and required staffing numbers each day, these were collated at the end of every month, and a report was then written and shared to the trust board.

During our inspection, we saw that on 29 and 30 January 2019, the unit appeared to be short staffed. Staff we spoke with said they felt very 'stressed' and "It was very busy". Some staff gave us examples of how busy they were, having two women in labour when it should be a "one to one" care, the midwife also had a post caesarean section woman, staff were able to share many examples. We fed back our concerns and within few hours we were given an action plan. A business case was developed based on a "Birth-rate plus" recommendations, the unit received its final report 22 January 2019, along with a formal request to Birth rate plus to supply Birth Rate Plus acuity tool. The unit have not yet introduced the Birth Rate Plus acuity tool; we also reviewed over three months of rota that showed on regular basis the unit were short staffed; however, the unit had a robust escalation policy for staffing or capacity issues.

On 7 February 2019, we carried out an unannounced visit to the department and found staffing had improved, this reflected on the upcoming rotas we reviewed. Staff told us they felt listened to and felt over the past week work was manageable and staff told us "we work amazingly together, especially through busy times".

During the inspection, we saw daily staffing meetings took place at 10 am, where staffing needs for that day were discussed.

We spoke with senior staff in maternity that confirmed they did not use agency staff to cover shifts. Midwives who worked for the trust on the bank worked additional shifts to ensure shifts were covered. A secure text messages was sent to midwifery staff on the nursing bank to inform them there was a shift that needed covering.

Planned vs actual

The trust reported the following midwifery staff numbers for the two periods below for maternity:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified midwifery staff	148.9	150.2	100.8%	147.5	143.1	97.0%

The trust reported an over established staffing level of 100.8% for qualified midwifery staff in maternity in March 2018. This over establishment related to 1.3 more WTE staff in post than planned for. The staffing level for qualified midwifery staff in maternity dropped to 97.0% in September 2018.

As at September 2018, there were 4.4 fewer WTE staff in post than planned for and 7.1 fewer WTE staff in post than in March 2018. There was a decrease of 1.4 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

Vacancy rates were low within the service with active recruitment and minimal temporary staffing usage. There was a high vacancy rate among medical staff with unfilled shifts.

From October 2017 to September 2018 the trust reported an overall vacancy rate of -0.2% for midwifery staff in maternity. This represents an over-establishment and was lower than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The turnover rate within the service was greater than the trust target. Staff told us that there was a stable base of staff working within the department but felt at times they were short and this did affect patients care at times.

From October 2017 to September 2018 the trust reported an overall turnover rate of 10.8% for qualified nursing and midwifery staff in maternity. This was greater than the trust target of 8.5%.

The breakdown by site was as follows:

- Russell's Hall Hospital: 11.7%
- Russell's Hall Hospital / Community: 7.6%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

The sickness rate was slightly higher than the trusts target. Any episodes of sickness were managed.

When we asked for plan of action around sickness, the directorate informed us they do not have an issue with long term sickness, but the following action and practices in place to manage their sickness.
- Monthly meeting of Human Resource (HR) business partners and maternity managers.
- Managers received monthly report from HR highlighting long term sickness and stages of sickness.
- Manage sickness for each individual staff member as per sickness policy.
- HR business partners invited to attend the Lead Midwives meetings to discuss sickness.
- Utilise Staff Health and Wellbeing service (SHaW).
- Utilise the Professional Midwifery Advocates for one to one support.
- Utilise reasonable adjustments to working to enable staff to return to work sooner.
- Phased returns utilised for long term sickness return.

From October 2017 to September 2018 the trust reported an overall sickness rate of 3.8% for

qualified midwifery staff in maternity. This was slightly greater than the trust target for sickness of 3.5%.

The breakdown by site was as follows:

- Russell's Hall Hospital: 3.4%
- Russell's Hall Hospital / Community: 5.1%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The trust did not provide information on the minimum number of shifts needing to be covered by bank and agency staff and the number of unfilled shifts. Maternity department did not use agency staff. Staff we spoke with said they all covered short falls in rota as part of the maternity team.

Trust wide

From October 2017 to September 2018 the trust reported 2,486.0 of the 198,038.0 available hours in maternity were filled by bank staff (1.3%) and no hours were filled by agency staff. In addition, there were 15,729.0 hours that needed to be covered by bank or agency staff but were unfilled (7.9%).

A breakdown of bank and agency usage by staff type is shown below:

October 2017 to September 2018

Staff type	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	1,975.0	1.4%	0.00	0.0%	8,478.0	5.8%	145,608.0
Non-qualified	511.0	1.0%	0.00	0.0%	7,251.0	13.8%	52,430.0
Total	2,486.0	1.3%	0.00	0.0%	15,729.0	7.9%	198,038.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

Midwife to birth ratio

Staff we spoke with told us that at times, one to one support in labour did not always happen when short staffed, one staff member gave us a very recent example of looking after high-risk patients and those in active labour and was not able to provide one to one midwifery care. Many staff told us at times they can be short when comparing to the flow of women arriving in the department.

From April 2017 to March 2018, the trust had a ratio of one midwife to every 26.6 births. This was similar to the England average of one midwife to every 25.7 births.

(Source: Electronic Staff Records – EST Data Warehouse)

Medical staffing

The service had medical staff with the right qualifications and skills to keep people safe from avoidable harm and abuse and to provide the right care and treatment. There was mixed opinions by all staff whether sufficient medical cover to provide consultant presence in the departments

There are 12 consultants in Obstetrics and Gynaecology providing 98 hour resident cover on labour ward. The labour ward consultant does not have any other commitments during this time. The labour ward consultant cover includes resident cover on weekends and bank holidays 9am and 6pm. There is a non-resident cover for overnight 8.30pm to 8.30am. There are five elective caesarean section lists per week which are undertaken by a second consultant obstetrician.

The trust informed us that as from October 2017 to September 2018, there were five GP trainees changing over in February 2018 and six career trainees, changing over in August 2018. One Foundation year one doctor changed over in August 2018. One specialty doctor was successful in obtaining a training post and left in October 2018. No other medical staff left in this period. Two Medical training initiative were recruited from overseas for a period of two years and commenced employment from August 2018. Trust ensured us that this was the reason behind the high turnover rate in the specified time period.

Planned vs actual

Please note, all medical staff in maternity are at Russell's Hall Hospital.

The trust reported the following medical staff numbers for the two periods below for maternity (and gynaecology in some cases):

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical staff	32.8	30.7	93.6%	35.4	31.6	89.3%

The trust reported a staffing level of 93.6% for medical staff in maternity (and gynaecology in some cases) in March 2018. This dropped to 89.3% in September 2018.

As at September 2018, there were 3.8 fewer WTE staff in post than planned for but 0.9 more WTE staff in post than in March 2018. There was an increase of 2.6 WTE planned posts between the two-time periods.

Trust informed us that there were gaps within the consultant rota due to long term sickness absence of two consultants. All vacant shifts were covered internally by the existing consultants except for one week, when an agency consultant locum was employed.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

Vacancy rates were high within the service and greater than the trust target with active recruitment and using temporary staffing usage.

From October 2017 to September 2018 the trust reported an overall vacancy rate of 10.7% for medical staff in maternity. This was greater that the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The turnover rate within the service was high and significantly greater than the trust target. Staff told us that there was a stable base of staff working within the department but at times this did affect patient care around reviewing patient quickly.

From October 2017 to September 2018 the trust reported an overall turnover rate of 25.0% for medical staff in maternity and gynaecology. This was greater than the trust target of 8.5%.

(Source: Routine Provider Information Request (RPIR) - Turnover tab)

Sickness rates

There was a low rate of sickness within the department, the rate was lower than the trusts target. Any episodes of sickness were well managed and appropriate backfill was arranged for any long-term sickness episodes.

From October 2017 to September 2018 the trust reported an overall sickness rate of 1.2% for medical staff in maternity (and gynaecology in some cases). This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The service used both locum and bank medical staff to cover any shortfalls in medical cover.

From September 2017 to August 2018, the trust reported 4,558.0 of the 70,756.0 available medical staff hours in maternity (and gynaecology) were filled by bank staff (6.4%) and 1,203.5 hours were filled by locum staff (1.7%). In addition, 1.6% of medical staff hours available were not filled by either bank or locum staff to cover staff absence.

	September 2017 to August 2018						
Core service	Bank		Locum		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Maternity (and gynaecology)	4,558.0	6.4%	1,203.5	1.7%	1,109.0	1.6%	70,756.0

(Source: Routine Provider Information Request (RPIR) – Medical agency locum tab)

Staffing skill mix

In September 2018, the proportion of consultant staff reported to be working at the trust was about the same as the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 29.8 whole time equivalent staff working in maternity at The Dudley Group NHS Foundation Trust.
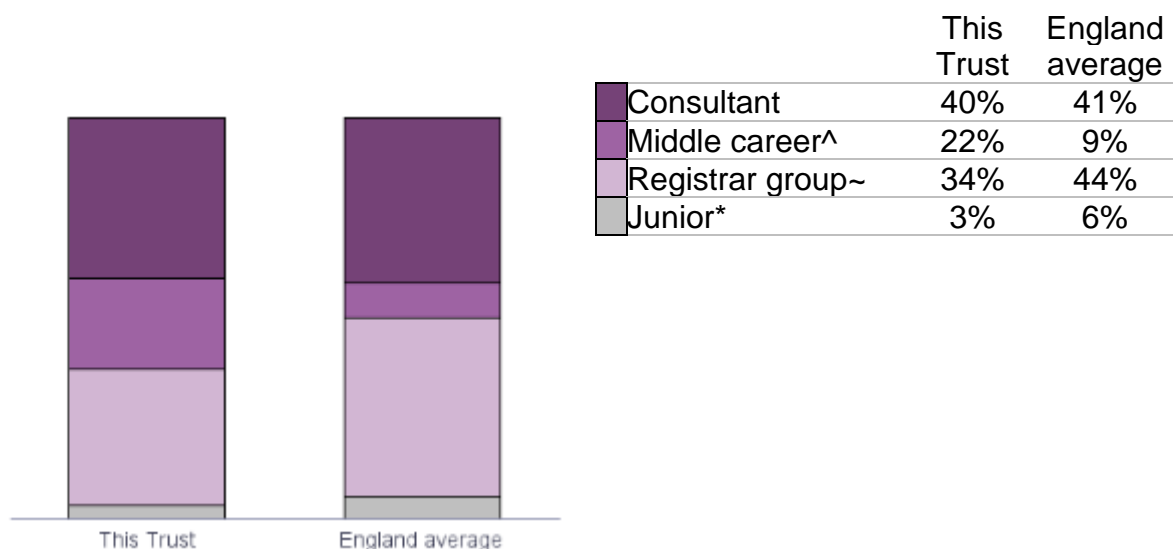
	This Trust	England average
Consultant	40%	41%
Middle career^	22%	9%
Registrar group~	34%	44%
Junior*	3%	6%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Some records around risk assessment, cardiotocography (CTG) monitoring and 'fresh eyes' lacked key information, staff did not always keep up to date records of patients' care and treatment. However, we raised our concerns with senior managers and we re-visited the unit unannounced and found concerns had been rectified.

We found the quality of women's and babies records were variable. They were not always contemporaneously completed or legible. We reviewed 26 records and 20 did not include relevant information to provide safe care and treatment. We found missing information around risk assessments, not all information was filled in the women's individualised care plans and many case notes were written retrospectively. However, where women had been referred to specialist services such as the trust's mental health team, or safeguarding referral this was clearly recorded in patient records. We re-visited the unit 7 February 2019 and found all records were completed accurately and correctly.

During the inspection, we found records were stored in locked trollies using a keypad code to securely store patient records.

Discharge arrangements were communicated to the women's GP, community teams including health visitors, family nurse practitioners and those involved in the women's discharge plan. Where relevant, letters were sent as soon as a woman was discharged from the unit, the records we reviewed showed this was conducted in a timely fashion.

Medicines

The service prescribed and stored medicines in line with local and national guidelines. Documentation around medications was consistent, documents and temperatures for the storage of medicines was recorded appropriately.

We observed midwives safely administering medication to women during our inspection.

Women's allergies were clearly documented in their prescriptions charts and found them all to be documented accurately.

All medicine fridge temperatures including room temperatures we reviewed were within range. The expiry dates of all drugs we checked and within their expiry date.

We saw medicines, controlled drugs and intravenous fluids were stored, managed and disposed of safely and securely in accordance with the trust's standard operating procedures.

Staff training on Patient Group Directions (PGDs), allows healthcare professionals to supply and administer specified medicines to pre-defined groups of patients, without a prescription. This training was included in the pharmacy and medicines management training, as at December 2018, 92.7% of staff had completed this training.

Pharmacy was open 9 am to 6 pm Monday to Friday with on call support if needed.

Incidents

Staff recognised incidents and reported them when they felt it was appropriate. Managers investigated incidents and shared lessons learned with the team and the wider service. However, during our inspection we were informed that stakeholders were currently investigating into six Root Cause Analysis, once completed the trust will share the outcome with CQC.

Staff had access to an electronic incident recording system. All staff had access to record incidents on the system. Each recorded incident was shared with managers who would then investigate or sign the incident off depending on the incident circumstances.

Staff understood their responsibilities to raise concerns, reports incidents and near misses. Staff gave examples of when something went wrong, investigations were conducted and lessons learnt.

Staff were aware of their responsibility around Duty of Candour (DoC). DoC is a regulatory duty that relates to 'openness', 'honesty' and 'transparency' and requires providers of health and social care services to notify patients or other relevant person(s) of certain notifiable safety incidents and provide reasonable support to that person.

We reviewed three root cause analysis (RCA) investigations in detail during our inspection and discussed them with senior maternity staff. Root Cause Analysis is an evidenced based, structured investigation process which uses tools and techniques to identify the true causes of an incident or problem, by understanding how a system failed. The RCAs were detailed and included relevant actions. We saw where recommendations had been raised as part of the RCA outcome, these had been implemented within the department.

Staff told us that they were encouraged to report incidents, learning from incidents was shared at team meetings, staff members told us that "incidents are always a topic for discussions in team meetings", Staff went on to tell us that any incidents that appear to have trends and themes may result in some additional training to support staff and any immediate concerns would be escalated.

Lessons learned were discussed and shared at governance meetings, in the maternity governance newsletter and at staff meetings.

Matron told us that Mortality and Morbidity meetings took place every six weeks during their clinical governance meeting, where they would discuss deaths that had occurred within their department. Investigation reports and further information were reviewed to identify any areas to improve.

During the last inspections of 2017, It was identified that the majority of incidents in maternity were raised due to capacity issues where there was insufficient space in the department available. Some single-bedded rooms were large in size and options had been discussed regarding converting them into two-bedded antenatal areas, or a four-bedded bay. This would increase the number of beds by five. During our recent inspection it was evident that three single rooms had been converted to double rooms and two single rooms had been converted to a four bedded bay.

Never Events

"Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event".

From December 2017 to November 2018, the trust reported no incidents which were classified as a never event for maternity.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

Type of incident	Number of incidents
Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)	1
Maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1
Maternity/Obstetric incident meeting SI criteria: mother only	1
VTE meeting SI criteria	1
Total	4

One incident (VTE meeting SI criteria) took the trust 84 days to report.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Safety Thermometer is used to record the prevalence of women and babies harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

The maternity safety thermometer is a measurement tool for improvement that focuses on perineal (the region of the body between the pubic arch and the tailbone) and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety.

The tool allows teams to keep regular checks on harm and record the number of harms associated with maternity care. It also records the proportion of mothers who have experienced 'harm free' care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This was recorded by the maternity department on a single day each month for all post-natal mothers and their babies. The data was collected from the midwifery led unit and maternity unit.

Is the service effective?

Evidence-based care and treatment

The service used current evidence-based guidance however, management did not always have oversight to ensure quality standards to inform the delivery of care and treatment were always followed.

We saw the service ensured women received care in line with evidence-based guidance, including NICE guidelines and quality standards for maternity. This ensured women had effective care and treatment outcomes.

The service held handovers in a structured manner and away from women and their babies. However, we saw handovers were not consistent in their content and format and did not follow a Situation Background Assessment Recommendation (SBAR) model. SBAR is a technique that can be used to help standardize and prompt communication. Senior staff told us there were plans in place to implement consistency and evidence effectiveness of handovers.

Staff were able to show us how they accessed clinical guidelines and local policies on their HUB intranet page

We saw women were placed on suitable pathways throughout our inspection. We saw pathways used followed national guidance and best practice.

Doctors had access to best practice guidelines from external websites operated by organisations such as National Institute for Health and Care Excellence (NICE guidelines) and The Royal College of Obstetricians and Gynaecologists (RCOG).

Majority of staff we spoke with, complained about the IT system, how this did not support the maternity department and that there was a lot of work to be done before the department were confident in going all electronic. Training was underway, and staff were able to record MEOWS electronically and were able to access E-sepsis to escalate or de-escalate a woman with query sepsis.

Nutrition and hydration

Staff monitored women and babies' nutrition and hydration needs, women had access to dieticians and breast-feeding specialist midwife.

We saw 11 Fluid balance charts were appropriately completed and up-to-date.

Maternity services had been UNICEF Baby Friendly accredited since 2002. We saw maternity infant feeding assistants supported women in their choice of baby feeding method. All staff in maternity received infant feeding training. We saw the unit using Unicef UK Baby Friendly Initiative breast feeding assessment tool that was adapted to the unit.

At the time of our inspection, the trust had eight breast pumps to support women to breastfeed their babies whilst in hospital, we saw refrigerator storage for milk was regularly checked and kept clean and tidy. We saw on average for August 2018 was 64% and the average for financial year at end of March 2019 was 59.5%.

The service had a Specialist Infant Feeding Midwife to provide further support for women to breastfeed their babies.

We observed staff offering drinks to women on regular basis throughout the day, women we spoke with said staff were very attentive.

Women who required additional specialist input received a referral, which could be made electronically to the dietician.

Pain relief

Staff assessed and managed pain on an individual basis and regularly monitored throughout women's care.

We saw analgesia was offered and given appropriately using the Five Rights of Medication Administration, one of the recommendations to reduce medication errors and harm is to use the "five rights": the right patient, the right drug, the right dose, the right route, and the right time.

The midwifery-led unit (MLU) had one birthing pool available to help women with pain relief and had recently purchased a mobile birthing pool that could be used in the acute setting or in community.

Staff we spoke with said some midwives were training in complimentary therapy such as aromatherapy, this promoted more choices for women and allow them additional pain relief and relaxation during or after labour. We saw posters were on display throughout the department.

The MLU contained equipment to support active births. Active birth classes were offered to women and their partners from 34 weeks of pregnancy to demonstrate how the equipment could be used.

Women had access to 24 hours anaesthetist support if women required epidural; Epidural consists of a fine plastic tube inserted into a woman's back through which pain-relieving medicines are given. We saw all epidural checklist documentation, consent and prescription chart were dated, signed and kept in women's medical records, vital signs were regularly checked and recorded electronically. We requested to see audits to see whether epidural was given within 30 minutes from request this was not provided.

Patient outcomes

The service did not always monitor the effectiveness of care and treatment and used the findings to improve them. The audits results were variable with actions plans in place to address areas that required improvements. However, trust carried out monthly audits and random audits to monitor effectiveness of care and treatment.

The trust measured women's outcomes and took part in national and local audits. Where outcomes did not meet national targets, the trust introduced action plans to improve.

Action plans we reviewed showed improvements were made in response to the findings from audits. Clinical leads reviewed audit results and monitored their progress in response to the audits, which was documented in associated action plans we reviewed.

The trust latest action plan showed that the leaders of the service reviewed the effectiveness of care and treatment that staff provided through local and national audit along with benchmarking against other maternity services in the region.

The trust's audit team was supporting the service to analyse findings from audit, and audit results were discussed at regular maternity clinical audit meetings attended by the multidisciplinary team.

For the Induction of labour NICE guidance, CG70, we received an action plan on how to improve women's experience and outcomes and this was to be implemented by an audit, medical and midwifery staff are planning to audit 50 case notes for induction of labour for compliance with the NICE guidelines Inducing labour - CG70 and QS60 to then review the outcomes of audit report and act upon findings on where the improvements are needed. The audit will be shared with CQC once completed.

National Neonatal Audit Programme

We received the trust action plan and we found it to be robust and clear with all actions completed apart from one action that was overdue which was around incident reporting to be completed if consultation within 24 hours is omitted, this was due to be completed in October 2018.

In the 2017 National Neonatal Audit Russell's Hall Hospital performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

There were 97 eligible cases identified for inclusion, 78.4% of mothers were given a complete or incomplete course of antenatal steroids.

This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

The hospital did not meet the audit's recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

There were 32 eligible cases identified for inclusion, 12.5% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

This was lower than the national aggregate of 43.5% and put the hospital in the bottom 25% of all units.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Standardised Caesarean section rates and modes of delivery

We reviewed the trust action plan and found it to be robust with all actions had been Completed, reviewed and updated.

Between April 2017 and March 2018, the total number of caesarean sections was higher than expected.

The standardised caesarean section rate for elective sections was higher than expected and the rate for emergency sections was similar to expected.

Standardised caesarean section rate (April 2017 to March 2018)					
Type of caesarean	**England**	**THE DUDLEY GROUP NHS FOUNDATION TRUST**			
	Caesarean rate	**Caesareans (n)**	**Caesarean rate**	**Standardised Ratio**	**RAG**
Elective caesareans	12.4%	585	14.3%	126.0 (z=2.2)	Higher than expected
Emergency caesareans	15.9%	791	19.3%	123.6 (z=1.7)	Similar to expected
Total caesareans	28.3%	1,376	33.6%	124.6 (z=3.2)	Higher than expected

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries.
Delivery methods are derived from the primary procedure code within a delivery episode.

In relation to other modes of delivery from April 2017 to March 2018 the table below shows the proportions of deliveries recorded by method in comparison to the England average.

The trust had lower proportions of instrumental and non-interventional deliveries and higher proportions of caesarean sections when compared to the England averages.

Proportions of deliveries by recorded delivery method (April 2017 to March 2018)			
Delivery method	**THE DUDLEY GROUP NHS FOUNDATION TRUST**		**England**
	Deliveries (n)	**Deliveries (%)**	**Deliveries (%)**
Total caesarean sections[1]	1,376	33.6%	28.3%
Instrumental deliveries[2]	359	8.8%	12.4%
Non-interventional deliveries[3]	2,360	57.6%	59.3%
Total deliveries	4,095	100%	100% (n=596,828)

Notes: This table does not include deliveries where delivery method is 'other' or 'unrecorded'.
1Includes elective and emergency caesareans
2Includes forceps and ventouse (vacuum) deliveries
3Includes breech and vaginal (non-assisted) deliveries

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

Maternity active outlier alerts

As at 4 December 2018, the trust has one active maternity outlier. This relates to an elective caesarean section which was generated in July 2017 and is currently being followed up by the inspection team. We reviewed the trust action plan dated October 2017 which was last updated May 2018 and found all areas had been completed.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.95.

This is up to 10% lower than the average for the comparator group rate.

(Source: MBRRACE UK)

Competent staff

Staff had the skills, knowledge, and experience to deliver safe care and treatment. Staff were appraised annually, staff told us they found appraisals to be useful and they were encouraged to identify any learning needs they had.

Staff were required to have a minimum requirement of skills and competency, this was achieved through statutory and mandatory training as well as additional training specific for staff working in maternity department. Maternity staff had appropriate qualifications, skills and experience to do their job. Staff we spoke with were knowledgeable about their role.

Staff told us that they were supported with the revalidation process. Revalidation was introduced by Nursing and Midwifery Council (NMC) in 2016. All nurses and midwives are required to follow this process every three years to maintain their nurses' registration.

Staff told us they were supported to conducted personal development training. Some maternity staff attended a sonography course to obtain new skills.

The maternity service had a training programme in place for the frenulotomy procedure. Frenulotomy is a procedure that separates a baby's tongue-tie.

Student midwives told us they were well supported by experienced staff.

Staff were required to conduct a CTG training every year and pass a competency test with a 90% pass mark. We saw the latest figures that showed as of 8th January 2018; Midwife compliance 94% and doctor's compliance: 88%. During our inspection staff told us and showed us they had been given a new CTG 'sticker' and found this to be a good prompt to use and remind staff to complete documentation.

We observed consultants and registrars taking the time to explain procedures to medical students and allowing them to undertake safe care and treatment of patients. The senior doctor showed great leadership to the junior team. Senior doctors had the skills and experience to lead their team and allow questions and explanations.

Appraisal rates

We saw there was a process in place within the department to monitor and arrange appraisal dates for staff. Staff told us their appraisals were a helpful and a good way to raise any concerns, training and development requirements.

Staff told us their appraisals were a helpful and a good way to raise any concerns, training and development requirements. Staff we spoke with said they were up to date with their appraisals.

Healthy Pregnancy Support service was at 75% (6 out of 8 staff) for appraisal September 2018.

For year to date, April to September 2018, 91.0% of required staff in maternity received an appraisal compared to the trust target of 90%.

The trust indformed us that the two healthy pregnancy support service staff were on long term sick leave during the appraisal time, although counted in the overall compliance their appraisal was done later and not counted towards percentage.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified midwifery staff	146	160	91.3%	90.0%	Yes
Support to doctors and midwives	63	70	90.0%	90.0%	Yes
Total	**209**	**230**	**91.0%**	**90.0%**	Yes

The appraisal data provided by the trust for medical staff was only provided at trust level, so could not be broken down by core service. For year to date, April to September 2018, 98.5% of medical staff trust wide received an appraisal compared to the trust target of 90%.

Russell's Hall Hospital

For year to date, April to September 2018, 92.2% of required staff in maternity at Russell's Hall Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified midwifery staff	117	127	92.1%	90.0%	Yes
Support to doctors and midwives	57	62	91.9%	90.0%	Yes
Total	**174**	**189**	**92.2%**	**90.0%**	Yes

Russell's Hall Hospital / Community

For year to date, April to September 2018, 85.4% of required staff in maternity at Russell's Hall Hospital / Community received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified midwifery staff	29	33	87.9%	90.0%	No
Support to doctors and nursing staff	6	8	75.0%	90.0%	No
Total	**35**	**41**	**85.4%**	**90.0%**	No

It should be noted the data only refers to two to four staff not having received an appraisal so the performance should be taken in context when dealing with small numbers of eligible staff.

Trust informed us that four staff were on long term sickness or on maternity leave during the appraisal window, therefore were unable to be counted in the overall compliance.

Multidisciplinary working

The multidisciplinary team worked well together to support women holistically; doctors, midwives and other healthcare professionals supported one another to provide good care.

Staff worked effectively as a multidisciplinary team (MDT). All health professionals worked as one team to ensure women's needs were met. Specialist services were requested when required such as social services, psychological support and learning disability teams to promote a holistic approach to any health condition management. Staff also told us they had access to additional support from pharmacy, physiotherapists, and other specialist services. Other services provided support on an on-call basis.

"Patient safety huddles" were held each day up to twice a day, so that information could be shared with all relevant staff involved in the care and treatment of the women. We saw one of these huddles where each woman was discussed, and decisions were made about further care and treatment.

Women had antenatal pregnancy records which sometimes had the lead named professional written on the front page, this was raised during our January 2019 inspection and actions were taken and when we re-visited in February 2019 this issue was resolved.

All midwives were encouraged to introduce themselves at the start of the shift so that women knew who was providing their care. Women we spoke to confirmed this took place and we observed midwives throughout the inspection doing so.

We saw a noticeboard in the antenatal clinic on display in the waiting area, to show which members of staff were working at the clinic. During the inspection we saw each morning there was a multi-disciplinary ward round for inpatient areas on maternity so that care could be planned and coordinated. All staff in maternity wore a name badge and the trust identification lanyard.

Seven-day services

The maternity department provided care for the local population 24 hours a day, seven days a week.

The maternity services were open 24 hours a day, seven days a week to provide care and treatment to women and their babies.

Staff told us if they had staffing or bed capacity issues, the service would suspend as per the maternity escalation standard operating procedure (SOP). We reviewed the escalation documentation and found it to be in date, management team told us women would be transferred to the nearest local hospital if capacity or staffing was at critical point.

We saw hospital inpatients had seven-day access to diagnostic services such as ultrasound.

The unit had security personnel who monitored access to the Maternity Unit 24 hours a day. There was a 24-hour access at the Maternity Entrance via an intercom.

The antenatal clinic was open from 9 am until 5 pm, Monday to Friday.

The Pregnancy Day Assessment Unit (PDAU), provided care for pregnant women who had concerns or complications after the 20th week of pregnancy. The clinic was open 8 am until 7pm Monday to Friday and 10 am until 2 pm on a Saturday.

Triage was open seven days a week and offered a 24-hour service.

The midwifery led unit (MLU) was a dedicated unit for women with a low risk pregnancy. The unit is run by midwives and offers a calm environment for women to deliver their baby. MLU is open 24 hours a day, seven days a week.

There were two obstetric theatres with a recovery area where staff are available 24 hours a day to assist with operative delivery and other surgical obstetric procedures. Anaesthetists were available 24 hours a day to provide women with epidural and other related pain relief when in labour if required.

There was a dedicated obstetric consultant anaesthetist from 8 am until 6 pm and a general on-call consultant anaesthetist from 6 pm until 8 am, Monday to Friday, and during weekends it will be the non-resident general on-call anaesthetist, in charge of obstetric anaesthetic care.

Health promotion

Health promotion materials were available throughout maternity services at the trust and staff knew which services to signpost women to.

The vulnerable woman midwife was responsible for providing teenage pregnancy support with support from the trust's safeguarding lead if required.

The trust had a "Heath in Pregnancy Support Service" (HPSS) that work alongside midwives in community antenatal clinics and also saw women on a one to one basis in their own homes, to support women and their families to make healthy choices. The HPSS service had three key elements; Stop Smoking, weight management and healthy lifestyles, and infant feeding support.

The maternity service undertook health promotion initiatives. An example of this was the service provided dedicated advice to women who smoked during their pregnancy. This included access to treatments such as nicotine replacement therapy.

We saw leaflets on display for members of the public to pick up and read if they required additional contact numbers for support.

The trust offered "Parentcraft sessions" daily to assist mothers in their new role. Staff told us they were well attended by first time parents.

All staff were trained to provide feeding support new mothers and new born baby. During the day and evenings, Maternity Infant Support Assistants (MIFAs) were also available to help.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Some staff awareness of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) was variable throughout the maternity service. This was also reflected in the low compliance rate within mandatory training for both medical and nursing staff where it was just below trust target.

Some staff understanding around the principles and values that underpinned the legal requirements in the Mental Capacity Act 2005 and Deprivation of Liberty safeguards was variable. For example, that a person must be assumed to have capacity unless it was established that they lack capacity. The service was working to improve training of the awareness of MCA and DoLS and was being monitored at service level.

Before any interactions were undertaken, we observed staff gaining consent throughout our inspection. We saw examples in women's notes within maternity service of consent documented in patient records.

Staff we spoke with were aware of the Gillick competence, which is a term, used in medical law to decide whether a child (under 16 years of age) can consent to his or her own medical treatment, without the need for parental permission or knowledge.

Women could also access antenatal and postnatal mental health support via the trust's mental health team. During the triage process, we saw documentation included three questions relating to a woman's mental health.

Staff told us they had access to mental health support from the trust's mental health team 24 hours a day, seven days a week. If staff had concerns regarding the wellbeing of women, they could readily access the team for advice if needed. During the triage process, we observed staff asking questions relating to a woman's mental health.

The trust had a perinatal mental health clinic pilot that began in February 2018. Since April 2018 it is no longer a pilot but funded through another service. This was led by the perinatal mental health team from a mental health unit in Birmingham. This had been set up with the aim to provide improved outcomes for the complex mental health issues some women experienced.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 86.6% of eligible midwifery staff in maternity. This did not meet the 90% target.

A breakdown of compliance by site for midwifery staff in maternity is shown below:

Site	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Russell's Hall Hospital / Community	30	33	90.9%	90.0%	Yes
Russell's Hall Hospital	112	131	85.5%	90.0%	No

In maternity the 90% target was met for the mental health law training module for which qualified midwifery staff at Russell's Hall Hospital / Community were eligible but was not met by qualified midwifery staff at Russell's Hall Hospital.

The trust did not provide mental health law training completion data for medical staff in maternity.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff cared for women with compassion and respect. Women's feedback and those close to them throughout our inspection was positive. Staff treated women and partners with dignity, respect and empathy.

Staff introduced themselves before any interactions with women; we observed staff to be respectful, polite, and friendly.

We saw support staff such as housekeeping staff, porters and administrative staff were friendly and engaging when speaking with women.

We spoke with women and their partners who provided positive comments regarding the care given by all levels of staff. Women told us that staff spoke kindly and respectfully towards them; and took time with care and treatment

We observed during our inspection and by speaking with women, staff pulled curtains around when performing more intimate procedures.

Women told us drinks and snacks were offered regularly where appropriate to ensure they were comfortable.

We observed staff using curtains when speaking with mothers to allow extra privacy and dignity.

Friends and Family test performance

Please note, no data is available for November 2017 from NHS England for any trust due to data quality issues.

Friends and family test performance (antenatal), The Dudley Group NHS Foundation Trust
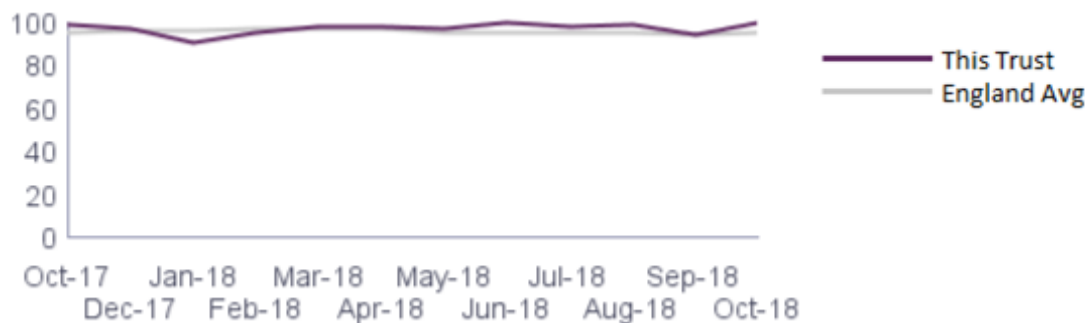
From October 2017 to October 2018 the trust's maternity Friends and Family Test (antenatal) performance (% recommended) was generally better than the England average.

The trust's performance was similar to or better than the England average with the exception of January and February 2018. In January 2018 the trust's performance dropped to 91% compared to the England average of 97%. In February 2018, the trust's performance dropped to 96% compared to the England average of 97%.

The trust's performance was better than the England average in October 2017 and from March to August 2018. In June 2018, the trust's performance was 100% compared to the England average of 96%.

The latest figures for October 2018 show the trust performance to be 100% compared to the

England average of 95%.

Friends and family test performance (birth), The Dudley Group NHS Foundation Trust

From October 2017 to October 2018 the trust's maternity Friends and Family Test (birth) performance (% recommended) was generally better than or similar to the England average.

In July 2018, the trust's performance was 100% compared to the England average of 97%.

The latest figures for October 2018 show the trust performance to be 100% compared to the England average of 97%.

Friends and family test performance (postnatal ward), The Dudley Group NHS Foundation Trust

From October 2017 to October 2018 the trust's maternity Friends and Family Test (postnatal ward) performance (% recommended) was better than the England average.
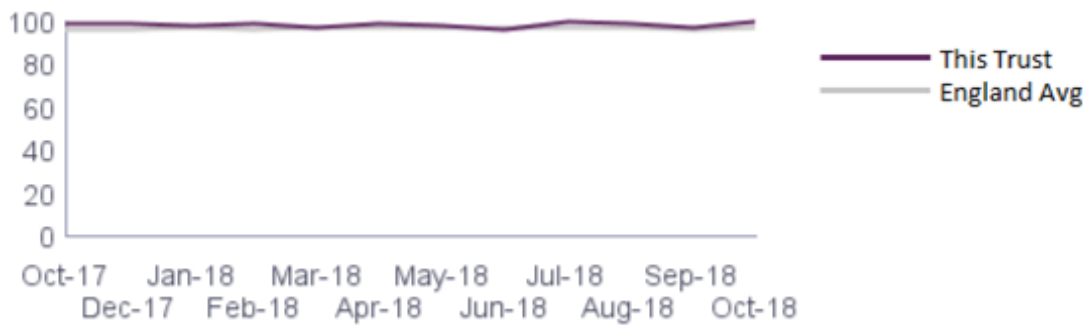
In both January and February 2018, the trust's performance was 100% compared to the England average of 95%.

The latest figures for October 2018 show the trust performance to be 99% compared to the England average of 95%.

Friends and family test performance (postnatal community), The Dudley Group NHS Foundation Trust
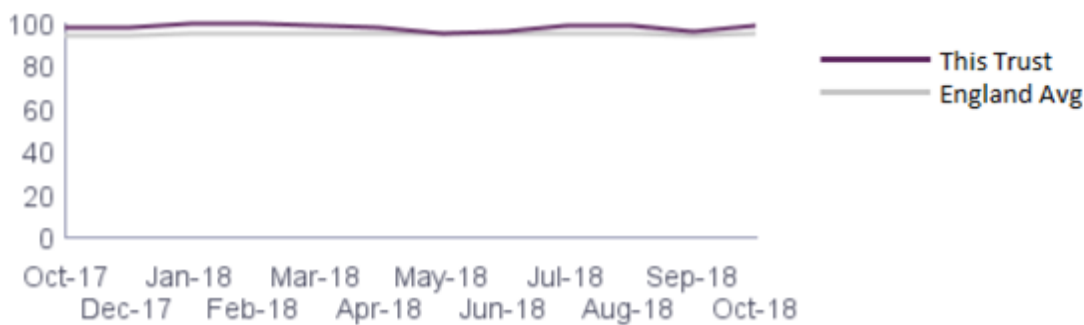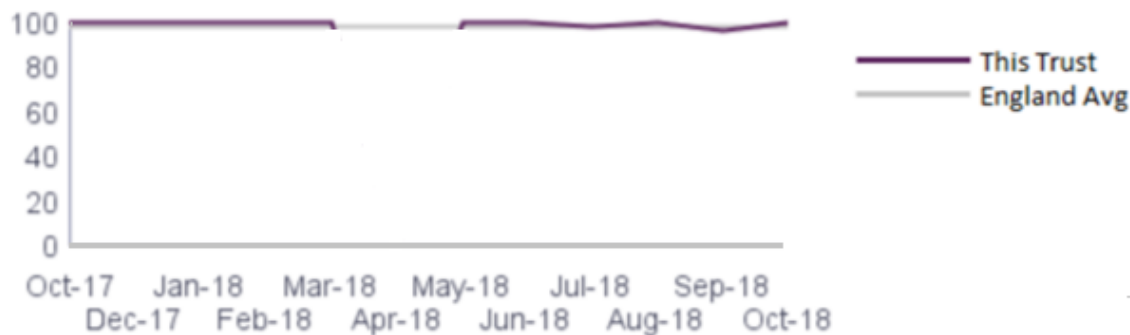

From October 2017 to October 2018 the trust's maternity Friends and Family Test (postnatal community) performance (% recommended) was generally better than the England average with the exception of September 2018 where trust performance was 97% compared the England average of 98% and July 2018 where trust performance was the same as the England average of 98%.

In nine months out of the 12-month period, the trust's performance was 100% compared to the England average of 98%.

The latest figures for October 2018 show the trust performance to be 100% compared to the England average of 98%.

Please note, for April 2018, no score is available for the trust as the trust's data was supressed due to low response figures.

(Source: NHS England Friends and Family Test)

CQC Survey of women's experiences of maternity services 2017

The trust was amongst the best performing trusts for one of the 16 questions in the CQC maternity survey and amongst the worst performing trusts for one.

The trust performed about the same as other trusts for the remaining 14 questions.

Area	Question	Score	RAG
Labour and birth	At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	8.29	About the same
	During your labour, were you able to move around and choose the position that made you most comfortable?	7.77	About the same
	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	9.71	About the same
	Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?	9.30	About the same
Staff during	Did the staff treating and examining you introduce	9.31	About the

labour and birth	themselves?		same
	Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?	8.04	About the same
	If you raised a concern during labour and birth, did you feel that it was taken seriously?	8.77	About the same
	Thinking about your care during labour and birth, were you spoken to in a way you could understand?	9.56	About the same
	If you used the call button how long did it usually take before you got the help you needed?	8.72	About the same
	Thinking about your care during labour and birth, were you involved enough in decisions about your care?	7.95	Worst performing trusts
	Thinking about your care during labour and birth, were you treated with respect and dignity?	9.57	About the same
	Did you have confidence and trust in the staff caring for you during your labour and birth?	9.15	About the same
Care in hospital after the birth	Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?	7.60	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	8.36	About the same
	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.11	About the same
	Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	9.29	Best performing trusts

(Source: CQC Survey of Women's Experiences of Maternity Services 2017)

Emotional support

Womens' emotional and social needs were considered as important as their physical well being. Women had access to the breastfeeding specialist midwife, bereavement service, chaplaincy service, patient's advice and liaison service (PALS), psychiatric services, social workers, safeguarding services, and smoking support, alcohol / drug liaison service.

Staff supported women and their partners to ensure their individual emotional needs were met. Patients told us staff interacted with them and their partners well and were reassuring when necessary.

Maternity has a specialist bereavement midwife that provides specialist support across the hospital and community. The specialist bereavement midwife also provides staff training.

Women who experienced the loss of a child were provided with some specialist bereavement support. All maternity staff conducted bereavement training as part of their mandatory training.

During our inspection we were given an example from a 'patient experience view' who attended a focus groups for bereaved parents and said they were able to talk with staff and other families. When we spoke with staff they told us they run many focus groups on a regular basis that cover different topics such as first-time parents, and many other topics depending on feedback by staff and women.

The service offers a birth reflection service to women requiring additional emotional support. The midwife who runs this service is s a qualified counsellor. Public health are currently funding a

midwife to complete a specialist course dealing with birth trauma. The Bereavement midwife has been supported to complete the specialist course dealing with birth trauma.

Profesional Midwifery Advocate's (PMA) were also available to offer support through Advocating and educating for quality improvement programme model of supervision including restorative supervision.

Understanding and involvement of patients and those close to them

Women who used the service and those close to them were active in their care and treatment.

Relatives and partners felt satisfied with the care and felt their loved ones were in safe hands. Mothers to be were encouraged to express themselves and were able to discuss their decisions with staff and loved ones.

Staff provided women with sufficient information regarding the birthing methods available to them so they could make an informed choice regarding their preferred method.

Easy Read format satisfaction questionnaires had been sent to women with a learning disability to obtain their views on the care and treatment they received in the maternity department.

Women, partners and relatives told us they were kept informed of any plans and treatment and told us staff were helpful and approachable.

Is the service responsive?

Service delivery to meet the needs of local people

Women's needs, and their preferences were considered and acted upon to ensure services were delivered and accessible in timely manner. The service planned and delivered services to meet the needs of people using the service.

The service had a large variety of information leaflets in a number of different formats and languages available on the unit, and the trust's website provide useful information to women and their partners.

Maternity service provided face-to-face interpreters for women and partners if they did not speak English as their first language. We saw the trust also had access to a translation line; staff we spoke with knew how to access this and said they used this translation line often.

Staff told us bariatric beds, or chairs (for heavier patients) could be ordered from stores and staff would bleep the switchboard for a porter to deliver. If a bariatric patient was being brought in by ambulance, then ambulance would notify staff ahead of arrival to order.

Maternity services were planned to consider the different needs of women they responded to, there were facilities for specialist services such as people experiencing mental ill health, or high risk pregnancy with long term conditions.

Since the last inspection of 2017, following a staffing review they identified the need for a specialist bereavement midwife. The maternity service now has a dedicated bereavement room and a dedicated bereavement midwife. Staff spoke very highly of this service, who are heavily involved with training to ensure they were able to provide a holistic service for bereaved parents.

Bed Occupancy

From April 2017 to September 2018 the bed occupancy levels for maternity did not follow any general trend when compared to the England average. Levels were higher than the England average from July to December 2017 and from April to June 2018. Levels were lower than the England average from April to June 2017, from January to March 2018 and from July to September 2018.

In the most recent quarter, Quarter 2 2018/19 the trust had 57.8% occupancy compared to the England average of 59.6%.

The chart below shows the occupancy levels compared to the England average over the period.

Maternity bed occupancy levels of The Dudley Group NHS Foundation Trust compared to the England average
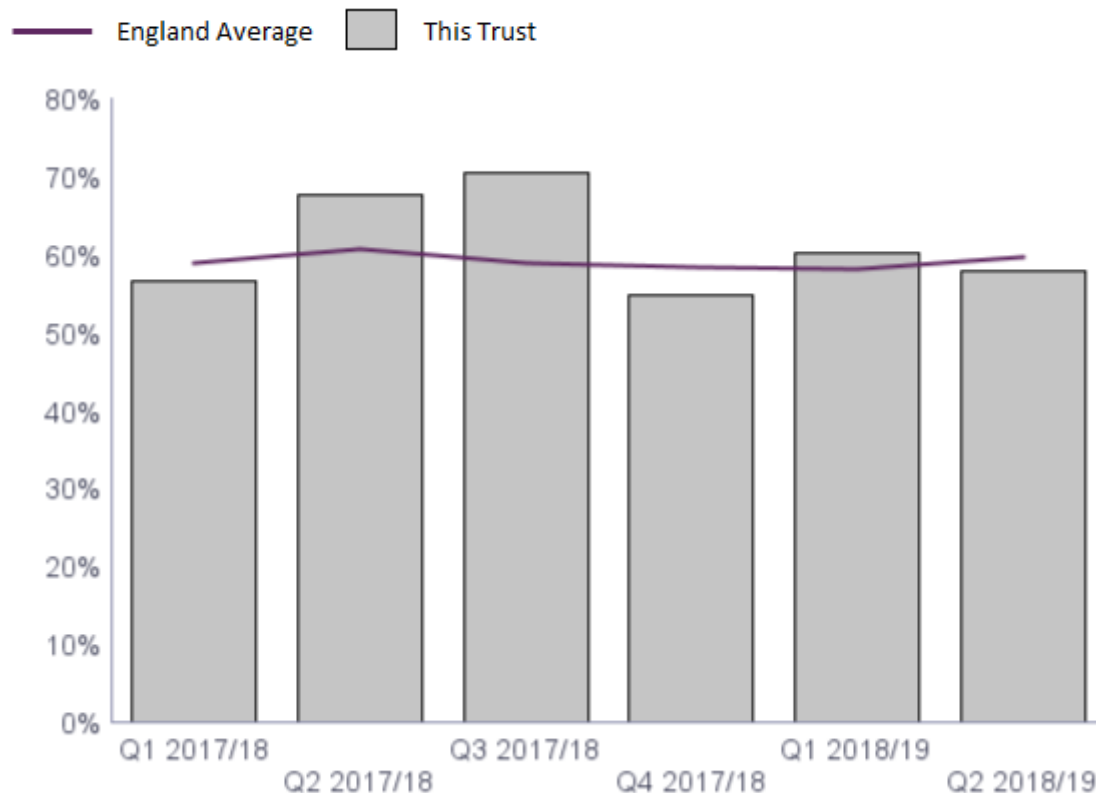
(Source: NHS England)

Meeting people's individual needs

Staff had access to interpreters to aid communication with their women. Women's needs were considered when delivering and coordinating services, including those who were vulnerable and had complex needs.

The maternity department had some specialist midwives and medical staff, such as for vulnerable women, substance misuse, diabetes, breastfeeding and bereavement to ensure staff provided women with additional needs with the necessary support.

Women were allocated a named midwife for their antenatal care, which provided continuity of care for women and partners.

The specialist's midwives for vulnerable women included teenage pregnancy. The community midwives make a referral to the specialist midwives when they have completed the booking appointment for teenage mothers. The specialist midwives and community midwives work closely with the Family Nurse Partnership, health visitors and social services.

The trust had a chaperone policy, women were offered a chaperone if they wished. This request was documented in women's medical notes if women required a chaperone.

Access and flow

Access to care was managed to take account of high risk women. Women had access to the right care at the right time.

Only women who were in established labour would be admitted to the maternity ward or delivery suite to prevent labour wards from being overcrowded. Women's needs were assessed on arrival at the maternity department and triaged to an appropriate area of the unit.

Discharge from maternity was communicated to womens' GPs by sending a standard discharge letter. This was completed on the day of discharge and sent by the hospital courier service to the GP surgeries the following morning to ensure GPs were updated regarding women as quickly as possible.

Learning from complaints and concerns

Women's concerns, and complaints were investigated, lessons were learned from complaints and shared with all staff. However, not all complaints were dealt with in a timely manner.

Staff we spoke with told us that any "Thank you" and compliments to individuals staff member were shared in monthly team meetings, staff handovers and an email would be circulated through the department.

We saw evidence of staff learning from complaints and these were routinely discussed on a monthly basis and complaints were discussed as part of the clinical governance meetings.

Staff were aware of actions to take if someone wanted to raise a complaint or a concern, and they would seek support from senior staff if they were not able to sort it. We saw leaflets on display throughout the trust with telephone numbers if women or partners wished to complain or share their compliment.

Women and partners, we spoke with knew how to make a complaint and were aware of PALS services.

Summary of complaints

From October 2017 to September 2018 the trust received 28 complaints in relation to maternity (5.7% of total complaints received by the trust). The main subject of complaints was patient care (17).

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient care	17
Communications	4
Values & behaviours (staff)	3
Diagnosis and tests	3
Appointments	1
Total	**28**

For the 18 complaints that had been closed at the time of data submission, the trust took an average of 67.2 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

The 10 complaints that had not yet been closed had been open for an average of 75.1 working days at the time of data submission. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 there were 908 compliments received for maternity (13.2% of all received trust wide).

Compliments were received in all 12 months of the period. January 2018 was the month where the most compliments were received (197).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers of all levels within maternity services had the right skills and abilities to run a service providing quality and sustainable care.

There were a number of up to date information on display boards for staff in the unit. The quality leads took responsibility for keeping the boards up to date with useful information. This meant that staff could, at a glance, be kept up to date. For example, the changes in practice to let staff know what's changed and how it affects them such as new 2019 NICE guidelines, revalidation, and trust newsletters.

The maternity department had a Non-Executive Director (NED) in post who was responsible for the maternity services. The Head of Midwifery (HoM) and the Clinical Director attended monthly clinical quality safety meetings to discuss maternity improvement action plan. This demonstrated joint working within the directorate and updates from this meeting were shared with the senior trust executive team and the board.

The senior maternity team had been strengthened in 2017 by the implementation of a consultant governance lead role and department was identifying lead roles for all consultants. This had increased allocated medical leadership time for the service

Maternity service had managers at all levels with the mix skills and abilities to run the service. Staff felt supported in their roles and felt they had opportunities for training and further develop within their role.

A staff member who we spoke with said they had been off work with an illness who returned to work with a supportive team and management who were very attentive and care for their well-being, "team are amazing".

Vision and strategy

The service had a vision of what it wanted to achieve and plans to turn it to action. Not all staff were able to recite trust values but staff we spoke with were able to demonstrate the values within their role.

The trusts vision is "*Trusted to provide safe, caring and effective services because people matter*". The strategic objectives that interlinked included to "*deliver a great patient experience, to drive service improvement, innovation and transformation, make the best use of what we have, deliver safe and caring services, be the place people choose to work and to deliver a viable future.* The trust had been concentrating on several priorities in 2018, including patient experience, pressure ulcers, infection control, nutrition and hydration and medication.

Staff we spoke with told us that values were an integral part of the trust induction programme for new staff and these were communicated across the trust to provide visibility for the workforce, patients and visitors. We saw prominent posters and screen savers displaying the values and vision across the trust.

Staff were not able to tell us the exact trust values, however we observed staff to be, kind and caring and women were at the centre of all they did. Staff were committed in improving women experience pre, during and after labour.

Staff we spoke with felt engaged with the department's strategy, understood that there was a clear vision for the service and knew their role in achieving the best outcomes for women and their

babies, this was despite the shortages of staff on the unit, staff pulled together to assure women had the best care possible whilst on the unit.

Managers of the department were able to talk us the through their future plans for the department. All staff had a clear understanding of the strategy to improve services for the women and their babies and the arrangements to meet the needs of the local population.

Culture

Managers across the maternity department promoted a positive culture that supported and valued their staff with shared values on womens care and improving the quality of care within the trust and their own department.

Staff told us the new matron has 'an open door' policy, and felt they were able to raise their concerns anytime.

Staff worked well as a team, we saw many examples where staff were very caring towards one another especially during busy and challenging times. Majority of staff throughout this inspection spoke positively of local working culture in which they felt valued and respected.

We found staff were proud of the service they delivered and spoke positively about the unit and the team. There was constructive engagement with staff; staff at all levels were encouraged to raise concerns.

The maternity service facilitated an open and transparent culture and the trust employed a freedom to speak up guardian. This was substantive members of staff employed by the trust to ensure staff felt safe to speak up for the benefit of patient care and staff wellbeing. Staff we spoke with told us the freedom to speak up guardians were approachable, accessible and effective in their role. Some staff we spoke with were interested in becoming a freedom to speak up guardian champion that the trust had recently implemented.

Governance

The governance arrangements within maternity, were sometimes clear and sometimes operated effectively and staff sometimes understood their roles and accountabilities.

We found there was a system of governance meetings which enabled the escalation of information upwards and cascading information from managers to front-line staff. Divisional governance meeting for both acute and community maternity service fed into the board meetings.

Senior staff told us they had monthly meetings, they would discuss safeguarding, mandatory training, incidents, complaints/compliments, and learning from legal and root cause analysis updates. Minutes from meetings and unit dashboard with performance data were shared with staff within the department.

The trust carried out local audits and used the outcomes to improve local delivery of services. Outcomes from audits highlighted what was working well, and where they could improve.

Findings from audits were shared with staff through a variety of means, such as team meetings, safety huddles, and information was provided on display boards, information contained comparisons with previous performance and latest performance throughout the maternity department.

We looked at the minutes from governance meetings, which demonstrated learning from audits, incident and changes to practice as a result. One example we found was around CTG monitoring,

trust had implemented a larger sticker to be attached to women's nursing records specifically for CTG monitoring that required staff to sign, date, any need to escalate and 'fresh eyes'. This was highlighted as a concern during our inspection in January 2019, we fed back to the management team about the completion of CTG documentation and the lack of understanding around 'fresh eye'. When we returned to the unit in February 2019 unannounced, we found numerous positive changes around documentation, CTG and 'Fresh eyes', all records we reviewed had been completed and was legible. This was in line with National Institute for Health and Care Excellence (NICE guidelines), The Royal College of Obstetricians and Gynaecologists (RCOG) and The Royal College of Midwifery (RCM).

Management of risk, issues and performance

The service had a system in place for identifying risks, planning to eliminate and reduce risks and the ability to cope with expected and unexpected challenges within maternity services. However, managers did not always accurately reflect the response to concerns raised*.*

Staff had access to information displayed in the maternity unit, mostly relating to risk management, staffing, governance, safeguarding, breast feeding, and freedom to speak up guardians.

We could see that the risks in the risk register were areas of focus. The risk register covered 'women's and children's services'; therefore, included maternity services, seven risks were currently on risk register. We saw the risk register for the department accurately reflected the main risks to the department. Senior staff reviewed the risk register each month both at a divisional and local level.

We saw the department had arrangements in place in the event of suspension of maternity services, such as transferring women to alternative trusts for care and treatment when necessary or capacity issues.

Managers told us in the event of high risk women attending the unit they would arrange with High Dependency Department for support, this included the outreach team and medical team.

The unit had an escalation staffing policy, if the unit was at a critical level due to shortage of staff they would contact the community midwives for support. We spoke with some community staff that were working on MLU during our inspection who told us they rarely get called in, one midwife said in the last six months she may have been called in to do four hours no more than twice.

We reviewed the trust Maternity Quality and Governance Meeting Minutes held on 11 December 2018. The meeting discussed one topic that staff had discussed with us around incident investigation and the completion of Root Cause Analysis (RCA). The Health Safety Investigation Board (HSIB) will become live in the West Midlands in February 2019. They will be taking over the investigations of any baby that comes under the "Each Baby Counts", this meant the trust will no longer be doing the formal RCA. The discussion went on to say that the trust will still be completing the initial 72 hours investigation and parents will be informed that there will be an independent investigation and that they will be contacting them to keep them informed. The independence investigators will be working closely with the trust at all stages of investigations. No action plan will be produced upon completion but recommendations with regard to learning will be made and they trust will need to ensure that these recommendations are followed up and completed. When we spoke with staff, many felt positive about this change as this would mean the investigation would be on 'neutral grounds' and learning will be a positive.

Information management

Management collected, analysed, managed, and used information to support the maternity activities using secure systems with security to safeguard all processes in use.

Unit managers were responsible for cascading information upwards to the trust management team. We saw information was shared during clinical governance meetings.

We saw information and updates were shared with maternity teams across acute and community through a variety of mediums such as team meetings, staff huddles and email updates.

Engagement

Staff engaged well with patients, staff, and the public and local organisations to plan and manage appropriate services and collaborated with partners' organisations effectively.

The trust engaged well with women, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. Examples we were given were focus groups specifically targeting parents.

Staff engagement included, 'Healthcare Heroes', monthly recognition awards, 'Listening into Action' which saw staff come together to discuss how to make improvements to specific areas or services.

The trust engaged with the public through various medium such as Facebook and Twitter, charitable events and listening into action events.

The trust employed a chaplaincy team who regularly attended the ward areas to provide multi faith support.

Learning, continuous improvement and innovation

Maternity department was committed in improving services by learning from things that have gone well and when things go wrong, promoting training, research, and innovation.

The trust had listened to staff, women's feedback and now have a bereavement named midwife.

We saw senior leaders and front-line staff continually drove to improve the maternity service. The service shared ideas locally and nationally via the maternity network. We saw evidence collaborative learning took place between the maternity services at local trusts within the Black Country region.

Senior staff regularly monitored actions completed in response to these results in improvement action plans for the service.

Head of Midwifery implemented a drop-in session in January 2017, to catch up with all staff at the unit to allow those who want to raise concerns or share ideas, offer ways to learn and improve, dates were circulated to the unit.

We found motivation amongst senior staff to make improvements and changes to the service. For example, when we raised our concerns around CTG monitoring we attended the CTG teaching session that had recently been implemented, this was run by the consultant obstetrician who bought in two cases of women, this allowed staff to review cases and share knowledge, allowed staff to ask questions from a midwife, medical and support workers perspective on women and baby care.

Services for children and young people
Facts and data about this service

The trust provides a full paediatric service with a dedicated paediatric assessment unit for the management of emergency referrals and a dedicated children's ward for emergency and elective admissions and a dedicated children's outpatient clinic.

The service had 30 inpatient beds for children and young people.

Inpatient surgical care includes elective and emergency surgery for children over two years of age across the following specialties:

- Ear nose and throat
- Trauma and orthopaedics
- General surgery
- Oral and maxillofacial surgery
- Plastics
- Ophthalmology
- Orthodontics.

The trust has a level 2 neonatal unit comprising 18 cots made up of three intensive care, two high dependency and 13 special care cots. The neonatal unit also supports a four-bedded area on the maternity unit for babies requiring transitional care. Within neonatal care, there are three levels of care: level one is intensive care, level two is high dependency care and level three is special care.

The trust provides a children's phlebotomy service as a walk-in service and for booked appointments from 8am to 5pm, Monday to Friday.

The trust is part of the Staffordshire, Shropshire & Black Country Newborn and Maternity Network.

(Source: Routine Trust Provider Information Request (RPIR) – Sites and context acute tabs)

Spells and appointments

The trust had 4,247 spells from July 2017 to June 2018.

Emergency spells accounted for 87% (3,685 spells), 10% (404 spells) were day case spells, and the remaining 4% (158 spells) were elective.

Percentage of spells in children's services by type of appointment and site, from July 2017 to June 2018, The Dudley Group NHS Foundation Trust.
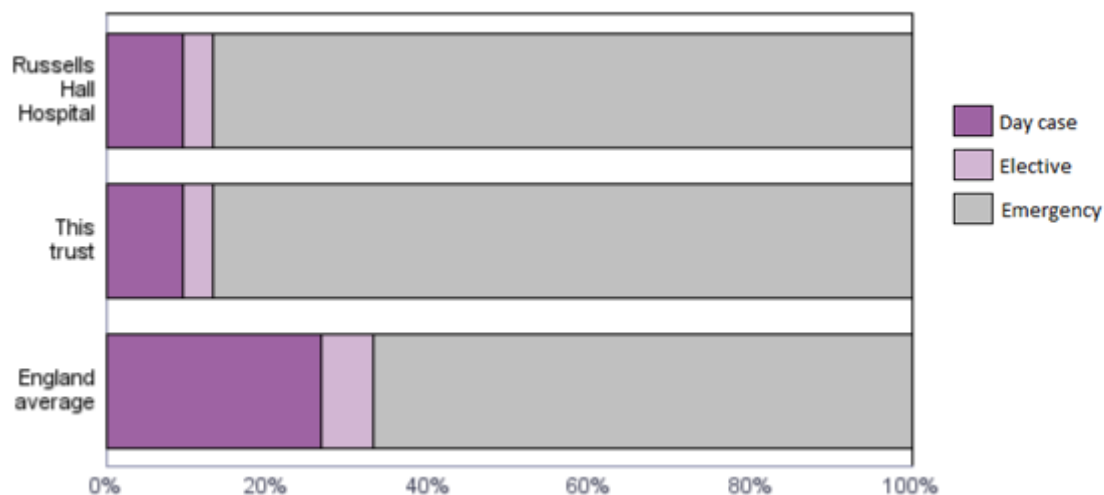
Total number of children's spells by Site, The Dudley Group NHS Foundation Trust.

Site name	Total spells
Russells Hall Hospital	4,247
England total	1,123,489

(Source: Hospital Episode statistics)

The inspection of children and young people's services at Russell's Hall Hospital was unannounced. We visited and reviewed information about the following clinical areas during the visit:

- Ward C2, children's ward
- Neonatal unit
- Children's outpatient clinic
- Fracture clinic
- Operating theatres

During the onsite visit, we spoke with five children, young people and their families, and reviewed 11 patient records for children and young people. We spoke with staff from different professions and grades, including healthcare assistants, registered nurses, doctors and senior managers.

Is the service safe?

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

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

Trust wide

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for qualified nursing staff in services for children and young people is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - adult	3	3	100.0%	90.0%	Yes
Health & safety	90	90	100.0%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	50	51	98.0%	90.0%	Yes
Manual handling (non-patient) / slips, trips & falls	38	39	97.4%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	86	90	95.6%	90.0%	Yes
Conflict resolution - level 1	84	90	93.3%	90.0%	Yes
Equality & diversity (including autism awareness)	84	90	93.3%	90.0%	Yes
Information governance	83	90	92.2%	90.0%	Yes
Fire	83	90	92.2%	90.0%	Yes
Infection control - clinical	83	90	92.2%	90.0%	Yes
Resus - paediatric	44	48	91.7%	90.0%	Yes
Resus - neonatal	32	39	82.1%	90.0%	No

In services for children and young people the trust had an overall mandatory training compliance rate of 93.8% for qualified nursing staff. The 90% target was met for 11 of the 12 mandatory training modules for which qualified nursing staff were eligible.

Resus - neonatal was the only training module which did not meet the 90% completion target.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for medical staff in services for children and young people is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Fire	20	20	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	20	20	100.0%	90.0%	Yes
Information governance	20	20	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	20	20	100.0%	90.0%	Yes
Health & safety	20	20	100.0%	90.0%	Yes
Conflict resolution - level 1	19	20	95.0%	90.0%	Yes
Resus - paediatric	18	20	90.0%	90.0%	Yes
Infection control - clinical	18	20	90.0%	90.0%	Yes
Manual handling (non-patient) / slips, trips & falls	18	20	90.0%	90.0%	Yes
Resus - neonatal	14	20	70.0%	90.0%	No

In services for children and young people the trust had an overall mandatory training compliance rate of 93.5% for medical staff. The 90% target was met for nine of the 10 mandatory training modules for which medical staff were eligible.

Resus - neonatal was the only training module which did not meet the 90% completion target.

(Source: Routine Provider Information Request (RPIR) – Training tab)

During the inspection, staff told us they were released to undertake mandatory training. Senior managers told us staff only got taken off mandatory training to work on the wards when absolutely necessary to maintain patient safety. Staff we asked told us they had completed their mandatory training in the previous year.

We found lead nurses were aware of which staff had completed mandatory training within their departments. Lead nurses could identify the reasons for non-compliance (for example where a member of staff had come back from long term sick leave) and the steps in place to make all staff compliant.

All new staff to the trust completed an induction programme that consisted of 17 topics, including:

- Fire safety and prevention

- Information governance and data protection

- Home Office WRAP radicalisation awareness

- Equality, diversity and autism awareness

- Conflict resolution

In additional to the topics listed above, we found staff undertook mandatory safeguarding children and adult training. We found the service delivered the required level of training to staff, in line with the intercollegiate document Safeguarding Children and Young People: Roles and competence for Health Care Staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

Trust wide

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules for qualified nursing staff in services for children and young people is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	90	90	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	90	90	100.0%	90.0%	Yes
Safeguarding adults	87	90	96.7%	90.0%	Yes
Safeguarding children level 3	83	87	95.4%	90.0%	Yes
W R A P	78	90	86.7%	90.0%	No

In services for children and young people the trust had an overall safeguarding training compliance rate of 95.7% for qualified nursing staff. The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in services for children and young people is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	20	20	100.0%	90.0%	Yes
Prevent	20	20	100.0%	90.0%	Yes
Safeguarding adults	20	20	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	20	20	100.0%	90.0%	Yes
Safeguarding children level 3	18	20	90.0%	90.0%	Yes

In services for children and young people the trust had an overall safeguarding training compliance rate of 98.0% for medical staff. The 90% target was met for all five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We asked staff about safeguarding and their responsibilities in safeguarding patients. All staff asked knew their responsibilities and could tell us how they would raise concerns about safeguarding. All staff asked had received safeguarding training appropriate to their role at the time of the inspection.

Staff spoken to had a good understanding of female genital mutilation (FGM) and their responsibilities in reporting suspected cases of FGM. Staff also understood their responsibilities in relation to preventing and reporting suspected radicalisation of young people.

We spoke with the safeguarding children team during the inspection. The team consisted of a named doctor and two named nurses. The named doctor for safeguarding children had been in post two weeks at the time of the inspection. We found the named doctor had not received the required level four safeguarding children's training. This posed a risk that the named doctor was not suitably trained to undertake the named doctor role.

Following the onsite inspection, the service told us the named doctor was interim in the role of named doctor for children's safeguarding, and had access to a children's safeguarding level 5 trained designated doctor within the trust.

We reviewed four patient records in relation to safeguarding. We found all but one record contained the required safeguarding information and documentation. One record reviewed did not contain a female genital mutilation assessment, despite concerns having been raised. The safeguarding team assured us that the assessment had been undertaken and this had not been filed appropriately. We did find that patient had been referred to social services and appropriate safeguards had been put in place to prevent harm coming to the patient.

We found an inconsistent approach to documenting safeguarding concerns within patient records. On the maternity unit and neonatal unit, staff documented safeguarding concerns on a specific colour of paper. However, this was not consistent within ward C2, or across the rest of the hospital. This posed a risk that staff would not be aware of previous or ongoing safeguarding concerns when a child or young person is admitted.

The service was part way through switching from paper to electronic records. We found that that staff checked relevant national data bases (child protection information system (CPIS) regarding safeguarding concerns during admission or outpatient attendances. The trust electronic records system placed a 'flag' on records of children and young people where safeguarding concerns were present. Staff were required to go fully into the record to review the concerns.

We reviewed the trusts safeguarding children policy and found it lacked some detail. The policy did state clearly the processes for staff to follow where they had concerns and detailed the process for missed appointments where staff had concerns. However, the policy did not have a reference to the use of volunteers within children and young people's settings, no reference to the safe recruitment of staff and no reference to the safeguarding children and young people: roles and competences for health care staff, Intercollegiate Document. We noted that the policy did not contain any contact details for the local authority or multi-agency safeguarding hub.

The policy referenced other policies, such as the female genital mutilation policy and the safeguarding children training policy. The service had a number of policies regarding safeguarding children and young people, and this could make it difficult for staff to find the relevant information in a timely manner.

Following the onsite inspection, the service told us that the safeguarding responsibilities of volunteers was set out within the volunteer's policy. The service told us that contact details for the local authority were on the trust intranet pages for staff to locate when needed.

The service had a safeguarding improvement action plan for children and young people's services at the trust. The improvement plan clearly detailed which trust level strategic objective it was associated with and had a named executive lead to oversee the progress, namely the chief nurse.

The improvement plan was first agreed and implemented on 20 March 2018. The improvement plan focussed on four main areas: governance, staffing, audit and training, with a total of 20

actions. We found the improvement plan was detailed with progress against actions clearly documented and estimated dates for completion for ongoing actions.

Cleanliness, infection control and hygiene

The service controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

CQC Children and Young People's Survey 2016

In the CQC Children and Young People's Survey 2016 the trust scored 8.13 out of ten for the question 'How clean do you think the hospital room or ward was that your child was in?'. This was worse than other trusts.

(Source: CQC Children and Young People's Survey 2016, RCPCH)

During the inspection we visited ward C2, the neonatal unit, children's outpatients and fracture clinic. All clinical areas visited were visibly clean. We observed all staff complying with 'bare below the elbows' and using hand sanitiser or washing their hands at required times.

We observed staff using personal protective equipment (PPE) at required times. We observed staff on the neonatal unit wearing disposable aprons and gloves when dealing with babies to reduce the risk of cross infection. We observed medical staff wearing gloves when taking blood and undertaking arterial blood gas analysis.

Staff cleaned all equipment, including beds, between patient use. We observed staff cleaning equipment between patients.

We reviewed hand hygiene audits for ward C2 and the neonatal unit.

Ward	October 2018	November 2018	December 2018
Ward C2	100%	No data submitted	95%
Neonatal Unit	100%	100%	100%

We reviewed cleaning audits for ward C2, the neonatal unit and children's outpatients. The cleaning audits looked at cleaning, nursing and estates scores. The overall compliance for October to December 2018 is below.

| | October 2018 | November 2018 | December 2018 |
Department	Overall Score	Overall Score	Overall Score
Ward C2	96.2%	96.3%	94.6%
Children's Outpatients	96.9%	99.1%	96.4%
Neonatal Unit	97.6%	94%	97.5%

The trust did not provide a benchmark or target for compliance. However, all areas scored above 92% for all areas audited over the time period.

The service had reported no instances of MRSA, MSSA or c difficile in either ward C2 or the neonatal unit between January and December 2018.

The service segregated waste, including general, clinical and offensive. We observed staff disposing of waste in the correct bags. Sharps bins were available for all staff to use to dispose of sharps, such as needles. We observed staff using sharps bins and taking them to the bedside of children and young people. This reduced the risk as staff were not walking round the clinical area with unsheathed needles.

We found no sharps bins or waste bins overfull or overflowing. Staff stored full waste bags, sharps bins and laundry bags securely whilst awaiting collection and removal.

Environment and equipment

The service did not always have suitable premises. The service had suitable equipment and looked after them well.

<u>Neonatal Unit</u>

We found equipment stored appropriately on the neonatal unit. We checked multiple pieces of equipment during the inspection and found all had been safety tested as required. We checked the resuscitation trolley and found all equipment was in date and matched the check-list. Staff checked the resuscitation trolley daily and undertook a full check of all items on a monthly basis.

Staff raised concerns during the inspection about the age of some of the neonatal cots that were 17 years old. We asked the leaders about these concerns and the leadership team told us that there was not a capital replacement programme in place to ensure the timely replacement of aging equipment. However, the leadership team did provide assurance that the manufacturer still supported the equipment, meaning that in the event of failure parts were still available to ensure timely fixing. However, the age of the cots posed an increased risk of failure and therefore an interruption in service delivery.

Following the onsite inspection, the service told us that the aging equipment within the neonatal unit was on the risk register, and the medical engineering department were aware of the concerns.

We found that the intensive care area of the neonatal unit was cramped and had limited space around each cot.

<u>Ward C2</u>

We checked multiple pieces of equipment on ward C2 during the inspection and found all had been safety tested as required. However, we did find one medication fridge that was broken, which staff removed and replaced in a timely way during the inspection.

We checked the resuscitation trolley and found all equipment was in date and matched the check-list. Staff checked the resuscitation trolley daily and undertook a full check of all items on a monthly basis.

We found concerns regarding the environment on ward C2, specifically in relation to the accessibility of areas with hazards by children and young people. All the door handles within ward C2 were low and could be reached by young children. The family sitting room had a small kitchenette with a water boiler on the wall. The water boiler was within reach of young children and therefore posed a risk of scalding. We informed the lead nurse and deputy matron who ensured that a key pad lock was fitted within two days to prevent children and young people gaining access without suitable supervision.

The environment did not promote the safety and welfare of children and young people with a mental health condition. Ward C2 did not have a designated room that had been made ligature

light or ligature free to reduce the risk of self-harm. We found no room that had suitable doors or bathrooms to promote the safety of children and young people with a mental health condition. We found bathrooms contained showers with hoses, which posed a ligature risk. The side room doors did not open both ways, and no ability for staff to override locks. This posed a risk that children and young people could lock themselves in a side room, with staff unable to gain timely entry to prevent harm.

We found the service and leadership team had not taken account of relevant national guidance around planning and implementing care for children and young people with a mental health condition. The service had not taken account of the Department of Health's Health Building Note 03-02 Facilities for child and adolescent mental health service, which gives guidance on the reducing the risks, including ligature risks, when providing mental health care to children and young people. The service had not taken account of guidance from the National Patient Safety Associations 2009 Preventing Suicide: A toolkit for mental health services.

The service did provide verbal assurance it would review the provision for children and young people with a mental health condition on ward C2.

We asked the service if risk assessments had been undertaken in respect of children and young people admitted for a mental health condition. However, the service was unable to show us any risk assessments for the care of children and young people admitted with a mental health condition, or for the treatment of these patients within the ward area.

Children's outpatient and fracture clinic.

Children's outpatient department consisted of a number of consulting rooms, plus a treatment room, storage areas and dirty utility for the storage and disposal of waste. We found each consulting room fit for purpose. Staff did not undertake invasive procedures within the outpatient department.

Fracture clinic, which saw a small number of children and young people who required specialist input from medical, nursing and allied health professionals following a fracture, had a designated treatment cubicle for children and young people. However, the department did not have a designated waiting area for children and young people. The lead nurse acknowledged this, and had put measures in place to safeguard children and young people. Staff would, wherever possible, see children and young people first in order to get them through the department as quickly as possible. However, this was not a formalised approach to children's care within fracture clinic.

Theatres

The theatre environment was fit for purpose to treat children and young people. Staff recovered children and young people in a separate area to adult patients. This consisted of four cubicles; however, one of these was used for storage at the time of inspection.

The children's recovery area had a dedicated resuscitation trolley. Staff signed to say they checked this daily, and recorded any concerns. Staff undertook a full check of all contents weekly, and the number of the secure tag was recorded and checked to ensure the contents had not been tampered with. We found all equipment on the resuscitation trolley was in date at the time of inspection.

Across all clinical areas visited, including ward C2, the NNU and children's outpatients, we found suitable waste disposal systems in place. We found waste bins to segregate waste, including

domestic, offensive and clinical. We observed staff segregating waste appropriately. Each clinical area had sharps 'bins' for disposing of used sharps. We observed staff taking sharps 'bins' to the patient bedside when required, rather than walking through clinical areas with unsheathed sharps.

Both ward C2 and NNU were cluttered, with equipment stored in empty areas, for example the sensory room on ward C2. In the event of an emergency, there was a risk that staff may not be able to access patients in a timely manner due to the limited and cramped space, such as on the neonatal units intensive care area.

Following the onsite inspection, the service told us that the sensory room on ward C2 should only be used to store sensory equipment. The service acknowledged the storage concerns on the NNU, and this was on the service's risk register.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

In the CQC Children and Young People's Survey 2016 the trust scored 6.93 out of ten for the question 'Were the different members of staff caring for and treating your child aware of their medical history?'. This was worse than other trusts.

In the CQC Children and Young People's Survey 2016 the trust scored 9.31 out of ten for the question 'Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?'. This was about the same as other trusts.

Question Number	Question	Age group	Trust score	RAG	KLOE
6	How clean do you think the hospital room or ward was that your child was in?	0-15 adults	8.13	Worse than other trusts	S1
20	Were the different members of staff caring for and treating your child aware of their medical history?	0-15 adults	6.93	Worse than other trusts	S3
36	Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?	0-15 adults	9.31	About the same as other trusts	S4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Ward C2 and the neonatal unit (NNU) used paediatric and neonatal early warning scores (PEWS and NEWS) in the assessment of babies, children and young people. Early warning scores allow staff to assess and monitor patients' physical observations (including heart rate, blood pressure and respiration rate). We reviewed audit data from both ward C2 and the NNU in relation to PEWS and NEWS completion.

Ward C2

October 2018	November 2018	January 2019
100%	100%	100%

Neonatal unit

November 2018	December 2018	January 2019
100%	98%	98%

We reviewed 11 patient records during the inspection and found all had completed PEWS or NEWS scores, with any required escalation in care undertaken.

The trust has a sepsis management: adult and paediatric policy in place at the time of inspection, implemented January 2018 and due for review July 2020. We found the policy was detailed, with a clearly defined process for escalation cases of possible sepsis. The policy contained appendices with a paediatric screening tool for children under five years old, those children and young people aged five to 12 years and one for young people aged over 12 years. The policy also contained a sepsis six pathway for each age range.

Staff had a good knowledge of the signs of potential sepsis and had received training in sepsis recognition and management. We found no children or young people at the time of inspection with suspected or confirmed sepsis.

The service had a policy and a standard operating procedure in place to support the transfer and admission of critically ill children and young people to Russell's Hall Hospital. The policy supported the transfer of critically ill children through the hospital, such as from the emergency department to the adult intensive care unit. We found the policy in date and contained an action plan for implementation, which was complete. The policy also contained a transfer chart for staff to use when transferring children and young people around the hospital. This was detailed and reflected the requirements of a critically ill patient.

The standard operating procedure (SOP) supported staff on the adult intensive care unit when admitting a patient aged under 16 years. The SOP was in date, had been reviewed and updated regularly and contained links to contact details for the children's intensive care transport service.

Theatres

Anaesthetic and recovery staff had completed paediatric immediate life support (PILS) resuscitation training. However, we found paediatric advanced life support trained staff were not available at all times within theatres, in line with the Association of Anaesthetics guidance.

Theatre and recovery staff did use the paediatric early warning score (PEWS) to assess and monitor children and young people post anaesthetic.

The service used the World Health Organisation (WHO) safer surgery checklist in theatre. The WHO safer surgery checklist aims to reduce errors and adverse incidents within theatre, and

increase teamwork and communication during surgery.

The service provided audit data for the completion of the WHO safe surgery checklist; however, this was not monitored specifically within the children and young people's service. The audit of completion of the WHO safer surgery checklist showed that between July and December 2018, 100% of WHO safer surgery checklists were completed in full.

Nurse staffing

The service did not have enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following qualified nursing staff numbers for the two periods below for services for children and young people:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing staff	80.9	80.4	99.5%	84.0	81.8	97.4%

The trust reported a qualified nursing staffing level of 99.5% in services for children and young people in March 2018. This dropped slightly to 97.4% in September 2018.

As at September 2018, there were 2.2 fewer WTE staff in post than planned for but 1.4 more WTE staff in post than in March 2018. There was an increase of 3.1 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 2.6% for qualified nursing staff in services for children and young people. This was lower than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 6.7% for qualified nursing staff in services for children and young people. This was lower than the trust target of 8.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 4.2% for

qualified nursing staff in services for children and young people. This was greater than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From October 2017 to September 2018, the trust reported 9,637 of the 195,574 available hours in services for children and young people were filled by bank staff (4.9%) and 5,617 hours were filled by agency staff (2.9%). In addition, there were 10,351 hours that needed to be covered by bank or agency staff but were unfilled (5.3%).

A breakdown of bank and agency usage by staff type is shown below:

	October 2017 to September 2018						
Staff type	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	5,770.0	3.6%	5,569.0	3.5%	7,309.0	4.6%	158,786.0
Non-qualified	3,867.0	10.5%	48.0	0.1%	3,042.0	8.3%	36,788.0
Total	9,637.0	4.9%	5,617.0	2.9%	10,351.0	5.3%	195,574.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

During the inspection, we found the service did not use a formalised or structured approach to assessing the number of registered and unregistered staff it required on ward C2 or the neonatal unit.

Ward C2

Ward C2 had eight registered nurses per shift. Ward C2 had a total of 32 beds, with three of these designated high dependency unit (HDU) beds.

The Royal College of Nursing (RCN) 2013 defining staffing levels for children and young people's service guidance states the following ratios:

Children under two years of age	Children over two years of age	High dependency children or young people
One nurse to three patients	One nurse to four patients	One nurse to two patients

We found planned registered nurse staffing did not always meet the guidance from the RCN. The planned staffing 24 hours a day was for eight registered nurses. This put the service at risk of not meeting the RCN guidance.

	29 patients, no HDU patients	29 ward patients and one to two HDU patients	29 ward patients and three HDU patients
Average nurse to patient ratio for ward patients	One nurse to 3.6 patients	One nurse to 4.1 patients	One nurse to 4.8 patients

The service provided data to show the average bed occupancy rate for ward C2 was 65.8% between January and November 2018. The occupancy count was taken at midday each day, and

did not include the paediatric assessment unit.

We requested data from the trust on the number of occasions staffing did not meet the RCN 2013 guidance on safe staffing levels on ward C2. The trust told us:

Month	Percent of shifts not compliant with RCN standards on safer staffing
January 2018	16%
February 2018	26%
March 2018	43%
April 2018	19%
May 2018	20%
June 2018	11%
July 2018	6%
August 2018	1.6%
September 2018	13%
October 2018	14.5%
November 2018	35%
December 2018	39%

The average number of shifts not meeting the RCN guidance on safe staffing levels between January and December 2018 was 20.3%.

We found that ward C2 did meet other aspects of the RCN 2013 guidance. We found a ward manager in post who was available Monday to Friday, and a band six nurse (as per the definitions from NHS Employers Agenda for Change pay scale) in charge of the ward 24 hours a day, seven days a week.

Neonatal unit

The planned staffing for the neonatal unit (NNU) was six members of staff. This consisted of four registered nurses and one unregistered member of staff, either a trainee nurse associate (TNA) or a nursery nurse.

The British Association of Perinatal Medicine (BAPM) 2010 guidance on nurse staffing numbers states the following ratios:

Intensive care	High dependency (HDU)	Special care
One nurse to one baby	One nurse to two babies	One nurse to four babies

The BAPM 2010 guidance states that registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a neonatal nurse with a 'qualified in speciality' (QIS) qualification.

During the inspection, we found that staffing did not reflect the number of beds available and could, if the NNU was at capacity, have resulted in unsafe staffing numbers. The NNU consisted of three intensive care cots, two high HDU cots and 13 special care cots. To achieve the BAPM staffing standards, the unit would require, if at capacity, eight nurses to safely provide care. The service provided information that shows an average cot occupancy rate of 80% between January

and November 2018.

Following the inspection, the service told us that, on average, between January and December 2018, the service had an average of 44.9% of shifts that did not meet the BAPM 2010 standards on safe staffing. The below table shows the number of shifts each month that did not meet the BAPM safer staffing standards.

Month	Percent of shifts not compliant with BAPM safer staffing guidance
January 2018	28%
February 2018	69%
March 2018	30%
April 2018	25%
May 2018	85%
June 2018	59%
July 2018	29%
August 2018	19%
September 2018	48%
October 2018	51%
November 2018	43%
December 2018	43%
Average	44.9%

The service counted TNAs in the registered nurse staffing numbers. The TNAs were still undertaking training and were not qualified or registered with the Nursing and Midwifery Council. This gave a false representation of the number of registered staff working on the unit, and posed a risk to patient safety through a lack of qualified and competent staff.

Children's outpatient

The department had two registered nurses on each day whilst the department was open. We spoke to staff during the inspection who told us they felt the nurse staffing was sufficient to support the number of clinics being undertaken.

The senior leadership team within the directorate told us that no formalised nurse staffing tool was used to establish the required number of nurses for ward C2 or the neonatal unit. Neither the senior leadership team or lead nurses could demonstrate a risk or evidence-based approach to calculating the required number of nurses. The senior leadership team acknowledged this during the inspection, and told us they would review how planned nurse staffing was calculated in the future. This posed a risk of clinical areas not having the required number of nurses to deliver safe care to patients, including at times of surge, when an unexpected number of patients attended the service.

We found senior staff had added neonatal ward staffing to the paediatric and neonates risk register. However, ward C2 staffing was not on the risk register.

Medical staffing

The service did not have enough medical staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below for services for children and young people:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical staff	38.2	37.2	97.5%	40.4	36.9	91.4%

The trust reported a medical staffing level of 97.5% in services for children and young people in March 2018. This dropped to 91.4% in September 2018.

As at September 2018, there were 3.5 fewer WTE staff in post than planned for and 0.3 fewer WTE staff in post than in March 2018. Overall, this was an increase of 2.2 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 7.1% for medical staff in services for children and young people. This was greater than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 27.3% for medical staff in services for children and young people. This was significantly greater than the trust target of 8.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 1.7% for medical staff in services for children and young people. This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) - Sickness)

Bank and locum staff usage

From September 2017 to August 2018, the trust reported 2,608.2 of the 81,519.0 available medical staff hours in services for children and young people were filled by bank staff (3.2%) and 1,447.6 hours were filled by locum staff (1.8%). In addition, there were not any medical staff hours available which were not filled by either bank or locum staff to cover staff absence.

Core service	September 2017 to August 2018						
	Bank		Locum		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Services for children and young people	2,608.2	3.2%	1,447.6	1.8%	0.0	0.0%	81,519.0

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was similar.

Staffing skill mix for the 32 whole time equivalent staff working in children's services at The Dudley Group NHS Foundation Trust

	This Trust	England average
Consultant	36%	43%
Middle career^	16%	7%
Registrar Group~	42%	43%
Junior*	6%	7%
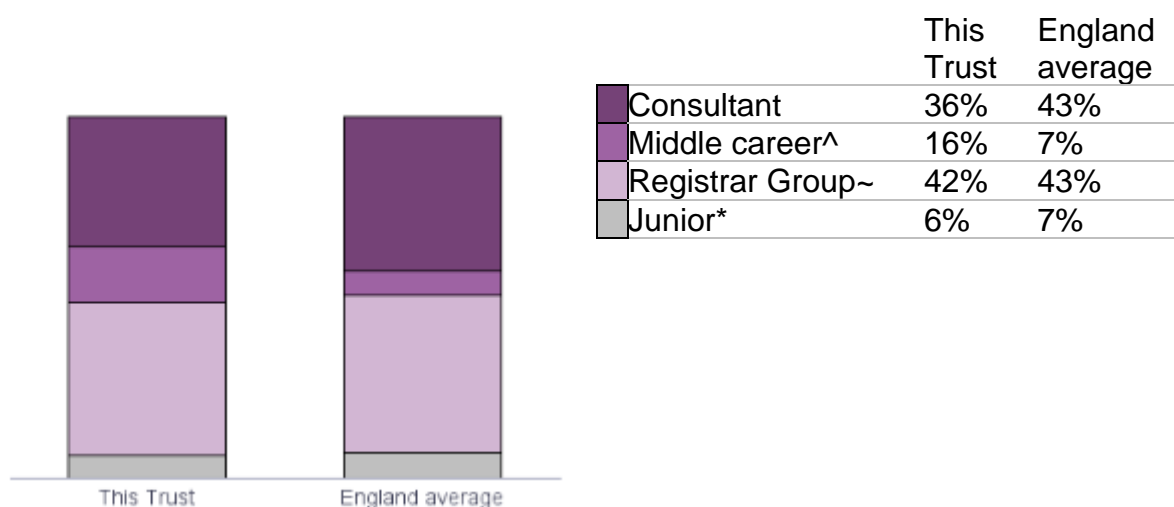
^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Consultants

We requested the consultant rotas for July to December 2018. The service provided rotas for July, October, November and December 2018 only. We found medical cover was provided 9am to 5pm for 'hot week' consultants, one for ward C2 and one for the neonatal unit. The 'hot week' consultant oversees the care of any admitted children or young people during that week. We found that a designated child protection consultant was on call overnight Monday to Friday; however, no cover over the weekends. Overnight, the on-call consultant covered 5pm to 9pm in the paediatric assessment unit and 9pm to 9am on call from home.

Of the four months of rotas reviewed, we found 11 days when there was no onsite cover within the paediatric assessment unit between 5pm and 9pm. This posed a risk of no senior oversight or support for junior and middle grade doctors admitting patients between 5pm and 9pm.

We found no gaps in the 'hot week' or overnight (9pm to 9am) consultant rota in the four months we reviewed.

The senior leadership team told us that they recognised the gaps in providing onsite consultant cover until 9pm at night. The senior leadership team highlighted this as one of the reasons for not meeting the Facing the Future Standards for consultant review. The senior leadership team told us that a business case had been formulated and the trust was currently considering this to allow for either an extension to onsite cover in the evenings or an overnight consultant presence.

Non-consultant medical staff

We found a good skill mix of junior and middle grade medical staff working within ward C2 and the neonatal unit. The service planned for a registrar to be available in each unit during the day, with one registrar covering overnight.

We requested the medical rotas for both ward C2 and the neonatal unit from the service to review medical staffing between July and December 2018. We found the service had one registrar on the neonatal unit (NNU) Monday to Friday 9am to 5pm and two registrars on the children's assessment unit Monday to Friday 9am to 5pm.

A further registrar was on site Monday to Friday 9am to 9:30pm to provide support across all units and a further registrar 1:30pm to 9:30pm Monday to Friday to provide support across all units. Monday to Friday 9:30pm to 9:30am, one registrar covered ward C2, including the children's admissions unit, and NNU.

Saturday and Sunday 9am to 2pm, two registrars covered ward C2 and NNU, with one registrar 2pm to 9:30pm. Saturday and Sunday, one registrar covered ward C2 and NNU from 9pm to 9:30am.

Medical staff and the senior management team told us they recognised one registrar overnight was not sustainable and the senior management team were reviewing medical provision overnight to ensure safe staffing levels.

The children's outpatient clinic had two designated registrars Monday to Friday to support consultants deliver clinics.

We reviewed the registrar rota for July to December 2018 and found this was covered well with no gaps. Medical staff were allocated days off after weekends and nights before returning to work.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

We reviewed 11 medical records for children and young people during the inspection. We found staff documented in a timely manner within records, the records we looked at were complete and the information was detailed. Staff worked within the trusts information governance policy and creation and management of patients' health records policy.

Ward C2 and the neonatal unit were in the process of transitioning from paper records to electronic records for all patients. At the time for the inspection, the service had moved observations electronic, known as e-obs, with the rest of the patients' records remaining paper.

Ward C2

Within the children's ward, staff completed records for all inpatients in a timely manner. We reviewed medical records and found care plans to be complete and care planning completed relevant to the child or young person's condition. Staff completed paediatric early warning scores (PEWS) for all children and young people, and we found documented evidence of escalation of high PEWS scores.

Within the high dependency area, staff completed critical care documentation, including one large observation sheet consisting of observations, fluid balance and medication, amongst other monitored parameters.

Neonatal Unit

Staff in the neonatal unit completed records for all patients in a timely manner. We observed staff completing relevant documentation for patients. The neonatal unit had trainee nurse associates (TNA) and a registered nurse counter-signed all TNA entries in records to ensure review of the patients care throughout the day.

Children's Outpatient Department

We found staff managed records well within the outpatient department. Staff ensured that records were kept safe when not with them, and records were not left in unoccupied clinic rooms. We found computers were locked or logged off when not in use to prevent unauthorised access to personal information.

On both ward C2 and the neonatal unit we found records were stored appropriately and only accessible to those that should have access. Staff logged off or locked computer screens when not using them to prevent inadvertent access to patient's personal information.

We reviewed documentation audits from ward C2 and the neonatal unit. The audits looked at five areas: patient observations, pain management, manual handling and falls assessments, tissue viability and medication assessment. The neonatal audits replaced manual handling with nutrition.

Each area had a set of criteria to meet. For example, the pain management section included taking a baseline pain score on admission, pain is assessed every four hours and documented evidence of actions where pain relief is not effective.

The compliance target was 90%.

Ward C2

Month	Patient observations	Pain management	Manual handling assessments	Tissue viability	Medication assessment
October 2018	100%	90%	100%	100%	100%
November 2018	100%	100%	100%	100%	100%
January 2019	100%	100%	100%	100%	100%

Neonatal Unit

Month	Patient observations	Pain management	Tissue viability	Nutritional	Medication assessment
November 2018	100%	100%	97%	98%	100%
December 2018	98%	96%	100%	100%	100%
January 2019	98%	98%	100%	100%	100%

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

During the inspection we found staff managed medicines well. Staff prescribed medication in accordance with current best practice. All prescription reviewed were legible and had been reviewed by a pharmacist.

We observed staff administering medication to children and young people on ward C2. Staff checked points of identification before administering medication, to ensure they were given to the correct patient.

We found allergies were documented within patient records, and patients with an allergy had a different coloured wrist band on to highlight this to staff.

We reviewed medication audits from ward C2 and the neonatal unit. The audits reviewed 10 areas, including the storage, administration, completion of records and management of ward stock.

We reviewed the last two medication audits for ward C2 from October and November 2018, and the last two audits from the neonatal unit from November and December 2018. In all cases for both wards, we found 100% compliance with all aspects of the medication audits.

We reviewed the stock of controlled drugs on ward C2 and the neonatal unit. We looked at three controlled drugs on each ward and found the levels recorded in the controlled drugs register matched the quantities available. However, we did find one bottle of a controlled drug that was out of date on ward C2. We informed the lead nurse who ensured this was removed and replaced in a timely manner.

We reviewed a number of non-controlled drugs on both wards and found all stock checked in date. Both ward C2 and the neonatal unit stored oral, topical and intravenous medications in different cupboards to reduce the risk of administering via the wrong route.

Within children's outpatients, we found no controlled drugs were stored or in use. All other medication as stored appropriately and only accessible to staff.

We found intravenous fluids were stored safely and were only accessible to those that should have had access.

Staff monitored and recorded the temperature of medication and milk fridges on ward C2 and the neonatal unit. We found no temperatures that were outside the required parameters in December 2018 or January 2019. Staff could explain the procedure if the temperatures did go out of the specified safe range.

During the inspection, we found the fridge on ward C2 had a broken seal and did not lock. We informed the lead nurse who ensured the fridge was replaced in a timely manner. As a precaution, all medication from the broken fridge was discarded by the pharmacy team and the fridge restocked with new medication.

Staff monitored and recorded the room temperatures where medication was stored. We found no temperatures that exceeded the parameters in December 2018 or January 2019. Staff could explain the procedure if the temperature did go out of the specified safe range.

The hospital used its only internal prescription charts for outpatient prescriptions. Patients could only process these at the internal pharmacy. We found all prescription pads on ward C2 and in outpatients securely stored, and only accessible by the nursing staff. This ensured the safe distribution of prescriptions.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team; however, not always with the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as never events for services for children and young people.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported five serious incidents (SIs) in services for children and young people which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is below:

- Abuse/alleged abuse of child patient by third party
- Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)
- Pressure ulcer meeting SI criteria
- Treatment delay meeting SI criteria

One incident had not yet had a category assigned as it was pending review.

(Source: Strategic Executive Information System (STEIS))

We reviewed four serious incident root cause analysis (RCA) reports for incidents between January 2018 and December 2018. We found that all four RCAs were detailed and included lessons learnt and an action plan for implementing recommendations. Each RCA contained a risk assessment for the likelihood of a similar incident reoccurring. Where appropriate, the RCAs detailed the involvement of other agencies and providers in the incident and subsequent investigation. Each RCA was completed within a timely manner after recognition of the incident being categorised as a serious incident.

However, we found that lessons were not always shared across different departments and areas. The senior leadership told us that lessons were shared in the area where the incident happened, and we saw evidence of this. However, the senior leadership team confirmed there was no structure in place to ensure shared learning across the directorate. This posed a risk of recurring incidents due to a lack of shared learning.

Following the onsite inspection, the service told us that incident learning was shared at a number of meetings, including the paediatric governance meeting, the neonatal quality, practice and development meeting and the paediatric quality practice and development meeting.

Safety thermometer

The service monitored safety through an evidence-based safety thermometer and reported trends to improve the safety of care.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from September 2017 to September 2018 for services for children and young people.

(Source: NHS Digital)

Each ward and department visited during the inspection displayed the safety thermometer data in

a public place. We found no concerns during the inspection with regards pressure ulcer management, falls or urinary tract infections. The trust target for compliance was 95% and zero for pressure ulcers and falls and serious injury.

Ward C2

	Pressure ulcers (grades 3 and 4)	Urinary catheter ongoing care	Falls, injuries and accidents
January 2018	0	100%	0
February 2018	0	100%	1
March 2018	0		3
April 2018	0		0
May 2018	0		1
June 2018	1		0
July 2018	0		0
August 2018	0		1
September 2018	0		0
October 2018	0		1
November 2018	0		0
December 2018	0		0
Average or total for 2018	1 (total for year)	100% (average for year)	7 (total for year)

Ward C2 had no patients with a urinary catheter between March and December 2018.

Neonatal unit

	Pressure ulcers (grades 3 and 4)	Falls, injuries and accidents
January 2018		
February 2018		
March 2018		
April 2018		
May 2018		2
June 2018		
July 2018		
August 2018		
September 2018		
October 2018		
November 2018		
December 2018		2
Average or total for 2018	None reported in 2018	4 (total for year)

The NNU did not report on urinary catheter care.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

We found the service had assessments and care plans in place for children and young people with a learning disability. We found staff on ward C2 completed a 'checklist for paediatric patients with a learning disability' assessment on admission. The assessment looked at communication needs, assessing pain, safeguarding and any reasonable adjustments that needed to be made or implemented. Staff completed a care plan following the assessment to ensure that staff met the needs of the child or young person.

The service used the current resuscitation guidance from the UK Resus Council. We found information on the wards for staff to refer to in an emergency reflected the current neonatal and paediatric resuscitation guidelines.

We found that the children's service used local safety standards for invasive procedures (LocSSIPs), which were based on national safety standards for invasive procedures (NatSSIPs). NatSSIPs are a set of national safety standards developed by NHS England in 2015 to reduce the number of patient safety incidents related to invasive procedure in which surgical never events could occur.

The service had a LocSSIPs standard operating procedure (SOP) in place, which was in date and contained the evidence-base within the references. The SOP contained a list of invasive procedures undertaken in children's and neonatal services and covered by the LocSSIP. Staff completed a LocSSIP checklist before each invasive procedure; however, we did not see any children or young people at the time of inspection that required an invasive procedure.

The trust undertook a trust wide audit of compliance with LocSSIPs, including across the surgery, women and children division in May 2018. The audit reviewed 100 records from across the division and showed the following compliance.

Standard	Target	Surgery, women and children division
Standard one: was the safety check completed?	100%	100%
Standard two: was general pre-commencement checks done?	100%	99%
Standard three: were post-operative procedures checked?	100%	99%
Standard four: is the checklist complete?	100%	92%

The service had been awarded the Baby Friendly Initiative certificate of commitment from UNICEF. The certificate of commitment demonstrates the services willing to achieve full Baby Friendly accreditation from UNICEF. The award showed the service had an infant feeding policy,

an action plan to achieve Baby Friendly accreditation and a commitment to implement the plan. We requested the plan from the service; however, the service did not provide this.

The service had an action plan to implement the Bliss Baby Charter across the service. The Bliss Baby Charter was designed to standardise high quality family-centred care across the UK. It is a practical framework for neonatal units to self-assess the quality of family-centred care they deliver against a set of seven core principles. We requested the action plan to achieve the Bliss Baby Charter status; however, the service did not provide this.

The service used the World Health Organisation (WHO) safer surgery checklist in theatre. The WHO safer surgery checklist aims to reduce errors and adverse incidents within theatre, and increase teamwork and communication during surgery.

The senior leadership team had identified, and added to the risk register, a lack of training in the delivery of total parental nutrition (TPN). The service has ensured that further evidence-based training is delivered to staff to ensure that effective management and delivery of TPN is undertaken within the neonatal unit.

The service had a service level agreement in place with the local child and adolescent mental health service (CAMHS). This ensured the service met the requirements of clinical guidance 16 from the National Institute of Health and Care Excellence, self-harm in over eights: short-term management and prevention of recurrence.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Staff assessed the nutritional needs of children and young people on admission. The initial assessment included documenting any specific requirements, for example if the child or young person was coeliac or diabetic.

On the neonatal unit, we found that mothers were offered food and drink during the time their baby was an inpatient on the unit. Families on the neonatal unit had access to a kitchen and food preparation area.

On ward C2, families had access to a kitchen and food preparation area. Children and young people could choose from a variety of food, including food suitable for specific requirements, including vegetarian and halal. Staff supported children and young people to choose foods that supported their recovery and met their nutritional needs.

Ward C2 had access to a dietician for advice and support.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We reviewed patient records during the inspection and found staff reviewed patients pain regularly. The trust had various pain scores in place, appropriate to the different ages of patients, for example the face, leg activity, cry and consolability (FLACC) scale.

We found no children or young people in pain during the inspection, and all families spoken to told us that their child or young person had received pain relief when required.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Paediatric diabetes audit 2015/16

HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time.

The proportion of patients receiving all key care processes annually was 0.0% which was a negative outlier, compared to a national aggregate of 35.5%. The previous year's score was also 0.0%.

The average HbA1c value (adjusted by case-mix) at the trust was 68.2 which was within the expected range, compared to a national aggregate of 68.3%. The previous year's score was within the expected range.

The median HbA1c value recorded amongst the 2015/16 sample was 65.0, which was better than the previous year's median which was 64.0. This indicated no clinically significant change.

(Source: National Paediatric Diabetes Audit 2015/16)

The service had developed an action plan for improvement against the paediatric diabetes audit. On review, the action plan was detailed, with clear improvement plans. The action plan contained eight agreed actions, with four completed, three in progress and one with overdue actions. However, the one overdue action had had work started and a clear plan for completion was documented.

Emergency readmission rates within two days of discharge

The data shows that between May 2017 and April 2018 there were no specialities with six or more readmissions for patients aged under one or aged 1-17 years old readmitted following an elective admission.

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

Tables for emergency readmissions within two days of discharge following emergency admission

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (May 2017 to April 2018)				
Specialty	**The Dudley Group NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	2.5%	1,467	36	3.4%
No other specialty at this trust had six or more readmissions				

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (May 2017 to April 2018)				
Specialty	**The Dudley Group NHS Foundation Trust**			**England**
	Readmission rate	**Discharges (n)**	**Readmissions (n)**	**Readmission rate**
Paediatrics	2.0%	2,635	52	2.8%
General surgery	4.1%	491	20	3.8%

The data shows that from May 2017 to April 2018 there was a lower percentage of under ones readmitted following an elective admission compared to the England average and a lower percentage of patients aged 1-17 years old readmitted following an elective admission compared to the England average.

Over the same time period, paediatrics had 36 emergency readmissions within two days of discharge following emergency admission for the under one age group. For the 1-17 years age group, the paediatrics specialty had 52 readmissions.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

Between June 2017 and May 2018, the trust reported there were no multiple admissions for children in the under one age group for asthma, diabetes or epilepsy.

The trust performed worse than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for asthma.

The trust performed better than the England average for the percentage of patients aged 1-17 years old who had multiple readmissions for diabetes.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (for children aged under 1 year and 1 to 17 years). (June 2017 to May 2018)				
Long term condition	**The Dudley Group NHS Foundation Trust**			**England**
	Multiple admission rate	**At least one admission (n)**	**Two or more admissions (n)**	**Multiple admission rate**
Asthma				
Under 1	-	-	-	8.6%
1 to 17	18.8%	69	13	16.1%
Diabetes				
Under 1	-	-	-	16.7%
1 to 17	0.0%	32	0	13.0%
Epilepsy				
Under 1	*	*	*	32.9%
1 to 17	*	19	*	27.4%

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with '*'.

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

In the 2017 National Neonatal Audit, The Dudley Group NHS Foundation Trust performance in the four measures relevant to children and young people's services was as follows:

- **Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5ºc-37.5ºc?**

There were 50 eligible cases identified for inclusion, 54.7% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

This was within the expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

The hospital did not meet the audit's recommended standard of 90% for this measure.

- **Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?**

There were 362 eligible cases identified for inclusion, 86.9% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission.

This was within the expected range when compared to the national aggregate where 90.5% of cases had the first consultation within 24 hours of admission.

The hospital did not meet the audit's recommended standard of 100% for this measure.

- **Do all babies < 1501g or a gestational age of < 32 weeks at birth receive appropriate screening for retinopathy of prematurity (ROP)**

There were 51 eligible cases identified for inclusion, 97.2% of babies with a weight of < 1501g or a gestational age of < 32 weeks at birth received the appropriate ROP screening.

This was within the expected range when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening.

The hospital did not meet the audit's recommended standard of 100% for this measure.

- **Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?**

There were 24 eligible cases identified for inclusion, 54.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

This was within the expected range when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

The hospital did not meet the audit's recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

We reviewed the action plan from the service for the national neonatal audit programme. The action plan sent by the service showed 12 actions to improve the 'Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5⁰c-37.5⁰c' standard. Of the 12 actions, staff had completed and implemented 10 of them.

However, the action plan for improvement did not contain any improvements for the remaining two outcomes of the national neonatal audit. We were not assured that the service had a robust plan in place to improve the effectiveness of care against the national neonatal audit outcomes.

We requested information on the services participation in other national audit programmes, including Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) and Epilepsy 12 from the Royal College of Paediatric and Child Health (RCPCH).

The service told us they participate in the Epilepsy 12 audit from RCPCH, which was introduced in 2009. However, the service told us they had begun to participate since July 2018 and had no outcomes or action plans as the service was currently collecting data.

Competent staff

The service did not always make sure staff were competent for the roles they were undertaking. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Appraisal rates

For year to date, April to September 2018, 92.9% of required staff in services for children and young people received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
NHS infrastructure support	1	1	100.0%	90.0%	Yes
Qualified nursing & health visiting staff (Qualified nurses)	84	90	93.3%	90.0%	Yes
Support to doctors and nursing staff	20	22	90.9%	90.0%	Yes
Total	**105**	**113**	**92.9%**	**90.0%**	**Yes**

The appraisal data provided by the trust for medical staff was only provided at trust level, so could not be broken down by core service. For year to date, April to September 2018, 98.5% of medical staff trust wide received an appraisal compared to the trust target of 90%.

(Source: Trust Provider Information Request – Appraisal tab)

Neonatal unit

We reviewed the number of registered nursing staff that had completed the 'qualified in speciality' (QIS) neonatal postgraduate training programme. The service told us that 47% of registered staff had the QIS qualification. A further four nurses were undertaking the course at the time of inspection, which would take the total amount to 56%. The British Association of Perinatal Medicine service standards for hospitals providing neonatal care, August 2010, states the following QIS numbers of staff:

Intensive care babies	One QIS nurse to one baby – the QIS nurse should not have any other responsibilities during the shift.
High dependency babies	One QIS nurse to one baby – however, a QIS nurse may directly oversee the care given by an experienced non-QIS nurse.
Special care babies	One nurse to four babies – unregistered healthcare staff and non-QIS trained nurses may care for special care babies; however, this should be under the direct supervision of a QIS trained neonatal nurse.

The unit had four trainee nursing associates (TNA). The neonatal unit (NNU) was utilising the TNAs in a registered nurse capacity. However, the skills and competence of the TNAs was not sufficient to be counted within the registered nurse numbers. This posed a risk of ineffective care delivery, particularly at times of increased patient numbers within the NNU.

The neonatal unit employed three nursery nurses. The service provided the following information on additional training and competence undertaken by the nursery nurses on the neonatal unit.

Competency	Percentage of staff compliant (out of three)
In service day training – three days per year (includes mandatory training, medical devices, neonatal specific training and unit meeting)	100%
Naso gastric tube competency	100%
Blood glucose training	100%
Blood collection training	100%
Blood gas training	100%
Hearing screening training and updates	100% Of designated unregistered staff who are hearing screeners
E-obs training	100%
New born Life support	100%

The NNU did not employ any clinical support workers.

Ward C2

Registered nursing staff could undertake additional training and competencies. We found that all senior staff nurses (band six) had completed paediatric intermediate life support. Senior staff nurses were encouraged to completed additional training in the care of the critically ill child, to lead within the high dependency area, and support other nurses on the ward.

Unregistered staff had skills training in place. All unregistered staff attend the trust's induction training, followed by completion of fundamental clinical skills programme. The clinical skills programme covered the key areas that all unregistered staff needed to know, including taking a blood pressure, oral hygiene, specimen collection and dignity in death. The taught skills were supported by observed clinical competencies whilst working on the ward.

However, we found that the fundamental clinical skills programme was adult focussed, with no specific skills in the care of children, young people and families.

All unregistered staff worked towards the care certificate, which included several clinical competencies. The care certificate allowed unregistered staff to demonstrate clinical competence through five levels working up to independent.

<u>Theatres</u>

Staff within the theatre department undertook additional training in the support of children and young people. All recovery staff undertook an online training course in the care of children and young people following anaesthetic. The service told us that all anaesthetic and recovery staff should complete paediatric immediate life support (PILS). At the time of inspection, staff were 74% compliant with PILS.

Multidisciplinary working

Staff worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

CQC Children and Young People's Survey 2016 – Q23

In the CQC Children and Young People's Survey 2016 the trust scored 8.19 out of ten for the question 'Did the members of staff caring for your child work well together?' This was about the same as other trusts.

Question Number	Question	Age group	Trust score	RAG	KLOE
23	Did the members of staff caring for your child work well together?	0-15 adults	8.19	About the same as other trusts	E4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

We found good multidisciplinary team (MDT) working throughout the inspection. We observed joint ward rounds between nursing, medical and allied health professionals. Each Thursday, staff undertook a 'grand round' where all staff involved in the care of the child or young person undertook the round to ensure that care was planned with an MDT approach.

On the neonatal unit we found staff worked well with each other. We found a good MDT approach to care delivery, with a mix of staff attending to babies. We found positive working relationships between the medical staff and the advanced nurse practitioners. The neonatal community outreach team worked well with the neonatal ward.

We found specialist staff, for example safeguarding or learning disability nurse specialists, worked well with staff on ward C2. We observed specialist staff attending ward C2 to provide support and guidance to staff, patients and families.

Seven-day services

The service provided seven-day access to acute services. However, some areas had limited cover at weekends and out of hours and overnight.

All acute services within the children and young people's service were available seven-days a week. However, we found that the services provided at weekends and overnight did not fully reflect the Monday to Friday daytime services.

The neonatal unit (NNU) had an advanced neonatal nurse practitioner (ANNP) working seven days a week to provide senior clinical input into the care of babies within the NNU.

Play specialists worked Monday to Friday daytime hours at the time of the inspection. The senior leadership team told us they had a plan to recruit further play specialists to move this service to seven days a week.

The high dependency unit (HDU) on ward C2 and the NNU had access to the following specialists Monday to Friday daytime:

- Pharmacist

- Dietician

- Occupational therapist

- Speech and language therapist

- Physiotherapist

Children's outpatient clinics were offered Monday to Friday, with no routine weekend or evening appointments. However, the service told us they could offer some Saturday appointments to ensure patients were seen within the required timeframe.

Health promotion

Staff supported children and young people to manage their own health and care needs, and assessed children and young people on admission for opportunities to improve their overall health.

We found staff were supportive of children and young people and undertook health promotion at each stage of treatment. Staff supported children and young people to be involved in their care and take ownership for the ongoing management of long term conditions.

The trust used health passports so children and young people could record all aspects of their condition and track progress. This allowed children and young people to take ownership and responsibility for the ongoing management of their condition.

On admission, staff asked questions to establish if specific health promotion support was required. Staff could offer smoking cessation advice and support, or a referral to a gastro-urinary clinic for any young people that were sexually active.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. they followed the trust policy and procedures when a patient could not give consent.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 100.0% of qualified nursing staff in services for children and young people. It should be noted that the data for nursing staff refers to one eligible member of staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

The trust did not provide any data for medical staff completion rates of mental health law training.

Other CQC Survey Data

CQC Children and Young People's Survey 2016 Data

The trust performed about the same as other trusts for four questions relating to effectiveness in the CQC Children and Young People's Survey 2016.

Question 54 had no score.

Question Number	Question	Age group	Trust score	RAG	KLOE
21	Did you feel that staff looking after your child knew how to care for their individual or special needs?	0-15 adults	8.01	About the same as other trusts	E3
9	Did staff play with your child at all while they were in hospital?	0-7 adults	6.72	About the same as other trusts	E4
19	Did different staff give you conflicting information?	0-7 adults	7.29	About the same as other trusts	E4
33	During any operations or procedures, did staff play with your child or do anything to distract them?	0-15 adults	7.18	About the same as other trusts	E4
54	Did hospital staff play with you or do any activities with you while you were in hospital?	8-11 CYP	No Score	No Score	E4

(Source: CQC Children and Young People's Survey 2016, RCPCH)

As part of our review of medical records, we looked at the consent process and reviewed consent forms for children and young people undergoing surgical procedures. We found written consent was taken prior to surgical procedures; however, the consent forms were not always legible. We found all the consent forms looked at did not have a legible printed name of the surgeon.

We found no evidence of the involvement of children and young people in the consent process. None of the 11 records we reviewed contained information that showed the child or young person had consented themselves to the procedure, or an assessment of capacity to consent.

Is the service caring?

Compassionate care

Staff cared for children, young people and those close to them with compassion. Feedback confirmed that staff treated children and young people well and with kindness.

During the inspection we spoke with five children, young people and families about the care they had received. We found all children, young people and families were happy with the care received. None of the children, young people or families asked raised any concerns to the inspection team.

We observed staff delivering care to babies, children and young people, and interacting with families and carers. Staff interacted with babies, children and young people in an age appropriate way during all observed interactions.

We observed staff interacting with families well. Staff delivered bad news in a supportive way and a way in which parents could understand and left them free to ask questions.

We were told by neonatal staff that when a baby died, parents were offered the chance to spend the night in the parent's accommodation with their baby. Parents also had the chance to bring in other relatives in these circumstances to spend the night.

Staff explained how they would interact with children and young people who were scared about medical procedures. Monday to Friday, the play specialists on ward C2 could undertake play therapy to help children and young people understand the procedure better and involve them in the process.

CQC Children and Young People's Survey 2016

The trust performed worse than other trusts for three questions and about the same as other trusts for the remaining seven questions relating to compassionate care in the CQC Children and Young People's Survey 2016.

Question Number	Question	Age group	Trust score	RAG	KLOE
10	Did new members of staff treating your child introduce themselves?	0-7 adults	8.61	About the same as other trusts	C1
14	Did you have confidence and trust in the members of staff treating your child?	0-15 adults	8.47	About the same as other trusts	C1
22	Were members of staff available when your child needed attention?	0-15 adults	7.04	Worse than other trusts	C1
42	Do you feel that the people looking after your child were friendly?	0-7 adults	8.56	Worse than other trusts	C1
43	Do you feel that your child was well looked after by the hospital staff?	0-7 adults	8.37	Worse than other trusts	C1
44	Do you feel that you (the parent/carer) were well looked after by hospital staff?	0-15 adults	7.36	About the same as other trusts	C1
58	Was it quiet enough for you to sleep when needed in the hospital?	8-15 CYP	6.12	About the same as other trusts	C1
64	If you had any worries, did a member of staff talk with you about them?	8-15 CYP	8.02	About the same as other trusts	C1

| 74	Do you feel that the people looking after you were friendly?	8-15 CYP	9.06	About the same as other trusts	C1
75	Overall, how well do you think you were looked after in hospital?	8-15 CYP	8.46	About the same as other trusts	C1

(Source: CQC Children and Young People's Survey 2016, RCPCH)

The service used the Friends and Family Test (FFT) to monitor whether patients and their relatives would recommend services to their friends and family. The service had a target of 97.4% recommendation rate.
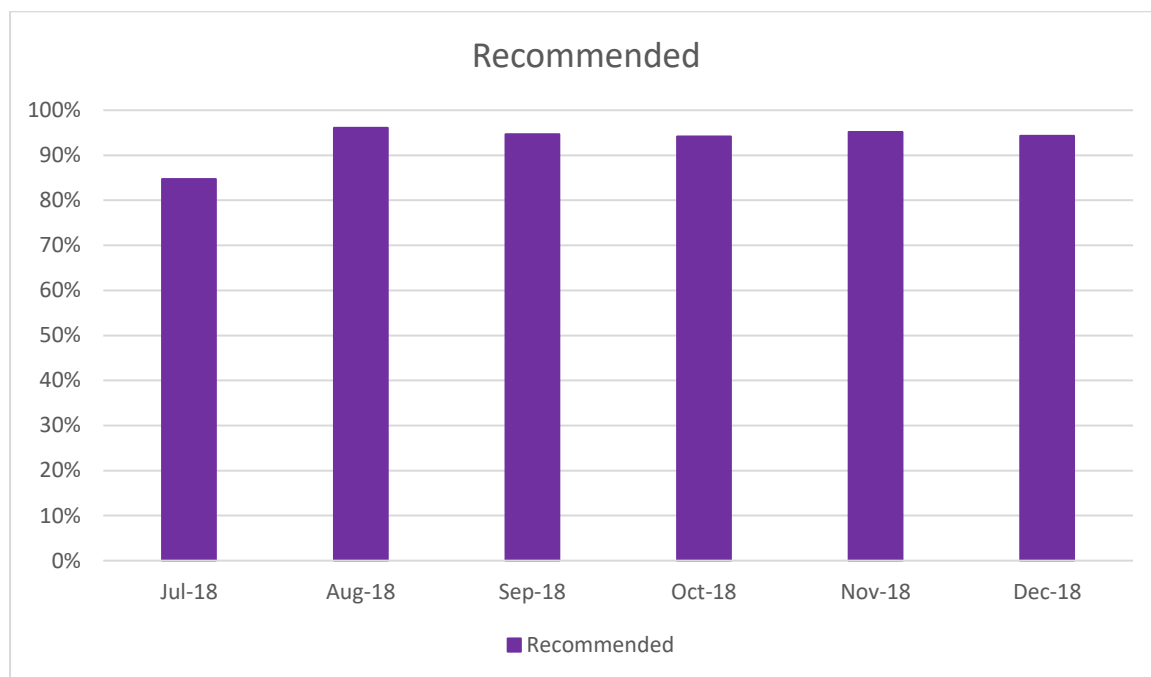
Ward C2
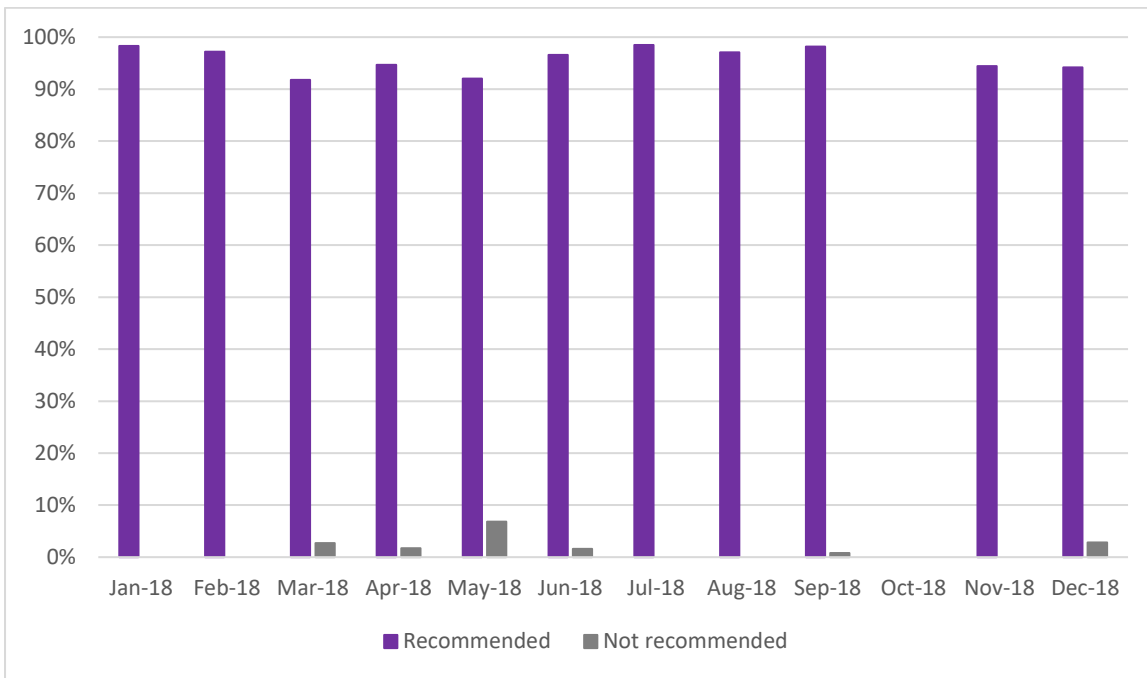
Neonatal unit
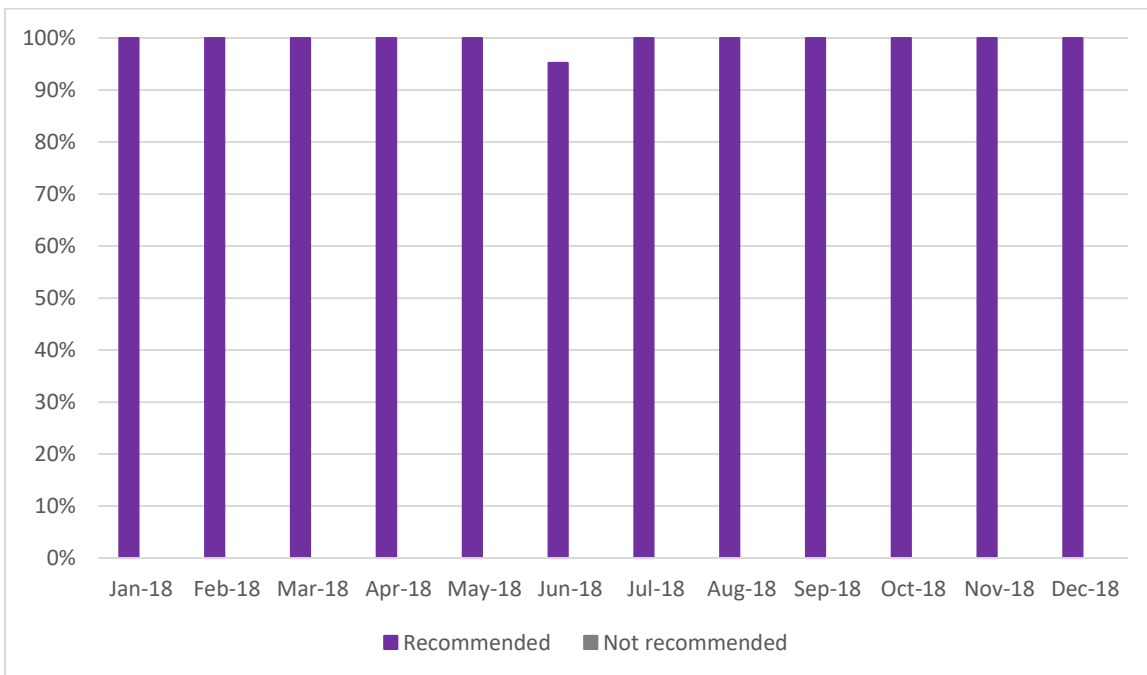
The neonatal unit did not receive any "not recommended" response to the FFT between January and December 2018.

Children's outpatient department

Recommended

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Recommended	~85%	~96%	~95%	~94%	~95%	~94%

The service did not provide information on the number of patients that did not recommend the children's outpatient department.

Emotional support

Staff provided emotional support to children, young people and those close to them to minimise their distress.

We found all staff provided emotional support to children, young people and those close to them. Staff displayed empathy towards children and young people at times of distress, such as during an unpleasant procedure such as taking blood.

Children, young people and families had access to chaplaincy staff to provide spiritual support during distressing times. Staff told us they were able to access a chaplain 24 hours a day if required.

On the neonatal unit (NNU), we found staff displayed a strong understanding of how to support families, especially in times of distress and uncertainty. We saw an example of twins on NNU that were in the special care unit. Staff were nursing the babies in one side room to allow them to bond and support each other through the comfort of touch. This also allowed the parents time with both babies in the same room.

Parents on the neonatal unit could access the bereavement specialist midwife when a baby died on the unit. The bereavement midwife could provide additional support and guidance to parents and families during this difficult time.

The community neonatal nurses provided support to parents taking babies home but requiring ongoing care and treatment. The community neonatal nurses provided support to parents prior to discharge on the NNU, and then followed them up in the community.

The service told us following the onsite inspection that the play team that works with children and

young people to minimise stress through distraction play. The learning disability team at the trust works with the surgical teams to ensure reasonable adjustments are made for children and young people with a learning disability.

CQC Children and Young People's Survey 2016

The trust performed worse than other trusts for two questions and about the same as other trusts for the remaining three questions relating to emotional support in the CQC Children and Young People's Survey 2016.

Question Number	Question	Age group	Trust score	RAG	KLOE
7	Was your child given enough privacy when receiving care and treatment?	0-7 adults	8.81	About the same as other trusts	C3
29	If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?	0-15 adults	7.42	Worse than other trusts	C3
45	Were you treated with dignity and respect by the people looking after your child?	0-7 adults	8.68	Worse than other trusts	C3
65	Were you given enough privacy when you were receiving care and treatment?	8-15 CYP	8.73	About the same as other trusts	C3
67	If you felt pain while you were at the hospital, do you think staff did everything they could to help you?	8-15 CYP	7.80	About the same as other trusts	C3

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Understanding and involvement of patients and those close to them

Staff did not consistently involved children, young people and those close to them in decisions about their care and treatment.

CQC Children and Young People's Survey 2016

The trust performed worse than other trusts for four questions and about the same as other trusts for 14 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People's Survey 2016.

Questions 66, 69 and 70 had no score.

Question Number	Question	Age group	Trust score	RAG	KLOE
11	Did members of staff treating your child give you information about their care and treatment in a way that you could understand?	0-15 adults	8.91	About the same as other trusts	C2

12	Did members of staff treating your child communicate with them in a way that your child could understand?	0-7 adults	6.82	Worse than other trusts	C2
13	Did a member of staff agree a plan for your child's care with you?	0-15 adults	8.42	Worse than other trusts	C2
15	Did staff involve you in decisions about your child's care and treatment?	0-15 adults	7.76	About the same as other trusts	C2
16	Were you given enough information to be involved in decisions about your child's care and treatment?	0-15 adults	8.15	About the same as other trusts	C2
17	Did hospital staff keep you informed about what was happening whilst your child was in hospital?	0-15 adults	7.56	Worse than other trusts	C2
18	Were you able to ask staff any questions you had about your child's care?	0-15 adults	8.48	About the same as other trusts	C2
31	Before your child had any operations or procedures did a member of staff explain to you what would be done?	0-15 adults	9.50	About the same as other trusts	C2
32	Before the operations or procedures, did a member of staff answer your questions in a way you could understand?	0-15 adults	9.37	About the same as other trusts	C2
34	Afterwards, did staff explain to you how the operations or procedures had gone?	0-15 adults	8.30	About the same as other trusts	C2
39	When you left hospital, did you know what was going to happen next with your child's care?	0-15 adults	7.96	About the same as other trusts	C2
41	Do you feel that the people looking after your child listened to you?	0-7 adults	8.01	Worse than other trusts	C2
59	Did hospital staff talk with you about how they were going to care for you?	8-15 CYP	9.01	About the same as other trusts	C2
60	When the hospital staff spoke with you, did you understand what they said?	8-15 CYP	8.24	About the same as other trusts	C2
61	Did you feel able to ask staff questions?	8-15 CYP	9.48	About the same as other trusts	C2
62	Did the hospital staff answer your questions?	8-15 CYP	9.59	About the same as other trusts	C2
63	Were you involved in decisions about your care and treatment?	8-15 CYP	5.51	About the same as other trusts	C2
66	If you wanted, were you able to talk to a doctor or nurse without your parent or carer being there?	12-15 CYP	No Score	No Score	C2
69	Before the operations or procedures, did hospital staff explain to you what would be done?	8-15 CYP	No Score	No Score	C2
70	Afterwards, did staff explain to you how the operations or procedures had gone?	8-15 CYP	No Score	No Score	C2

72	When you left hospital, did you know what was going to happen next with your care?	8-15 CYP	8.29	About the same as other trusts	C2

(Source: CQC Children and Young People's Survey 2016, RCPCH)

We observed staff speaking with children and young people in a way that they could understand, including the use of interpreters and other alternative forms of communicating. However, we found that children and young people were not always fully involved in the decisions about their care.

We found no evidence to demonstrate that children and young people had been involved in the consent process before undergoing surgical procedures. However, children and young people were told what was going to happen.

The service had limited child friendly ways of delivering information, such as child friendly or easy read leaflets about their condition of care. Some specialities, for example diabetes care, had easy read leaflets for children and young people. However, easy read material was not readily available across all services.

During the inspection, two of the families spoken to were asked to attend ward C2 at a certain time; however, staff did not inform them of what was going to happen after they arrived or how long they were going to have to wait.

The majority of the children, young people and families spoken to did tell us that staff generally kept them informed about their care and communicated changes and care plans with them. We found that children, young people and families could be involved in the consultant's ward round, and were given the chance to ask questions.

Is the service responsive?

Service delivery to meet the needs of local people

The trust did not plan and provide services in a way that met the needs of all children, young people and their families.

CQC Children and Young People's Survey 2016

The trust performed better than other trusts for one question, worse than other trusts for one question and about the same as other trusts for 14 questions relating to responsiveness in the CQC Children and Young People's Survey 2016.

Question 55 had no score.

Question Number	Question	Age group	Trust score	RAG	KLOE
4	For most of their stay in hospital what type of ward did your child stay on?	0-15 adults	9.89	About the same as other trusts	R1
5	Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	0-15 adults	8.95	About the same as other trusts	R1
25	Did you have access to hot drinks facilities in the hospital?	0-15 adults	7.49	About the same as other trusts	R1
26	Were you able to prepare food in the hospital if you wanted to?	0-15 adults	4.19	About the same as other trusts	R1
28	How would you rate the facilities for parents or carers staying overnight?	0-15 adults	6.97	About the same as other trusts	R1
55	Was the ward suitable for someone of your age?	12-15 CYP	No Score	No Score	R1
8	Were there enough things for your child to do in the hospital?	0-7 adults	6.60	Worse than other trusts	R2
24	Did your child like the hospital food provided?	0-7 adults	5.31	About the same as other trusts	R2
37	Did a staff member give you advice about caring for your child after you went home?	0-15 adults	8.22	About the same as other trusts	R2
38	Did a member of staff tell you who to talk to if you were worried about your child when you got home?	0-7 adults	8.23	About the same as other trusts	R2
40	Were you given any written information (such as leaflets) about your child's condition or treatment to take home with you?	0-15 adults	6.85	About the same as other trusts	R2
56	Were there enough things for you to do in the hospital?	8-15 CYP	5.40	About the same as other trusts	R2
57	Did you like the hospital food?	8-15 CYP	6.74	About the same as other trusts	R2

71	Did a member of staff tell you who to talk to if you were worried about anything when you got home?	8-15 CYP	6.95	About the same as other trusts	R2
73	Did a member of staff give you advice on how to look after yourself after you went home?	8-15 CYP	7.83	About the same as other trusts	R2
2	Did the hospital give you a choice of admission dates?	0-7 adults	2.36	About the same as other trusts	R3
3	Did the hospital change your child's admission date at all?	0-7 adults	9.68	Better than other trusts	R3

(Source: CQC Children and Young People's Survey 2016, RCPCH)

Local leaders and the services senior management team had good knowledge of the requirements of children, young people and those close to them in the planning of services. However, we found areas in which the service had not considered the specific needs of children, young people and families.

However, we found the service did not have a patient involvement strategy in place to ensure that service planning and changes were undertaken with the input of children, young people and those close to them.

Ward C2

One relative could stay overnight with children and young people. Staff provided fold down beds for relatives to stay. However, we found no specific overnight accommodation facilities for families of children and young people that may be in hospital for long periods of time, or those children and young people receiving palliative or end of life care.

Ward C2 had access to two bathrooms for parents and carers to use, and access to a small kitchenette for parents and carers to use if they stayed overnight.

The service had not fully considered the needs of children and young people with mental health conditions. Ward C2 did not have designated rooms or cubicles to support the needs of these children and young people. Staff on ward C2 utilised whichever rooms or bed spaces were free at the time of admission.

The service had recently appointed a number of new specialist nurses to help support children, young people and those close to them with long term conditions such as diabetes and epilepsy. The nurse specialists could provide targeted support, tailored to the needs of the individual and their families.

During the onsite inspection, the service told us it did not have transition arrangements to support young people moving from children's service to adult service with long-term conditions, such as diabetes and epilepsy. The lack of a transition plan meant young people were at risk of not getting the continued support needed in a smooth way when moving from children's to adult services.

The National Institute for health and Care Excellence (NICE) guidance NG43, published February 2016, sets out the key principles for transition planning for children and young people moving from children's to adult service within health care settings. NICE guidance NG43 states that children's and adult's service managers should work together in an integrated way to ensure a smooth and gradual transition. During the inspection, we found no such joint working between young people's service and adult service was taking place. The NICE guidance also

recommends children and young people should be involved in the development of a vision and strategy for the transition of care to adult service. However, we found no strategy in place for the children's service as a whole, or for the transition of young people to adult service.

Following the onsite inspection, the service told us that a diabetes transitional pathway was in place; however, they did not provide any further evidence regarding this. The service also told us the clinical nurse specialists were discussing and developing pathways with adult services for their individual specialities. The service provided evidence to show this work had begun for long-term and complex disabilities and in epilepsy care.

We found ward C2 to be child and young person friendly. The admission area and high dependency were located in a different part of the ward to the general admission beds. This promoted a quieter environment for children, young people and families overnight.

Ward C2 had specific areas for children, young people and those close to them to be away from the bed space. Ward C2 had a relatives sitting room that contained a small kitchen area for friends and family to make drinks and warm food.

Ward C2 had three distinct areas: the admissions and high dependency unit, and two areas for inpatient admissions. Senior staff told us they would, wherever possible, keep children and young people separate, with young children allocated beds at one end of the ward and older children and young people at the other.

Children and young people had access to a school class room whilst an inpatient. Trained teaching staff provided support to children and young people who were in hospital for a long time to continue with their education.

Younger children had the option of using one of two toy cars to take themselves from ward C2 to either theatre, imaging or outpatients. This helped to promote independence and reduce anxiety amongst young children going for operations or procedures across the trust.

Neonatal unit (NNU)

We found staff on the NNU were family focused. The NNU had three distinct clinical areas: intensive care, high dependency unit and special care unit. Each area had the required equipment to deliver the care; however, we found the environment did not support the requirements of parents, specifically in relation to the intensive care area. We found the space around the cots and generally within the intensive care area limited and did not promote privacy and dignity of parents.

The NNU had, what was referred to as, a parent flat. This had a bedroom, lounge, kitchen area and bathroom. The parents flat gave families the ability to remain on the NNU with critically unwell babies. However, we found limited space for other families and parents, to be able to stay overnight.

The NNU worked well with the maternity unit when mothers were inpatients on the post-natal unit and their babies were on the NNU.

Meeting people's individual needs

The service did not consistently take account of the individual needs of children, young people and those close to them.

Ward C2

Children and young people with long-term conditions, such as diabetes and epilepsy, had support from specialist nurses. We found health passports in place for children and young people to record their progress in relation to their long-term health conditions. However, we found the trust did not have a formalised transition pathway between the children's service and adult services. The senior leadership team told us that specialist nurses would start conversations with young people and families around the age of 13 or 14 years about transitioning to adult service. The service had no structure in place to facilitate joint outpatient clinics between children and adult teams to support a smooth transition to adult service. The service had no policy or procedure in place to support young people to attend appointments without the support of those close to them, to promote independence and support the transition to adult services.

Following the onsite inspection, the service told us that a diabetes transitional pathway was in place; however, they did not provide any further evidence regarding this. The service also told us the clinical nurse specialists were discussing and developing pathways with adult services for their individual specialities. The service provided evidence to show this work had begun for long-term and complex disabilities and in epilepsy care.

Ward C2 had a policy in place that supported children and young people with certain long-term conditions to have direct access to ward C2. This meant children and young people could ring ward C2 and, where a bed was available, be admitted without the need to attend the emergency department. This reduced the stress and anxiety of children and young people, and prevented children, young people or families repeating information to the emergency department staff, and then again on admission to ward C2.

We found a mixed approach to meeting the needs of children and young people with a mental health condition. We found the facilities available for children and young people with a mental health condition within ward C2 did not meet their needs. We found side rooms were not ligature light or ligature free, and staff did not have the ability to enter rooms if a child or young person locked the door. This put children and young people at risk, and did not fully support the needs of this group of children and young people.

However, the service had a service level agreement in place with the local child and adolescent mental health service) CAMHS, and had introduced i-CAMHS. Through i-CAMHS, the service aimed to review every child or young person who was admitted to ward C2 with self-harm or other mental health conditions within 24 hours. Staff could access this service seven days a week, with referrals accepted Monday to Friday 8am to 8pm, and 9am to 2pm on weekends. The service told us that 100% of children and young people referred to the CAMHS was seen within 24 hours. However, the service did not tell us over what time period this included.

Staff assessed the needs of children and young people on admission to ward C2. This included communication, diet and religious needs and spiritual. Staff had a good knowledge of how to support children and young people, and those close to them, to meet their individual needs.

Staff used an assessment tool to identify the needs of those children and young people with a learning disability. This included how to assess pain, any communication needs and what reasonable adjustments needed to be made. The nursery nurses on ward C2 had a good

knowledge of how to support children and young people with a learning disability throughout their stay in hospital.

Nursing staff told us that within theatre, children and young people with a learning disability, such as autism or Downs syndrome, could enter theatres a different way. This enabled these children and young people to avoid the busy waiting area and go straight into the anaesthetic room. Staff told us that children and young people could visit the theatre and ward before their admission date to familiarise themselves with the environment, therefore reducing anxiety on the day of admission.

On ward C2 staff used a 'bumble bee' device to support children and young people nervous about having blood taken. The 'bumble bee' used thermal, non-medicated technology to reduce pain during procedures without the use of conventional oral or topical pain relief.

For children and young people with a sensory impairment, or those requiring a quiet space, ward C2 had a sensory room. This consisted of soft flooring, relaxed lighting and access to sounds that helped to relax children and young people. The play specialists encouraged families to utilise the sensory room whenever possible. However, we found that the sensory room was small and used for storage when not in use for its intended purpose. Parents struggled to get a chair in the room for them to sit on.

A number of staff on ward C2 had undertaken additional training in Makaton sign language to support children and young people who used Makaton as their preferred communication method.

We asked the lead nurse how staff would support children and young people who were transgender or non-binary. The lead nurse told us that staff had training in how to support lesbian, gay, bisexual and trans (LGBT) children and young people. The lead nurse told us that they would ask the child or young person what name they wanted to be known by and ensure this was clear on admission documentation, and included in nursing and medical handover documentation. Where possible, staff would try to keep same-sex bays for young people on the ward. The lead nurse told us that a trans or non-binary young person would be given the option as to which bay they would feel most comfortable in, or, wherever possible, the option of a side room would be given with access to their own toilet and bathroom facilities.

Ward C2 had worked with Scouts and started a scouting group at the hospital. This was the first district general hospital based Scout group in the country, and provided an opportunity for children and young people to participate in a social activity. This promoted a sense of independence, but also normality for children and young people in hospital for long periods of time.

The neonatal unit (NNU)

Staff on the NNU had a good understanding of how to support parents of critically ill babies or those requiring special care. Staff could explain how they would support parents who had additional needs, such as mothers with a learning disability. The NNU and maternity units worked well together to provide a smooth transition for all mothers, with additional consideration given to those mothers with additional needs, from the post-natal unit to the NNU.

The NNU had an effective system for the transition of babies from the acute care setting into the community. The NNU had two senior community neonatal nurses that provided support to parents on the NNU prior to discharge. The community staff provided continuing care within the community to support parents, improve outcomes of babies and prevent unnecessary readmissions to the acute hospital setting.

Staff undertook a discharge assessment for all babies being discharged from the service. The assessment process ensured staff had completed all the required steps prior to discharge,

including new born screening tests, referrals to other services and ensuring discharge paperwork had gone to all the professionals required.

The NNU had the facilities to provide individualised care to the parents of babies receiving end of life care. The NNU had facilities to allow parents and other family members to stay on the ward in the parents' accommodation. Staff could access a cooled cot to allow the parent's and family to spend time with their baby in the parents' accommodation following death. The NNU could access advice and assistance from the trusts specialist bereavement midwife in all cases of neonatal death.

Ward C2, the neonatal unit and children's outpatients

Staff in all areas visited had a good understanding of how to support children, young people and those close to them whose first language was not English. The service had access to phone and face-to-face translation services that included British sign language.

Senior staff told us that information leaflets were available in written format in languages other than English, including easy read for some information.

Children, young people and families could access free internet throughout their stay in hospital.

Fracture clinic

Within fracture clinic, staff had ensured that suitable and age appropriate toys and distraction equipment was available for children and young people. The clinic used portable buzzer systems to allow children, young people and families to leave the department and the system would alert them when they needed to return for their appointment. This meant children and young people were not unduly waiting in an adult focussed waiting room for extended periods of time.

Senior staff within fracture clinic had recognised the distress that can be caused to a child or young person when applying and removing plaster of Paris (POP) casts. The lead nurse in fracture clinic had purchased specialist POP casts specifically for children and young people, such as camouflage, animal print and glitter that could be applied to plain casts. This supported inclusion in decision making, but also reduced anxiety amongst children and young people as they were involved in the process and could decorate their POP cast in an individual way.

Access and flow

Children and young people could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

We reviewed bed occupancy rates for ward C2 and the neonatal unit. The service told us that the average cot occupancy rate for the neonatal unit between January and November 2018 was 80%. For ward C2 we found the following monthly average bed occupancy rates:

Month	Average bed occupancy
January 2018	64%
February 2018	64%
March 2018	72%
April 2018	64%

May 2018	84%
June 2018	68%
July 2018	60%
August 2018	59%
September 2018	69%
October 2018	52%
November 2018	68%

During the inspection, we found that babies, children and young people had no access problems getting into the service.

We reviewed the services referral to treatment (RTT) data for non-admitted pathways. The national target was for 92% of patients to be seen within 18 weeks of referral.

Speciality	January to December 2018 average RTT compliance
Paediatric surgery	95.4%
Paediatric trauma and orthopaedics	97.6%
Paediatric ear nose and throat	100%
Paediatric plastic surgery	97.5%
Paediatric gastroenterology	92.1%
Paediatric endocrinology	100%
Paediatric clinical immunology	46.8%
Paediatric dermatology	58.2%
Paediatric respiratory medicine	87.9%
Paediatric diabetic medicine	100%
Paediatric cystic fibrosis	100%
Paediatric neuro-disability	96.8%
Paediatric cardiology	72.1%
Paediatrics	93.7%
Paediatric neurology	90.9%
Total average	90%

We found the four best performing specialities between January and December 2018 were ear, nose and throat, endocrinology, diabetic medicine and cystic fibrosis, each seeing 100% of patients within 18 weeks of referral. The three worst performing service were clinical immunology, dermatology and cardiology. Overall, children and young people's services were slightly worse the target achieving an average for 2018 of 90% compliance with the 18-week target.

The service assessed performance against the Facing the Future standards from the Royal College of Paediatric and Child Health (RCPCH). The service did an audit of 50 admissions against standards two and three. Standard two states that every child admitted with an acute

medical problem is seen by a healthcare professional with appropriate competencies within four hours. Standard three states that every child admitted with an acute medical problem is seen by a consultant within 14 hours.

The trust told us that of the 50 records audited, 100% of children were seen within four hours as per standard two. The trust told us of the 50 records audited, 23 were seen by a consultant within 14 hours, 19 had a stay less than 14 hours and were not reviewed by a consultant and 7 patients breached the 14 hour review timeframe. The remaining record did not have documented times so the trust were unable to say if the child was seen within 14 hours.

During the inspection, we found all clinics ran smoothly and with minimal delays.

Learning from complaints and concerns

The service did not investigate concerns and complaints in a timely manner or share lessons learnt all staff.

Summary of complaints

From October 2017 to September 2018 the trust received 23 complaints in relation to services for children and young people (4.7% of total complaints received by the trust). The main subject of complaints was patient care (11).

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient Care	11
Communications	5
Values & behaviours (staff)	3
Other (specify in comments)	2
Admin/policies/procedures (including patient record)	1
Appointments	1
Total	**23**

For the 13 complaints that had been closed at the time of data submission, the trust took an average of 97.2 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

The 10 complaints that had not yet been closed had been open for an average of 47.6 working days at the time of data submission. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Following the inspection, the trust provided updated data on the average number of working days to respond to complaints. The service told us from October 2017 to September 2018, they took an average of 125.5 working days to respond to complaints. However, the service told us that they have two complaints in excess of 300 working days due to not being able to organise

discussions between the patients and or families and the trust to resolve the complaint.

Number of compliments made to the trust

From October 2017 to September 2018 there were 202 compliments received for services for children and young people (2.9% of all received trust wide).

Compliments were received in all 12 months of the period except for March 2018. December 2017 was the month where the most compliments were received (34).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

 (Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service monitored complaints and compliments received on a monthly basis. The service provided additional information with regards complaints and complements received. From January to December 2018 ward C2 received 14 complaints and 49 complements. The neonatal unit received three complaints and 95 complements from January to December 2018.

Is the service well-led?

Leadership

Managers at all levels in the service did not have the right skills and abilities to run a service providing high-quality sustainable care.

The children and young people's service consisted of the neonatal unit, ward C2 and children's outpatient's department. A lead nurse oversaw each ward or department. Children and young people's services were managed by a deputy matron, who reported to the divisional management team consisting of a head nurse, lead consultant and general manager.

We found all lead nurses knowledgeable about their own area, including the patients admitted at the time of inspection, staffing numbers and risks. During the inspection, we found the lead nurses were responsive when concerns were raised and took timely and appropriate actions to rectify the concerns raised.

Staff told us that the lead nurses were approachable and worked clinically with the staff, making them accessible and visible. Staff told us that the leadership team for the division was visible and accessible, and staff felt confident to approach the leadership team.

However, we found the senior leadership team did not fully understand the risks posed within the service, or taken timely action where areas for improvement had been previously identified. The leadership team had not recognised the shortfall in registered nurses on ward C2, and had not taken robust steps to ensure this was escalated through the governance arrangements, for example by including nurse staffing on the services risk register.

We did find some areas where the leadership team had taken actions from the previous CQC inspection, including in areas related to safeguarding and improved governance arrangements.

The leadership team acknowledged that they had not made progress in relation to requirements set out during the previous CQC inspection of children and young people's service. We found the leadership team had not taken steps to develop a service wide strategy to support the vision. We found the service did not have a pathway or process in place to support young people with long-term conditions transitioning from children's service to adult services.

We were not assured the leadership team had oversight on the service as a whole, and taken steps to reduce risks. For example, the children's safeguarding team had not recognised the risks of the newly appointed interim lead consultant for children's safeguarding not undertaking or holding the required level of safeguarding training. The safeguarding team were unable to provide assurance that this was being addressed in a timely manner to ensure the ongoing safety of children and young people using the services at Russells Hall Hospital.

We were not assured that the leadership team had recognised the importance of issues previously raised, and this had impacted on the delivery of safe, responsive care across the service.

Vision and strategy

The service did not have a robust vision for what it wanted to achieve, and could not demonstrate workable plans to turn it into action, developed together with staff, patients and key groups representing the local community.

The children and young people's service had a vision in place. The leadership team could explain the vision to us during the inspection.

The vision consisted of:

- Strengthen emergency care – provide high quality paediatric and neonatal care seven days a week
- Implement Royal College of Paediatric and Child Health recommendations
- Eradicate overdue GP follow ups and strengthen community paediatric service

During the inspection, the senior leadership team spoke about how it wanted to achieve the vision. We requested a copy of the strategy from the service to demonstrate workable plans to achieve the vision. The service told us "there is no written strategy currently; however, prior to the CQC inspection the department had committed to undertaking a paediatric team away day where the strategy would be developed."

We did not have assurance that the service had a robust or measurable vision, strategy or workable plans to improve the service in the coming months and years. Therefore, we were unable to measure change and development in the service.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

We found a culture across children's services that was positive and inclusive of all staff. Staff told us on all areas we visited that managers were approachable and supportive.

Staff told us and we observed senior managers supporting staff clinically on ward C2 and the neonatal unit when these areas were busy.

We found a culture that promoted shared responsibility for patient care amongst all clinicians, including doctors, nurses, allied health professionals and clinical support staff. For example, consultants would remain within clinical areas when required to support nursing teams to deliver the care that was required to patients. Consultants supported junior and middle grade staff where rota gaps had occurred to ensure they felt supported and could deliver the level of care required.

We found a culture that promoted shared learning across departments and professions; however, we found scope to improve on the way shared learning was done across the whole service. The consultant rota allowed for those consultants with more expertise in the care of neonatal patients to support less experienced consultants. Senior nursing staff also provided support to junior medical staff and non-registered staff. The learning culture was most evident through the 'ground round' each Thursday morning, where all professionals involved in the care of a patient conducted the ward round together and share knowledge and learning about the care of the patient with each other.

The culture within the children and young people's service encouraged inter-professional challenge. Nurses were encouraged to challenge decisions by doctors where they felt these were not in the best interests of the patient or family. We found clinical support staff provide challenge to

registered nurses around care delivery and senior staff respect the challenge and provide support and explanation of the decisions made.
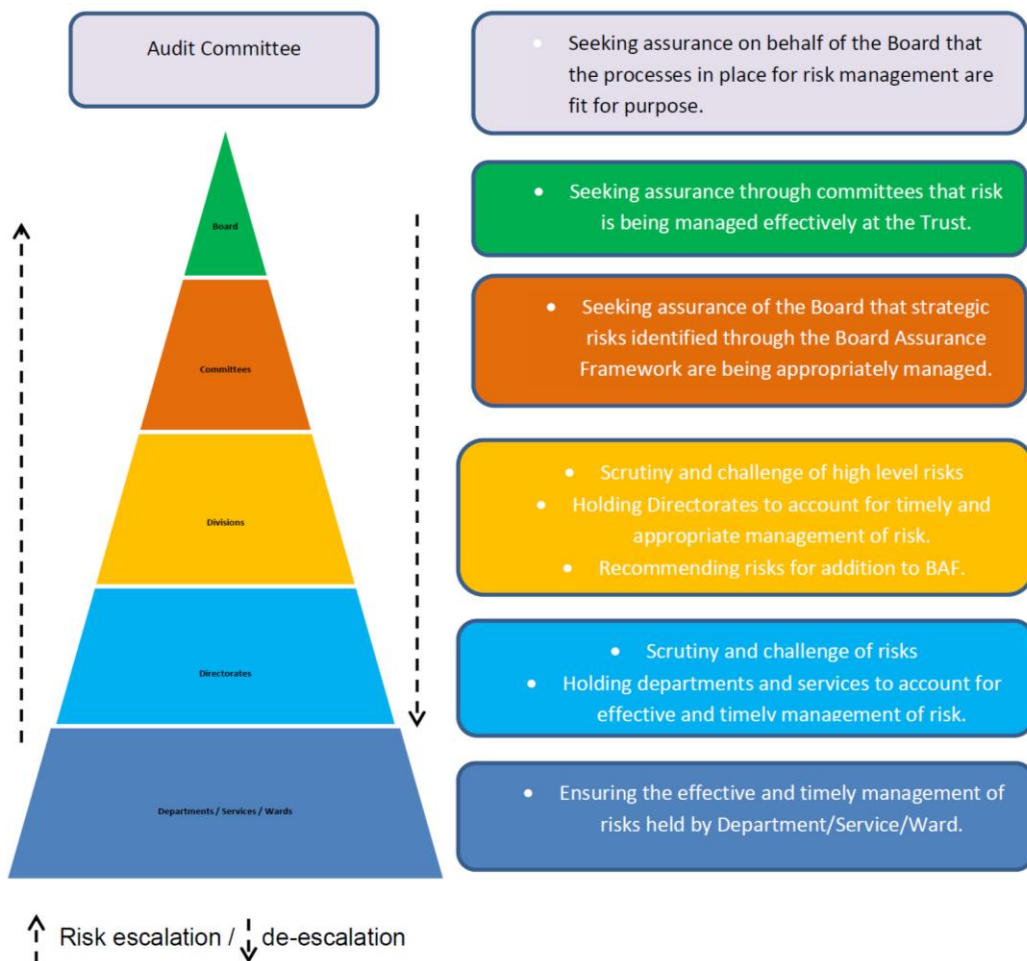
Governance

The service used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

We reviewed the governance structures in place within the children and young people's services. Women and children's services was within the surgical division. The service had scheduled governance meetings to have oversight of the service, including: bi-monthly paediatric meetings, bi-monthly neonatal meetings and monthly directorate meetings for women and children's directorate.

We found clear reporting mechanisms from ward level up to the board of directors and back to ward again. We found that the directorate level reported to the governance assurance meeting and then upwards to the divisional management team meeting. Following this, the divisional management team escalated to trust level teams through the performance review group. This in turn fed into one of four groups before reaching the board of directors: workforce and staff engagement committee, clinical quality, safety and patient experience committee, audit, risk and assurance or finance and performance.

The trust had clear structures of accountability within the governance framework, which the children and young people's service followed. This is shown in the below infographic, where service level sits within the blue and yellow areas of the pyramid.

(Source: data request submission from The Dudley Group NHS Trust)

We spoke with the directorate management team during the inspection who told us the governance arrangements worked well within the service and the trust. We found that ward lead nurses had confidence in escalating through the trusts governance structure and that feedback would come back down from 'board to ward'.

Management of risk, issues and performance

The service had some systems for identifying risks, planning to reduce them, and coping with both the expected and unexpected. However, these were not always effective in identifying, monitoring and reducing risks in a timely manner.

We reviewed the paediatric and neonatal risk register and found it contained 12 risks, which were:

- Neonatal staffing

- Risk of harm to staff through lone working

- Lack of psychology support for diabetic patients

- Safeguarding workload for diabetes team

- Replacement of incubators on neonatal unit

- Inadequate facilities for parents

- Access to training for neonatal staff in total parental nutrition (TPN)

- Neonatal unit capacity and occupancy

- Neonatal unit risk of cross contamination

- Inadequate storage facilities within the neonatal unit

- Inadequate cot spaces

- Risk of unsafe paediatric and neonatology service due to a limited number of senior doctors covering out of hours

Local managers for each clinical area were aware of some of the risks associated with their wards and departments. We found a good understanding amongst senior nursing and medical staff of the risks. The divisional senior management team were knowledgeable about the risks and the steps being taken to reduce them.

However, the risk associated with neonatal staffing related specifically to nurse staffing. We found that during the inspection the nurse to patient ratio was maintained in line with best practice guidance. The senior leadership team and the lead nurse for neonatal ward told us that daily monitoring of nurse staffing levels was ongoing and a clear escalation pathway was in place to report shortfalls in staffing. The neonatal unit had employed four trainee nursing associates that, once qualified, would be able to provide care independently on the unit.

Neonatal unit

We reviewed meeting minutes from September, October and November 2018. We found the September and November meeting minutes were detailed and contained information about discussions and which staff had responsibility for actions. The minutes also detailed who had attended and who had sent apologies. We found there was no 'standard agenda items' between the meeting minutes; however, some similar areas were discussed, such as staffing and incidents.

The meeting minutes from September and November did not show evidence of discussions around risks or the risk register.

The October 2018 meeting minutes contained very little detail, no actions and no information on who attended. The minutes appeared to be a list of bullet points.

We were not assured from the three sets of meeting minutes submitted by the service that these meetings had standard agenda items to support shared learning, or consistency in the recording of minutes to assist staff not in attendance.

Ward C2

We requested team meeting minutes from ward C2. However, the service told us staff had a daily huddle Monday to Friday, where a range of topics were discussed. The serviced confirmed the recording of the huddle has been "inconsistent", which was an identified area for improvement.

We were not assured of consistent information sharing amongst all staff. We had no assurance that information was shared other than during huddles; therefore, there was a risk staff not at work on that day would miss out on important information.

We found the service and leadership team had not taken account of relevant national guidance around planning and implementing care for children and young people with a mental health condition. The service had not taken account of the Department of Health's Health Building Note 03-02 Facilities for child and adolescent mental health service, which gives guidance on the reducing the risks, including ligature risks, when providing mental health care to children and young people. The service had not taken account of guidance from the National Patient Safety Associations 2009 Preventing Suicide: A toolkit for mental health services.

The service had not undertaken any risk assessments in relation to the environment on ward C2 for delivering care to children and young people with a mental health condition. We did not have assurance that the leadership team had taken sufficient steps to identify and reduce the risks associated with delivering care to this vulnerable group of children and young people.

Children's outpatient department

We requested team meeting minutes from the children's outpatient department. The service told us that "regular" team meetings had been set up to begin from February 2019.

We were not assured of consistent information sharing amongst outpatient department staff. We had no assurance that information was shared; therefore, there was a risk staff in the children's outpatient department would not be aware of crucial information relating to safety and change.

Mortality and morbidity

We requested minutes from the last three mortality and morbidity meetings for children and young people's services. The service told us they do not currently minute these meetings. Therefore, we were unable to form a judgement on the ability of the service to learn from episodes of morbidity or the death of children and young people within the service. This demonstrated the inability of learning from mortality and morbidity review meetings to be shared more widely amongst staff to improve the safety and effectiveness of care.

During the previous inspection in 2018, we highlighted several concerns across the children and young people's service. During this inspection, we found some areas that were still a concern and had not been fully addressed to reduce the risk.

In 2018, we raised concerns about safeguarding supervision for medical staff and the robustness of safeguarding processes within the children and young people's service. We've found some improvements during this inspection; however, medical staff were still not receiving routine safeguarding supervision and the newly appointed named doctor for children's safeguarding had not received appropriate training or support to undertake the role.

In 2018, we raised that the service had no transition policy to support young people transitioning to adult services. During this current inspection, the senior leadership team confirmed the service did not have a transition pathway for young people.

Following the onsite inspection, the service told us that a diabetes transitional pathway was in place; however, they did not provide any further evidence regarding this. The service also told us the clinical nurse specialists were discussing and developing pathways with adult services for their individual specialities. The service provided evidence to show this work had begun for long-term and complex disabilities and in epilepsy care.

In 2018, we found the service did not fully participate in national audit programmes, or use the information to improve patient outcomes. During this inspection, we found the service participated in some audit and accreditation programmes; however, the service had only begun participating in all national programmes, such as the Epilepsy12 audit programme, in July 2018.

We did not have assurance that the service had robust procedures in place to improve care delivery based on the assessment and monitoring of risk.

Information management

The service did not always collect, analyse, manage and use information well to support all its activities. However, the service did use secure electronic systems with security safeguards.

Local managers, including lead nurses and the deputy matron, had a holistic understanding of performance against national standards and data sets. Senior staff used information at ward level to improve the care delivered to patients. We found some limited inclusion of children, young people and families views in the service, through the "shout up" group, where children, young people and families could provide feedback. This had been in place since 2015. However, this had been implemented recently and the service could not yet demonstrate change as a direct result of the group.

The service could not demonstrate integrated approaches for both quality and sustainability at all levels. The senior management team had a good understanding of both quality and sustainability; however, the information was not collated into a measurable approach. We found the neonatal unit (NNU) focussed on quality improvement within the unit meetings; however, we saw little evidence within meeting minutes of discussions relating to sustainability of the service. We were unable to assess this for ward C2 and the children's outpatient department as no meeting minutes had been taken, or team meetings held.

The service did have clear and robust service performance measures in place at ward level and divisional level. This included the use of a comprehensive dashboard reviewing compliance with aspects of care delivery, including the number of complaints and compliments received. However, the senior leadership team told us and we found no evidence of senior staff sharing local success

with other areas of the children's service to support improvements in quality and promote sustainability of the service moving forward.

Following the onsite inspection, the service told us that information about success was shared with other areas through the trusts children's services group.

Senior staff could demonstrate that the information gathered as part of the dashboard at ward level and other monitoring tools was accurate and a true representation of performance. The deputy matron gave an example when the service switched from recording observations on paper to e-obs (the electronic recording of observations). The deputy matron observed a significant drop in the achievement of staff undertaking observations at the required time. The deputy matron undertook some analysis and identified that the electronic system was reporting the time staff inputted the information, rather than the time staff actually undertook the observations. The senior management team have revised the monitoring of this performance indicator, and the compliance rates have improved significantly over a four-month period.

Ward C2 had implemented e-obs, which automatically alerted staff to an increased paediatric early warning score (PEWS). However, senior staff told us the system did not automatically alert medical staff and this was still the responsibility of nursing staff. Senior staff told us the introduction of e-obs improved patient safety and care; however, had its limitations and needed some improvement.

We found staff utilised external information to complete a full and holistic assessment of children and young people. Staff would check the local safeguarding systems for every child and young person coming through the hospital, both acute admissions and outpatient attendances, to ensure they were no outstanding safeguarding concerns. The safeguarding team monitored this, and found staff utilised the systems well and this had supported in the safer delivery of care and escalation of concern.

In August 2018, the service undertook an 'ideal two weeks', where senior managers ensured all areas of the children and young people's service was fully resourced to show how, in an ideal two weeks, the service would run. The senior leadership team were looking at the outcomes of this at the time of the inspection and formulating action plans and learning to share with the trust to encourage change and better resourcing.

Engagement

The service did not consistently engage well with children, young people and families, staff, the public and local organisations to plan and manage appropriate services.

The service did not have a patient public involvement (PPI) strategy. We found the service gathered views of children, young people and families ad hoc and utilised the NHS Friends and Family Test (FFT) data to monitor satisfaction.

Ward C2 had introduced a "shout up" group, which engaged with children, young people and parents. The service had implemented the "shout up" initiative after receiving a complaint from a parent. The initiative was nominated for a Nursing Times award.

Staff undertook a yearly staff survey to give feedback on the trust and service. However, at the time of inspection, the latest staff survey results were not available.

We found the senior leadership team within the service engaged well with external stakeholders, such as CQC and the Royal College of Paediatric and Child Health (RCPCH). The service engaged with the RCPCH who undertook a review of paediatric services.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they go wrong, promoting training, research and innovation.

The service had a number of innovations that had started and recent changes to the service. These included:

- Hospital at home service to provide antibiotics in patient's homes to prevent readmissions to hospital

- Monthly paediatric feeding clinics ran by a consultant and a speech and language therapist

- Implementation of neonatal mannequin for resuscitation simulation

- Implementation of artificial limb to support cannulation learning

- Amalgamation of advanced neonatal nurse practitioners onto middle grade rota to support the neonatal unit 24 hours a day

- Appointment of three clinical nurse specialists to support children's gastroenterology, neurology and epilepsy

- Staff have undergone Makaton sign language training

- Implementation of a Scout group at Russell's Hall Hospital

On ward C2 staff used a 'bumble bee' device to support children and young people nervous about having blood taken. The 'bumble bee' used thermal, non-medicated technology to reduce pain during procedures without the use of conventional oral or topical pain relief.

The senior leadership team were passionate about improving the service and wanted to strive to make improvements. The lack of a strategy did inhibit the ability to instigate innovation as there was no clear structure to map change to; therefore, measuring impact was difficult.

End of life care

Facts and data about this service

The trust provides end of life care at Russells Hall Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,784 deaths from August 2017 to July 2018.

(Source: Hospital Episode Statistics)

End of life care (EOLC) at the trust is provided by a specialist in patient and community palliative care service, led by dedicated palliative care consultants. Advice, guidance and education and treatment is provided by these teams to support patients with complex pain management needs. The trust works in partnership with the Macmillan service based at Mary Stevens Hospice, which is a GP led service.

The Dudley Specialist Palliative Care team (SPCT) is a multidisciplinary team consisting of consultants in palliative medicine, clinical nurse specialists in palliative care, clinical psychology, occupational therapy and physiotherapy. The team provides specialist advice alongside the patient's own medical team or GP whether that be in hospital or at home.

The team work with the local hospices in the surrounding area. The team are also active members of the Dudley Economy Strategy group, West Midlands Palliative Care Physicians meeting, the Palliative and End of Life Care Expert Advisory Group West Midlands Network and the Black Country STP end of life care working group.

The trust provides a bereavement service which is an office based service providing practical help, advice and support for death registration. The service works alongside the mortuary services, helping to facilitate efficient death certification and HM Coroners cases. The service also arranges viewings and can on rare occasions arrange funerals for people without families.

The trust provides a chaplaincy service which aims to help facilitate the spiritual care of patients and their visitors, and to meet any religious needs. The chaplaincy service consists of chaplains from various faiths and helps with the spiritual care of patients and visitors. A chaplain is available during working hours, Monday to Friday 8 am to 6 pm.

(Source: Routine Provider Information Request (RPIR) – Context acute, EOLC networks and sites tabs)

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service provided the specialist palliative care team (SPCT) with mandatory training and monitored its compliance. SPCT staff provided specific mandatory training sessions in relation to end of life care to other hospital staff.

Mandatory training completion rates

The trust exceeded its set target of 90% for the completion of all mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in end of life care at the trust is shown below:

Name of course	April to September 2018				
	Number of staff trained	Number of eligible staff	Completion rate	Trust target	Met (Yes/No)
Resus - adult	6	6	100.0%	90.0%	Yes
Information governance	6	6	100.0%	90.0%	Yes
Fire	6	6	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	6	6	100.0%	90.0%	Yes
Infection control - clinical	6	6	100.0%	90.0%	Yes
Conflict resolution - level 1	6	6	100.0%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	6	6	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	6	6	100.0%	90.0%	Yes
Health & safety	6	6	100.0%	90.0%	Yes

The trust had an overall training compliance rate of 100.0% for qualified nursing staff in end of life care. The trust's training target was met for all nine mandatory training modules for which qualified nursing staff were eligible.

It should be noted that the data for nursing staff refers to six eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in end of life care at the trust is shown below:

Name of course	April to September 2018				
	Number of staff trained	Number of eligible staff	Completion rate	Trust target	Met (Yes/No)
Resus - adult	2	2	100.0%	90.0%	Yes
Infection control - clinical	2	2	100.0%	90.0%	Yes
Health & safety	2	2	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	2	2	100.0%	90.0%	Yes
Manual handling (non-patient) / slips, trips & falls	2	2	100.0%	90.0%	Yes
Conflict resolution - level 1	2	2	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	2	2	100.0%	90.0%	Yes
Information governance	1	2	50.0%	90.0%	No
Fire	1	2	50.0%	90.0%	No

The trust had an overall training compliance rate of 88.9% for medical staff in end of life care at the trust. The trust's training target was met for seven of the nine mandatory training modules for which medical staff were eligible.

The modules with the lowest completion rate were information governance and fire, with 50.0%. However, this relates to only one member of staff not having completed the training in each case.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The SPCT staff we spoke with could tell us how they would recognise and report potential abuse in line with local and national safeguarding procedures. One member of staff gave us an example of how they had involved dedicated safeguarding staff when a patient was at risk of their family not following their expressed wishes. Safeguarding information for visitors and staff was displayed in public areas to support them to identify the signs of abuse and inform the appropriate persons.

There were policies in place for the safeguarding and protection of adults at risk and safeguarding children. The adult safeguarding policy had an approval date of August 2016, and was due to be reviewed in August 2019. We reviewed the content of the policy and found it was version controlled. The policy referred to PREVENT (a part of the UK's counter terrorism strategy). It also had information for staff on the different types of abuse, roles and responsibilities of staff. The children's safeguarding policy was dated August 2016, was version controlled, contained a flow chart and links to relevant guidance. Polices provided guidance for staff about how to support people who may be at risk of Female Genital Mutilation (FGM).

Safeguarding training completion rates

The trust exceeded its set target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April to September 2018 for qualified nursing staff in end of life care at the trust is shown below:

Name of course	April to September 2018				
	Number of staff trained	Number of eligible staff	Completion rate	Trust target	Met (Yes/No)
W R a P	6	6	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	6	6	100.0%	90.0%	Yes
Prevent	6	6	100.0%	90.0%	Yes
Safeguarding adults	6	6	100.0%	90.0%	Yes

The trust had an overall safeguarding training compliance rate of 100.0% for qualified nursing staff in end of life care at the trust. The trust's 90% completion target was met for all four safeguarding training modules for which qualified nursing staff were eligible.

It should be noted that the data for nursing staff refers to six eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for safeguarding training courses from April to September 2018 for medical staff in end of life care at the trust is shown below:

Name of course	April to September 2018				
	Number of staff trained	Number of eligible staff	Completion rates (%)	Trust target	Met (Yes/No)
W R a P	2	2	100.0%	90.0%	Yes
Prevent	2	2	100.0%	90.0%	Yes
Safeguarding children level 3	2	2	100.0%	90.0%	Yes
Safeguarding adults	2	2	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	2	2	100.0%	90.0%	Yes

The trust had an overall safeguarding training compliance rate of 100.0% for medical staff in end of life care at the trust. The trust's 90% completion target was met for all five safeguarding training modules for which medical staff were eligible.

It should be noted that the data for medical staff refers to two eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Environment and equipment

The service had suitable premises and equipment and looked after them well.

There was no dedicated palliative care ward and patients received the palliative care they required on the wards best able to manage their underlying conditions or illness. There were side rooms available when patients receiving palliative care required to be nursed in isolation to reduce the risk of acquiring an infection or to respect people's privacy and dignity. Wards had dedicated quiet areas for patients to meet with family members and for staff to discuss their conditions in private.

When necessary, syringe drives were available to provide end of life patients with medication. A syringe driver is a small battery-powered pump that delivers medication at a constant rate through a very fine needle under the skin. Prior to usage, syringe drivers were stored in sealed boxes with all the additional equipment such as lines, dressings, needles, batteries and syringes staff would need to provide a patient's medication. There were daily collections of used syringe drivers from the wards which were then checked and prepared for reuse. Maintenance records showed the syringe drivers were regularly serviced and it was policy that batteries were replaced once they had a 50% charge remaining. This reduced the risk of syringe drivers breaking down or running out of charge when being used.

The mortuary had enough suitable storage facilities. Fridge and freezer temperatures were regularly monitored and we found them to be within acceptable limits. Fridge alarms were linked to the hospital's switchboard so staff could take prompt action if the storage facilities malfunctioned. They were facilities for bariatric patients who may require larger storage space and pop up/ temporary storage spaces were available when there was a general increase in demand.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

The trust had effective systems in place for identifying and responding to patient risks. Risk assessments such as pressure ulcer and manual handling were undertaken in line with national guidance. Staff talked to us about the use of national early warning scores (NEWS) and sepsis screening tools. These systems allowed staff to identify early if a patient was experiencing or at risk of deteriorating health. There were systems in place to escalate concerns about a patient's health to other appropriate health care professionals.

Staff completed specific care plans for patients who were considered to require end of life care. These included assessments for pain, shortness of breath, weakness, poor appetite, mouth care and poor mobility. Staff completed regular pulse and blood pressure checks so that changes in people's conditions could be detected, recorded and escalated if required.

The SPCT were able to quickly identify patients in the last days of life and provide them with timely support and treatment. Patients who required end of life care were usually identified by ward staff, however staff were able to contact the SPCT for advice if they required support with that judgement. Staff were able to identify patients who may require urgent care and these patients would be prioritised by the SPCT. The SPCT told us they aimed to see every dying patient daily and ward staff confirmed that this was most often the case and stated that they felt well supported by the SPCT.

Nurse staffing

The service was taking action to ensure there were enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

Total staffing: planned vs. actual

The trust has reported the following qualified nursing staff numbers for the two periods below in end of life care.

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing staff	8.1	6.8	83.8%	7.8	7.6	97.4%

The trust reported a staffing level of 83.8% for nursing staff in end of life care in March 2018 which increased to 97.4% in September 2018.

As at September 2018, there were 0.2 fewer WTE staff in post than planned for but 0.8 more WTE staff in post than in March 2018. There was a decrease of 0.3 WTE planned posts between the two time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 11.7% for qualified nursing staff in end of life care. This was higher than the trust's overall target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 0.0% for qualified nursing staff in end of life care. This was lower than the trust target of 8.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 1.0% for qualified nursing staff in end of life care. This was lower than the trust's target of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From October 2017 to September 2018 the trust reported 4,586.0 of the 32,155.0 available hours in end of life care were filled by bank staff (14.3%) and 1,957.0 (6.1%) hours needed to be covered by bank or agency staff but were unfilled. The trust reported that no hours were filled by agency staff.

A breakdown of bank and agency usage by staff type is shown below:

	October 2017 to September 2018						
Staff type	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	35.0	0.2%	0.0	0.0%	1,957.0	12.1%	16,132.0
Non-qualified	4,551.0	28.4%	0.0	0.0%	0.0	0.0%	16,023.0
Total	4,586.0	14.3%	0.0	0.0%	1,957.0	6.1%	32,155.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative care recommend that there should be a minimum of one specialist palliative care nurse per 250 beds in a hospital. However, long-term sickness and maternity leave amongst the SPCT meant they were not meeting this recommendation. Action was being taken by senior SPCT staff to increase the number of nursing staff working in the service and existing members of the team had worked additional hours to cover these absences. All the staff we spoke with on the wards told us these staff shortages had not affected the care people received and the SPCT always responded quickly to referrals and requests for support.

Medical staffing

The service was taking action to ensure there were enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below for end of life care:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical staff	1.5	1.5	100.0%	1.5	1.5	100.0%

Staff fill rates for medical staff in end of life care were 100.0% in both March 2018 and September 2018. Planned WTE and actual WTE staff posts were the same in both time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 0.0% for medical staff in end of life care. This was lower than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 0.0% for medical staff in end of life care. This was lower than the trust target of 8.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 0.0% for medical staff in end of life care. This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) - Sickness tab)

Bank and locum staff usage

From September 2017 to August 2018, the trust reported no FTE shifts in end of life care that were covered by medical bank or locum staff or left unfilled.

(Source: Routine Provider Information Request (RPIR) - Medical agency locum)

At the time of our inspection visit the specialist palliative care team (SPCT) did not have sufficient medical staffing for the size of the service. The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative care states that there should be a minimum of one consultant per 250 beds. Senior SPCT staff told us that a recently appointed consultant had withdrawn their application to join the service.

Action was being taken by senior SPCT staff to increase the number of consultant staff in line the national recommendation for consultant cover in specialist palliative care. Existing members of the team had worked additional hours to cover these vacancies. All the staff we spoke with on the wards told us that these staff shortages had not affected the care people received and SPCT consultants always responded quickly to referrals and requests for support.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed six sets of records for patients who were receiving palliative and end of life care. Records were clear and easy to read. They were completed in detail and included discussions with patients and relatives to ensure individual needs and choices were being met.

When appropriate, records contained details of patients' mental health, learning disability and dementia needs alongside their physical health needs. There were specific records for patients receiving end of life care which identified their individual needs and wishes. These also identified if the patient or family were feeling anxious or depressed so staff could support their mental wellbeing when necessary.

The mortuary had a system for checking the deceased patients into and out of the mortuary. They compiled a death notification form and two members of staff completed a tracking form and the corresponding tag numbers were included in patients' paperwork.

There was clear guidance for staff when patients in the mortuary had similar names to reduce the risk of mistaken identity and bodies being mixed up.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

All the records reviewed showed medicines to support patients receiving end of life care had been prescribed appropriately. Patients receiving end of life care were prescribed anticipatory medication to manage symptoms that may be present at the end of life. Anticipatory medication is prescribed to be given when it is needed, rather than on a regular basis. This ensured people had ready access to medicines if they started to experience symptoms associated with their specific conditions such as pain, nausea, vomiting, agitation and breathlessness. We noted these had been prescribed in line with recognised good practice guidelines from the National Institute for Health and Care Excellence (NICE) such as CG140/NG31/QS13/QS144.

All medicines were reviewed regularly, including anticipatory medication, to ensure people receiving end of life care had received their medication as prescribed.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff we spoke with were aware of the process for reporting untoward events and could describe occasions when they had raised incidents. There were processes in place for investigating incidents and staff informed us that feedback was shared at a local level by managers and through trust-wide communication when appropriate. We saw learning from incidents was displayed around the wards and public areas.

We looked at a recent incident relating to a patient who was receiving palliative care. We saw the incident was investigated and action taken to prevent a similar incident from happening again. This involved a member of the SPCT conducting educational sessions with ward staff.

Incidents were reported though the trust's electronic reporting system which enabled them to be analysed for trends and the risk of them reoccurring. The electronic system prompted staff to apologies if appropriate and provide open and honest responses when things went wrong. A review of two complaint records showed staff had compiled with this requirement in line with their duty of candour.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as a never event for end of life care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from December 2017 to November 2018.

(Source: Strategic Executive Information System (STEIS))

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The trust had an adult end of life care strategy which referred palliative care staff to various national standards and guidance; such as National Institute for Health and Care Excellence (NICE) guidelines including *NICE CG140 Palliative care for adults: strong opioids for pain relief, QS144 Care of dying adults in the last days of life and QS13 - End of Life Care for Adults.* Dedicated training courses supported staff to apply this guidance when providing palliative care.

The service had worked with other palliative care providers to establish local best practice guidance for the prescription and administration of palliative medicines. These guidelines were based on national research projects and clinical papers.

The service was undertaking a programme to introduce the 'Gold Standards Framework' (GSF). The GSF promotes a multidisciplinary approach to identify and meet the specific care and welfare needs of patients and their families while promoting choice and respecting peoples wishes.

The hospital had recently produced a trust wide end of life action plan which was based on recommendations taken from the *National Care of the Dying Audit 2016* and *NICE Guidance (NG31 Dec 15) Care of dying adults in the last days of life* and their own local surveys. The service had begun to audit itself against specific objectives from these recommendations, such as designing a rapid discharge pathway and establishing palliative care staff champions.

The service had acted on recommendations from 'The 2013 National Care of the Dying Audit for Hospitals' (NCDAH) to develop a programme of audits plan to monitor effectiveness of the service. Audits included records, symptoms management and hydration and nutrition. A recent audit showed that during 2018, 67% of patients died in their preferred place of death. A review of DNACPR forms identified 80% of forms sampled during 2018 had been completed correctly. We noted that action had been taken to improve these figures.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Staff understood the importance of providing the appropriate nutrition to support people with end of life care. Patient's swallowing abilities were monitored and when indicated referrals were made to dieticians and speech and language therapists who could support people to receive nutrition in a form which meet their specific needs. There were drinks and ice popsicles available to help people improve their fluid intake and relieve the symptoms of a dry mouth.

Patients were provided with hot and cold meals and snacks, tea and coffee and cold drinks throughout the day and when necessary were supported by staff to eat and drink. Throughout our inspection, we saw patients had drinks within easy reach and were routinely offered fluids throughout the day.

There was a choice of meal items to reflect people's cultural and religious needs. The wards operated a protected meal time system so patients who needed support to focus on eating and drinking were not distracted by visitors or staff during meal times.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The trust had guidelines for the management of pain for patients in the last days of life. This was available in the trust's end of life policy and as flow charts in a dedicated guidance for the prescription and administration of palliative medicines policy. A review of patients' medical administration records and care plans identified that people's pain was being assessed in line with this guidance and the appropriate pain relief prescribed.

Medications were also prescribed for use on an 'as required' basis should a person require additional support to manage their pain and members of the SPCT had completed prescribing courses which meant that they could administer pain medication to patients and promptly ease their discomfort.

Staff on all the wards we inspected told us SPCT consultants and nurses were able to provide guidance on the most effective and appropriate treatments and care at the end of life, which included pain relief and management of anxiety, nausea and vomiting.

Where appropriate, patients had a syringe driver which delivered measured doses of pain relief medication automatically over 24 hours.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

The service was working towards the GSF independent accreditation standard to improve patient involvement and ensure care was focussed on the individual needs of palliative care patients.

The trust had taken part in the End of Life Care Audit – Dying in Hospital 2015 and had achieved nine of the ten organisational Key Performance Indicators (KPIs). At that time the trust was failing to provide communication in the last hour of people's lives training for staff, however we noted that this was now being covered in staff training.

The Trust had conducted an 'Priorities for Care of the Dying' audit which comprised of a retrospective review of hospital records of patients who died during the period December 2016 to June 2017 whilst an inpatient admission. The audit had recognised that 79% of records sampled had identified that the patient required end of life care and this was discussed with 93% of patients and/or their families. Recognition that the patient was dying was documented in 236 (79%) of the 297 records. This audit was used to inform the trust's end of life action plan.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

There were dedicated SPCT staff (assistant practice facilitators) to educate and train staff in how to support the needs of palliative care patients and their families. There was a programme of staff study days which included training on 'loss, grief and bereavement', 'spirituality and psychological support', 'symptom control' and 'communication and care in the dying'. Records showed training sessions were held regularly and well attended.

The service had developed an end of life care e-Learning data base for staff which included training on end of life care needs and how to have sensitive conversations with patients and their families. The SPCT held drop in sessions twice a week for staff who wanted support to complete their e-Learning. This meant palliative care patients were supported by staff with the skills and knowledge required to meet their specific needs. On one ward staff demonstrate good communications skills when we observed them talk sensitively and patiently with a family about a person's preferred place of death.

Wards had dedicated palliative care champions and clinical leads who had received dedicated training in how to fulfil their roles. This enable them to provide prompt expert and guidance to other staff when necessary. All the staff we spoke with were aware of any palliative care patients on their wards and could describe their individual needs and preferences. Staff said the SPCT and senior staff were approachable if they required guidance or were worried they might have made a mistake with a patient's care.

Staff we spoke with said they had regular formal and informal supervisions with senior staff to reflect on their performance and improve their knowledge. There were reminders and posters around the ward for staff, promoting good palliative care practices. Staff had been issued with pocket size prompt cards identifying the information they needed to include in a patient's discharge letter.

The service was in the process of developing a training package for staff about care after death. This would involve ward staff escorting patients to the mortuary and a member of the portering team said they were working with the service to develop a training DVD about the safe and dignified transport of patients to the mortuary.

Appraisal rates

For year to date, April to September 2018, 100.0% of required staff in end of life care received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified nursing & health visiting staff	6	6	100.0%	90.0%	Yes
Other qualified scientific, therapeutic & technical staff	4	4	100.0%	90.0%	Yes

Support to doctors and nursing staff	3	3	100.0%	90.%	Yes
Qualified allied health Professionals	2	2	100.0%	90.0%	Yes
Qualified healthcare scientists	3	3	100.0%	90.0%	Yes
Total	**18**	**18**	**100.0%**	**90.0%**	Yes

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Each ward specialised in meeting the needs of patients with specific conditions. Nursing staff felt confident to refer to the SPCT and to ask for advice and support. They told us they had access to SPCT consultants and staff and a range of appropriate medical staff such as psychologists and occupational therapists for expert advice and guidance on how to meet the needs of palliative and end of life patients.

SPCT staff attended multidisciplinary team meetings (MDT) every two weeks when patients receiving palliative and end of life care were reviewed with other clinicians, such as oncologists, who had a role in meeting their specific care needs. This promoted a collaborative approach to people's care pathways to maximise their health and wellbeing. A dietician told us they would often work with SPCT staff to identify how best to meet peoples' individual nutritional needs.

SPCT staff told us however they could not always attend MDT as planned due to current staff shortages in the team. Records from these meetings, however were saved in an electronic data base which enabled SPCT staff to comment on and act on the outcomes of the MDT meetings.

Referrals to the SPCT came from various professionals, including nursing, medical and allied health professionals. Audits showed that staff made prompt referrals to the SPCT when people were recognised as requiring palliative care and most patients were seen by the SPCT within 24 hours of referral.

The SPCT worked closely with the chaplaincy, mortuary and bereavement teams. Staff within each team told us they had good working relationships with each other and that this benefitted the services offered to patients and their families.

There were effective processes in place to involve other health professionals when people were discharged from the hospital. The service had access to a dedicated ambulance for the safe transport of palliative care patients. Systems were in place to notify the community palliative care team and GPs when people returning home requiring end of life care. The service provided palliative care study days and guidance to local care homes, hospices and GP practices so people received continuity of care in the community.

Seven-day services

The service was operating five days a week but plans were in place to ensure a seven-day service.

The SPCT currently provided a service from Monday to Friday however they were actively recruiting additional staff to provide a seven-day service. Staff could access a palliative care

consultant and lead nurse for advice out of hours when required. Staff told us there were processes in place to ensure palliative care patients received any medicine they needed at all times.

The multi-faith chapel was open 24 hours a day. The hospital chaplaincy service had chaplains of various denominations that could be contacted to provide support for staff, patients and families.

The mortuary and bereavement team provided a service during the day Monday to Friday and had a 24-hour emergency on-call system so they could respond out of hours.

Porters had access to the mortuary at any time which enabled the prompt transfers of deceased patients from clinical areas to the mortuary. There was a system in place for approved funeral directors to also have access to the mortuary at any time which enabled the prompt repatriation of deceased patients when necessary.

Health promotion

Patients were supported to live healthier lives.

Staff told us they provided support to a wide range of patients in receipt of palliative care and not just those in the last days of life. These included supporting patients who had comorbidities such as cancer and identifying any actions patients could take to reduce the impact these conditions had on their health and wellbeing.

The SPCT could refer patients to other clinical services across the hospital such as dieticians for advice and support to improve their health. The team monitored the well-being of any patients in receipt of palliative care and took appropriate action to promote health and well-being, such as reviewing medication and sign posting to external support organisations.

There were patient leaflets on the wards relating to specific conditions and the actions palliative care patients with these conditions and their families could take to manage their symptoms and reduce the risk of their conditions worsening. This enabled people to make informed decisions about their life style choices and how they could improve the quality of their lives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Capacity Act 2005 (MCA). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff we spoke with gave examples of how they applied the principles of the MCA to patients receiving palliative and end of life care. This included staff ensuring patients were involved in their care planning and supported to express their preferences and wishes such as their preferred places of care and death.

We observed a meeting between a patient and their family with staff. Staff discussed with the patient their prognosis and agreed a care plan which reflect the patient's expressed wishes. Records contained people's end of life care plans and the actions required to meet people's preferences.

We reviewed the 'Do not attempt cardio pulmonary resuscitation' (DNACPR) records of six patients. These are records of decisions made in advance by patients and clinicians that resuscitation would not be appropriate for a person in the event of cardiac arrest. They provide immediate guidance to staff on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. All DNACPR records were completed correctly and reviewed at timely intervals. Records were completed by senior clinicians and involved family members and others who knew the patient when they lacked the mental capacity to make the decision themselves. This enabled decisions to be made in the patients' best interests. These records were stored at the front of the patient's file so staff could identify their wishes quickly in an emergency.

Staff told us that they would involve Independent Mental Capacity Advocates (IMCA) to represent the interest of people who lacked mental capacity and did not have others who were close to them.

At the time of our inspection there were no patients at the end of life or receiving palliative care that had an active DoLS authorisation in place. However, staff we spoke with had a good understanding of DoLS and knew to approach the trust's safeguarding team if they felt a patient was at risk of harming themselves.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 100.0% of eligible nursing staff in end of life care. It should be noted that the data for nursing staff refers to six eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

The trust did not provide any data for medical staff completion rates of mental health law training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff told us they had training in how to transport deceased patients with dignity. There was a rear entrance to the mortuary for funeral directors so bodies could be moved with discretion and protected patients and visitors from observing a procedure they might find distressing.

The family of a patient who was receiving end of life care told us staff were very compassionate and sensitive to the patient's and their own needs. They told us staff were sensitive when discussing the patient's prognosis and answering their questions. They said, "Nothing was too much trouble."

During our inspection we observed staff taking time to interact with patients and demonstrating a sensitive and supportive attitude. Staff told us that they had arranged weddings and the renewal of wedding vows for patients receiving end of life cares. Patients could be joined on the wards by family and friends to celebrate these occasions.

Staff ensured that people's privacy and dignity needs were met. We observed staff closing curtains while undertaking physical care or examinations. Staff told us that as far as possible they tried to place patients receiving end of life care in side rooms to further protect their privacy and dignity.

A nurse told us they had developed an activities box for children who were visiting parents and relatives receiving end of life care. The box contained drawing equipment and other play items to keep children entertained and for use as a distraction if they became upset while on the ward.

Mortuary staff honoured the cultural wishes of the of deceased patients and their families. This included preparing bodies promptly so funerals could occur in line with the required timescale of the person's religion.

Staff worked to make patients as comfortable as possible. We saw staff responding to call bells in a timely manner when patients required support with their care needs or felt distressed. Syringe drivers were available when patients receiving end of life care experienced pain or discomfort.

Emotional support

Staff provided emotional support to patients to minimise their distress.

The service ensured that sensitive communication took place between staff and patients and their relatives. We observed staff talking sensitively with patients and their relatives and promptly provided reassurance when patents became anxious or upset. Staff told us and records confirmed they received training in how to provide emotional support and hold sensitive conversations with patients and their families. This enabled staff to empathise with patients receiving end of life care and provide information at a pace which met people's needs.

Patients receiving palliative care were supported by the trusts psychology service to express their views and any anxieties. Staff told us clinical psychologists responded promptly to request for support. Records showed that patients had psychological assessments when necessary which provided guidance for staff about the specific emotional support a patient required. The psychology service also supported the mental well-being of relatives when required.

The bereavement service offered a follow up service to the relatives of patients who died at the hospital. The bereavement service sent a letter to relatives following the death of the patient to express their sympathy. This also invited the family to approach them for additional support if required. The service advised relatives on where they could receive additional support including meeting with relevant staff at the hospital to discuss any questions or issues they may have had relating to the care of their loved one.

When appropriate, the service would provide relatives with mementoes of the loved ones such as locks of hair. There was a dedicated viewing room where relatives could view the deceased patient. This supported relatives to pay their respects and gave them time to come to terms with their loss and grief.

The chaplaincy service provided support to patients and their families should they wish to practice their faith or remember their loved ones. There were regular services which were well attended. In one instance additional services had been introduced due to the high demand. The chaplaincy service provided a multi faith chapel which provided relatives with a quiet space so they could have time to reflect and grieve. There were regular events where relatives could return to the hospital and remember their loved ones.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff regularly interact with patients and their relatives. We observed a member of staff discussing a patient's condition with them and a relative. The member of staff discussed the patients care plan and asked how they wanted to be supported. They discussed the patients DNACPR wishes and the person's relative agreed with their wishes. Records sampled for patients who were receiving palliative and end of life care showed that discussions took place between clinicians and patients where appropriate with patient's relatives.

Staff supported patients to make advanced decisions about their care. The SPCT provided patients with support and information about their options for care and had conversations with patients about their preferred place of care and death.

Relatives and friends of patients in receipt of end of life care could visit at any time and stay as long as they liked. Wards had camp beds so relatives could stay and support their loved ones. Relatives could provide personal care to people if this was what they wanted. Family members could help to dress and wash their relatives body after death which enabled them to respect the deceased's customs and wishes.

Patients and their families could give feedback on the service and staff supported them to do this. The service conducted several surveys of patient and relatives experience, including a survey of bereaved relatives.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

There were policies and processes in place which supported staff to meet people's palliative and end of life care needs. Referrals to the SPCT could be made any time during a patient's treatment and records showed that the team responded promptly to facilitate the most appropriate care and treatment. The SPCT provided training to staff about the needs of palliative care patients and there were systems in place so staff could seek advice and guidance when necessary.

People were supported to discuss their specific wishes such as their preferred place of care and they could by supported by relatives if they wanted. Patients care plans were documented and monitored by the SPCT. This enabled them to identify if a patient's condition was deteriorating and review care plans and symptoms management.

Staff told us that wherever possible side rooms would be used for patients who were in their last days of life to maintain their dignity and privacy. There were no visiting restrictions on the wards for family or friends of those receiving end of life care. There were camp beds and toiletries available for relatives so they could spend unlimited time with their loved one. Staff offered relatives hot drinks throughout the day.

The trust had additional specialised staff such as dementia champions, speech and language and clinical psychologists who could support palliative care patients to express their views.

There were various quiet rooms with access to drinks, sofas and soft furnishings. Staff told us these were often used for families of end of life patients, for quiet time or breaking bad news.

The trust had a discharge team that facilitated fast track discharge and end of life care planning for those patients wishing to die at home.

Meeting people's individual needs

The service took account of patients' individual needs.

People being supported by the SPCT were able to express their views and preferences in a dedicated care plan. This identified their care needs, wishes and what was important to them. Staff used this as a guide to provide care which was centred to peoples individual needs. In one instance a member of staff had arranged for a person's husband to bring their pet dog to visit because their care plan had identified their dog was very important to them. The member of staff said this had improved the person's mood. On another occasion staff took action to isolate a fire detector in a patient's room so staff could support them to hold a lighted candle as they died. Staff told us this was in line with the person's chosen belief.

There were systems in pace to meet peoples religious and cultural needs. Staff gave examples of when wedding ceremonies and other services such as the renew of vows had been organised for patients and staff within the hospital. There were process in place to facilitate the rapid discharge of a deceased person in order to meet their religion's specific requirements. A variety of leaflets were available on the wards including information about coping with dying, chaplaincy and spiritual care and what to do following bereavement.

Information was available and displayed around the wards and public areas in a variety of styles such as different languages and easy read formats to meet peoples preferred style of communication. The trust had a system in place to access telephone and face to face translation and interpreter services.

The mortuary service was equipped to meet people's individual needs. A dedicated viewing room was decorated and furnished with comfortable homely furniture, helping bereaved families feel at ease. There was equipment for the management of bariatric patients and those with pacemakers or other equipment which may need to be removed before a body could be safely released. The bereavement care team gave bereaved families a guidance booklet. This outlined what to expect following the death of a loved one, and included signposting to relevant information and support.

When possible, patients who were at the end of their life were nursed in side rooms to provide them and their relatives with privacy. Patients were encouraged to make their surroundings as pleasant as possible and bring belongings from home such as framed pictures and their own bedding. Illuminated skyscapes had been installed above some beds which gave the illusion of a sunny sky and helped to prevent those patients who were unable to leave their beds from feeling isolated.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

Patients, relatives and staff we spoke with all said members of the SPCT were easily accessible and responded promptly to requests for support. Audit data showed that SPCT staff responded within 24 hrs to all referrals. The SPCT were avoidable Monday to Friday and plans were in place to recruit additional staff so the service would operate seven days a week.

There were processes in place to ensure patients were supported in their preferred place of care and death. Audits showed that about 66% of patients had been supported to receive support in their preferred place of death. There was a rapid discharge plan in place to get people to their referee place of care. A member of staff in the emergency department gave an example of how they took prompt action to discharge a person safely back to their home within four hours of arrival when it was known this was their preferred place of death.

There were systems in place to support the viewing and transport of the deceased. Relatives could view the deceased person in dedicated viewing rooms Monday to Friday. There were rapid discharge plans in place to enable the prompt release of the deceased so funeral arrangements could be made in line with their religious practices. This included porters and funeral directors being able to access the mortuary at any time and death certificates being available for signature by doctors outside of normal working hours.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Staff we spoke with knew how to direct people to the trust's complaint policy if needed but all said they would take immediate action if possible to address peoples' concerns. There were processes in place to support patients and visitors to make formal complaints such as feedback forms available on the wards and communal areas. Relatives said staff were approachable and felt they would be listened to if they had any concerns.

Complaints relating to end of life care were reviewed by the SPCT and discussed at the end of life steering group meeting. We saw that appropriate action plans were in place to ensure action was taken to address the themes identified through complaints. In one instance we saw a member of the SPCT had conducted additional medicines training with ward staff to reduce the

risk of patients receiving end of life care from being discharged without all the medicines they required.

The trusts maintained an electronic register of complaints so they could be shared, reviewed and analysed for trends. This could identify action which may prevent similar complaints from happening again. Complains were reviewed to see if people had received full and open responses and apologies when appropriate. This was to ensure the trust's compliance with its duty of candour.

Summary of complaints

From October 2017 to September 2018 the trust received two complaints in relation to end of life care (0.4% of total complaints received by the trust). Both related to the behaviour or attitude of staff in the mortuary at Russells Hall Hospital.

Both complaints had been closed at the time of data submissions and the trust took an average of 10.5 working days to investigate and close these. This is in line with their complaints policy, which states complaints should be closed within 40.0 working days.

(Source: Routine Provider Information Request (RPIR) - Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 there were 62 compliments received for end of life care (0.9% of all received trust wide).

Compliments were received in five months of the 12 months of the period. November 2017 was the month where the most compliments were received (29).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The SPCT leadership team consisted of dedicated clinical and nurse leads. They were supported by the deputy chief nurse who was a board member and a nonexecutive director (NED) with responsibility for delivery and oversight of the end of life service. Projects such as the introduction of the GSF were led by dedicated leads whose roles were to provide guidance to staff so new practice would became imbedded and sustainable.

Each ward had an end of life champion to promote and offer guidance to patients, relatives and staff about the palliative care service.

Staff said they were encouraged to engage with the SPCT staff and felt comfortable to do so. Staff received regular communication from the SPCT team and updates on how the service was performing, it's plans and the challenges it faced.

Wards had photographs of the SPCT and their local palliative care champions so patients, relatives and staff could identify who they were and who to approach for support if necessary.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust had an end of life strategy and improvement plans to monitor and review the service. This provided staff with a clear vision and set of values to provide an effective and caring service to palliative care patients. All the staff we spoke with were passionate to deliver a sensitive and person-centred approach. We consistently observed staff demonstrating ways in which they achieved this such as displaying empathy and sensitivity when discussing a patient's diagnosis with relatives, the provision of activity boxes for visiting children, 'skylights' and arranging people's pets to visit.

Senior members of the SPCT were working jointly with other stakeholders in the community including the local clinical commissioning group (CCG), GPs, care homes and hospices. This ensured their strategies and plans were fully aligned with plans in the wider health economy so patients and their families would receive the same standard and continuity of care when they transferred between these services.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Palliative care champions had shared a sense of common purpose with their colleagues. On one occasion when we asked to speak with a ward's palliative care champion a nurse told us they were away, but it was, "Not a problem, we are all champions." Staff were engaged with the end of life strategy and proud of the care and treatment they provided for patients during this time.

The service actively encouraged staff to drive improvement. Staff were felt empowered to meet people's specific care needs and wishes. A care support worker told us they had encouraged a relative to bring in a patient's pet dog to visit them. They said they had not needed to consult with other staff about this decision because the patient's care plan had identified the dog was very important to them. Another care support worker told us how they were confident to recently challenge a senior consultant about how best to meet a patient's deteriorating care needs. They told us the consultant was happy to reflect their views when updating the person's care plan.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There were established systems to ensure good governance and monitor performance of the end of life care service.

There was an executive lead, non-executive lead and clinical lead for end of life care. We found they had an active role in end of life care and its plans for continuous improvement.

The SPCT had regular team meetings, in which issues and general communications were shared and discussed.

There were several groups such as the end of life steering group, quality safety group and clinical quality group responsible for identifying priorities, managing performance and setting objects for the palliative care service.

There was an end of life working group that met regularly and was chaired by the deputy chief nurse. We attended the January meeting and found it to be focused and well managed. The group reviewed the quality of the service being provided and monitored performance against set objectives such as the recruitment of additional SPCT staff and the introduction of the GSF.

The service produced regular reports for the trust's quarterly safety group and clinical quality group which ultimately reported to the Trust Board.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

The service kept a risk register, which was up to date and staff knew how to escalate any concerns. The risks on the risk register reflected those staff had told us about throughout our inspection, such as the absence of a seven-day specialist palliative care service and adequate records storage. Mitigation was in place for the risks and action taken was reported and reviewed at regular governance meetings and shared with directors.

The service had recently developed a quality assurance dashboard that audited performance of the service. It recorded data such as referral times, where people died and time between admission and death. This identified any adverse trends and was used to target education to the wards and areas that required it most.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Leaders had access to a range of performance measures about quality, operations and finances, and used it to improve the service. The information systems facilitated the management of data in

line with data security standards and action had being taken to ensure concerns about secure records storage were addressed.

The SPCT had read access to the electronic system used by the community service. This helped the SPCT to effectively encourage appropriate interaction and promote coordinated, person-centred care to palliative and end of life care patients.

The service had a dedicated page on the trust's website where patients and relatives could access the service's policies and information which would be useful when visiting the hospital. The site also identified where people could obtain additional information and support if they were anxious or unsure about the quality of care they should expect to receive.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

All the wards we visited had end of life care champions who assisted with sharing information relating to end of life care with patients and relatives and engaged the wider staff team in new developments.

The hospital had an awards system for staff aimed to reward and recognise both teams and individual staff members who had 'made a difference' for patients, visitors or colleagues. A member of the SPCT had recently won this award for their work in educating staff and promoting the role of the SPCT in the hospital.

The hospital conducted a bereavement care questionnaire 'Voices' which gave the public an opportunity to suggest improvements. An analysis of returns received between July 2018 to August 2018 showed a high level of satisfaction.

The bereavement care service, in the weeks following the death of their loved ones, offered a follow up service for bereaved families. This gave the bereaved families an opportunity to talk to hospital staff to seek support or advice.

Leaders engaged with external stakeholders to build a shared understanding of challenges and opportunities for the service when transferring patients to locations outside the hospital.

Learning, continuous improvement and innovation

The service was committed to improvement by learning from when things went well and when they went wrong, promoting training, research and innovation.

The service had been working in partnership with other stakeholders in the community to identify a common set of standards all people receiving end of life care should expect. This involved various training initiative and setting performance measures with the local CCG.

The SPCT had developed an end of life care dashboard to monitor the quality of the service. Information from the dashboard would be used to inform future strategy. The service had also developed a dedicated eLearning courses to provide training and learning for ward staff about how to meet the specific care needs of patients receiving palliative care.

Staff told us they had regular feedback about incidences reported within the hospital including any relating to palliative care and how they could be prevented from happening again. Wards displayed details about incidences and rated them by severity. Plans to reduce the risk of similar incidences reoccurring were formulated so staff could act to prevent patients undergoing unsafe care or poor experiences.

Outpatients

Facts and data about this service

The trust provides a range of outpatient services across three hospital sites:

- Russells Hall Hospital
- Corbett Outpatient Centre
- Guest Outpatient Centre

The outpatient department sees 500,000 outpatients each year. This includes both adult and paediatric outpatient's appointments.

Services are provided in community sites across the region, more recently expanding into the Wyre Forest area.

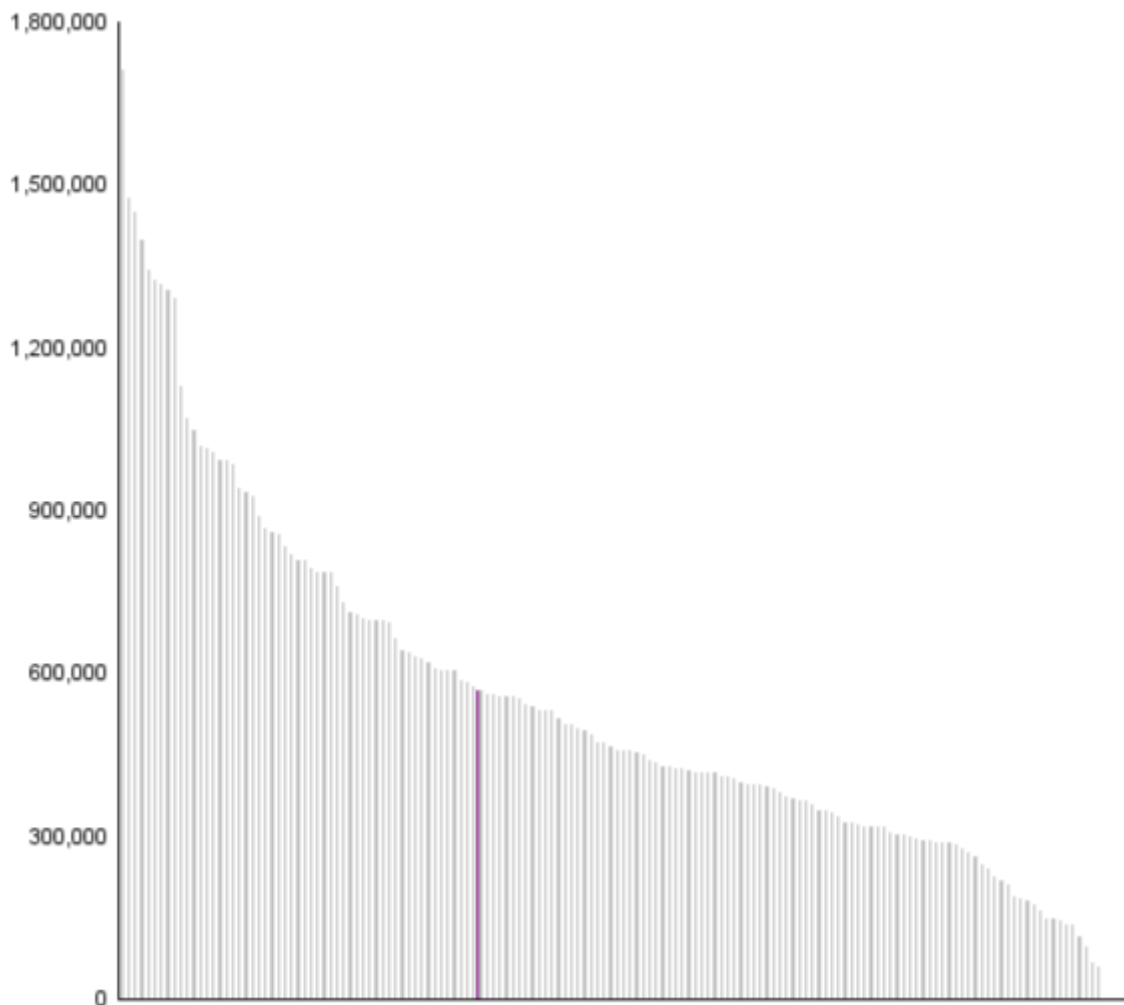The trust provides the following outpatients clinics:

Location	Clinic name	Service provided
Russells Hall Hospital	Trauma & orthopaedics - elective clinics	Consultant led service, incorporating lower limb, upper limb, foot and ankle and back specialisms.
	Trauma & orthopaedics - nurse led elective clinics	Nurse consultant and Advanced Nurse Practitioner led lower limb arthroplasty clinics and virtual follow up clinics.
	Trauma & orthopaedics - fracture clinics	Consultant led face-to-face fracture clinic service and consultant-delivered virtual fracture clinic service.
	Ophthalmology clinic	Consultant delivered service, including specialist glaucoma, retina, corneal, oculoplastic and paediatric ophthalmology service. Urgent referral service provided during weekday hours.
	Low vision clinics	Dedicated low vision service provided by the orthoptist and optometrist team.
	ENT clinics	Consultants working alongside nurses and audiologists.
	Oral /Maxfax clinics	Consultants work alongside nurses, specialist registrar's and trainees to deliver care.
	Orthodontics clinics	Management of teeth correction predominately for paediatrics.
	Plastics clinics	Consultants work alongside specialist registrar's and senior house officers to deliver care relating largely to skin cancer, hand problems, breast reconstruction and plastics urological concerns.
	Vascular	Consultant delivered regional vascular arterial network hub. Full range of index arterial procedures provided, and endovascular aneurysm repair service. Abdominal Aortic Aneurysm Screening programme hub.

Russells Hall Hospital	Pain Management	Consultant led, specialising in pain management
	Anaesthetics	Consultant anaesthetists (including pain and intensivist posts)
	Haematology	Provides care to patients with problems including general and malignant haematology and thrombosis. Care is provided in outpatient clinics and the Georgina day case unit
	Immunology	Specialist immunology and allergy service for diagnosis and management of a range of primary and secondary immunodeficiency disorders as well as routine and complex allergy for both for both adult and paediatric patients. Consultants have regular outpatient and day case sessions each week. The clinical service is supported by an immunology laboratory and the medical day case unit where patients receive immunoglobulin replacement and attend for specialist allergy testing and immunotherapy.
	Anticoagulation Clinic	Nurse led team providing clinics at both Russells Hall Hospital and in the community.
	Clinical Chemistry	Specialist referral for service lipid disorders and patients with metabolic abnormalities for Dudley. The team also provide a referral service for bariatric patients from the region.
	Adult Phlebotomy	Walk in service from 8am to 6pm from Monday to Friday and from 8am to 1pm on Saturdays. Booked appointments are available from 8am to 5.30pm from Monday to Friday and 8am to 12.30pm on Saturdays.
Corbett Hospital	Trauma & orthopaedics - elective clinics	Consultant led service, incorporating lower limb, upper limb, foot and ankle and back specialisms.
	Trauma & orthopaedics - nurse led elective clinics	Nurse consultant and Advanced Nurse Practitioner-led lower limb arthroplasty clinics and virtual follow up clinics.
	ENT clinics	Consultants work alongside nurses and audiologists.
	Anticoagulation clinic	Nurse led team provide clinics at both Russells Hall Hospital and Corbett Hospitals in the community.
	Phlebotomy	Walk in service from 8am to 6pm from Monday to Friday in addition to booked appointments covering all of these times.
Guest Ambulatory	Pain management	All day Friday pain clinic including multidisciplinary and Monday afternoon. Pain management programme assessment clinics, Transcutaneous Electrical Nerve Stimulation (TENS) clinics, acupuncture clinic, general medical and general surgical outpatient clinics.
Wyre Forest	ENT clinics	Consultants working alongside nurses and audiologists.

(Source: Routine Provider Information Request (RPIR) – Sites tab; Acute RPIR – Context tab)

Total number of first and follow up appointments compared to England

The trust had 566,801 first and follow up outpatient appointments from July 2017 to June 2018. The graph below represents how this compares to other trust's.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments

The following table shows the number of all outpatient appointments by site, a total for the trust and the total for England, from July 2017 to June 2018.

Site Name	Number of spells
Russells Hall Hospital	791,321
Corbett Hospital	8,652
Guest Outpatient's Centre	2,684
Halesowen Health Centre	1,490
Netherton Health Centre	1,283
This Trust	**806,630**
England	**106,661,135**

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018:

Number of appointments at The Dudley Group NHS Foundation Trust from July 2017 to June 2018 by site and type of appointment.
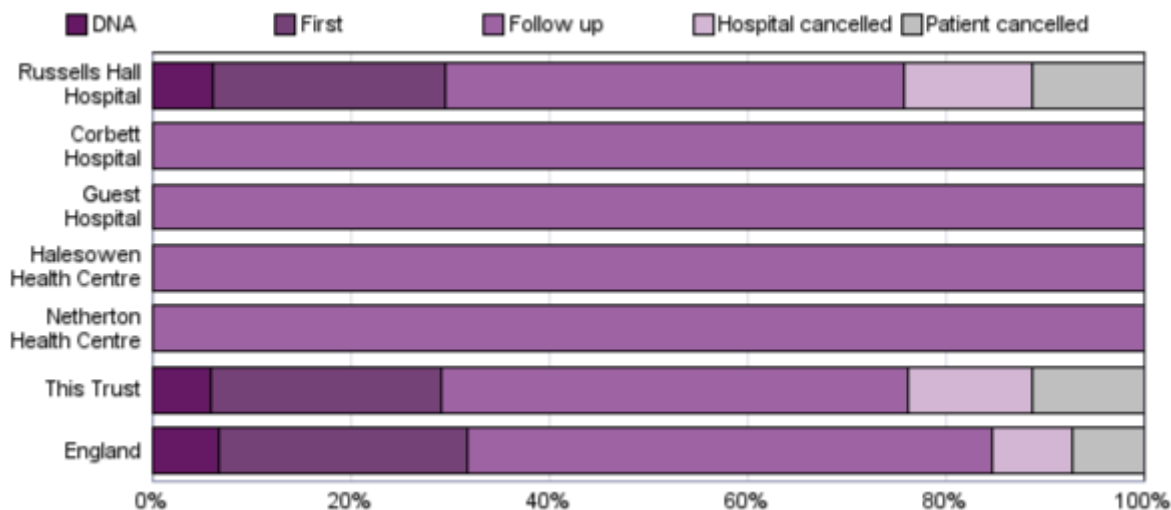
(Source: Hospital Episode Statistics)

Further information showed clinics at Guest Outpatients Centre included gastrointestinal, renal, respiratory, pain, dermatology, rheumatology, haematology and phlebotomy.

The inspection of Russells Hall Hospital and Guest Outpatients Centre took place over three days. During this time, we reviewed 11 sets of patient notes, spoke with 20 patients and 22 members of staff. Staff we spoke with included consultants, senior staff, nurses, clinical support workers, reception staff and volunteers. We visited various clinics including ophthalmology, phlebotomy and the trauma and orthopaedics department.

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills. However, they did not always ensure everyone had completed every course.

Mandatory training completion rates

The trust set a target of 90% for completion of mandatory training.

Trust wide

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 at trust level for qualified nursing staff in outpatients is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual handling (non-patient) / slips, trips and falls	1	1	100.0%	90.0%	Yes
Health and safety	36	36	100.0%	90.0%	Yes
Equality and diversity (including autism awareness)	36	36	100.0%	90.0%	Yes
Infection control - clinical	35	36	97.2%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	34	36	94.4%	90.0%	Yes
Information governance	33	36	91.7%	90.0%	Yes
Fire	32	36	88.9%	90.0%	No
Conflict resolution - level 1	32	36	88.9%	90.0%	No
Manual handling (patient) / slips, trips and falls	31	35	88.6%	90.0%	No
- Resuscitation paediatric	12	14	85.7%	90.0%	No
Resuscitation - adult	27	36	75.0%	90.0%	No

In outpatients the trust had an overall mandatory training compliance rate of 91.4% for qualified nursing staff. The 90% target was met for six of the 11 mandatory training modules for which qualified nursing staff were eligible.

Russells Hall Hospital

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 for qualified nursing staff in outpatients at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality and diversity (including autism awareness)	28	28	100.0%	90.0%	Yes
Health and safety	28	28	100.0%	90.0%	Yes
Infection control - clinical	27	28	96.4%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	26	28	92.9%	90.0%	Yes
Information governance	26	28	92.9%	90.0%	Yes
Fire	25	28	89.3%	90.0%	No
Manual handling (patient) / slips, trips and falls	24	28	85.7%	90.0%	No
Resus - paediatric	6	7	85.7%	90.0%	No
Conflict resolution - level 1	24	28	85.7%	90.0%	No
Resus - adult	20	28	71.4%	90.0%	No

In outpatients the service had an overall mandatory training compliance rate of 90.3% for qualified nursing staff at Russells Hall Hospital. The 90% target was met for five of the 10 mandatory training modules for which qualified nursing staff were eligible.

There was a mixture of on line and face to face training.

Resuscitation training levels were a concern. However, leaders told us adult resuscitation training figures had increased to 82% across all three Hospital sites at the time of inspection. Staff still outstanding resuscitation training had been booked onto training in January and February 2019. There was an electronic mandatory training tracker making it easy to view if training was due to expire.

Medical staff working in the outpatients' department met the trust's target in relation to mandatory training in ten out of seventeen modules. Eight medical staff did not meet the target with compliance rates ranging between 80% and 88%. Mental Health Law compliance rates were low at 57%. We asked what was being done to improve mandatory training compliance. Leaders told us each specialty within the Surgery, Women and Children's division not meeting the required standard, have worked with the trust mandatory training lead to put on bespoke mandatory training sessions for doctors that were not compliant. Dates had been set for this training throughout February 2019.These were arranged for the evening and designed to be tailored around the doctor's day

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Trust wide

A breakdown of compliance for safeguarding training courses from April to September 2018 at trust level for qualified nursing staff in outpatients is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	36	36	100.0%	90.0%	Yes
Prevent	36	36	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	35	36	97.2%	90.0%	Yes
W R A P	33	36	91.7%	90.0%	Yes
Safeguarding children level 3	28	32	87.5%	90.0%	No

In outpatients the trust had an overall safeguarding training compliance rate of 95.5% for qualified nursing staff. The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

Russells Hall Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to September 2018 for qualified nursing staff in outpatients at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	28	28	100.0%	90.0%	Yes
Prevent	28	28	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	27	28	96.4%	90.0%	Yes
W R A P	25	28	89.3%	90.0%	No
Safeguarding children level 3	22	25	88.0%	90.0%	No

In outpatients the service had an overall safeguarding training compliance rate of 94.9% for qualified nursing staff at Russells Hall Hospital. The 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible.

The training figures provided in the routine provider information included the mandatory training for the Guest. This is due to staff working across hospital sites and the data was not split.

At the time of our inspection the overall training rates for safeguarding adults across all three sites was 96% and safeguarding children was 100%. Staff were aware of the trust's safeguarding lead, what to do in a safeguarding situation and where they could access safeguarding policies. There were safeguarding policies for adults and children; they were up to date, version controlled and contained relevant links to supporting policies. They included flow charts and the responsibilities of key contacts. Safeguarding incidents were followed up with the trust's safeguarding lead and local authority social service department.

Female Genital Mutilation (FGM) leads were in place at the trust and there were processes for recording and reporting if any cases of FGM were to arise.

The head of safeguarding attended external meetings where safeguarding subject matters including child sexual exploitation, female genital mutilation and modern-day slavery and trafficking were discussed.

Cleanliness, infection control and hygiene

Staff kept themselves, equipment and the premises clean. However, staff did not always use control measures to prevent the spread of infection.

We reviewed hand hygiene audits from July 2018 to December 2018 and found the outpatients department at Russell's Hall Hospital met the trust's target compliance rate of 95% and above in all instances, however results were unavailable for November and December. Guest outpatients' department met the target of 100% in all months. Patients told us they saw staff washing their hands and using hand gel. There were hand gel dispensers throughout the outpatients' department including at nurses' stations. Hand washing facilities were available in clinical rooms.

The outpatient's departments were visibly clean. Cleanliness audits were completed as part of the private finance initiative (PFI) contract and there were audit failure action lists. Contactors had one hour to respond to any issues once reported. We reviewed action lists and found they included areas such as dusty wall buffers and discoloured ceiling tiles. Departments kept monthly cleaning audit scores; these were rated red, yellow or green depending upon compliance to target. From July 2018 to December 2018 the outpatients 'department at Russells Hall Hospital met the target of 95% most months. Guest Outpatient's Centre met the trust target most of the time, however, was rag rated red for the main entrance in August and December 2018 and within the blood test department in December 2018 when they scored below trust target. Cleaning teams came to the department each evening. The trust had infection control link nurses' staff could contact for advice.

There was a standard (universal) infection control precautions policy. This was in date and version controlled. Staff used I am clean stickers to show equipment had been cleaned. All staff were "arms" bare below the elbow, had long hair tied back and washed and gelled their hands. In the staff room there was information on Carbenemase Producing Enterobacteriaceae (CPE) and which countries had a high prevalence of cases.

Signed cleaning rotas were in toilets and consultation rooms. We noted signing of cleaning rotas was discussed in a weekly huddle. Staff knew what to do if an area needed a deep clean and could arrange this via the help desk. They could also ring the helpdesk if they needed additional cleaning materials or hand gel. Russells Hall Hospital outpatient's department had an information

board displaying infection control information such as the chain of infection, modes of transmission and portals of entry.

However, we saw on two occasions at Russells Hall Hospital (nurse led clinic and phlebotomy) staff used sharps but did not use Personal Protective Equipment (PPE) aprons and gloves. Staff in the phlebotomy department told us they only used these on high risk patients. This was not in line with the trust's sharps selection, handling and disposal policy. We also noted a fabric tourniquet in the phlebotomy department was not cleaned between patients.

Environment and equipment

Resuscitation trolleys were tamperproof, and staff completed daily checks. However, the outpatients' department at Russells Hall Hospital and Guest Outpatients only had one resuscitation trolley, this meant that staff may need to go quite a distance to collect it and it could be an issue if two emergencies were to happen at the same time.

All consumables were intact and in date and contactors tested electrical equipment for safety. We found one label was out of date and raised this with leaders. Following investigation, leaders confirmed the equipment had been tested but a label was not applied. One piece of equipment which had several labels attached as the out of date ones had not been removed and this could lead to confusion.

Staff disposed of clinical waste appropriately in accordance with trust policy and guidance. Trust policy was based on national guidance such as the Health and Safety (sharp instruments in Healthcare) Regulations 2013, and the Control of Substances Hazardous to Health 1999. There were clinical waste bins in consultation rooms. Sharps bins were available and dated and there were processes were to empty them.

Assessing and responding to patient risk

Risks to people such as deterioration of patients and sepsis were not always adequately assessed and were not always managed safely.

In the ophthalmology department we found local rules were dated 2014 with no updates noted. Risk assessments for laser were completed in 2013 with laser competencies completed in 2010. This did not provide us with assurance that risk assessments were up to date and that patients were safe. We escalated this at the time, following the inspection the trust provided us with assurance of immediate actions taken.

Senior staff told us they were aware there was some work to do on improving how they identify and monitor deteriorating patients in outpatients. We were told discussions had been had at a senior level about how they could learn from the experience of staff in the emergency department around identifying patients at risk of deterioration. However, there were no clear plans on how this would be developed. Reception staff who were not registered practitioners did not receive training on how to recognise a deteriorating patient. This was important as on induction reception staff were instructed to inform the nurse in charge if patients reported they felt unwell or if they witnessed deterioration.

In an emergency situation the process was staff would take an Airway, Breathing, Circulation, Disability, Exposure (A, B, C, D, E) approach to assess and treat the patient. A set of observations would be taken, and a 222 call would be initiated. The registered practitioners attending the emergency would assess the patient and if required arrange a rapid transfer to the hospital's accident and emergency department.

Staff were aware to contact 222 in an emergency and could provide examples of when they made such a call.

There was no sepsis screening tool in use at Guest Outpatient Centre; leaders told us that they were aware they needed to have a better process for deteriorating patients, particularly at Corbett and Guest and that they were planning on working with the matron to develop a pathway. They also told us a discussion would take place at the deteriorating patient group on 30 January 2019 with regards to a screening tool for sepsis in outpatient centres.

The divisional chief nurse had identified risks and actions to raise awareness about the lack of an off-site outpatient sepsis tool at the deteriorating patient group (January 2019) and to implement an off-site outpatient's sepsis tool. Resuscitation and observational policies were in place and up to date.

Nursing staff showed a good understanding around sepsis such as taking bloods, giving antibiotics and use of oxygen. Training for sepsis was incorporated in the mandatory annual training of the management of deteriorating patient (resuscitation training) and included primary assessment, track and trigger (NEWS) and specialist requirements for individual areas such as anaphylaxis. There were six staff awaiting this training and all had planned dates.

At Russells Hall Hospital there was a large visible sepsis board. The board had information on the sepsis six including if the patient was a child, there was also a sepsis link nurse. There were e-learning sepsis modules to teach staff about the new electronic sepsis report. However, e-obs had not yet been rolled out across the outpatients' department, 21 out of 51 staff had completed the training, with 20 passing the assessment. The sepsis board had details of how staff could access the training.

Nursing staff giving patients injections ensured they had the correct person by competing identification checks such as asking the patient details such as their name and date of birth.

Patient safety bulletins including areas of focus were displayed in the staff room. There was information for staff on where to find information on topics such as risk and incidents.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and provide the right care and treatment.

Total staffing: planned vs. actual

The trust has reported the following qualified nursing staff numbers for the two periods below for outpatients.

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Nursing	61.4	55.7	90.7%	62.0	56.7	91.4%

The trust reported a qualified nursing staffing level of 90.7% in outpatients in March 2018 which increased to 91.4% in September 2018.

As at September 2018, there were 5.3 fewer Whole Time Equivalent (WTE) staff in post than planned for but 1.0 more WTE staff in post than in March 2018. There was an increase of 0.6 WTE planned posts between the two-time periods.

The trust did not provide this data in a format which allowed us to undertake site level analysis.

Leaders had recently recruited to several nursing posts and were fully staffed. Vacant shifts were covered by the departments own staff. Additional shifts went to bank staff. Having the correct staffing levels is important to ensure patients are safe and to make sure clinics run on time with minimal delays.

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 7.7% for qualified nursing staff in outpatients. This was higher than the trust's overall target of 6.3%. The trust were unable to break down this information at site level.

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 3.6% for qualified nursing staff in outpatients. This was lower than the trust target of 8.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 1.4%
- Russells Hall Hospital / Corbett Hospital: 11.1%

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 3.1% for qualified nursing staff in outpatients. This was lower than the trust's target of 3.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 3.3%
- Russells Hall Hospital / Corbett Hospital: 2.2%

Bank and agency staff usage

From October 2017 to September 2018, the trust reported 11,410.0 available hours in outpatients were filled by bank staff (5.1%) and 947.0 (0.4%) were filled by agency staff. In addition, there were 17,850.0 hours that needed to be covered by bank or agency staff but were unfilled (7.9%).

A breakdown of bank and agency usage by staff type is shown below:

Staff type	October 2017 to September 2018						
	Bank		**Agency**		**Unfilled**		**Total**
	Hours	**%**	**Hours**	**%**	**Hours**	**%**	**Hours**
Qualified	3,206.0	2.7%	947.0	0.8%	10,002.0	8.4%	119,763.0
Non-qualified	8,204.0	7.8%	0.0	0.0%	7,848.0	7.4%	105,825.0
Total	**11,410.0**	**5.1%**	**947.0**	**0.4%**	**17,850.0**	**7.9%**	**225,588.0**

The trust provided us with details of bank and agency staff usage broken down by site. We reviewed the data for Russells Hall Hospital between October 2017 to January 2019 and found bank and agency staff usage fell below the trust target of 18% in all months. The Guest outpatient's centre did not require any bank and agency cover.

Medical staffing

The trust was unable to provide separate staffing data for medical staff in outpatients.

The trust clarified the medical staff who work in outpatients, work across both inpatients and outpatients. Accordingly, in the trust's HR and training data these staff are mapped to the relevant inpatient service.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

Records

Records were not always available to all staff providing care. However, records reviewed were found to be appropriate and up to date.

There were processes for the collection and transfer of records to centre file where patient notes were stored, and date stamped. Records were brought to the department daily and stored securely in a room next to the reception desk with keypad entry. Hospital porters collected the notes and transferred notes to the department. Reception staff then reviewed the records to see if any were missing. Records were collected by porters, transported to the relevant secretaries and returned to centre file following use.

Leaders told us staff reported unavailable and missing notes on the electronic reporting system. Staff at Russells Hall hospital estimated there could be up to 60 sets of notes unavailable in any one-day. They told us they had a lot of unavailable notes, and unavailable and missing files were one of the main incidents dealt with on reception. However, none of the patients we spoke with during our inspection raised concerns about missing records.

The policy was staff should report missing and unavailable notes on the electronic incident reporting system. We asked leaders for details of how many incidents had been raised about notes being unavailable for clinics in October, November and December 2018; the service reported there were 14 across all three sites. However, leaders recognised due to the volume of unavailable notes it was unlikely staff had the time to report each unavailable or missing set. They also told us most notes were not missing but later found in other departments. Staff at Guest Outpatient's Centre staff told us they felt the number of patients seen with temporary files was approximately eight to 10 a day. Leaders confirmed there would need to be a manual audit of the electronic recording system looking at reported incidents to determine how often notes were unavailable.

Staff mitigated risks of unavailable notes by setting up a temporary folder using information available such as previous letters and test results

Missing and unavailable notes were recognised as one of top three risks by service leads. They recorded this as an issue in a lead nurses' assessment of the department. Staff told us they

worried about vulnerable patients who attended appointments when there were unavailable notes. This was because they may not be able to fill in any gaps of information themselves.

Systems and processes were being introduced to ensure notes could be located such as introducing a check box into the booking in system and an electronic note tagging system so notes could be located. However, this was not yet in place.

The service completed an audit of outpatient documentation 2018/19 (respiratory medicine) with the aim of monitoring record keeping standards of health records for outpatients against the structure and content standards for outpatient records and communications from the Royal College of Physicians and Health and Social Care information Centre (2013). Areas of good practice and concern were identified. Staff devised an action plan based on the audit findings. Actions included ensuring the patients full name and NHS number was in dictation of patient letters and ensuring the complete recording of allergies in new patient letters. Positive findings included 97% of cases a clear diagnosis or differential diagnosis was recorded in the patient letter and 100% of letters in the sample had a legible printed name and designation.

We reviewed eleven sets of patients' notes. We found them to have relevant information such as treatment plans, test results, diagnosis and follow ups. Records were signed, dated and written in black ink. However, in some instance's pages were loose which could mean important information could be lost and some hand writing was difficult to read.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

The ophthalmology department had patient group directions (PGDs). They were reviewed, updated and approved at the Drugs and Therapeutics Committee. In the outpatients' department prescription pads were stored securely in a locked drawer. Medications were in date, stored appropriately with daily fridge temperatures and resets recorded. Room temperatures were also monitored. Staff kept medications securely in locked cupboards inside rooms with key pad entry.

We reviewed the most recent ward/department medicines storage and handling checklists dated August 2018. The audit at Guest Outpatient's Centre (August 2018) found non-compliance in four out of 26 domains. An action plan was introduced and was noted to be complete in all areas. Russells Hall Hospital was non-compliant in one out of 26 domains (November 2018) and all actions on the action plan were recorded as complete.

Anaphylaxis kits were kept in locked cupboards at both Russells Hall and Guest Outpatient Centre. We raised concerns at Guest Outpatient Centre about the time it would take to access these in an emergency, especially if there was more than one nurse on duty with staff needing to find keys. At Russell's Hall Hospital keys were stored in a key pad with easy access. At the time of the inspection the pharmacy department told us they were exploring the possibility of storing pre-filled adrenaline auto injectors in a tamperproof box. This would allow improved access to the emergency drugs through storage outside of the medicine's cabinet. Anaphylaxis (recognition and emergency treatment in anaphylactic reactions) guidelines were in place. Following the inspection leaders told us that anaphylactic packs were now provided and stored on the resuscitation trolleys.

At Guest Outpatients Centre we saw intravenous antibiotics were kept on the emergency trolley for rapid treatment initiation in sepsis.

In the ophthalmology department some medicines that required refrigeration were being stored in a room which doubled as a consultation room. This meant staff could not always access some of the medications easily when the room was in use.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learnt with the whole team and wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as a never event for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is below:

- Slips/trips/falls meeting SI criteria

- Surgical /invasive procedure incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Staff spoke of an open reporting culture and could give examples of incidents they had raised. Information on reporting, managing and learning from incidents was displayed in the outpatient's staff room alongside an example of an incident and learning.

Staff received feedback in weekly huddles. We heard of practice changing because of incidents. Root cause analysis (RCA) reports were completed following serious incidents. We reviewed a serious incident report and found it had a root cause, actions and identified areas for shared learning. Incidents and incident themes were discussed in confirm and challenge quality meetings and referenced in nursing governance assurance reports dated October to December 2018.

Following a serious incident of laser treatment to eye of incorrect patients in ophthalmology measures had been introduced to reduce the risk of a repeat incident. These included additional identification checks and comparing against health records and labels. Minutes from the ophthalmology weekly huddle referenced the risk register.

The department used duty of candour proformas. The department had one instance in the last year which they had applied duty of candour due to a patient falling in the department. We

reviewed the duty of candour proforma and found it included patient preferences such as how they wanted to be told of investigation findings and of any specific question's family wanted answering. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reason able support to the person. Staff understood the principles of duty of candour and the importance of being open and honest.

Nurse leaders from the department told us they were not involved in mortality and morbidity reviews and that it would be good to have shared learning. We were also told they were looking at a consultant lead who would be able to attend in the future.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

Policies and procedures based on such guidance were available and accessible to staff via the trust internet. Policies we viewed as part of our inspection were in date and made reference to guidance used in the development.

There was a Local Safety Standards for Invasive Procedures (LocSSip) Audit (May 2018). The audit was to demonstrate compliance against the LocSSip policy. LoccSSips are based on the national safety standards (NatSSips). They were set up to enable the trust to review current local processes for invasive procedures. They are needed to make sure procedures and processes provide assurance invasive procedures are recognised and managed safely. The audit identified there was a lack of knowledge in some areas about the standards and what they were for. However, it also showed overall compliance with the policy was good.

Leaders carried out self-assessments of outpatient services which were aligned with CQC domains of safe, caring, effective, responsive and well led. The process found areas for action. For example, ensuring staff obtained patient consent and resuscitation trolleys were visibly clean, in good order and had the required equipment.

Staff adhered to national guidance such as the "*The National institute for Health and Care Excellence"* (NICE) Glaucoma: diagnosis and management, age-related macular degeneration, Asthma UK and COPD guidelines. The pain clinic had developed a migraine management policy in line with NICE guidance. Leaders told us the outpatient service had not taken part in any peer reviews.

The ophthalmology department had taken part in an audit in relation to intravitreal injections; however, results were not yet available.

Nutrition and hydration

There was enough food and drink to meet patients' needs and improve their health

There were water dispensers in the waiting areas. The hospital had various areas patients and their visitors could buy food, drinks and snacks. Staff could order patients snack boxes if needed. Drinks and snacks were kept in the department for urgent situations.

The trust had a dietetics and speech and language therapy department that supported both inpatients and outpatients in the community. We did not meet anyone that needed a referral to this service during our inspection.

Pain relief

The service provided specialist pain services to assess patients' pain and provide ongoing support.

Stocks of simple analgesia were available in general outpatients. Pain clinics were held in the outpatient department. Outpatient referrals were received via the patients GP. The pain team linked in with community pharmacists and had provided training for GP's. The pain team had introduced a migraine management pathway. The service had integrated a clinical nurse specialist to support consultants in outpatient clinics.

The service had implemented the faculty of pain core standards for pain management and was compliant for both acute and chronic pain. Key standards relevant to the outpatient department included no sole practitioner acting in isolation and specialist pain management services must have access to dedicated pharmacy input.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Follow-up to new rate

The trust provided their follow-up to new rate for November 2017 to December 2018 for all specialties together with the 'peer' rate of other acute NHS hospitals. This included both face to face and non-face to face attendances.

Twenty-one specialties had a rate higher than the reported peer group

Specialty grouping	Trust	Peer
Anticoagulant service	36.9	14.3
Nephrology	11.3	7.9
Orthodontics	10.8	9.4
Maxillo-facial surgery	9.8	1.5
Clinical oncology	9.2	7.5
Programmed pulmonary rehabilitation	8.8	6.6
Respiratory physiology	8.7	1.9
Clinical haematology	7.4	6.4
Rheumatology	7.3	4.2
Diabetic medicine	5.9	5.1
Chemical pathology	5.8	2.2
Endocrinology	4.6	2.9
Orthoptics	4.5	3.6
Dietetics	3.6	1.8
Dermatology	3.4	2.3
Physiotherapy	3.3	2.7
Urology	3.1	2.2
Audiology	2.1	1.3
Trauma & orthopaedics	1.9	1.8
Cardiology	1.3	1.3
Transient ischaemic attack	0.6	0.4

Twenty-three specialties had a lower rate than the reported peer group.

Specialty grouping	Trust	Peer
Medical oncology	7.6	8.7
Occupational therapy	2.4	2.4
Ophthalmology	2.3	3.1
Plastic surgery	1.8	2.5
Pain management	1.7	2.2
Optometry	1.7	2.7
Respiratory medicine	1.5	2.0
General surgery	1.4	1.5
Neurology	1.3	1.9
Vascular surgery	1.2	1.3
ENT	1.2	1.4
Clinical immunology and allergy service	1.2	1.4
Stroke medicine	1.1	1.3
Oral surgery	1.1	1.2
Gastroenterology	1.1	1.9
Breast surgery	0.8	1.2
Geriatric medicine	0.7	1.3
General medicine	0.6	1.2
Anaesthetics	0.4	1.8
Colorectal surgery	0.2	1.1
Interventional radiology	0.1	0.4
Clinical genetics	0.0	0.4
Clinical psychology	0.0	3.6

(Source: Data Request DR87)

Follow up to new data was reported trust wide rather than being broken down by site. Therefore, we were unable to break this down by individual hospital site. However, staff worked across hospital sites.

In December 2018 data showed the last validated number of overdue follow ups in ophthalmology was 853.The department had worked hard to reduce the numbers which had reduced from 2978 in January 2016.The department operated a partial booking system. The maximum time in advance the department booked follow up appointments was five weeks due to booking rules. An action plan was in place with many actions being completed. Actions included to recruit to position of glaucoma practitioner, to make the corneal consultant full time and to submit plans for three estate options to expand the outpatient's department. It was recognised the risk of overdue follow ups was one of highest scoring risks in the division, and there was an action plan to address this.

In 2018 a serious incident happened in ophthalmology due to a follow up appointment being missed. This was due to the previous booking system which was not felt to be robust. Processes were introduced to identity all patients that could have been missed since 2013. At the time of the inspection all patients identified had either been seen or had been placed on a booking list for sub specialist clinics with an urgent priority with all patients being assessed for harm. Leaders told us the harms review will be documented to identify priority conditions and learn from errors. The service were interviewing for a clinical fail-safe lead to ensure clinical reviews took place of every patient that was overdue by 25% of the intended follow up interval. The position would also ensure there were automatic failsafe processes by the outpatients booking team where patients

can be escalated, and effective actions taken, ranging from a clinical phone call to virtual review.

The haematology department had joint accreditation committee ISCT-Europe and EMBT (JACIE). JACIE is Europe's only official accreditation body in the field of haematopoietic stem cell transplantation and cellular therapy. Accreditation promoted high quality patient care and medical and laboratory practice through a profession-led, voluntary accreditation scheme.

The respiratory outpatients' clinic were gathering data for the refractory asthma registry. Data for the registry would be used to measure the performance of patients particular clinic compared to other UK refractory asthma clinics, judging which treatments were of greater benefit and how care was improving, to identify different sub groups of refractory asthma and trial new refractory asthma therapies, to provide information for planning future services for people with refractory asthma and to identify patient groups who could be approached to take part in particular research studies.

The outpatients' department used outcome forms to record the patients' referral to treatment status, outcome of their appointment and, if applicable, when the next appointment should be. Management of outcome performance was via access and performance meetings. At the time of the inspection (January 2019). Guest Outpatient's Centre had 88 outstanding outcome forms (the oldest was 15 January -1 day). Russells Hall Hospital had 832 outstanding outcome forms with the oldest being six weeks. Leaders told us outcome forms included patients that did not attend, referred to other services and discharges.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance to provide support and monitor the effectiveness of the service.

Appraisal rates

For year to date, April to September 2018, 95.1% of required staff in outpatients received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to scientific, therapeutic & technical staff	3	3	100.0%	90.0%	Yes
Other qualified scientific, therapeutic & technical staff	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	54	55	98.2%	90.0%	Yes
Qualified nursing & health visiting staff	33	36	91.7%	90.0%	Yes
Qualified allied health professionals	7	8	87.5%	90.0%	No
Total	**98**	**103**	**95.1%**	**90.0%**	Yes

Russells Hall Hospital

For year to date, April to September 2018, 98.6% of required staff within outpatients at Russells Hall Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Other qualified scientific, therapeutic & technical staff	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	45	45	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	27	28	96.4%	90.0%	Yes
Total	**73**	**74**	**98.6%**	**90.0%**	Yes

Russells Hall Hospital / Corbett Hospital

For year to date, April to September 2018, 86.2% of required staff within outpatients at Russells Hall hospital / Corbett hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to scientific, therapeutic & technical staff	3	3	100.0%	90.0%	Yes
Support to doctors and nursing staff	9	10	90.0%	90.0%	Yes
Qualified allied health professionals	7	8	87.5%	90.0%	No
Qualified nursing & health visiting staff	6	8	75.0%	90.0%	No
Total	**25**	**29**	**86.2%**	**90.0%**	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

All new staff and volunteers attended a trust induction programme and were provided with additional role specific training as needed. The trust induction included mandatory training and an induction to the trust as a whole as well as individual hospital sites.

People had their needs assessed by staff with the right skills and knowledge. There were many consultant and nurse specialist clinics. Clinical nurse specialists were involved in many patient clinics at Russells Hall Hospital such as respiratory, pain, neurology and specialist asthma clinics. At Guest Outpatient's Centre clinics included respiratory, pain and tuberculosis (TB).

There were competency frameworks in ophthalmology for ophthalmic trained nurses and clinical support workers. Competencies for clinical support workers included maintaining patient hygiene, maintaining patient privacy and dignity and working in a patient centred way. Nurse competencies included anatomy and physiology of the retina, post-operative eye examination and slit lamp and use equipment. Staff competencies were signed off by senior staff to show they

were competent, and each staff member had a folder. The plaster technician in trauma and orthopaedics had completed the British casting certificate. Competency assessments were completed and signed off in the outpatient's departments where staff were assessed in areas such as taking venous blood samples, disposal of sharps and ECG competency.

Leaders told us staff learning needs were identified through appraisals, listening to staff and through observation. There had been opportunities for staff to go into other areas of the trust and to shadow clinical nurse specialists. We spoke with several staff who had been supported with development. For example, we spoke to a band 5 nurse who had started in the role of a clinical support worker and was being encouraged to do their band 6 development course. We also met a nurse in the ophthalmology department who had been promoted to shift lead. Leaders were able to give an example of when they had needed to manage poor performance.

We spoke with a hospital volunteer who was supporting patients in the outpatient's department, they told us how they received training such as safeguarding.

In the ophthalmology department we found refresher training for patient group directives (PGDs) had last taken place in 2017. Leaders told us it had been missed in 2018; there were plans for training to be completed by June 2019.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed all staff working well together to ensure the smooth running of the department. Staff spoke of good multidisciplinary working relationships. Clinical nurse specialists held nurse led clinics.

There was a one-stop clinic for breast suspected cancer This clinic was led by a consultant surgeon and a breast nurse consultant and supported by mammographers and radiographers. Once the patient had seen the consultant/nurse consultant, they would receive diagnosis as appropriate. Patients were given a diagnosis on the day.

The pain service ran a multidisciplinary clinic where a pain consultant, a psychologist and a physiotherapist worked together to support patients with their pain.

The ophthalmology department employed an eye clinic liaison officer (ECLO) who worked closely with the local authorities' vision support services. An ECLO works directly with people with low vision, deteriorating vision, sight loss or impending sight loss, and their carers. They provide practical and emotional advice that is extended to carers and family members. ECLOs connect people with the practical and emotional support they need to understand their diagnosis, deal with deterioration in their sight and maintain their independence.

Seven-day services

The department held weekend clinics to meet patient demand and were working towards seven-day working.

To meet demand staff in the outpatients' department had been holding weekend clinics, these were mainly held on a Saturday. Leaders aspired to work towards seven-day working however, they first needed to ensure there were enough staff to provide cover.

Health promotion

The department took part in health promotion. Patients were referred to other services for support when needed.

There was a range of information available for patients such as breast cancer awareness and giving up smoking. We observed a consultant giving a patient dietary advice in relation to their condition.

Nursing staff told us patients health related questions, for example, if they smoked there was the opportunity for a referral for smoking cessation. Written information was available for patients about their condition.

The chemical pathology department held weight reduction clinics where patients were given lifestyle and dietary advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust's policy and procedures when a patient could not give consent.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 83.3% of eligible nursing staff in outpatients.

A breakdown of compliance by site for qualified nursing staff in outpatients is shown below:

Site	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Russells Hall Hospital	24	28	85.7%	90.0%	No
Russells Hall Hospital / Corbett Hospital	6	8	75.0%	90.0%	No

In outpatients the 90% target was not met by either site for the mental health law training module for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff spoke of situations when patients had needed mental capacity assessments and best interest decision meetings when there were concerns around a patient's capacity to make decisions, this was in line with the trust's assessing mental capacity policy and the key principles of the Mental Capacity Act 2005.

Nursing staff told us consultants completed mental capacity assessments, but they were involved in best interest meetings. Staff could contact the dementia lead for advice if needed.

Staff were aware of the importance of gaining patient consent and followed trust policy. Consent forms were drawn up in some areas such as for the UK refractory asthma registry information, other types of consent included verbal and non-verbal. The trust's policy on consent was up to date and version controlled, it recognised consent could be withdrawn at any time. The department did not audit consent processes and compliance with trust policy.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

The service took part in the Friends and Family Test (FFT). Results showed an average of 90% of patients would recommend the outpatients service to family and friends (January 2018 to December 2018). However, response rates were low at an average of 59% in the same period. Leaders told us they were trying to improve response rates and had asked volunteers and staff to support patients with completing the survey.

Friends and Family test slips were available for patients in waiting areas, there was patient feedback leaflets available. Friends and Family results and actions were included in assurance reports.

Volunteers supported patients on their arrival to the department. One patient told us they had found the volunteers "brilliant" and they had found them a wheelchair to use.

Staff supported vulnerable patients and directed them to where they needed to go. Staff maintained patient privacy and dignity by ensuring doors were closed, consultations took place in private rooms. The reception area had a privacy notice asking patients to stand behind the line.

Patients told us they felt "respected and listened to", staff were "very nice", introduced themselves and they "could not fault the service they received".

There was a chaperone policy. There were chaperone posters on display in waiting areas asking patients to inform staff if they required a chaperone. Nursing staff accompanied most patients in consultations as it was felt this supported patient flow.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff gave an example of when a patient had come into the department confused and how they had sat with the patient until their appointment. Another staff member told us if a patient was upset they would take them to a quiet area and offer to call a relative to support.

Consultants and nurses discussed treatment options with patients.

Psychologists were part of the multidisciplinary pain service. This meant that patients could receive appropriate psychological support to help with their pain.

We observed nursing staff acting in an empathetic way towards patients.

We saw psychological input was available within specific pathways, for example for patients following a stroke. Staff were able to refer patients for emotional support through the improving Access to Psychological Therapies (IAPT) services.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Patients felt listened to, respected and their views were considered. Patients family members and friends were welcome and treated as important partners in the delivery of care. Patients told us staff communicated well so they understood their care and treatment.

Patients could be supported in clinics by family members. Patients told us they knew who to contact if they had any concerns about their care and treatment following their appointment. One long term patient told us they could ring the consultants secretary at any time.

We observed staff in the phlebotomy department explaining the procedure to the patient.

We observed several clinics and saw staff listened to patient's, confirmed their understanding, provided verbal information and answered questions. Patients felt they were given the time and opportunity to ask questions.

We observed several clinics and saw staff listened to patients, confirmed their understanding, gave verbal information and answered questions. Family were involved in discussions when appropriate. Patients said they felt they were given the time and opportunity to ask questions.

Is the service responsive?

Service delivery to meet the needs of local people

The service did not always plan services that took account of patient's individual needs. The environment was not suitable for the number of patients seen. Leaders recognised the need to review patient flow through the department.

The waiting rooms did not have any magazines for patients to read. Staff told us this was due to infection control advice received. There were no televisions in waiting areas; however, leaders told us plans for televisions were in progress.

Staff told us there were times when waiting areas were overcrowded. Leaders recognised the need to review patient flow to better utilise space. At the time of our inspection, the waiting areas in the main outpatient's department were busy but all patients had a seat. However, in the ophthalmology department we saw overcrowding in one of the corridors/waiting areas. Some patients were standing, there was limited space for wheelchairs or patients with mobility issues to manoeuvre. There was also limited space in the visual field room of the ophthalmology department; the room could be used for up to seven assessments at a time. This led to issues around confidentiality as patients were assessed close together and there were no partitions between the patients. The ophthalmology risk register included the visual field room and associated risks

There were water machines in waiting areas and enough toilet facilities.

The hospital car parking system was pay and display system which was managed as part of the hospitals' PFI contract, there were disabled car parking spaces. The outpatients' department was signposted from the main entrance.

Leaders gave examples of working with the local clinical and commissioning groups (CCG's) and NHSI to improve patient experience.

Meeting people's individual needs

The service took account of patients' individual needs.

Information was in accessible formats. For example, in the ophthalmology department information leaflets such as what is glaucoma and having cataract treatment were in yellow print, had clear visual aids and large print. In all areas outpatients and ophthalmology staff wore yellow identification badges to make them easier to read.

At Guest Outpatient's Centre we saw a how do you communicate poster for patients who needed information in a different way.

Staff knew to contact an interpreter if a patient's first language was not English. However, we were unable to corroborate if this happened as we did not meet any patients who needed an interpreter during our inspection.

Staff told us they did not know if a hearing loop was available. This meant that patients with a hearing impairment may not have been supported with their communication needs.

Patients who needed information in a different format or language could contact the trust's information officer. Some leaflets were already in different language formats, others were not There was a notice in one waiting area to advise of priority seating for patients with limited mobility.

The trust had a mental health liaison nurse staff contacted to provide specialist support when needed.

The trust had a learning disability nurse that could provide staff or patients with additional support. There was a flagging system in place to alert staff if a patient had additional needs. Nursing staff told us they would try to get patients seen sooner if they identified a need.

The ophthalmology department had an area for assessment for patients who needed additional support such as patients living with a learning disability or dementia. The area was quieter and partitioned off.

Staff had compiled a dementia board in one of the outpatient waiting areas. There was information for patients and their carers on what is dementia, dementia signs and symptoms, contact numbers to dementia support groups and the name of the dementia champion. There was a dementia link nurse who staff could go to for advice. Staff told us that they would try to get patients living with dementia seen sooner so they did not need to wait a long time in the waiting area. We did not meet anyone living with dementia at the time of our inspection in order to gather their views.

There were bariatric chairs available in the waiting area and the department had bariatric scales Leaders told us they had close links with the hepatitis nurse who held a Thursday afternoon clinic.

Qualifying patients with asthma were provided with an asthma action plan. The plan by asthma UK provided a step by step guide to help patients stay on top of their asthma. The plan provided details of what to do in the event of an asthma attack.

Patient toilets had handrails and call bells to support patients living with a disability.

The maxillofacial department made prosthetic parts such as eyes and noses. Staff told us how these had been custom made for patients using their personal preferences such as eye colour.

Access and flow

People could access the service when they needed it. Most waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice, action plans were in place for those that were not.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for non-admitted pathways was consistently better than the England average. The latest figures for August 2018, showed 94.9% of this group of patients were treated within 18 weeks versus the England average of 88.4%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, The Dudley Group NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Twelve specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Plastic surgery	100.0%	90.6%
Ear, nose & throat	98.9%	85.2%
Thoracic medicine	98.8%	87.0%
Geriatric medicine	98.4%	95.5%
Oral surgery	97.0%	83.5%
Neurology	96.1%	79.8%
Cardiology	95.0%	86.3%
Trauma & orthopaedics	94.8%	86.3%
Gastroenterology	94.7%	83.8%
Other	94.6%	91.0%
Urology	94.3%	87.2%
General Surgery	94.2%	88.9%

Three specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Dermatology	87.9%	89.1%
Ophthalmology	87.1%	89.2%
Rheumatology	86.2%	88.3%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for incomplete pathways was consistently better than the England overall performance. The latest figures for August 2018, showed 93.6% of this group of patients were treated within 18 weeks versus the England average of 86.8%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, The Dudley Group NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Fifteen specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General medicine	100.0%	92.7%
Geriatric medicine	99.4%	96.1%
Thoracic medicine	99.0%	88.8%
Ear, nose & throat	97.6%	84.8%
Trauma & orthopaedics	97.4%	82.1%
Rheumatology	97.1%	92.6%
Gastroenterology	96.7%	90.1%
Oral surgery	96.4%	84.5%
Other	96.4%	90.1%
Dermatology	95.8%	90.7%
Cardiology	94.9%	89.7%
Neurology	94.4%	87.3%
General surgery	92.8%	84.3%
Plastic surgery	91.5%	83.0%
Urology	89.7%	86.6%

One specialty was below the England average for incomplete pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Ophthalmology	83.2%	88.2%

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), The Dudley Group NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to

first definitive treatment (All cancers)

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), The Dudley Group NHS Foundation Trust
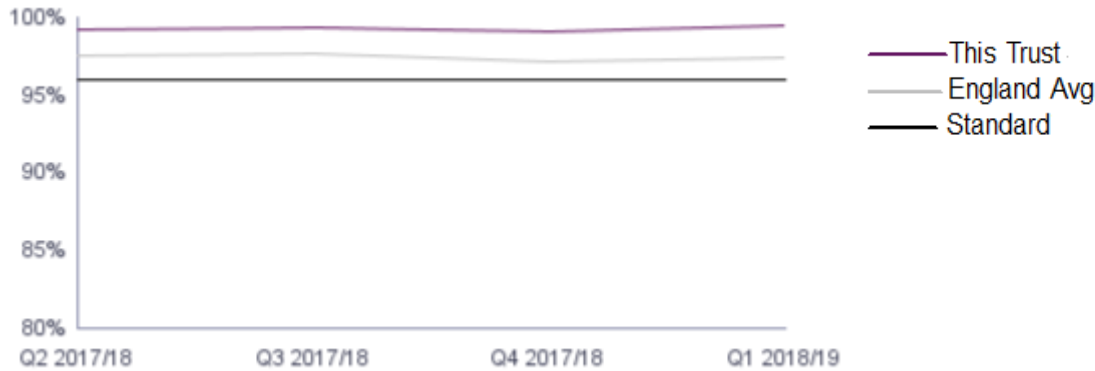

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust was performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance was better than the standard and England average from Q2 17/18 to Q4 17/18 but then dipped below the standard, although still above the England average, in Q1 18/19.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, The Dudley Group NHS Foundation Trust
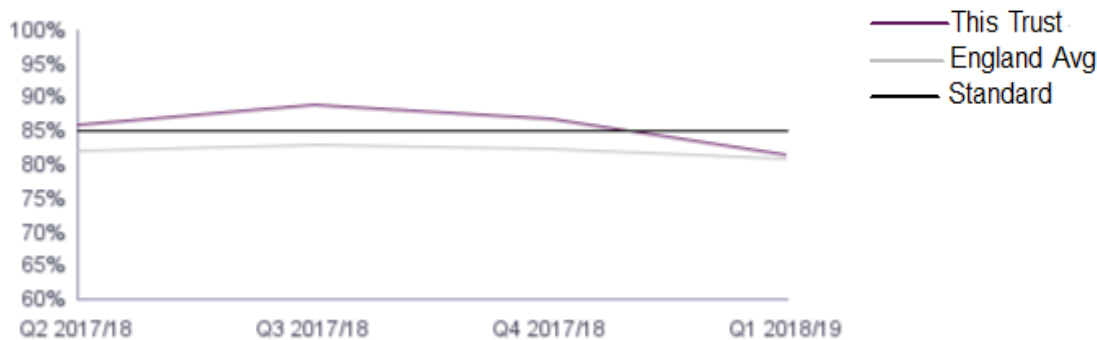
(Source: NHS England – Cancer Waits)

Did not attend rate

From July 2017 to June 2018 the 'did not attend' rate for Russells Hall Hospital was lower than the England average. The rate remained consistently lower than the England average, except for December 2017, where the rate was similar to the England average.

The chart below shows the 'did not attend' rate over time.

Proportion of patients who did not attend appointment, The Dudley Group NHS Foundation Trust.

(Source: Hospital Episode Statistics)

The department had introduced a text message service to support improving did not attend rates. If a patient did not attend an appointment the consultant made the decision around what happened next. The appointment reminder service cou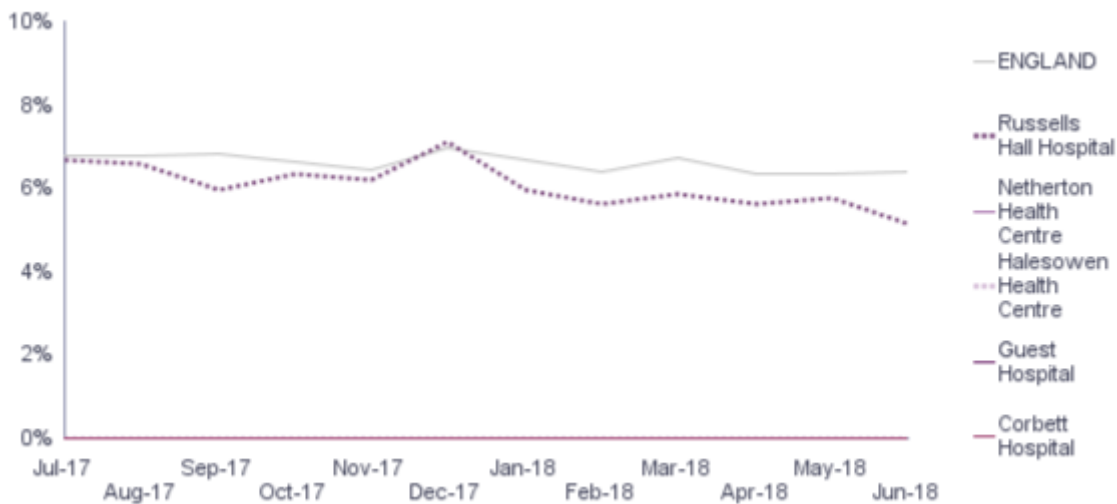ld be accessed via text or landline. Details of the service was displayed in the waiting area. Leaders told us all patients who did not attend were followed up. Reception staff told us doctors recorded the decision on an outcome form and this was returned to reception staff who would action.

Patient's described good communication including follow up letters. However, one patient raised concerns around communication between the clinic and their GP.

There was a referral to treatment action plan in ophthalmology with recommended actions such as upskilling theatre staff in ophthalmic surgery so ocular plastic cases would be moved into a separate theatre to generate more capacity for cataracts and to buy additional equipment.

The rheumatology department (who were below average for non-admitted pathways percentage within 18 weeks) had not met the target of 95% in August and September 2018 but had achieved the target in October, November and December 2018.

There was a choose and book system for outpatient appointments. Choose and book enables patients to choose the hospital they would like to attend and book a convenient date and time for their appointment.

On arrival patients presented to the main reception desk. Hospital volunteers waited near the main reception to direct patients to the correct area. There were several waiting areas depending on which clinic patients were waiting for. Nurses or clinical support workers called patients in for their appointment. The consultant or outpatients' booking team would make any further referrals. The hospital booking team were responsible to inform patients of any planned change of consultant.

Information boards advised patients to book in at the reception desk and displayed the name of key staff. Staff recorded consultant names and delays on an information board; recorded delays ranged from 15 minutes to an hour. There was an electronic board displaying details of clinics.

Leaders gave examples of when they had planned extra clinics to meet demand. For example, there had been a bowel cancer campaign. To ensure the service was prepared meetings took place beforehand and extra clinics were programmed, it was felt this had worked well.

The trauma and orthopaedic department held virtual fracture clinics. Leaders told us this had reduced hospital attendance and feedback had been positive. The ophthalmology department held virtual clinics for glaucoma.

In the phlebotomy department there was a number system a pager system alerted the phlebotomist when the next patient was due.

There was rapid access to appointments if needed. However, staff told us that the rapid access team would book an appointment, but the reception staff would not always receive the communication to alert them the patient was coming. This meant that staff may not have been prepared for the patients' arrival which could lead to confusion and delays for the patient.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared those with staff.

Summary of complaints

From October 2017 to September 2018 the trust received 56 complaints in relation to outpatients (11.4% of total complaints received by the trust). The main subjects of complaints were patient care (15) and communications (13).

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient care	15
Communications	13
Appointments	13
Values & behaviours (staff)	8
Other (specify in comments)	2
Access to treatment or drugs	1
Admissions and discharges (excluding delayed discharge due to absence of care package)	1
Waiting times	1
Prescribing	1
Transport (ambulances)	1
Total	**56**

For the 40 complaints that had been closed at the time of data submission, the trust took an average of 74.9 working days to investigate and close these. This was not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

The 16 complaints that had not yet been closed had been open for an average of 83.0 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 there were 234 compliments received for outpatients (3.4% of all received trust wide).

Compliments were received in all 12 months of the period. May 2018 was the month where the most compliments were received (47).

The trust reported key themes emerging from the compliments supported the information found in other surveys undertaken and included care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The trust looked at complaints in their entirety and produced an annual learning from complaints report. We reviewed the report and found it looked at complaints' numbers in comparison to other trust's, themes, if the complaint had been upheld, partially upheld or not upheld. It had information on complaints referred to the Parliamentary Health Service Ombudsman (PHSO). At the time of inspection leaders were unable to tell us what was being done to improve complaint response times.

We reviewed three recent complaints responses (August to December 2018) and found they had details of the investigation, an apology, when appropriate, patients were offered the opportunity to see a different consultant. Details of how to complain to the PHSO if they remained dissatisfied were included in the response. Leaders recognised the importance of good communication with patients who had made a complaint.

Information on how to make a complaint was readily available in waiting areas alongside details of the patient advice and liaison service (PALS). Complaints and compliments were an agenda item in confirm and challenge quality meetings and were discussed in weekly huddles. Staff were able to give examples of complaints and how practice had changed as a result. For example, one staff member told us that they used to get a lot of complaints about waiting times, it had been fed back to staff that they had forgotten to write clinic delays on the waiting room notice boards to keep patients updated. It was felt this had now improved delays were written on boards and staff would come out and let patients know of any delays.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The outpatients and ophthalmology department fell under the surgery, women and children division. The leadership structure included the chief of surgery, the director of operations, the divisional chief nurse, the matron and lead nurses. The matron had recently been appointed and it was felt the post was proving to be beneficial. Staff were positive about having a dedicated outpatient matron in post, telling us that they had previously felt there had been a lack of leadership and that outpatients had not been viewed as a priority by the trust. Leaders and staff rotated across all three hospital sites.

Leaders were able to understand the challenges to good quality care and identify actions needed to address them. Lead nurses completed assessments of the service including medications, resuscitation trolleys and availability of clinical notes.

Staff of all levels were clear about their roles, what they were accountable for and to whom.

We saw the leadership team were visible within the department and they interacted well with staff and patients. A notice board in the reception area had the name of shift leads. Staff spoke positively of the leadership team and felt they were approachable.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

There was an annual plan (2019/20) which incorporated the trust's six strategic objectives. The plan contained goals, key actions and timescales. Key actions included to develop a plan to improve and standardise the outpatient environment including reception and waiting areas, to implement an enhanced tracking system for health records and to continue two-way texting service. Leaders could discuss their vision for the department.

Staff adhered to trust values (providing caring services), this was demonstrated in the way they cared for patients. Feedback from patients showed a positive patient experience. Posters displaying trust values were displayed in waiting areas.

Culture

Managers across the service promoted a positive culture that supported and valued staff, created a sense of common purpose based on shared values.

Staff spoke of a supportive culture, which was open and where they felt confident to raise concerns; staff felt respected and valued. Staff spoke of enjoying their role in the department.

Staff were supported in progress through appraisals and other development opportunities. Mechanisms were in place to provide staff with the development they needed such as appraisals and development opportunities.

We observed cooperative, supportive and appreciative relationships among staff. Staff worked collaboratively. Leaders could provide an example of addressing behaviour inconsistent with trust values regardless of seniority.

Governance

There were examples of ineffective governance systems in some areas such as risk registers and audits.

Some areas of governance needed improvement. For example, risks had limited movement from the initial risk rating to the current risk rating. In the ophthalmology department we found that competencies, risk assessments and local rules were out of date.

There was a lack of effective systems of audit in some areas and a clear disconnect from what we were told and what data showed. For example, in relation to missing/unavailable patient notes staff told us there could be up to 60 sets of notes unavailable in any one-day and unavailable and missing files were one of the main incidents dealt with on reception. We asked for details of how many incidents had been raised about notes being unavailable for clinics in October, November and December 2018; the service reported there were 14 across all three sites. This meant there was a clear disconnect between the numbers of missing/unavailable notes staff were telling us about and the amounts actually recorded. Leaders recognised that staff would not have the time to complete incident reports for all missing and unavailable notes.

At the time of the inspection there were no quality dashboards in the outpatient's department, this would form part of an ongoing roll out of dashboards across the trust.

However, there was information on display in the staff room about who were the governance leads.

The monthly nursing governance section of the assurance report dated December 2018, contained information on formal complaints, compliments, trends and themes which included clinic waiting times, car parking and late arrival of doctors. These were included on the agenda within confirm and challenge quality meetings.

There were structures to ensure information was passed from ward to board and back again. The department held regular huddle meetings where issues such as compliments and complaints and learning from incidents were discussed.

Lead nurses reported into confirm and challenge meetings monthly. The divisional chief nurse led these. A presentation was produced for this including key areas relating to areas such as workforce, finances and quality and governance; the matron attended the meeting. Each department fed into their departmental governance meetings.

The directorate manager and chief nurse reported into the surgical divisional management team where they fed up risks from confirm and challenge meetings, governance and huddle meetings. Each speciality provided an update to the governance assurance meetings.

Presentations from key speakers were cascaded down to departments by the matron. The governance assurance meeting chair produced a highlight report which was presented to clinical quality, safety and patient experience committee (committee of the board).

Management of risk, issues and performance

The system had the processes to manage current and future performance and there was a system in place to identify, understand, monitor and manage current and future risks. However, risk registers showed limited movement.

There were departmental risk registers which identified many areas of risk we had identified during our inspection. However, there was limited movement from the initial risk rating to the current risk rating and it was not always clear which site the risks corresponded to. Risks recorded included the risk of delay in ophthalmology follow up appointments due to demand; the visual field room not being appropriately sized and quality dashboards not available for outpatient departments. Risk

registers contained details on the impact of risk, controls in place, the risk description but they also identified many gaps in control.

There were issues with the tracking of patient notes which were transported between the department and centre file where records were being stored. This had not yet been resolved. This meant staff often needed to make up temporary sets of notes until notes could be located. There were also issues around the collection of data of how often this happened. The outpatient's department mainly relied on paper records

Some areas were not audited or not audited effectively such as notes being unavailable for clinics, consent, and compliance with The National Institute for Health and Care Excellence (NICE) guidelines.

In the ophthalmology department local rules and risk assessments were out of date, this had not been identified by leaders.

Local rules were dated 2014 with no updates noted. Risk assessments for laser were completed in 2013 with laser competencies completed in 2010. This did not provide us with assurance that risk assessments were up to date and that patients were safe.

Electronic tagging which was being introduced to help with location tracking of patient notes, had not been implemented. Leaders recognised the risks within their department and could identify solutions. For example, leaders in ophthalmology discussed how a business case was being discussed around the redesign of the environment.

We saw an action plan had been introduced in ophthalmology to reduce the number of overdue follow ups and to implement more robust processes for monitoring.

Risks identified in matron's audits were discussed in confirm and challenge meetings in addition to updates on the risk register. We reviewed the minutes from a weekly huddle in January 2018 and saw leaders had told staff to see the poster in the staff room, so they know their risks.

Information management

The service did not always collect, analyse, manage and use information as well as it could to support all its activities.

Space was limited for the storage of patients notes. During our inspection leaders were meeting with estates to review the space available in Russells Hall Hospital reception. Notes were stored in small storage rooms with keypad entry. Limited space to secure patient notes securely was recognised as a risk on the outpatients' risk register. Empty cages to transport notes were left in patient waiting areas awaiting collection by porters.

On one occasion we noted a consultation room door was wedged open with a bin and patient details were visible. However, in most instances information on computers was kept secure. The ophthalmology department had notes cupboards with key pad entry.

There were issues around availability of notes and monitoring of this. Leaders told us that the patient access team had responsibility for monitoring this and that this was monitored monthly with temporary note figures reported each month if a clinic was delayed. If a clinic was delayed as a result of missing notes staff were required to submit an incident.

The service collected data and used it appropriately for example to produce assurance reports. Data was discussed in confirm and challenge meetings, assurance reports contained data on quality, governance, finance and workforce. Data collected included friends and family test results, complaints, outstanding follow up rates in ophthalmology and LoccSSips.

Engagement

The service engaged well with patients, staff the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There were various ways the service engaged with staff these included patient safety bulletins, trust governance newsletter, team briefs and emails.

"You said, we did" information was displayed in waiting areas. Patients' views were collected through family and friend's data.

Patient stories took place at board level.

The eye clinic liaison officer worked closely with the local authorities and was included of the patient experience committee who met on a fortnightly basis.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

A professor at the service had been trained to carry out flexible endoscopic treatment of Zenkers Diverticulum to treat patients with a pharyngeal pouch. The condition can lead to food entrapment, difficulty swallowing, a persistent cough and potentially aspiration phenomena. The condition was historically treated through the use of a rigid endoscope under general anaesthetic. The new technique entailed flexible endoscopy treatment performed as an outpatient. The procedure had an 80% success rate and was the subject for the Patient Story at the January 2019, board meeting.

The plastics department were taking part in research with another NHS trust around if an injection was as good and as safe as surgery in the correction of Dupuytren's contracture of the hand. At the time of the inspection the department was looking for participants age 18 years and older. The research had clear inclusion and exclusion criteria.

Leaders strived for continuous improvement; learning from incidents and complaints was embedded in the departments culture. This was evident in the department's incident reporting culture and aspirations. Staff were able to give examples of when practice had changed as a result of a complaint and there was evidence when things went wrong this was communicated effectively with staff.

Diagnostic imaging

Facts and data about this service

Diagnostic imaging is provided through a range of services on the three sites within the Trust:

Corbett Out-patient Centre

- Plain film – two X-ray rooms.

- Ultrasound imaging – one ultrasound room. The service provides musculo-skeletal to include both diagnostic and therapeutic, general, gynae and small parts scans.

- DEXA imaging (a test that measures bone mineral density) – one DEXA room.

Opening hours for all services are 8am to 5.30pm Monday to Friday.

Guest Out-patient Centre

- Plain film – one X-ray room. Opening hours are 8.30am to 5pm Monday to Friday.

- Ultrasound imaging - One ultrasound room. The service provides general, gynae and small parts scans. Opening hours are 8.30am to 5pm Monday to Friday.

- CT (computed tomography scan allows doctors to see inside the body. It uses a combination of X-rays and a computer to create pictures of the organs, bones, and other tissues) - One 64 slice CT scanner. Opening hours are 8am to 4pm Monday to Friday.

- MRI (Magnetic resonance imaging is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body). - One 1.5 MRI scanner (the most common magnet strengths in MRI machines used in clinical settings are 1.5T and 3.0T). Opening hours are 8am to 8pm Monday to Friday as well as ad hoc sessions on Saturday between 8.30am and 4.30pm as required.

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- Plain film – four X-ray rooms within the main imaging department with a further two dedicated x-ray rooms located within the emergency department. Provision of plain film X-ray is 24 hours a day seven days a week spread across the two areas as appropriate.

- Ultrasound - four ultrasound rooms within the main Imaging department with a satellite unit on the surgical assessment unit, through which emergency, inpatients and outpatients are scanned. The service provides musculo-skeletal, general, gynae and small parts scans. There are also two ultrasound machines within the vascular lab and five ultrasound machines within obstetrics. Opening hours are from 8.30am to 5pm Monday to Friday, with an on call service outside of these hours. Adhoc lists can be provided during evenings and weekends according to waiting list / demand.

- CT - two CT scanners, one 128 slice and one 64 slice, located within the main Imaging department. The service is moving towards having one dedicated machine for emergency and inpatients to improve patient flow and contribute towards reduced length of stay. Opening hours are from 8am to 8pm Monday to Friday, 8.30am to 4.30pm Saturday and Sunday with an on call service available outside of these hours.

- MRI - two scanners at the front of the hospital near the emergency department providing scans for emergency, inpatients and outpatients. MRI provision is currently 8am to 8pm seven days a week with no on call provision outside of these hours.

- Fluoroscopy (an X-ray procedure that makes it possible to see internal organs in motion). - two fluoroscopy rooms within the main imaging department, in addition to six mobile image intensifiers supporting theatres. Opening hours are 9am to 5pm Monday to Friday with image intensifiers used on an as and when required basis.

- Interventional (is a radiology specialty which provides minimally invasive image-guided diagnosis and treatment of disease) - one interventional theatre within the main Imaging department which is the Black Country hub for vascular patients. Opening hours are 8am to 5pm Monday to Friday, with an on call service outside of these hours. Case mix consists of both vascular and non-vascular patients and is also a hub for non-vascular patients across the Black Country on a rota basis.

- Nuclear Medicine (procedures are non-invasive and, with the exception of intravenous injections, are usually painless medical tests that help physicians diagnose and evaluate medical conditions. These imaging scans use radioactive materials called radiopharmaceuticals or radiotracers) - two nuclear medicine scanners, one of which has SPECT CT capability (a SPECT scan produces images that show how the organs work), within the main department. Opening hours are 9am to 5pm Monday to Friday. There is no on call service provided.

- Breast Imaging (symptomatic and screening) - two dedicated mammography X ray rooms and one dedicated breast ultrasound room within the main department. Opening hours 8:30am to 5pm Monday to Friday, 8.30am to 1pm on Saturday. Three mobile screening vans operate from 8.30am to 4.30pm Monday to Friday. This is provided by Dudley Group NHSFT with a SLA with a neighbouring trust; the service provides screening for the Dudley, Wolverhampton and South West Staffordshire population.

- Medical Illustration (a specialist profession supporting other healthcare professions within a medical environment).

(Source: Routine Provider Information Request (RPIR) Acute – Context tab, Routine Provider Information Request (RPIR) Universal – Sites tab)

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it. The trust set completion targets in line with other trusts nationally but medical, nursing and allied professional staff did not meet all of these targets.

Mandatory training completion rates

The trust set a target of 90% for the completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - adult	6	6	100.0%	90.0%	Yes
Information governance	6	6	100.0%	90.0%	Yes
Health & safety	6	6	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	6	6	100.0%	90.0%	Yes
Conflict resolution - level 1	6	6	100.0%	90.0%	Yes
Fire	5	6	83.3%	90.0%	No
Equality & diversity (including autism awareness)	5	6	83.3%	90.0%	No
Infection control - clinical	5	6	83.3%	90.0%	No
Manual handling (patient) / slips, trips & falls	4	6	66.7%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	2	3	66.7%	90.0%	No

In diagnostic imaging the trust had an overall mandatory training compliance rate of 89.5% for qualified nursing staff. The 90% trust target was met for five of the ten mandatory training modules for which qualified nursing staff were eligible.

It should be noted that the data for nursing staff refers to between three and six eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Information governance	19	19	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	19	19	100.0%	90.0%	Yes
Health & safety	19	19	100.0%	90.0%	Yes
Conflict resolution - level 1	19	19	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	17	19	89.5%	90.0%	No
Fire	17	19	89.5%	90.0%	No
Infection control - clinical	16	19	84.2%	90.0%	No
Resus - adult	16	19	84.2%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	3	4	75.0%	90.0%	No

In diagnostic imaging the trust had an overall mandatory training compliance rate of 92.9% for medical staff. The 90% target was met for four of the nine mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified allied health professionals in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Clinical governance (including incidents, complaints & claims investigations)	77	81	95.1%	90.0%	Yes
Health & safety	77	81	95.1%	90.0%	Yes
Equality & diversity (including autism awareness)	73	81	90.1%	90.0%	Yes
Conflict resolution - level 1	65	81	80.2%	90.0%	No
Information governance	65	81	80.2%	90.0%	No
Resus - adult	53	75	70.7%	90.0%	No
Fire	56	81	69.1%	90.0%	No
Manual handling (patient) / slips, trips & falls	52	76	68.4%	90.0%	No
Infection control - clinical	53	81	65.4%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	2	5	40.0%	90.0%	No

In diagnostic imaging the trust had an overall mandatory training compliance rate of 79.3% for qualified allied health professionals. The 90% target was met for three of the 10 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

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A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in diagnostic imaging at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	3	3	100.0%	90.0%	Yes
Resus - adult	3	3	100.0%	90.0%	Yes
Information governance	3	3	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	3	3	100.0%	90.0%	Yes
Conflict resolution - level 1	3	3	100.0%	90.0%	Yes
Infection control - clinical	3	3	100.0%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	2	3	66.7%	90.0%	No
Fire	2	3	66.7%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	2	3	66.7%	90.0%	No
Equality & diversity (including autism awareness)	2	3	66.7%	90.0%	No

In diagnostic imaging the 90% target was met for six of the 10 mandatory training modules for which qualified nursing staff at the hospital were eligible.

It should be noted the data only relates to three eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in diagnostic imaging at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - adult	3	3	100.0%	90.0%	Yes
Infection control - clinical	3	3	100.0%	90.0%	Yes
Health & safety	3	3	100.0%	90.0%	Yes
Conflict resolution - level 1	3	3	100.0%	90.0%	Yes
Manual handling (non-patient) / slips, trips & falls	3	3	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	3	3	100.0%	90.0%	Yes
Information governance	3	3	100.0%	90.0%	Yes
Fire	3	3	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	2	3	66.7%	90.0%	No

In diagnostic imaging the 90% target was met for eight of the nine mandatory training modules for which medical staff at the hospital were eligible.

It should be noted the data only relates to three eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified allied health professionals in diagnostic imaging at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Clinical governance (including incidents, complaints & claims investigations)	12	12	100.0%	90.0%	Yes
Health & safety	11	12	91.7%	90.0%	Yes
Information governance	9	12	75.0%	90.0%	No
Equality & diversity (including autism awareness)	9	12	75.0%	90.0%	No
Conflict resolution - level 1	8	12	66.7%	90.0%	No
Fire	7	12	58.3%	90.0%	No
Resus - adult	4	7	57.1%	90.0%	No
Infection control - clinical	6	12	50.0%	90.0%	No
Manual handling (patient) / slips, trips & falls	3	7	42.9%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	2	5	40.0%	90.0%	No

In diagnostic imaging the 90% target was met for two of the 10 mandatory training modules for which qualified allied health professionals at the hospital were eligible.

Training completion rates were particularly low for manual handling (patient) / slips, trips & falls (42.9%) and manual handling (non-patient) / slips, trips & falls modules (40.0%). However, it should be noted the data only relates to five or seven eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital / Corbett Hospital

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality & diversity (including autism awareness)	3	3	100.0%	90.0%	Yes
Information governance	3	3	100.0%	90.0%	Yes
Fire	3	3	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	3	3	100.0%	90.0%	Yes
Resus - adult	3	3	100.0%	90.0%	Yes
Conflict resolution - level 1	3	3	100.0%	90.0%	Yes
Health & safety	3	3	100.0%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	2	3	66.7%	90.0%	No
Infection control - clinical	2	3	66.7%	90.0%	No

In diagnostic imaging the 90% target was met for seven of the nine mandatory training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible.

It should be noted the data only relates to three eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Information governance	16	16	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	16	16	100.0%	90.0%	Yes
Health & safety	16	16	100.0%	90.0%	Yes
Conflict resolution - level 1	16	16	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	15	16	93.8%	90.0%	Yes
Fire	14	16	87.5%	90.0%	No
Infection control - clinical	13	16	81.3%	90.0%	No
Resus - adult	13	16	81.3%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	0	1	0.0%	90.0%	No

In diagnostic imaging the 90% target was met for five of the nine mandatory training modules for which medical staff at Russells Hall Hospital / Corbett Hospital were eligible.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified allied health professionals in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	66	69	95.7%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	65	69	94.2%	90.0%	Yes
Equality & diversity (including autism awareness)	64	69	92.8%	90.0%	Yes
Conflict resolution - level 1	57	69	82.6%	90.0%	No
Information governance	56	69	81.2%	90.0%	No
Resus - adult	49	68	72.1%	90.0%	No
Manual handling (patient) / slips, trips & falls	49	69	71.0%	90.0%	No
Fire	49	69	71.0%	90.0%	No
Infection control - clinical	47	69	68.1%	90.0%	No

In diagnostic imaging the 90% target was met for three of the nine mandatory training modules for which qualified allied health professionals at the hospital were eligible.

After our inspection visit we asked for updated figures for mandatory training for imaging staff at Russells Hall Hospital. This showed out of a possible thirteen mandatory training modules the trust target was met for only four, with manual handling, conflict resolution and mental health law achieving less than 70% compliance. Clinical governance, equality and diversity, fire and health and safety training modules achieved the 90% target.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The Russells Hall Hospital Diagnostic Imaging services treated patients under 18 years. The Guest Outpatient Centre did not treat children. The trust had appropriate child and vulnerable adult safeguarding arrangements in place.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April to September 2018 for qualified nursing staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P (workshop to raise awareness of Prevent)	6	6	100.0%	90.0%	Yes
Prevent (works to stop individuals from getting involved or supporting terrorism or extremist activity)	6	6	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	5	6	83.3%	90.0%	No
Safeguarding adults	5	6	83.3%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 91.7% for qualified nursing staff. The 90% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. All six eligible qualified nurses had completed WRAP and prevent training. However, only five of the six eligible qualified nurses had completed safeguarding children level 1 and 2 and safeguarding adults.

It should be noted that the data for nursing staff refers to six eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	19	19	100.0%	90.0%	Yes
Prevent	19	19	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	18	19	94.7%	90.0%	Yes

W R A P	16	19	84.2%	90.0%	No
Safeguarding children level 3	12	15	80.0%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 92.3% for medical staff. The 90% target was met for three of the five safeguarding training modules for which medical staff were eligible. Safeguarding adults and prevent training modules both had completion rates of 100.0%.

A breakdown of compliance for safeguarding training modules for qualified allied health professionals in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	76	80	95.0%	90.0%	Yes
Safeguarding adults	74	81	91.4%	90.0%	Yes
Safeguarding children level 1 & 2	74	81	91.4%	90.0%	Yes
W R A P	54	81	66.7%	90.0%	No
Safeguarding children level 3	11	18	61.1%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 84.8% for qualified allied health professionals. The 90% target was met for three of the five safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital

A breakdown of compliance for safeguarding training modules from April to September 2018 for qualified nursing staff in diagnostic imaging at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	3	3	100.0%	90.0%	Yes
Prevent	3	3	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	2	3	66.7%	90.0%	No
Safeguarding adults	2	3	66.7%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 83.3% for qualified nursing staff at Russells Hall Hospital. The 90% target was met for two of the four safeguarding training modules for which qualified nursing staff at the hospital were eligible. Prevent and WRAP training modules both had completion rates of 100.0%.

It should be noted that the data for nursing staff refers to three eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in diagnostic imaging at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	3	3	100.0%	90.0%	Yes
Prevent	3	3	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	3	3	100.0%	90.0%	Yes
W R A P	2	3	66.7%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 91.7% for medical staff at Russells Hall Hospital. The 90% target was met for three of the four safeguarding training modules for which medical staff at the hospital were eligible. Safeguarding adults, safeguarding children level 1 & 2 and prevent training modules all had completion rates of 100.0%.

It should be noted that the data for medical staff refers to three eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for safeguarding training modules from April to September 2018 for qualified allied health professionals in diagnostic imaging at Russells Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	10	11	90.9%	90.0%	Yes
Safeguarding children level 1 & 2	10	12	83.3%	90.0%	No
Safeguarding adults	9	12	75.0%	90.0%	No
W R A P	5	12	41.7%	90.0%	No
Safeguarding children level 3	0	1	0.0%	90.0%	No

In diagnostic imaging trust had an overall safeguarding training compliance rate of 70.8% for qualified allied health professionals at Russells Hall Hospital. The 90% target was met for one of the five safeguarding training modules for which qualified allied health professionals at the hospital were eligible.

These figures include staff working at The Guest Outpatient Centre as they moved between that service and Russell's Hall Hospital.

Russells Hall Hospital / Corbett Hospital

A breakdown of compliance for safeguarding training modules from April to September 2018 for qualified nursing staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	3	3	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	3	3	100.0%	90.0%	Yes
Prevent	3	3	100.0%	90.0%	Yes
Safeguarding adults	3	3	100.0%	90.0%	Yes

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 100.0% for qualified nursing staff at Russells Hall Hospital / Corbett Hospital with all staff having completed the relevant courses.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	16	16	100.0%	90.0%	Yes
Prevent	16	16	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	15	16	93.8%	90.0%	Yes
W R A P	14	16	87.5%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 92.4% for medical staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for three of the four safeguarding training modules for which medical staff were eligible. Safeguarding adults, prevent and safeguarding children level 1 & 2 training modules all had completion rates of 100.0%.

A breakdown of compliance for safeguarding training modules from April to September 2018 for qualified allied health professionals in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	66	69	95.7%	90.0%	Yes
Safeguarding adults	65	69	94.2%	90.0%	Yes
Safeguarding children level 1 & 2	64	69	92.8%	90.0%	Yes
W R A P	49	69	71.0%	90.0%	No
Safeguarding children level 3	11	17	64.7%	90.0%	No

In diagnostic imaging trust had an overall safeguarding training compliance rate of 87.0% for qualified allied health professionals at Russells Hall Hospital / Corbett Hospital. The 90% target

was met for three of the five safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We asked the trust for the position on mandatory training and safeguarding training compliance as of January 2018. Safeguarding adults training was at 80.9% and safeguarding children training was at 85.7% for all staff at Russells Hall Hospital. These are below the trust target of 90%.

All staff we spoke with were able to describe the safeguarding children and vulnerable adult responsibilities within their role. They all said they were confident that any concern they raised to a manager would be taken seriously and acted on appropriately. We saw no information on display to the public and patients about safeguarding.

Although children had to wait in close proximity to adult strangers in the cramped speciality waiting areas at Russells Hall Hospital for MRI, CT and ultra sound scans, staff told us there was a system in place for clinics to identify and give parents appointments for their children at the top of the list, morning or afternoon. If this was not possible they ensured they saw children very quickly after they arrived. We observed one paediatric patient arrive with their parent and sibling mid-morning and they went into the scanning room within ten minutes.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Diagnostic Imaging services environments within Russells Hall Hospital and the Guest Outpatient Centre were clean and uncluttered. Equipment, furniture and fittings were clean. We saw cleaning schedules on display and the service used the 'I am clean' sticker system. Staff wore personal protective equipment as appropriate to protect themselves and patients from infection. We saw these gloves and aprons easily available to staff in clinical areas. Staff kept their arms bare below the elbow.

We saw staff cleansing their hands regularly and there were hand cleansing gel dispensers on walls at appropriate intervals for staff, patients and visitors to use. Toilets and hand basins were clean and displayed notices about effective handwashing.

We did not see any patients or visitors using the hand cleansing gel at either site on the days we visited them. Reception staff did not prompt people to use them and this was a missed opportunity.

Environment and equipment

The service had suitable equipment and had recently invested in some new equipment and a refurbished outpatient centre at the Guest Hospital, and looked after it well.

The premises at Russells Hall Hospital were not large or spacious enough to deal with current patient demand and installation of new equipment had made this worse. The service was not up to date with the most recent ionising radiation regulations.

We saw resuscitation equipment was readily available, checked and re stocked regularly. One resuscitation trolley at Russells Hall Hospital Imaging service was in the MRI corridor and was not ideally situated; it restricted the potential emergency evacuation route. At the Guest Outpatient Centre, the trolley was in treatment room adjacent to the scanning and waiting rooms and patients would be brought to the trolley.

The trust had a contract in place to carry out checks and service all equipment. Staff told us contractors responded quickly if the trust called them out to repair any faults with machines

We saw the service handover documents for the new scanners dated 8 January 2019 signed off by the engineer and trust staff. There was a fault log in place and daily checks on machines, we saw checklists were completed.

At Russells Hall hospital imaging department the trust had recently replaced MRI scanners as part of the capital replacement programme. However, local managers told us the reconfiguration of space to accommodate this had resulted in a two foot reduction in the MRI corridor. This made it too narrow to safely accommodate a hospital bed along side chairs in a waiting queue that compromised flow through the passageway. Staff told us it also involved the decommissioning of the paediatrics waiting area, which had not been replaced. The trust told us there had never been a paediatric waiting area.

We heard conflicting information involving the decommissioning of the paediatrics waiting area, which staff told us, had not been replaced after the scanners were installed. The trust subsequently told us there had never been a paediatrics waiting room in the imaging department.

Much of the imaging department space was cramped. Although the general waiting area was large enough to accommodate a basic space for children at the back with a few toys, this meant children waited in close proximity to adult strangers when they moved along to the speciality waiting areas.

We observed inpatient and emergency department (ED) patients were brought to X- ray imaging services in chairs and trolleys that enabled imaging to take place without the patient experiencing further mobilising.

Out patients were provided with changing cubicles close to waiting areas and adjacent to Imaging rooms and there were safe systems in place to manage their clothes and other belongings.

We found policies and protocols associated with IR(ME)R and the updated IRR (2017) compliance was not updated. At the Russells Hall Hospital service they were widely not known by Radiographer staff when we spoke with them. Many staff we spoke with could not articulate who was the Radiation Protection Advisor or Radiation Protection Supervisor. Health and safety risk assessments in place were 2015 versions and not up to date. Radiation risk assessments were not up-to-date on either site.

At the Guest Outpatient Centre, the manager told us they had put in place the changes in the updated IRR (2017) although the trust polices and protocols had not been updated to meet them.

We saw rooms where ionizing radiation exposure occurred were clearly signposted with warning lights. Access was restricted by secure doors. A system of checking lead aprons for damage was in place. The service monitored staff for radiation exposure.

All X- ray rooms had system of work notices and controlled area signs in place to restrict patient access.

The service had 24 hour a day, seven days a week picture archive computer system (PACS). However local managers told us its storage capacity was exhausted and this was top of the

service' risk register. Problems in transfer of images, for example to other trust services had generated a number of incident reports during 2017/18. Impact on patients was being monitored and managed by the risk register. The trust told us a business case for an upgrade to the system was approved through directors on 19th September 2018 and subsequently at the Board on 4th October 2018. The department, in conjunction with IT and information governance were in the process of procuring the new system at the time of the inspection.

Assessing and responding to patient risk

There was no system in place to assess and monitor the condition of inpatients or emergency department patients as they attended Imaging services. The service had insufficient protocols in place to manage a deteriorating child or adult patient.

The interventional imaging service utilised a digital tool to support the detection and response to clinical deterioration of patients (EObs).

Beyond this, imaging services at the trust had no agreed and signed off protocol in place for managing a deteriorating adult or child. We raised this with the trust while we were on site. The trust took immediate action to develop them and sent us copies for assurance.

Although children were treated at Russells Hall Hospital Imaging services and there was a paediatrics resuscitation trolley, the trust did not provide staff with paediatric resuscitation training. The Guest Outpatient Centre did not treat children. Resuscitation training adults was only 70% compliant across all staff groups at Russell's Hall Hospital Imaging and the Guest Outpatient Centre.

We observed inpatients at Russell's Hall Hospital were subjected to a queuing system for 'general imaging' that required they waited on trolleys or hospital mobile chairs in the corridor outside of the X -ray rooms. Most were very frail elderly patients. They wore hospital gowns which for some (on chairs) meant their legs were bare and (on trolleys) parts of their chest and neck and shoulders were often bare where gowns had slipped.

The queuing system and restriction of space within the physical environment meant some patients lying on trolleys, including those asleep and those living with dementia were exposed to the draught of cool air moving through the corridor. One patient we spoke with told us they were being X- rayed to assess if they had pneumonia. These patients had no means of removing themselves from this situation or insisting on being provided with warmer clothing or a warmer environment.

We asked five inpatients in the waiting areas at different times of the day on 15 and 16 January 2019 if they felt sufficiently warm. Three patients told us they did not. We asked staff nearby on each occasion to get blankets for these patients which they immediately did. We were concerned this waiting system was the standard and routine approach used by the trust for inpatients to access imaging services.

On 15 January 2019 we stood and observed for 40 minutes the patient flow and access to the general X-ray rooms. It was very busy.

We saw most patients waited to access or to be collected from X- ray for about 20 minutes each. Most patients were frail and elderly and lying on bed trolleys; some had fluid drips and cannulas. Some patients we spoke with were living with dementia. Other patients in the queue were asleep. Most patients had no escort with them.

The corridor was busy with staff coming and going to and from the various imaging clinics. The X-ray staff were working from a nurse's station behind a wall in relation to these patients. They

therefore could not see them. There was no nursing supervision or accountability for these patients while they waited in that area. There was no method such as a call bells by which they could bring attention to themselves.

On the 15 January 2019 at 2.25pm we noted a patient appeared to show signs of pain. This became progressively worse and we intervened to raise a member of staff to attend to them. The manager for the general imaging area looked at them immediately, agreed the patient was not a 'good colour' and arranged for them to be returned to the ward immediately by porters, which they did.

The manager then telephoned the ward to tell them to expect the patient back as they were unwell. This was the usual procedure and the imaging department had insisted on a named nurse being identified on the patient's form from the ward in case they had to make a call to report a patient being returned was unwell.

We asked the manager why a patient at risk of deterioration would be left unsupervised in this way. The manager told us it was the responsibility of ward staff to assess the condition of a patient for X ray and if they needed an escort. Trust policy was a patient should not be allowed to leave a ward unaccompanied unless they were fit to do so.

The manager showed us a scanned copy of the form brought from the ward by the porter who collected the patient for the imaging appointment. It showed the ward nurse had ticked that this patient was fit to leave the ward without nursing supervision.

The manager also told us Imaging staff were nearby and constantly coming and going and 'keep an eye on ' patients waiting in the X-ray corridor. That was not what we observed as we saw staff constantly walking past patients on trolleys and in hospital mobile chairs without looking at them.

There was no system in place in the department to assess the condition of inpatients waiting to access imaging services or waiting to be taken back to their ward by porters. This meant, despite a ward leave form system for inpatients attending imaging, patients were at risk of any sudden deterioration in their condition while attending for imaging, going unnoticed for a time.

We reported this back to the trust executive team at the end of our inspection visit. The trust sent us an action plan for improvement of this situation the week following our visit. We remain in contact with the trust over this situation.

The service had appointed a radiation protection supervisor in each clinical area.

Radiographer managers told us intravenous (IV) contrast was given to patients only by a radiographer when there was medical cover available for example; there was always a doctor on site at the Guest Outpatient Centre.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below in diagnostic imaging;

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing staff	1.3	1.3	102.4%	1.3	1.3	102.4%

The trust reported a qualified nursing staffing level of 102.4% in diagnostic imaging in both March 2018 and September 2018, with an overfill of 0.03 WTE staff in both time periods.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported a vacancy rate of -2.4% for qualified nursing staff in diagnostic imaging. This was less than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 20.0% for qualified nursing staff in diagnostic imaging. This was greater than the trust's 8.5% turnover target. This relates to one member of qualified nursing staff leaving over the 12 month period.

It should be noted that the high rate for qualified nursing staff is partly due to the small number of nursing staff in diagnostic imaging so each leaver represents a large proportion of the total staffing level.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 3.6% for all staff in diagnostic imaging. This was just above the trust target for sickness of 3.5%.

For the same time period, the trust reported an overall sickness rate of 1.6% for qualified nursing staff in diagnostic imaging. This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From October 2017 to September 2018 the trust reported no nursing bank or agency use in diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below for diagnostic imaging;

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical staff	19.1	19.9	104.3%	22.3	18.1	81.3%

Staff fill rates for medical staff in September 2018 have seen a reduction from March 2018. There were 0.8 more WTE staff in post than planned for in March 2018; in September 2018 there were 4.2 less WTE staff in post than planned for.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 4.3% for medical staff in diagnostic imaging. This was less that the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 9.4% for medical staff in diagnostic imaging. This was greater than the trust's 8.5% turnover target. This relates to 1.6 members of medical staff leaving over the 12 month period.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 1.1% for medical staff in diagnostic imaging. This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From September 2017 to August 2018 the trust reported 4,579.0 of the 41,877.0 available medical staff hours were filled by bank staff (10.9%) and 1,212.3 hours were filled by locum staff (2.9%) in diagnostic imaging.

A breakdown of bank and locum usage in diagnostic imaging is shown below:

| Core service | September 2017 to August 2018 | | | | | | Total Hours |
| | Bank | | Locum | | Unfilled | | |
	Hours	%	Hours	%	Hours	%	
AC - Diagnostic imaging	4,579.0	10.9%	1,212.3	2.9%	0.0	0.0%	41,877.0

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Qualified allied health professionals staffing

Allied health professionals made up the largest group of staff in imaging services. The service did not have enough allied health staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment and this situation was deteriorating. Staffing issues represented a number of the key risks to the trust's quality improvement plans for 2019/20.

Total staffing: planned vs. actual

The trust reported their qualified allied health professional numbers for the two periods below in diagnostic imaging;

| Staff Group | March 2018 | | | September 2018 | | |
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified allied health professionals	97.3	75.0	77.1%	97.2	72.3	74.4%

The trust reported a qualified allied health professionals staffing level of 77.1% in diagnostic imaging in March 2018. This dropped to 74.4% in September 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

Staffing resources were not used effectively to ensure examinations are reported in an appropriate timeframe

From October 2017 to September 2018 the trust reported a vacancy rate of 22.5% for qualified allied health professionals in diagnostic imaging. This was greater than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Local managers told us during our inspection visit that staffing shortage was due to funding. The service was dependant on overtime spending to cover its needs. However the trust had recruited three new radiographers in the six months prior to our inspection.

The staff team rotated across three sites and had 17 vacancies, including health care assistants, at the time of our inspection. Radiographers told us the available reporting radiographers (diagnostic image interpretation and clinical reporting) were not allocated time to report on images and the numbers of reporting radiographers available could not meet the reporting demands of the service.

Turnover rates

From October 2017 to September 2018 the trust reported a turnover rate of 6.1% for qualified allied health professionals in diagnostic imaging. This was lower than the trust's 8.5% turnover target.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 3.8% for qualified allied health professionals in diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Local managers told us there were insufficient radiographers to meet the increasing demand of the service. The department had 15 when it needed 28. Staff told us maternity leave, sickness and difficulty in retaining MRI specialists for 12 hour shifts once they were trained (two at a time in the department) meant MRM and CT scan services at Russell's Hall Hospital depended heavily on overtime.

Overall the trust had identified staffing as a number of the key risks to it quality improvement plans for 2019/20:
- shortage of obstetrics and gynaecology ultrasound staff
- inability for radiology staff to fully implement the written evaluation policy of diagnostic images; lack of CT & MRI radiographers
- diagnostic standard at risk for imaging to support multiple pathways
- insufficient capacity of breast radiologists
- inability to support proposed ED opening times with the present staffing

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The Imaging service had access to the patient records they needed electronically. Within CT and MRI we saw radiographers were able to access patient records for bloods and previous imaging and documented blood results prior to administering contrast on referral forms, when indicated.

The trust told us it intended to upgrade the patient record system during 2018 but this had been put back to mid-2019 because of competing budget priorities.

For plain film X-ray, inpatient appointment forms from the ward were delivered to imaging staff by hand through porters and scanned into the patient's record.

Local managers told us the PACs system used to store and transmit images to other health providers was overloaded and unreliable. This was managed through the department risk register. A new system had been recently put on order to replace it.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

The imaging service used nuclear medicine and followed 'The Medicines Administration of Radioactive Substances Regulations 1978 (MARS)'. Radiographers held the keys to the drug cupboard. We saw that contrast media and other drugs were stored securely and correctly.

The service had put in place patient group directives (PGDs) for medicines used in imaging services. The radiographers we spoke with had a sound knowledge of the PGDs and all the medication they used.

The service had in place processes to ensure the right radio pharmaceutical was injected. This included the safety pause to check – right patient, right procedure, right medication.

Radiographers held appropriate certificates for administration of radioactive medicinal products including the certificate of competence in administering IV injections (accredited by the college of radiographers).

Incidents

The service managed reported patient safety incidents well. Although staff recognised incidents they did not always report them appropriately. Although managers investigated reported incidents lessons learned were not always shared with the whole team and the wider service. When things went wrong, staff did apologise and gave patients honest information and suitable support**.**

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018 the trust reported no incidents classified as never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from December 2017 to November 2018.

Both of these were diagnostic incidents including delay meeting SI criteria (including failure to act on test results) and resulted in unexpected / potentially avoidable injury causing serious harm. One incident occurred in July 2018 and one in August 2018.

(Source: Strategic Executive Information System (STEIS))

After our inspection visit we asked the trust to send us a copy of the root cause analysis (RCA) of an incident involving breast screening reporting it had recently submitted to the clinical

commissioning group (CCG). The trust told us, 'The RCA had been submitted to the Screening Commissioners (the incident management procedures oversight for NHS screening programme providers and commissioners) who have returned the document to the trust with queries. These queries are currently being answered by the trust; subsequently we do not have a final version of the document.

We followed an example of another incident under investigation and review through the trust's electronic reporting system and noted the process was thorough and timely. However, some radiologists/radiographers we spoke with were not confident in their explanation of how they would report incidents.

In line with Royal College of Radiologists recommendations there was a dedicated discrepancy lead consultant, who led regular discrepancy meetings with radiologists to facilitate collective learning from radiology discrepancies and errors and thereby improve patient safety.

Data sent to us by the trust showed imaging staff reported 32 extravasation incidents from 1 December 2017 to 31 December 2018. Contrast media extravasation (CMEV) refers to the leakage of contrast media from the normal intravascular compartment into surrounding soft tissues; It is a well-known complication of contrast-enhanced CT scanning. It can also occur in MRI studies, but the complications are rare given the low volume that is used.

However, we saw no patient outcome assessment of the frequency of this occurrence within the service or comparison with similar services.

The governance manager told us they were working to encourage staff to better identify and make incident reports so that quality themes could be recognised and addressed. For example, the incident we observed during our inspection of a deteriorating patient without supervision in the general X -ray corridor was not logged as an incident.

Safety thermometer

There is no recognised nationally recognised safety thermometer tool for outpatient services. However, the service did not collect or use any safety monitoring results.

Staff did not collect safety information nor shared it with staff, patients and visitors. Managers could not use safety monitoring results to improve the service.

We saw no safety thermometer data on display within imaging services neither at Russells Hall Hospital nor at the Guest Outpatient Centre. Local managers confirmed the trust did not expect them to collect this data and could give us no reason.

The trust had recently appointed a governance manager to work within imaging services to support the collection and use of safety and quality data. We spoke with them and could see this was a positive move that could benefit patients. However, they told us the trust needed to secure funds to establish this post beyond the current financial year.

Is the service effective?

Evidence-based care and treatment.

Although the service provided care and treatment based on national guidance and evidence of its effectiveness but it was not always up to date; it undertook some audit activity but checking was not done consistently. There was little activity of audit against NICE guidelines, measuring patient outcomes or bench marking against other providers.

Name	Status
Intravenous administration of Contrast Media for CT examination by Radiographer	Awaiting Ratification by Division
MRI Scanning for Patients with Cardiac Implantable Electronic Devices (Pacemakers and Implantable Cardiac Defibrillators)	Awaiting Ratification by Department
Standing Spine SOP	Awaiting Ratification by Division
Diagnostic Images Written Evaluation SOP	Active
Radiology LocSSIP SOP	Active

We requested a list of Standard Operating Procedures (SOP) for Radiology. The above table is what the trust sent us. It shows three out of five SOP were not signed off by the trust at the time of our inspection.

We found overall a lack of documentation and little evidence of local policies specific to MRI. For example although we saw systems of work and contingency plans and information for pregnant staff, MRI authorised personnel lists needed to be updated and what existed had not been signed off.

We found the authorisation guidelines within interventional radiology were in keeping with the Ionising Radiation (Medical Exposure) Regulations 2017(IR(ME)R), rather than the NICE guidelines. We noted the interventional radiology modality did have authorisation guidelines in place including for paediatrics, patient preparation and clinical indication.
After our inspection the trust told us, 'all interventional procedures meeting NICE approval guidelines are initially subject to review by the the internal new interventions group and risk assurance committee, secondary to this, authorisation guidelines within interventional radiology ensure legal compliance with IR(ME)R 2017.'

'Pause and check' signage was on display in Imaging rooms to remind staff. The service checked six points of identification and used the society of radiographer's guidelines. We saw examples of radiographers also routinely checking each referral form/letter from GP's and consultants to confirm the imaging request was appropriate for the diagnostic sought.

IR(ME)R (2017) replaced the 2000 regulations (including amendments made in 2006 and 2011). However, we found the regulations available to staff at Russells Hall Hospital and the Guest Outpatient Centre were the 2000 regulations (and 2006 and 2011 amendments). Staff confirmed the trust had undertaken no update of its processes in line with the 2017 regulations. We raised this with the executive team at the end of our inspection visit. The trust informed us the following week that procedures and risk assessments had been re written and we found these were in line with the 2017 regulations.

Radiation protection audit forms were available for each area to use but the process was not standardised.

The department did not participate in the imaging Services Accreditation Scheme (ISAS). There was no lead person for reviewing and circulating changes to National Institute for Health and Care Excellence (NICE) guidance. The trust has commented since our inspection visit, 'although there was not a lead person responsible for NICE guidance, there is a clear process in place and this is monitored via the divisional governance structure. To strengthen this internal, it has been included in the job description for the departmental governance role.' We noted the departmental governance role was just a few weeks in existence at the time of our inspection visit.

We noted that local diagnostic reference levels (DRLs) were in place and displayed in X-ray rooms, as evidence of service improvements in patient radiation protection. CT authorising guidelines were in place to reflect current accepted practice and local service provision in accordance with IR(ME)R. However, there was no evidence of version control on the CT patient safety questionnaire document. Managers told us the CT questionnaire was under review for wording and version. There was gatekeeping in place to manage CT pathways within the service. This was undertaken by an experienced CT manager.

There was documented evidenced in the governance meeting minutes that the newly appointed clinical governance manager had begun to implement staff feedback on adverse events and lesson learned. Staff reviewed discrepancies and adverse events and learned from them. The discrepancy lead led regular discrepancy meetings to improve outcomes for patients. The clinical audit lead was a consultant radiologist.

The trust had an adult observational policy in place that incorporated the national early warning score (NEWS). NEWS is a guide used in clinical settings to help standardise the assessment and response to acute illness. However, the NEWS was not in use within the Imaging department except in interventional radiology as this is the basis of electronic observation tool.

There were few examples of regular audit undertaken and these were local audits mostly in interventional radiology services.

We saw that actions had been put into place because of the audit such as an emergency audit for diabetes in interventional radiology. This found radiologists were not informing nurses or doctors about patients' diabetes. The action to improve practice was the nurse became responsible for checking a patient's status and adding this to the world health organisation (WHO) checklist; a time and motion audit was presented in December 2018. This indicated delay in theatre was contributed to by porters and consultants not being included in the team.

An audit was undertaken for service improvement. Audit actions were to improve the scheduling of interventional cases and to maintain on-call (after 5pm) examinations for emergency rather than elective cases. There was an on call audit undertaken by location, cases and referrers. Local managers told us, as a vascular centre, they wanted to review by site the number of vascular cases performed after 5pm- that is 'on call'. They found the cases were from elective lists that had overrun the list planned time and that had not in fact been requested 'on call'. The agreed action for improvement was consultants would review if cases were appropriate for on call cases.

Nutrition and hydration

Food and drink was not conveniently available to patients while they visited imaging services.

There were no drinking or eating facilities within or near the Imaging departments at Russells Hall Hospital.

Carers accompanying outpatients who depended on the NHS transport services, told us reception staff at Russells Hall Hospital, provided hot drinks for patients who were waiting over long to get home.

Pain relief

With the exception of interventional Imaging, staff did not always assess and monitor patients to see if they were in pain. Subsequently they did not always support those unable to communicate using suitable assessment tools and give additional pain relief to ease pain.

The trust had in place inpatient (Acute) pain guideline for adults and these were applied trust wide across services.

These guidelines included use of the Abbey Pain Score for patients with dementia. The Abbey Pain Scale is a standardised pain assessment tool developed for use in non-verbal patients with dementia, a group believed to be nationally under-treated for pain. A standardised tool may help improve management. We asked some staff working within X- ray imaging if they had any tool available to assess pain in inpatients living with dementia and they said they did not.

Imaging services at Russells Hall Hospital treated children. Staff were not aware of trust guidelines for pain in children and these were not among the procedures and guidelines we were given when we asked for them. The trust later told us; 'There are 3 ratified guidelines within the Trust for managing pain in children; 'Acute Pain in Children (management of)', PCA/NCA pain management in children guideline', and 'pain management after surgery (children) - leaflet.'

Patient outcomes

Managers did not monitor the effectiveness of care and treatment or use the findings to improve care. The trust did not compare local results with those of other services to learn from them.

We did not hear or see any evidence of sufficient measurement of patient outcomes for imaging services. We asked the trust to send us details after our inspection visit but we received no further information. The trust subsequently sent us the following statement, 'we have a number of [outcome measures] an example of this would be all patients attending for MSK (musculoskeletal) therapeutic ultrasound are given a pain diary to complete and return. Radiologists conduct patient satisfaction audits. Audit of histology versus ultrasound diagnosis for biopsies and fine needle aspirations are just some examples of patient outcome related audits that are carried out by the audit team.'

An MRI Superintendent told us the newly commissioned MRI scanner did not have the software needed to support an MRI cardiac service, they had not been advised by senior managers when this would we made available. This lack of software had a detrimental effect on the patient waiting lists for cardiac MRI. Cardiology had no post processing software so the trust was unable to report.
The trust subsequently told us, 'there was adequate cardiac software available in relation to post processing in MRI, however, the consultants in cardiology desired an upgraded package for which they had to produce and deliver a business case. It is important to note that this software was

purchased additional by cardiology in the first instance and was not part of the MRI replacement programme.'

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The department provided professional training for MRI radiographers. We observed student radiographers working alongside and being taught by those who were qualified. Those we spoke with were vague about their induction process and sign off for duties. The trust later informed us 'the training provided by the trust is observational so they do not have to be signed off in MRI. They are there in an observational capacity - if they chose to work in MRI on completion of their degree further training with signed off competencies is provided.'

We noted from a sample of records non-medical referrers for example, stroke nurses were requesting imaging within their scope of practice. In keeping with IR(ME)R, a document was evidenced of the non-medical referrers and their scope of practice which radiographers could use to identify what examinations could be requested.

There was evidence of advanced practice within the radiology service as there were ten reporting radiographers. However, due to a shortage of clinical radiographers the reporting radiographers did not have 'protected' reporting times and were often 'pulled' from this duty to support in a clinical capacity.

In accordance with MRI safety guidelines the MRI department must have a list of the authorised personnel described either by name or by occupation. The document we were shown was incomplete and lacked version control.

Medical physics expert (MPE) services were available to the radiology services to provide optimisation of dose and radiation protection advice. Clinical leads of the radiology departments told us the MPE service was readily accessible for support and guidance.

Appraisal rates

For year to date, April to September 2018, 92.6% of required staff in diagnostic imaging received an appraisal compared to the trust target of 90.0%.

A breakdown of appraisal completion by staff group for April to September 2018 is shown below:

Staff group	Individuals required	Appraisals completed	Completion rate	Trust Target	Target met
Support to doctors and nursing staff	5	5	100.0%	90.0%	Yes
Qualified healthcare scientists	23	5	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	5	23	100.0%	90.0%	Yes
NHS infrastructure support	27	28	96.4%	90.0%	Yes
Qualified allied health professionals	75	81	92.6%	90.0%	Yes
Support to ST&T staff	28	34	82.4%	90.0%	No
Total	**176**	**163**	**92.6%**	**90.0%**	**Yes**

All staff aside from support to ST&T staff met the 90.0% target. Last year (April 2017 to March 2018) 64.7% of all staff in diagnostic imaging received an appraisal.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Russell's Hall Hospital

For year to date, April to September 2018, 94.3% of required staff within diagnostic imaging at Russells Hall Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified healthcare scientists	23	23	100.0%	90.0%	Yes
Support to doctors and nursing staff	4	4	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	3	3	100.0%	90.0%	Yes
Support to ST&T staff	10	11	90.9%	90.0%	Yes
Qualified allied health professionals	10	12	83.3%	90.0%	No
Total	**50**	**53**	**94.3%**	**90.0%**	Yes

All staff aside from qualified allied health professionals met the 90.0% target. Last year (April 2017 to March 2018) 63.4% of all staff in diagnostic imaging at the hospital received an appraisal. Only three members of staff at Russells Hall Hospital had not had an appraisal.

Russells Hall Hospital / Corbett Hospital

For year to date, April to September 2018, 91.9% of required staff within diagnostic imaging at Russells Hall Hospital / Corbett Hospital received an appraisal compared to the trust target of 90%. This had improved from the previous year.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to doctors and nursing staff	1	1	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	2	2	100.0%	90.0%	Yes
NHS infrastructure support	27	28	96.4%	90.0%	Yes
Qualified allied health professionals	65	69	94.2%	90.0%	Yes
Support to ST&T staff	18	23	78.3%	90.0%	No

Total	113	123	91.9%	90.0%	No

Last year (April 2017 to March 2018) 65.9% of all staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital received an appraisal.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

The department undertook cannulation audits every January to check staff competence. Staff told us it was difficult for them to take advantage of continuing professional development opportunities because of the shortage of staff in the service.

However, we asked the trust to give us information on staff professional development and it sent us the table below for 2018/19.

Examples of programmes-initiatives to invest in improving skills among staff and leaders in the imaging services during 2018-19		
2018	Updating best ultrasound practice (paediatric hips)	1 x Staff
2018	Foetal Growth Scans Conference in Milan	2 x Staff
2018	Introduction to MRI	2 x Staff
2018	MRI in Practice	1 x Staff
2018	Cannulation Course	1 x Staff
2019	Cannulation Course	2 x Staff
2018	Introduction into Cranial CT reporting	1 x Staff
2018	Managing workplace behaviour	1 x Staff
2018	Trained Midwives in ultrasound to carry out foetal growth scans (Certificate in Ultrasound Practice)	4 x Staff
2019	To train Midwife in ultrasound to carry out foetal growth scans (Certificate in Ultrasound Practice)	1 x Staff
2018-19	SVT Ultrasound qualification	1 x Staff
2019	Vascular ultrasound course	1 x Staff
2019	Reporting module for nuclear medicine	1 x Staff

2018	Leadership Course	2 x Staff
2019	Leadership Course	3 x Staff
2018	Health Equalities in Breast Screening	2 x Staff
2019	Supported Breast Screening Manager through MBA	1 x Staff

Multidisciplinary working

Staff of different professions worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

We observed staff in a variety of roles and levels working well together. Radiologists, radiographers, nurses and other healthcare professionals and secretarial and reception staff supported each other to provide good care.

The trust had identified some shortfall in communication between theatres and radiography staff that resulted in delayed procedures. It had taken steps to improve this.

Seven-day services

Some services were offered outside of average office working hours and on Saturday mornings.

The core service times were Monday to Friday between 8/8.30 am to 4.30/5pm at Russell's Hall Hospital and the Guest Outpatient Centre,

Russell's Hall Hospital additionally provided:
- Plain film X-ray 24 hours a day, seven days a week spread across the general X- ray and emergency department as appropriate. Plain film, theatres and mobile X- ray were covered by a 24/7 rostered shift. There was a second on call service available to support during the night if the department becomes busy to ensure timely access to imaging.
- CT scanners available from 8am to 8pm Monday to Friday, 8.30am to 4.30pm Saturday and Sunday with an on call service available outside of these hours.
- MRI provision 8am to 8pm seven days a week with no on call provision outside of these hours.
- Breast imaging (symptomatic and screening) 8:30am to 5pm Monday to Friday, 8.30am to 1pm on Saturday.

Health promotion

We saw little active health promotion by way of general healthy living advice and support to patients.

The patient information service at Russells Hall Hospital provided information on health conditions, treatments and services. Some health promotional leaflets were available on the trust's web site related to specific conditions such as diabetes. We saw smoking cessation posters and leaflets in the main reception areas.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Mental Capacity Act and Deprivation of Liberty training completion

From April to September 2018, the trust reported that Mental Capacity Act (MCA) training was completed by 80.0% of all staff in diagnostic imaging compared to the trust target of 90.0%.

Within professional groupings, qualified nursing staff did not meet the 90.0% target for MCA training with a completion rate of 66.7%. It should be noted that the data for nursing staff refers to three eligible staff and so the performance should be taken in context when dealing with small numbers of eligible staff.

However both allied health professionals and medical staff met the trust target for MCA training with a completion rate of 100.0%. It should be noted that the data for allied health professionals and medical staff refers to one member of eligible staff each and so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Radiographers we spoke with told us they were involved in 'best interest meetings' for patients without capacity to make decisions. Nurses were able to give us examples of how the service respectfully managed patients who became non-compliant with treatment.

Staff confirmed consultants did not proceed with interventional procedures when they were not assured the patient fully understood what they were consenting to.

Staff obtained consent for imaging at the clinic appointment. Staff checked with the patient they had confirmed consent before continuing with any diagnostic procedures. For general anaesthetic cases, formal consent was taken.

We saw staff asking patients if they knew what they were there for, explaining to patients what they were planning to do and obtaining the patient's consent before continuing with examinations. All children and young people we saw were accompanied by adults.

Compassionate care

Although feedback from patients was that staff treated them well and with kindness, some institutionalised systems had a negative impact on patient's dignity and privacy.

All of the patients and accompanying visitors we spoke with told us all staff treated them warmly and kindly. We saw staff of all professions and ancillary staff approaching people who appeared unsure of their way and offering help. Staff maintained a warm and cheerful disposition in their contact with patients.

We observed at the general imaging reception desk at Russells Hall Hospital imaging service patients were able to speak with reception staff without being overheard. However, the sub reception area for MRI and CT scanning was a shared and cramped waiting space in which it was very difficult for staff to protect the privacy of a verbal exchange. We overheard the safety questionnaire put to an MRI patient and so did everyone else in the waiting area. Staff told us a reduction in this space had come about since two new scanners were installed in December 2018.

Patients were informed they could ask for a chaperone but this was not always appropriate for imaging services where radiation exposure risk was kept to a minimum.

There were privacy blinds on the two-way windows between the control room and the scanner room for certain procedures.

Staff we spoke with demonstrated a non-judgemental attitude in conversation about mental ill health, learning disability, autism and dementia. Staff were able to describe examples of how they positively responded to patients who might be frightened, confused or phobic about imaging procedures.

However we also found at Russell's Hall Hospital inpatients were subjected to a queuing system for 'general imaging' that required they waited on trolleys or hospital mobile chairs in the corridor outside of the X- ray rooms. We saw most were very frail elderly patients. They wore hospital gowns which for some (on chairs) meant their legs and arms were bare to view and (on trolleys) their chest and neck and shoulders were bare to view where gowns had slipped.

The queuing system and restrictions of space within the physical environment meant some patients lying on trolleys, including those asleep and those living with dementia were exposed to the constant gaze of other patients, who waited on seating in the adjacent general waiting area of the imaging department. These patients had compromised means of removing themselves from this situation or insisting on being provided with more privacy.

We also saw patients brought from the ED were left sitting in hospital mobile chairs in hospital gowns in the corridor outside ultrasound rooms with parts of their naked backs and their naked legs on view to other patients and a full visitors waiting in the adjacent seating area.

This had a detrimental impact on the dignity of and respect for the most vulnerable of the trust's patients.

We observed for 45 mins on 15 January 2019 and noted the system remained in place on the morning and afternoon of 16 January 2019. This was the standard and routine system for inpatients to access imaging services. Managers told us this situation occurred through lack of space in the department. They said they worked well with portering services to move flow as quickly as possible to get patients to the department very close to their appointment time and then back to their ward. We noted the turnaround time for most patients we observed was about 20

mins, but for patient it was nearly 40 minutes, most of which was spent waiting in the corridor. Managers also said this matter had been on the departmental risk register but was closed off when mitigation to restrict use of a set of corridor doors to the main hospital was put in place. This did not address the privacy issue effectively. We asked to see the imaging services risk register and this was not an entry.

We saw staff escorted outpatients to cubicles very close to the appropriate waiting area and imaging room for their appointment and gave them clear instructions of what to do. They provided clean hospital gowns for each patient and gave them a standard bright yellow polythene hold-all for their own clothes and belongings.

However sub waiting areas were cramped. Men, women and children sat together in outdoor clothes or in hospital gowns in Russells Hall Hospital. We did not see children wearing hospital gowns during our inspection visits. We did see two children with their parents in the cramped ultra sound waiting area near another adult who was vomiting.

The Guest Outpatient Centre had a similar mixed sex secondary waiting arrangement, although not cramped and this service did not treat children. Patients we asked on the morning we visited told us they did not mind the mixed sex arrangement. The third waiting area outside of the scanning rooms was visible to patients waiting for outpatients clinics outside of the Imaging suite. We saw all outpatients were dressed in hospital gowns at this stage of their wait for imaging services in readiness for the scan. Two patients wore a dressing gown and they told us their outpatient appointment letter had advised them to bring one. Most patients we saw did not bring a robe or dressing gown.

We raised this with the trust executive at the end of our inspection visit. On the week following our visit the trust sent us an action plan to improve the mixed sex changing and waiting situations on both sites. We will remain in contact with the trust about this issue.

Emotional support

Staff provided emotional support to patients to minimise their distress.

We saw examples of staff taking extra time with people who were nervous of their imaging tests. Staff demonstrated an awareness and understanding of patients with complex and additional needs.

Chaplains were available 24 hours a day, seven days a week. They represented different denominations and had contact with all the major faith communities.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We observed staff provided out patients and relatives/carers with appropriate listening time to ensure patients understood what they were there for and felt comfortable proceeding with their treatment.

We saw examples of staff working alongside a patient's relatives and friends to carry out their diagnostic tests with the minimum of distress.

However, the trust did not undertake any observation audits to look at the interactions between staff and their most vulnerable patients.

Is the service responsive?

Service delivery to meet the needs of local people

Shortage of a consistent staff group with the appropriate qualifications and some poor systems of communication was a challenge. This frustrated the trust's plans to provide services in a way that met the needs of local people because of delays in reporting diagnostic images and the high costs of contracting out much of the reporting.

The trust is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest. Imaging services across three sites including Russells Hall Hospital (main site) and the Guest Outpatients Centre support outpatients departments that treat 500,000 and an emergency department that treats almost 100,000 patients in a year.

Local managers told us the imaging services that Russells Hall Hospital had doubled in size since 1995. The trust had also opened a new outpatient centre at the Guest Hospital in 2017.

There was a breast imaging (symptomatic and screening) service at Russells Hall Hospital. This had a waiting area separated from the main areas of the department, with its own reception and secretarial staff. However staff told us there was a shortage of staff to respond to the demands on this service. The trust has since told us, 'the trust had completed prior to the inspection visit a staffing review in breast screening and a subsequent business case had been completed and approved in principle by NHS England in December 2018 - the business case was fully approved in January/February 2019'

There was an insufficient number of radiologists and radiographer staff that were qualified to interpret and report on images. This is a national issue. To mitigate the impact the trust was outsourcing to ensure timely reporting.

The trust has commented since our visit, 'KPI's (key performance indicators) were being met for a number of modalities as evidenced by DM01 performance and internal KPI's for the emergency department and inpatient service.' We did not receive data to support this.

We found some poor communication was causing some difficulties for patients on occasion. For example, an evening cardiology list had been scheduled but no cardiologist was available. This meant five patients appointments needed to be rescheduled. Those patients had to wait a further 2/3 weeks.

The trust was reviewing staffing levels within the diagnostic imaging services to meet the current demand for services. This could include providing sufficient staff at the right level of qualification to run further lists out of The Guest Outpatient Centre which, had capacity.

Meeting people's individual needs

The service took account of individual needs of some patients but those inpatients living with dementia were not well supported.

Imaging services at Russells Hall Hospital and The Guest Outpatient Centre were accessible to people with physical disabilities.

The trust had a learning disability lead nurse. Staff we spoke with knew who this was and confirmed she would be involved for any patients with learning disabilities needs from the start of their contact with the service liaising with staff about a forthcoming admission or appointment.

Staff gave us an account for example, of a patient who would have panicked by coming through main entrance and reception with other people around. The service therefore arranged for this patient to be driven to the back of the Guest Outpatient Centre where they came into a quieter environment and this worked well.

However most patients living with dementia came from inpatient wards in Russells Hall Hospital. We saw no evidence within the imaging department of a support scheme, for example the Butterfly scheme to provide a system of hospital care for people living with dementia or who simply find that their memory is not as reliable as it used to be. We observed these patients attending X- ray, were not usually with a carer or member of staff.

Diagnostic staff identified patients who needed extra support, such as patients in the last 12 months of their lives through the referral system and met these patient needs through systems such as prioritising more urgent referrals.

Language line was available for patients whose first language was not English. Staff told us however, they tended to rely on other staff or family members for interpretation. This is not good practice.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to diagnostic testing were not all in line with good practice. On site waiting was efficiently managed.

The imaging department at Russells Hall Hospital and services at the Guest Outpatient Centre were accessible to people with mobility impairment. Car parking was close to both sites and they were served by public transport networks. The service provided for urgent appointments and escalated reporting times where necessary.

The imaging service risk register showed the diagnostic standard (DS) at risk due to continuing demand for imaging to support multiple pathways. This could mean excessive waiting times for patients with potential to impact on both 18 week and cancer treatment times. The trust attributed this to difficulties in recruiting to key posts but had with rolling adverts out for such staff.

At the time of our inspection the waiting lists for three key diagnostic tests had breached the standard. These were paediatrics anesthetic cases, (children who needed a general anaesthetic to safely undertake the imaging process) which were six months behind and cardiac MRI, which were six months behind.

Community outpatient services had been set up at the Guest Outpatient Centre, a recently refurbished facility which housed an MRI scanner and a CT scanner. The manager told us there was no CT waiting list over two weeks and by the time of our inspection the Centre had doubled its workload and turnaround since re opening.

Diagnostic waiting times (percent waiting 6+ weeks)

From September 2017 to August 2018 the percentage of patients waiting more than six weeks to see a clinician was consistently lower than the England average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England.

The chart below shows 6+ weeks percentages over time
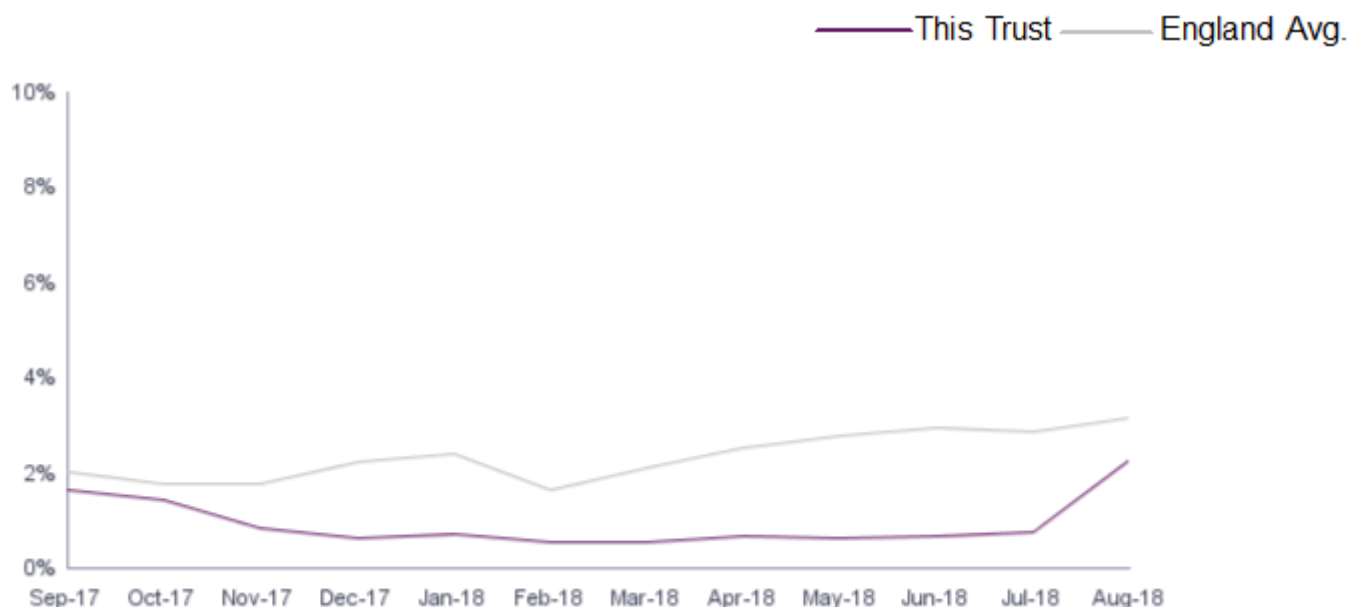
(Source: NHS England – Diagnostic Waits)

However, this position changed after August 2018. We asked the trust to send us data for their waiting times for each modality as at end of December 2018. The data is shown in the table below and is trust wide:

Modality	Inpatient (Days)	Outpatient (Weeks)	GP Direct Access (Weeks)
Angiography	4	7 (20)	N/A
Mammography	0	4	N/A
CT	1	7	7
Fluoroscopy	5	3 (11)	3 (11)
MRI	3	7	7
Cardiac MRI	N/A	11	N/A
Paeds GA MRI	N/A	47 (57)	N/A
Nuclear Medicine	0	15 (29)	N/A
Radiology (Plain film)	1	6	6
Radiology (DEXA)	N/A	8	8
Non-obstetric Ultrasound	0	8	8

The trust explained, the first numbers in the table above are the true waiting times for patients referred to these services. Where there are numbers in brackets, these indicate the longest waiters within this modality but there have been exceptional reasons for patients waiting that duration, for example, they require special arrangements such as sedation, one or more appointments were cancelled by the patient or during part of their wait they were admitted to hospital.

This shows inpatient demand for imaging (where relevant) were responded to within one day for X- ray and CT scan with MRI, angiography and fluoroscopy between three to five days wait. For outpatients, with the exception of mammography, fluoroscopy and plain film X- ray all other modalities were in breach of the NHS Diagnostic Standard.

The trust put in place a recovery plan in August 2018 to respond to the beginning of a rise in wait times with a recovery target to 99% to be achieved by December 2018. However it acknowledged 'There remains the issue of the GA and sedation MRI waiting lists which may grow to levels that mean the overall target is unachievable'.

Local managers we spoke with during our inspection visit were clear the cause lay with the trust decision to replace both MRI scanners in autumn 2018 and the subsequent safety limitations of the temporary mobile units. This accounted for the spikes for Cardiac MRI, paediatrics sedation MRI and Nuclear Medicine waiting times which had not reduced in January 2019.

Reporting on images created a challenge for the trust. Managers told us all outpatient image reporting was sent out of the trust if it remained outstanding after one week. Specialist Imaging requiring discussion at an MDT e.g. rapid access were not outsourced. Trust data of breakdown of incidents reports for Imaging service January 2018 to December 2019 showed (total number of incidents reported 314) by far the highest number were delayed diagnosis (42 reported incidents); delay in obtaining test (19); delay in receipt of test results (11); delay in care and treatment (12).

Inpatient imaging was reported in house by radiologists and there were ten radiographers qualified to do this. Local managers viewed this as having a negative impact on patient flow.

The trust imaging reporting standards performance - exam to reported target percentage for patient type for modality CT, MRI, non-obstetrics ultrasound and radiology were

A & E attender   90% for 7 days
GP direct access patient 90% for 10 days
In patient   90% for one day
Outpatient   90% for 10 days.

The trust reported to us after the inspection it has achieved its DM01 (times and activity data set), for nine out of the previous 12 months and overall improved its postion.

On site waiting was efficiently managed. We followed six inpatients accessing general X- ray services at Russell's Hall Hospital. We saw that all but one, arrived by porter from their ward had their imaging appointment and returned to the ward within approximately 30 minutes. The X- ray service had effective logistics, working closely with porters to ensure patients did not arrive too early or stay longer than necessary in a very tight waiting space.

We noted over the two days of our inspection visit, the general (initial) large waiting area for imaging services rarely had more than four patients waiting to be directed on to the speciality waiting areas for their appointments.

During the morning we visited the Guest Outpatient Centre we found it busy but well organised and the logistics overseen by a health care assistant. This included when patients had to spend two hours in waiting areas because two measures of fluid intake was necessary for their scan.

Did not attend rates (DNA) rates ran at an average of 5% during 2018/19. Only the MRI service had a two way text message reminder service in place for patient appointments.

Out of hours service

The department provided an out-of-hours service for patients with an urgent need who could not wait until opening hours. Staff provided a 24 hour on call service.

The main reasons radiographers were called included supporting theatre overrunning. Staff told us theatres overrunning was not technically an out of hours call, however it was not usual to be called out for this reason.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. These were not always shared with all staff.

Summary of complaints

From October 2017 to September 2018 the trust received nine complaints in relation to diagnostic services (1.8% of total complaints received by the trust). Diagnosis and tests was the main subject of complaint, with five of the nine complaints relating to this. Patient care was the main subject of two of the nine complaints.

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Other (Diagnosis and tests)	5
Patient Care	2
Values & behaviours (staff)	1
Communications	1
Total	**9**

For the eight complaints that had been closed at the time of data submission, the trust took an average of 69.8 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40-day working days. Two of the nine complaints were closed within the 40-day target.

The one complaint that had not yet been closed had been open for 28 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From October 2017 to September 2018 the trust received 38 compliments about for diagnostic imaging (0.6% of all received trust wide).

Compliments were received in all 12 months of the period. November 2017 was the month where the most compliments were received with seven.

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

Some staff we spoke with told us they were not able to attend staff meeting where learning from complaints was discussed.

We saw no information displayed within the imaging department about how to feedback a concern, complaint, comment or compliment within Imaging services. There was a large PALS sail banner on display at the main reception to the hospital.

Is the service well-led?

Leadership

Managers at all levels in the trust did not have the right skills and abilities to run Imaging services and provide high-quality sustainable care. Local leaders were not aware of all the risks and challenges in the service. Managers and clinical leads did not have oversight of the overall quality of the service provided. There was no effective line of sight from the Board to the imaging department.

During our inspection visit we found no clarity in the management arrangements and governance structure for imaging services within the trust structure. The imaging department was managed by the clinical support services manager. We asked the trust to provide us with information about the governance structure of the imaging services but we received little clarity beyond an imaging governance group authorised by the clinical support services governance group.

Leaders were not driving effective change. There was no grip. They had not implemented new IR(ME)R (2017) regulations. Senior staff did not have effective arrangements in place to maintain and improve the performance of staff so that the trust achieved its goals and staff were developed.

Staff rotated between the Russells Hall Hospital, the Corbett Hospital and the Guest Outpatient Centre. However, managers and clinical leads did not have oversight of the overall quality of the service provided. For example, local leaders told us they were not aware of the lack of understanding of the new IR(ME)R (2017) regulations, we found existed among staff. Staff told us there was a lack of staff training, development and overall support.

After our inspection the trust told us 'training for IRR and IR(ME)R regulations was provided in November 2017, delivered by Medical Physics Expert. This training was aligned to the 2017 regulations inacted in February 2018.' The trust sent us the training programme however we do not know which or how many staff attended this training.

Staff confirmed the trust had undertaken no update to its processes in line with the Ionising Radiation (Medical Exposure) Regulations 2017. This project had been delegated to one of the Radiation Protection Supervisors who became absent from work for a period and none of the other Radiation Protection Supervisors were asked to pick this up.

Quality assurance was patchy and left to the efforts of individual staff within modalities. There was no overall approach or accountability. For example, there was no lead person for reviewing and circulating changes to National Institute for Health and Care Excellence (NICE) guidance or formulating a programme of clinical audit or of consistent local audit across the department.

Trust leaders were not visible. Local leaders were not clear about the boundaries of their roles and responsibilities beyond their clinical practice. For example, some local leaders although responsible for services at another trust location were vague about their accountability.

Vision and strategy

The service had a vision for what it wanted to achieve in imaging services but workable plans to turn it into action were not developed with sufficient involvement from staff, patients, and key groups representing the local community.

The trust told us its vision, values and strategic objectives were as follows:

- The trust vision was: trusted to provide safe, caring and effective services because people matter.

- The trust values were: care, respect and responsibility

The trust had six strategic objectives which were:
- Deliver a great patient experience
- Be the place people choose to work
- Deliver safe and caring services
- Make the best use of what we have
- Drive service improvement, innovation & transformation;
- Deliver a viable future.

We noted the trust's vision and values were not clearly displayed within imaging services. Staff we spoke with did not articulate a clear vision and set of values. There little understanding among staff of a coherent strategy for the imaging services beyond providing further lists at the Guest Outpatient Centre and a reduction of expenditure on contracting out imaging reporting.

The trust did have a plan for 2018/19 and 2019/20 for imaging services which were aligned to the values and objectives. A number of projects had been brought forward from 2018/19 and this suggested some drag on momentum. These were; radiology machine utilisation; replace computed radiography with digital radiography; imaging staffing review (radiologist reporting efficiency four eyes intelligence - reduce outsourcing).

New schemes identified for 2019/20 included: a two-way text reminder service for other radiology modules (this already existed for MRI); purchase of iRefer by the CCG; reduce inappropriate referrals by 40-50%; reduction in scans required by 40-50%; reduce sonographer overtime, bank and agency usage; consider purchasing iRefer for DGFT to improve utilisation for all imaging diagnostic modalities; electronic vetting and booking of radiology requests; CRIS upgrade (date & cost was unconfirmed). Efficiency gains, increase in slot utilisation, dates and costs of clinical equipment refreshment programme and reduction in paper use were identified as not yet established.

The trust had invested in high cost equipment renewal and replacement in 2018 and a refurbished outpatient centre in 2017. However, the view of staff was new imaging equipment at Russells Hall Hospital had been installed without proper consultation with local leaders and staff and this had led to compromised quality for privacy and dignity of patients. The Guest Outpatient Centre could not run to capacity until sufficient numbers of appropriately qualified staff were appointed. The trust told us, 'It was never expected that the Guest would run at capacity at the current point in time, as level of growth of the service had to be realised therefore, recruitment to vacancies had been purposely staggered recognising the fact that training would be required for relevant individuals.'

Culture

Managers did not consistently promote a positive culture that supported and valued staff in imaging services, creating a sense of common purpose based on shared values.

Staff were patient focussed and the culture centred on the needs of the patients. For example, staff would often work over their contracted hours to support theatre lists overrunning.

There were cooperative, supportive and effective relationships within the teams and with other specialist services. However, there was also a culture of senior allied health care staff feeling they had to take home governance tasks and do them in their own time. Staff resented this and much governance work had been left undone. The trust has told us that staff were always paid for hours they worked.

The small sample of staff we spoke with held contradictory views about the culture of the imaging department. Some said it was supportive and helpful, encouraged openness and transparency and leaders understood the importance of staff being able to raise concerns without a culture of blame. Others said there was a culture of management bullying, wide spread nepotism and fear of speaking up.

Staff told us the monthly staff meeting and the modality lead meetings were poorly attended. There was a culture of experiencing 'ground hog day' with plans going in circles and always sticking on staffing shortage and poor staff retention in key roles. Some local managers described the service as a training stream for radiographers, who would then move on to other trusts.

The trust has commented ' there are ongoing competency documents to support development of band 5 to band 6 in CT/MRI and interventional radiology. Radiographers are trained to move to Mammography and the majority of the Sonographer workforce have been trained inhouse to suport RCOG guidelines and DM01. Appraisal rate within the department was compliant with the Trust target of 90%, within the appraisal and Personal Development plan is developed in conjunction between the line manager and staff member to support staff development'

Staff we spoke with demonstrated the importance of being open and honest with patients when something went wrong.

Governance

The service did not use a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish in imaging services.

Local managers acknowledged governance arrangements within the service had not been robust. Governance tasks had been divided among specialist imaging practitioner managers. They were optimistic about the new post of governance manager which was only three months old and not yet secured by funding. Local managers believed this would make a very positive difference.

An imaging governance group had been constituted as recently as November 2018. This included a range of Imaging managers, supervisors, superintendents and advisors from within the department and intended to meet 12 times each year. The group was authorised by the clinical support services governance group 'to investigate any activity within its terms of reference' and was expected to make recommendations to the clinical support services governance group. It was too soon to judge the effectiveness of this arrangement.

At the time of our inspection some imaging modality leads undertook some clinical and local audits while others did not. There was no clear expectation from the trust. There was no quality and

safety dashboard in place and no evidence of structured scrutiny of data until the recent arrival of a risk governance manager. Consultant radiologists advised clinicians through the MDT meetings of long waiting times where they existed, but no one at any higher leadership level within the trust appeared to be taking any ownership of this problem.

We saw some evidence of staff meeting minutes within CT services but they were relevant only to CT radiographers and there was no evidence of information being fed in from other areas of the radiology service or governance. The new risk governance manager did produce evidence that they were starting to feed information about quality and safety into staff meetings.

Staff meetings were poorly attended. We noted from minutes of staff meetings across the different modalities there was no standing agenda. This meant no consistency of communication across the department. Some staff we spoke with told us they were never able to attend staff meetings and this was where any learning from incidents and complaints was discussed.

Management of risk, issues and performance

The service did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected in imaging services. This was in the process of changing at the time of our inspection.

The trust kept a risk register for imaging services. The trust's strategy for diagnostic imaging services 2019/20 directed that risks should be identified for each new project and added to department risk register. We noted the risk register contained no dates whatever and in this respect was not fit as a working document. We also noted it was not up to date as the highest risk, the use of mobile scanners for five months in 2018 while new ones were installed at Russells Hall Hospital, no longer applied.

The trust had recently created the post of risk governance manager for the service. The governance manager told us they would be taking an overview of incident reporting. They were anticipating the use of a software quality management system to look at compliance and complaints and make use of the performance data the trust collected about the service.

During our inspection we found a number of areas where the trust was not proactively managing risk in imaging services. We found for example no protocol in place for managing a deteriorating child or adult patient, no medical supervision of very vulnerable inpatients waiting in corridors for their imaging appointments, IR(ME)R regulations had updated in 2017 but trust policies and procedures and risk assessments not updated.

We found no effective escalation process in place, for example oversight of medical wards practice of sending inpatients unescorted to imaging services when they may not be fit to be left alone in a corridor. This was contrary to trust policy.

However, action plans were put in place to address each of these issues within days of our verbal feedback to the Executive. We will remain in contact with the trust over these matters.

Information management

The service did not always collect, analyse, managed and use information well to support all its activities, using secure electronic systems with security safeguards.

Managers did not demonstrate a holistic understanding of performance which looked at people's views with information on quality, operations and finance.

All staff had access to the trusts computer systems, where they could access policies and procedures and standard operating procedures relating to their role.

However, we saw a list of patient names on display on a computer monitor in an X- ray room visible from the open door to the corridor and adjacent waiting area. Staff told us it was not possible to minimise the screen and the monitor did not default to a screen saver. It was the practice to leave the door open to demonstrate the room was not occupied. We raised this with the local manager at the time of our inspection visit and they undertook to improve it.

Engagement

The service did not always engage well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There were some examples of positive and collaborative relationships with external partners to build a shared understanding of challenges within the system, the interventional imaging service was the Black Country hub for vascular patients; the breast imaging (symptomatic and screening) services had a service level agreement with a neighbouring trust and provided screening for the Dudley, Wolverhampton and South West Staffordshire population.

However, we saw little evidence of staff engagement, for example local leaders in imaging told us they felt the trust had carried out ineffective consultation with them over the scanner replacement project. This led to errors and risks that may have been avoided or better controlled. The trust refuted this and subsequently assured us it had consulted local leaders. However, we could see no reference to it within the DGT strategy refresh feedback matrix 2017/18 that the trust sent us as evidence of this consultation.

We found no examples of strategic patient engagement in imaging services. At a local level we saw Friend and Family Test cards and boxes in place for patients to use but we did not see reception staff encouraging patients to use them and this was a missed opportunity.

Learning, continuous improvement and innovation

Although the service had identified key objectives for imaging services, it was not committed to improving imaging services by strategic learning from when things went well and when they went wrong, promoting training, research and innovation.

Imaging services learned from exception reporting but there was no comprehensive plan of audit in place to drive improvement and recognise excellence. Training opportunities were hampered by less than optimum staffing levels. We were offered no examples of innovation and no one we spoke with made any reference to research.

The trust had supported five staff from imaging through leadership courses during 2018/19

For 2019/20 the trust had identified six key objectives for imaging services:

- Increase ED radiology opening hours review (evening and weekends) – deliver a great patient experience, deliver safe and caring services and decrease LOS.
- Reduce out-sourcing of reporting (STP procurement) – drive service improvement, deliver viable future and make the best use of what we have
- Upgrade for PACS – deliver a viable future and make the best use of what we have.
- Clinical equipment replacement programme – deliver safe and caring services, drive service improvement, innovation and transformation and be the place people choose to work.
- Improve CT & MRI accessibility for in-patient requests (re-align to business model) – deliver safe and caring services, deliver a great patient experience and deliver a viable future.
- Electronic booking & CRIS upgrade – deliver a great patient experience, drive service improvement, innovation and transformation, make the best use of what we have & deliver a viable future.

Acute services

Corbett Hospital

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Stourbridge
West Midlands
DY84HZ

Tel: 01384566111

www.dgoh.nhs.uk

Surgery

Facts and data about this service

The Dudley Group NHS Foundation Trust has 214 surgical inpatient beds across eight wards:

Ward/unit	Speciality or description	Inpatient beds
East B2 – Trauma	Trauma and orthopaedics	24
East B2 - Hip fracture	Orthopaedic trauma and hip suite	30
East B1 – Elective	Elective orthopaedics	26
East B3	Vascular and general surgery ward	42
West B4	General and colorectal surgery / elective surgery	48
West B5	General surgery and gynaecology	12
Surgical Assessment Unit (SAU)	Surgical assessment and surgical ambulatory emergency care unit	12
West C6	Urology and general surgery	20

The service's theatre suite comprises 10 main operating theatres, including one dedicated emergency theatre and one dedicated trauma theatre, four day case theatres on the Russells Hall Hospital Site, and a day case theatre on the Corbett Hospital site.

The trust has a dedicated day surgery unit on the Russells Hall Hospital site.

The trust also has a specialist operating theatre in the x-ray department where certain vascular operations are performed. At Corbett Outpatient Centre, a standalone day case unit provides a service for minor orthopaedic and dental procedures. The patients recovered from surgery on the unit itself unless they could leave immediately post-surgery.

The main surgical specialities provided are:

- General surgery
- Vascular surgery
- Orthopaedics and trauma
- Gynaecology
- Urology
- Plastic surgery
- Ear, nose and throat surgery
- Maxillofacial surgery

The trust also provides paediatric surgery in general surgery, trauma and orthopaedics, ear, nose and throat, oral and maxillofacial surgery, plastics, ophthalmology and orthodontics.

(Source: Routine Provider Information Request (RPIR) Sites tab, acute RPIR context acute tab and trust website)

The trust had 33,662 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 9,366 (27.8%), 20,496 (60.9%) were day case, and the remaining 3,800 (11.3%) were elective.

(Source: Hospital Episode Statistics)

Surgery is provided at Corbett Hospital, it is for people of all ages. It is a day case surgery unit with no overnight beds. It has one operating theatre with one recovery area. From the 1 January to 31 December 2018 they saw 5,505 patients.

We inspected the whole core service as part of the routine comprehensive inspection cycle. Whilst on inspection we spoke with 22 people including; five patients, eight nurses, two consultants, two clinical support workers, a radiographer, a matron, the director of operations, the chief of surgery and the divisional chief nurse.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it.

Mandatory training completion rates

Trust wide

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual handling (non-patient) / slips, trips & falls	5	5	100.0%	90.0%	Yes
Health & safety	300	307	97.7%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	288	307	93.8%	90.0%	Yes
Equality & diversity (including autism awareness)	285	307	92.8%	90.0%	Yes
Conflict resolution - level 1	279	306	91.2%	90.0%	Yes
Infection control – clinical	268	307	87.3%	90.0%	No
Resus – adult	262	306	85.6%	90.0%	No
Information governance	259	307	84.4%	90.0%	No
Fire	253	307	82.4%	90.0%	No
Resus – paediatric	33	41	80.5%	90.0%	No
Manual handling (patient) / slips, trips & falls	232	302	76.8%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 87.9% for qualified nursing staff. The 90% target was met for five of the 11 mandatory training modules for which qualified nursing staff were eligible.

Manual handling (non-patient) / slips, trips & falls was the only training module with a completion rate of 100.0% although the data only relates to five eligible staff so the performance should be taken in context when dealing with small numbers of eligible staff.

A breakdown of compliance for mandatory training courses from April to September 2018 at trust level for medical staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	132	140	94.3%	90.0%	Yes
Equality & diversity (including autism awareness)	127	140	90.7%	90.0%	Yes
Information governance	122	140	87.1%	90.0%	No
Clinical governance (including incidents, complaints & claims investigations)	118	140	84.3%	90.0%	No
Fire	113	140	80.7%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	111	140	79.3%	90.0%	No
Resus – adult	110	140	78.6%	90.0%	No
Resus – paediatric	39	50	78.0%	90.0%	No
Conflict resolution - level 1	109	140	77.9%	90.0%	No
Infection control – clinical	101	140	72.1%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 82.6% for medical staff. The 90% target was met for two of the 10 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital / Corbett Hospital

A breakdown of compliance for mandatory training courses from April to September 2018 at Russells Hall Hospital / Corbett Hospital for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Information governance	9	9	100.0%	90.0%	Yes
Resus – adult	9	9	100.0%	90.0%	Yes
Infection control – clinical	9	9	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	9	9	100.0%	90.0%	Yes
Conflict resolution - level 1	9	9	100.0%	90.0%	Yes
Health & safety	9	9	100.0%	90.0%	Yes
Fire	8	9	88.9%	90.0%	No

Equality & diversity (including autism awareness)	8	9	88.9%	90.0%	No
Manual handling (patient) / slips, trips & falls	7	9	77.8%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 95.1% for qualified nursing staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for six of the nine mandatory training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible. These six modules all had completion rates of 100.0%.

In surgery post inspection we requested the data for mandatory training for Nursing staff from October to December 2018. The trust then had an overall compliance rate of 91.6% for qualified nursing staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for six of the nine mandatory training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible. The trust did not meet the target for Information Governance (85%), Fire (75%) and Manual handling (patient) / slips, trips & falls (84.2%).

It should be noted that the data for nursing staff refers to nine eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff. These staff were all within the Corbett Day Case Theatre team.

A breakdown of compliance for mandatory training courses from April to September 2018 at Russells Hall Hospital / Corbett Hospital for medical staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus – paediatric	4	5	80.0%	90.0%	No
Fire	6	8	75.0%	90.0%	No
Infection control – clinical	6	8	75.0%	90.0%	No
Information governance	6	8	75.0%	90.0%	No
Conflict resolution - level 1	6	8	75.0%	90.0%	No
Clinical governance (including incidents, complaints & claims investigations)	6	8	75.0%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	6	8	75.0%	90.0%	No
Equality & diversity (including autism awareness)	6	8	75.0%	90.0%	No
Health & safety	6	8	75.0%	90.0%	No
Resus – adult	5	8	62.5%	90.0%	No

In surgery the trust had an overall mandatory training compliance rate of 74.0% for medical staff at Russells Hall Hospital / Corbett Hospital. The 90% target was not met for any of the 10 mandatory training modules for which medical staff at Russells Hall Hospital /Corbett Hospital were eligible.

In surgery post inspection we requested the data for mandatory training for medical staff from October to December 2018. The trust then had an overall compliance rate of 89% for qualified medical staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for three of the ten mandatory training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible and did not drop below 80% on any of the modules. The trust did not meet the target for Infection control – clinical (83.8%), Information governance (89.2%), Conflict resolution – level 1 (83.8%), Clinical governance (including incidents, complaints & claims investigations) (86.4%), Equality & diversity (including autism awareness) (86.5%), Health and safety (89.2%), Resus – adult (81.1%).

It should be noted that the data for medical staff refers to five to eight eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff. These staff were all within the ENT team.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The hospital had a clear system in place for ensuring staff received mandatory training. Nursing staff were sent an email when they were due for mandatory training and the ward sister was also made aware. Mandatory training data was also displayed in the staff room so staff members were reminded if mandatory training was due. If bank nursing staff dropped below 85% mandatory training completion shifts could be cancelled so this encouraged staff to complete mandatory training.

All staff we spoke with at Corbett Hospital told us mandatory training was of a good quality. Most training was delivered by e-learning and some training courses were face to face.

Staff at Corbett Hospital sometimes struggled to access face to face mandatory training. The hospital delivered most face to face training at Russells Hall Hospital which meant that staff members from Corbett hospital had to drive to and from the Russel Hall Hospital which meant staff would need to be released for a much longer period of time.

Staff received mandatory training in sepsis and the e-observation system. All nursing staff received training in sepsis as an integral part of their resuscitation training. As of January 2019, 91.7% of nursing staff at Corbett Hospital had completed this training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training completion rates

Trust wide

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules for qualified nursing staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	301	307	98.0%	90.0%	Yes
Safeguarding children level 1 & 2	273	292	93.5%	90.0%	Yes
Safeguarding adults	278	307	90.6%	90.0%	Yes
W R A P	277	307	90.2%	90.0%	Yes
Safeguarding children level 3	20	24	83.3%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 92.9% for qualified nursing staff. The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in surgery is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding children level 3	69	73	94.5%	90.0%	Yes
Prevent	131	140	93.6%	90.0%	Yes
Safeguarding children level 1 & 2	127	140	90.7%	90.0%	Yes
Safeguarding adults	125	140	89.3%	90.0%	No
W R A P	108	140	77.1%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 88.5% for medical staff. The 90% target was met for three of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital / Corbett Hospital

A breakdown of compliance for safeguarding training courses for qualified nursing staff in surgery at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	9	9	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	9	9	100.0%	90.0%	Yes
Prevent	9	9	100.0%	90.0%	Yes
Safeguarding adults	8	9	89.9%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 97.2% for qualified nursing staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for three of the four safeguarding training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible. The completion rates for these was 100.0%.

In surgery post inspection we requested the data for mandatory training for nursing staff from October to December 2018. The trust then had an overall safeguarding training compliance rate of 97.5% for qualified nursing staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for all four of the safeguarding training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible.

It should be noted that the data for nursing staff refers to nine eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff. These staff were all within the Corbett Day Case Theatre team.

A breakdown of compliance for safeguarding training courses from April to September 2018 for medical staff in surgery at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	6	8	75.0%	90.0%	No
Prevent	6	8	75.0%	90.0%	No
Safeguarding adults	6	8	75.0%	90.0%	No
Safeguarding children level 1 & 2	6	8	75.0%	90.0%	No
Safeguarding children level 3	5	7	71.4%	90.0%	No

In surgery the trust had an overall safeguarding training compliance rate of 74.4% for medical staff at Russells Hall Hospital / Corbett Hospital. The 90% target was not met for any of the five safeguarding training modules for which medical staff at Russells Hall Hospital / Corbett Hospital were eligible.

In surgery post inspection we requested the data for mandatory training for medical staff from October to December 2018. The trust then had an overall safeguarding training compliance rate of 90.7% for medical staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for two out of five of the safeguarding training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible and did not drop below 80% on any of the modules. The trust did not meet the target for Safeguarding adults (86.5%), Safeguarding children 1 & 2 (86.5%), Safeguarding children level 3 (80.6%).

It should be noted that the data for medical staff refers to between seven and eight eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff. These staff were all within the ENT team.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The hospital had the systems and processes in place to keep people safe and these systems were communicated to staff. Nursing staff had good access to safeguarding training and were able to

demonstrate their knowledge of safeguarding. The trust processes were in place and embedded amongst the staff group. The unit offered a chaperone service to patients if they felt like they needed it.

Staff members could recognise signs of abuse and knew the process to follow if abuse was disclosed or suspected. Different staff were also to provide several examples where they had recognised signs of potential patient abuse or neglect and went through the safeguarding process. Staff at the day case unit had received positive feedback from the safeguarding team for how they dealt with safeguarding issues. Staff could access the specialist safeguarding team via a hub on the internal intranet. Staff told us they could access this service is they needed additional support.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The ward and theatres were visibly clean. The hospital did monthly cleaning audits to assess the results, the average score between July and December 2018 for the ward was 97%. The most recent cleaning audit score was displayed in the waiting room on an information board. There were 'I am clean' stickers with recent dates on visible on most machines within the ward. Patients who attended the hospital regularly for appointments told us that the hospital was always clean. Housekeeping staff completed and signed and cleaning records on a daily basis.

Staff at the unit ensured standards of cleanliness and hygiene were maintained. Staff were seen washing their hands regularly, they were bare below the elbows at all time and did not wear their scrubs outside of the theatre. The unit had hand cleansing gel outside every theatre door, in recovery, the reception desk, front entrance and at every patient bay.

The unit had systems and processes in place to ensure good standards of cleanliness and hygiene are maintained. The day case unit had an infection prevention control link nurse who carried out monthly audits in areas such as handwashing. The trust had an up to date infection prevention policy.

The hospital had a screening emergency and elective patient's policy in place which was in date. The policy explained the process for screening for patients and they had pathways in place for both emergency and elective patients if the results came back as negative.

Environment and equipment

The service mostly had suitable premises and equipment and looked after them well.

The hospital had suitable premises for the services they provided. The hospital was built in 2007. The day case surgery ward was spacious and had a large waiting area, large ward area with 10 beds and one operating theatre. Staff also used an anaesthetist's room which could for some procedures so the service could run two surgical lists at the same time. There were several side rooms, which were used by staff to do the pre operation checks on patients.

All equipment was well maintained and used correctly. All electrical equipment had portable appliance testing (PAT) stickers, which were within date. The PAT test is a regular routine check that ensures the safety of electrical items. There was one resuscitation trolley within the day case ward. Staff checked the resuscitation trolley daily when the ward was open Monday to Friday, there were no gaps in the paperwork last three months of checks. We carried out checks on some of the equipment within the resuscitation and equipment was all in date. Staff told us they would call Russells Hall Hospital if there were any issues with equipment, if it was urgent they would

arrive within 30 minutes. Staff listed all repair jobs in a log book which included the staff member that reported it, the date and the log number.

The storage of some Control of Substances Hazardous to Health (COSHH) products did not keep patients safe from harm. Staff stored all COSHH products in locked cupboards in line with guidance however, flammable products were stored in wooden cupboards. This posed a risk to patient safety in the event of a fire. Staff were made aware of this whilst we were on site and the trust put a plan in place to replace the wooden cupboards with metal cupboards.

Systems and processes for managing waste keep patients safe from harm. Staff disposed of all dirty instruments and rubbish in the sluice provided. All sharps bins were positioned in the closed position in both theatre and recovery in line with best practice. All bins had lids on and were open and closed with a pedal in line with best practice. The surgery department had a decontamination team based at Russells Hall Hospital. Staff at Corbett Hospital sent their instruments to be cleaned at Russells Hall Hospital.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

Staff carried comprehensive pre- operation assessment checks. Staff at the unit carried out pre-operation assessments on all patients prior to the undergoing any procedure. Staff would record this and it was stored in patient records. Patients often disclosed new information during these assessments, which all staff members involved in the procedure would discuss fully during the team brief. Staff could delay or cancel surgery if new risks were disclosed that could affect the procedure.

Not all staff had the appropriate level of training to meet national guidance. All surgical staff are trained to a minimum of level intermediate life support. All anaesthetists are trained in advanced life support (ALS). At the time of inspection, there were no surgical nursing staff on the unit that had up to date ALS. According to The Association of Anaesthetists of Great Britain and Ireland (AAGBI) Immediate Post-anaesthesia Recovery 2013 guidance states 'At all times, at least one member of staff present should be a certified Acute Life Support (ALS) provider and, for children, hold an appropriate paediatric life support qualification. All staff should be encouraged to attain and maintain at least one such life support qualification.' The service were not meeting these guidelines. There were no anaesthetists at Corbett Hospital on Monday or Tuesday so no one on the unit had ALS training. The trust were made aware of this issue whilst we were on site and since the inspection have trained four staff in ALS and plan to train the rest by June 2019 in order to meet the guidelines and safeguard patients. The trust provided a risk assessment for the interim process whilst staff receive appropriate ALS training.

Staff indicated changes in the surgical list to highlight any changes in risk. Staff usually printed the surgery list on white paper. Common issues that caused the list to change on the day were patient illness, lateness, late arrival of notes and newly disclosed information. Staff would print the surgery list on a different colour of paper to let everyone within the surgery team know that there had been changes to the list.

The service complied with the World Health Organisation (WHO) checklist. The WHO checklist is simple checklist developed by the World Health Organisation which reduces surgical morbidity and mortality and sentinel events by carrying out simple exercises confirming things such as patient identity and the surgical site. Staff adhered fully with the sign in, time out, sign out and de brief process during the six patient's procedures that were observed. In the four records seen on site all

the paperwork was complete and signed for the whole process. The service carried out monthly documentation audits on the WHO checklist, the average result between July and December 2018 were 100%. The trust did not do observational audits of the WHO checklist.

Staff complied with the accountable items procedure. In the six observed procedures staff counted all instruments used both before and after every procedure in order to ensure nothing was left inside the patient during surgical procedures. Staff used and signed the appropriate documentation that recorded this process.

The trust had introduced the use of e-observations to monitor patients' health and to identify any deteriorating patients. The staff used the National Early Warning Score 2 (NEWS2) which produced a score after vital signs tests were done, including temperature check, blood pressure and oxygen saturations. Staff were prompted as to how often to repeat observations or when to alert medical staff to a deteriorating patient depending on the score. NEWS2 scores were recorded and stored electronically. Staff could either use a hand-held device to record the observations; or alternatively a 'computer on wheels' could be taken round the patients' bedsides.

Nursing staff assessed patients using NEWS2 at least once before any surgery. Nursing staff assessed patient's post-surgery using NEWS2 at least once for patients who had been under local anaesthetic and four times for patients who had been under general anaesthetic. Staff recorded these checks in the records. If there were any concerns staff would escalate any these immediately and the patient would be transferred to Russells Hall Hospital.

Staff were automatically prompted to undertake a screen for more serious conditions such as sepsis when a patients NEWS2 score escalated. Where required staff would then initiate a 'sepsis six' bundle which aimed to ensure patients at high risk of sepsis were treated quickly to prevent death or very serious complications.

The Hospital had an appropriate system in place in case a patient deteriorated. Patients who deteriorated or needed to stay in hospital overnight were transferred to Russells Hall Hospital. The hospital had a Transfer of patients and handover policy which was up to date and outlined the whole procedure. Nursing staff would fill in a handover sheet and also give verbal feedback to Russells Hall Hospital staff over the phone. The handover sheet contained all the appropriate information and had a section outlining the current patient risks which could be graded Green (no risk), Yellow (some risk) and Red (high risk). The action that staff needed based on patient risk was also on the handover sheet.

The hospital carried out falls risks assessments appropriately. Staff members had access to falls risk assessments on the unit if they were required. Staff at the unit did not use falls risk assessments very often as patients did not stay overnight or get left alone for a long period of time. High risk patients would receive treatment at Russells Hall hospital.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following qualified nursing staff numbers for the two periods below or surgery across the whole trust:

Staff Group	March 2018	September 2018

	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Nursing	319.6	272.7	85.3%	378.1	267.8	70.8%

We requested Corbett hospital specific staffing data which was not received

The trust reported a qualified nursing staffing level of 85.3% in surgery in March 2018 which dropped to 70.8% in September 2018.

As at September 2018, there were 110.3 fewer WTE staff in post than planned for and 4.9 fewer WTE staff in post than in March 2018. There was an increase of 58.5 WTE planned posts between the two time periods.

The drop in fill rate was due to a large increase in baseline whole time equivalent staff rather than a loss of staff. This meant there were not much less staff of the wards, however the fill rate has decreased. The trust were running lots of recruitment initiatives in order to try and fill these new posts.

Staffing levels are planned in advance so that patients receive safe care. Staffing is planned based on the surgery lists they are running for that day and planned around three months in advance. Staff ran regular lists that ran on a two-weekly basis with variance between week one and week two. The ward sister ensured actual staffing levels matched the planned staffing levels, this could be seen on the staffing rotas.

The staffing skill mix was appropriate to provide patients with safe care. The ward sister ensured there was appropriate staff skill mix on ward to cope with demand. As of January 2019, 72% of the staff group were multi-skilled and could work in both theatres and on the rest of the unit. This helped the ward sister to get bank cover for shifts on both sides of the unit.

Staff felt that the unit was well staffed most of the time. Most of the nursing staff worked full time at this site and occasionally work bank shifts at Russells Hall Hospital. All staff members told us they thought staffing levels are appropriate with in the day case unit are to maintain safe levels of care and treatment.

The unit followed guidance on theatre staffing levels. The ward sister set out minimum staffing levels that were in line with Health and Care Professions (HCPC) guidance. The unit was staffed in line with HCPC guidelines the whole time we were inspecting.

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 21.2% for qualified nursing staff in surgery. This was greater that the trust target of 6.3%. The rate was high as the trust had recently increased the establishment levels and was recruiting in order to meet these new levels. This did not have much of an impact on the staffing levels at Corbett Hospital.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 8.2% for qualified nursing staff in surgery. This was lower than the trust target of 8.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 8.2%
- Russells Hall Hospital / Community: 0.0%
- Russells Hall Hospital / Corbett Hospital: 7.6%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Corbett Hospital nursing staff turnover rate was 0.9% below the trust target of 8.5%.

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 4.7% for qualified nursing staff in surgery. This was greater than the trust target for sickness of 3.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 4.8%
- Russells Hall Hospital / Community: 0.0%
- Russells Hall Hospital / Corbett Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Corbett Hospital nursing staff had a sickness rate 0.9% below the trust target of 3.5%.

Bank and agency staff usage

Trust wide

From October 2017 to September 2018 the trust reported 131,646.0 of the 1,059,009.0 available hours in surgery were filled by bank staff (12.4%) and 46,229.0 hours filled by agency staff (4.4%). In addition, there were 90,024.0 hours that needed to be covered by bank or agency staff but were unfilled (8.5%).

A breakdown of bank and agency usage by staff type is shown below:

Staff type	October 2017 to September 2018						
	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	54,378.0	8.4%	45,707.0	7.1%	77,604.0	12.0%	644,200.0
Non-qualified	77,268.0	18.6%	522.0	0.1%	12,420.0	3.0%	414,809.0
Total	131,646.0	12.4%	46,229.0	4.4%	90,024.0	8.5%	1,059,009.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The hospital arrangements for bank and agency staff kept patients safe. The hospital had a core group of bank staff that they used on a regular basis. The ward sister told us that the hospital used agency staff on a weekly basis; they used the same agency staff to help with continuity.

Agency staff all completed an induction to the ward, which were kept in a file in the ward sister's office.

Handover arrangements and team briefs kept patients safe. All staff, including bank and agency staff, involved in patient lists would have to attend the full team brief beforehand where all patients on the list were discussed. At the team brief staff discussed any changes to the list as well as anything that had been disclosed or discovered at the pre-operation stage. Staff would also discuss patients' mental and physical wellbeing so as all staff members were aware of any potential issues. Staff would have a handover at lunchtime if new staff were starting on shift.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below for surgery across the whole trust:

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical	226.0	212.0	93.8%	232.8	217.5	93.4%

We requested Corbett hospital specific staffing data which was not received

Staff fill rates for medical staff in September 2018 remained similar to March 2018 with fill rates of 93.4% and 93.8%. There were 14.0 less WTE staff in post than planned for in March 2018 and 15.3 less WTE staff in post than planned for in September 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Medical staffing was at the appropriate level and had the appropriate skill mix. There were surgeons who carried out all the procedures on the list for their part of the day. The unit often had two lists running at the same time.

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 7.6% for medical staff in surgery. This was greater that the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 7.6% for medical staff in surgery. This was lower than the trust target of 8.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 8.0%
- Russells Hall Hospital / Corbett Hospital: 0.0%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

There was no medical staff turnover at Corbett Hospital between October 2017 and September 2018.

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 1.5% for medical staff in surgery. This was lower than the trust target for sickness of 3.5%.

The breakdown by site was as follows:

- Russells Hall Hospital: 1.4%
- Russells Hall Hospital / Corbett Hospital: 2.4%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From September 2017 to August 2018, the trust reported 12,607.5 of the 463,695.0 available medical staff hours in surgery were filled by bank staff (2.7%) and 9,447.3 hours were filled by locum staff (2.0%). In addition, 2.4% of medical staff hours available were not filled by either bank or locum staff to cover staff absence.

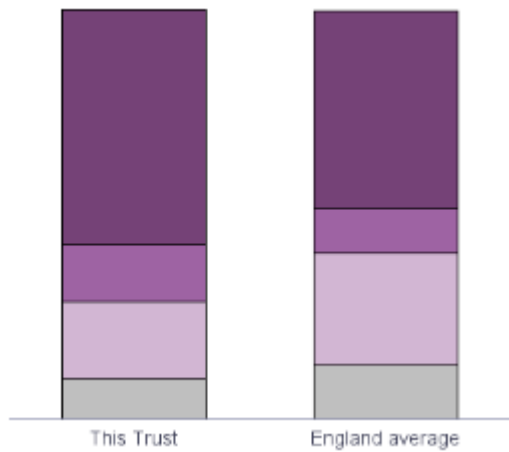| Core service | September 2017 to August 2018 | | | | | | |
| | Bank | | Locum | | Unfilled | | Total |
	Hours	%	Hours	%	Hours	%	Hours
AC –Surgery	12,607.5	2.7%	9,447.3	2.0%	11,029.0	2.4%	463,695.0

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Staffing skill mix

In July 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the whole time equivalent staff working at The Dudley Group NHS Foundation Trust

	This Trust	England average
Consultant	57%	48%
Middle career^	14%	11%
Registrar Group~	19%	27%
Junior*	10%	13%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff kept detailed records of patients' care and treatment. Records were up-to-date and stored securely. Records were not always easily available and often in poor condition.

Staff at the day case unit managed records in a way that kept patients safe. Patient's records were accurate, complete, legible and stored securely on the ward. We reviewed four sets of patient records whilst on the ward and they contained the patients named surgeon, diagnosis and management plan, record of patients national early warning score 2 (NEWS2) observations, pre operation checklist, completed World Health Organisation (WHO) checklist, signed consent form and Nurse led discharge checklist. Records were stored securely in the office behind reception.

Delivery of records often caused delays in surgery. The hospital stored records at Russells Hall Hospital and sent them to the day case unit at Corbett Hospital when they were required. Records were sometimes late or did not arrive at all, which meant surgery was delayed or cancelled. Staff at the day case unit had repeatedly raised this issue.

Staff received records in poor condition. The day case unit received records that were often in poor condition with confidential information displayed. Staff at the day case unit added a front sheet to these records in order to protect the patient information and inform the records office about the problem. The records were often long and it could be difficult for staff to find relevant information in the files.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines.

The hospitals medicine management systems kept patients safe. The unit would order drugs directly from the pharmacy team on a weekly basis. Staff at the unit were responsible for what they ordered. Staff on the unit would monitor drug stock levels and order enough to ensure that there was always a safe amount on the ward.

Staff correctly stored and monitored controlled drugs on the ward. Staff stored controlled drugs in a locked cupboard inside a locked room in the recovery area. The unit had a controlled drugs

book, which staff used to monitor the amount of controlled drugs stored on the ward. Whilst on site we checked a sample of controlled drugs and all of them were at the matched the amount stated in the controlled drugs book.

Staff stored and monitored drugs correctly in fridges. Staff carried out daily fridge temperature checks, these had been completed every day for the last three months. Staff had noted that the temperature was within range every day. The temperature range was on the fridge temperature checklist.

The hospital had a routine monthly audit, one of the areas it looked at was medicines. Between October and December 2018, the average score for day case for all the areas that were looked at was 97.3%. Over the same time period the average score for medicine for the recovery area for all the areas that were looked at was 100%.

There service had one incident relating to medicine between 1 January and 31 December 2018. The incident was related to an incorrect quantity of medication. The service carried out a full investigation and changed practice as a result.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported one incident classified as never events for surgery. This related to a retained foreign object post procedure in October 2017, this was not reported until February 2018.

(Source: Strategic Executive Information System (STEIS))

The never event took place at Russells Hall Hospital. The hospital carried out a thorough investigation of the incident and made changes as a result. Staff at the Corbett Hospital site were aware of the incident and the change in practice that took place.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 22 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from December 2017 to November 2018.

A breakdown of the incident types reported is in the table below:

Type of incident	Number of incidents	Percentage of total

Pressure ulcer meeting SI criteria	6	27.3%
Slips/trips/falls meeting SI criteria	4	18.2%
Treatment delay meeting SI criteria	4	18.2%
Surgical/invasive procedure incident meeting SI criteria	2	9.1%
Medication incident meeting SI criteria	1	4.5%
Environmental incident meeting SI criteria	1	4.5%
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	1	4.5%
HCAI/Infection control incident meeting SI criteria	1	4.5%
Sub-optimal care of the deteriorating patient meeting SI criteria	1	4.5%
Pending review (a category must be selected before incident is closed)	1	4.5%
Total	22	100.0%

One incident has not yet had a category assigned as it is pending review.

One of these serious incidents happened at Corbett Hospital. It was a falls incident that resulted in a fracture in August 2018.

(Source: Strategic Executive Information System (STEIS))

Staff were aware of their responsibilities to raise concerns, record safety incidents, concerns and near misses. All staff members told us there was an open incident reporting culture on the unit and all staff members were encouraged to report any incidents that occurred.

Staff thoroughly investigated incidents. Incidents were investigated by either the ward sister, deputy matron or matron. Staff discussed incidents as part of the theatres governance meeting. The ward sister attended this meeting when possible. Staff had also recently started a Corbett Hospital governance group where incidents could be discussed.

Staff members were able to give examples of where they had reported incidents, they had been investigated, and all staff had a debrief. The ward sister would deliver verbal feedback and explain any lessons learnt at team briefs and meetings. The ward sister would also put written feedback in the staff room in the unit for anyone who was not present for the verbal feedback.

All staff demonstrated a good understanding of duty of candour and were able to give examples of when they had apologised to patients when something had gone wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The trust had an in date duty of candour policy.

Staff shared learning across the sites at the two different hospitals. Staff at Corbett Hospital were able to talk about incidents that had taken place at Russells Hall Hospital. The management above ward sister level worked across both sites so learning could be transferred across easily. The whole surgery department did six weekly audit afternoons where there were no lists and staff across both sites would meet at Russells Hall Hospital. Staff would share learning from incidents

at team meetings and reflective practice sessions during these afternoons.
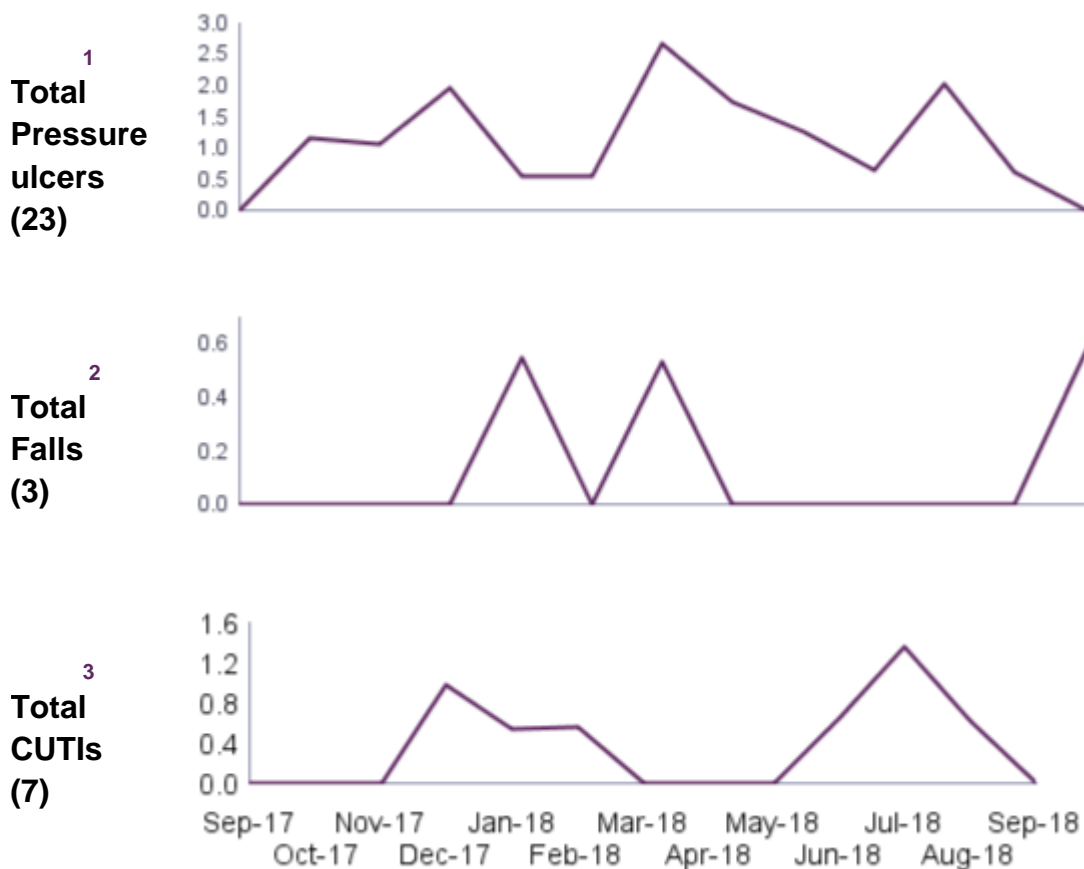
Safety thermometer

The information in this section relates to Russells Hall Hospital and not Corbett Hospital as the indicators were not applicable to the services they carried out.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 23 new pressure ulcers, three falls with harm and seven new catheter urinary tract infections from September 2017 to September 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at The Dudley Group NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

The service had three falls between 1 January and 31 December 2018. One of each of the falls was categorised as a 'fall – off furniture', 'slip – on floor, just cleaned' and 'patient fall - Fall/Trip/Slip while Mobilising Alone'.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The day case unit kept up to date with relevant and current best practice. The main surgery department at Russells Hall Hospital was responsible for disseminating any new guidance to the ward sister at the day case unit. The ward sister would then verbally inform everyone about new guidance and put up a notice in the staff room to make everyone aware. Staff could access any new guidance on the hub through the hospital intranet. Staff told us they had time to read any new guidance. The whole surgery department did six weekly audit afternoons where there were no lists and staff across both sites would meet at Russells Hall Hospital. Staff would be informed about new practice that was being implemented during team meetings at the afternoons. There was information on sepsis, falls and dementia and boards on the unit.

Best practice procedures were consistently followed within theatres. These were in relation to pre, peri and post-operative actions. For example, staff followed guidance with regards to checking and documenting accountable items including disposable surgical instruments as per the Association of Perioperative Practice (AfPP).

Staff did not discriminate on the grounds of age disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation when making care and treatment decisions. Staff had awareness and training in equality and diversity. No patient feedback indicated that patients had ever felt discriminated against by staff on the unit.

The unit used new technologies to enhance patient care. The unit used two accu chek machines to monitor and track glucose levels in patients with diabetes. Each trained member of staff has a unique barcode which the machine recognised when scanned into therefore the results recorded can identify the user. The patient also had a unique barcode on their identification band which when scanned brought up their hospital details. Staff would be alerted if the results is out of range. The user then had to confirm that they are aware that the result is abnormal. All staff we spoke with had received specialist training in this before they used the machine.

Staff were aware of the Mental Health Act (MHA). Staff could not recall a time where they had treated a patient who was detained under the MHA. Staff had mandatory yearly e-learning on the MHA.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other preferences.

Staff met patient's nutrition and hydration needs whilst they were in the unit. Most patients on the unit had local anaesthetic so did not need to fast beforehand due to the type of surgery being carried out. The unit was a day case unit so no patients stayed overnight or received meals whilst on the unit. The Hospital had a café on site so patients could get food if they wanted to. The café could cater to patients religious, cultural and any other preferences. Patients were routinely offered drinks whilst on the ward.

The trust audited certain nutrition criteria as part the nurse care indicators on a monthly basis. Staff checked that patients had clear post-operative information on food and drink recorded in

patient notes, an ongoing IV fluid prescription if needed and that the levels of fluid input and output recorded on the recovery paperwork and anaesthetists' paperwork. Between October and December 2018, the average score for the day case unit was 89.7%.

Staff could access a dietician for patients. The trust had dietician services based at Russells Hall Hospital who could be contacted by staff on the unit if they were needed. Due to the type of surgery carried out at Corbett Hospital staff would not use these services very often.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed and managed the pain of patients on a regular basis. Patients on the unit told us that staff regularly came around and asked how they were feeling and would provide them with timely pain relief if it was required. Staff had access to specialised tools to help those unable to communicate.

Staff noted the pain score when they recorded during observations. This was completed on the observation records we saw during the inspection. The trust audited the documentation of the pain score as part of the monthly nurse care indicator assessments. Between the months of October and December 2018, the average score for the day case unit was 69%.

The trust had a specialised pain team based at Russells Hall Hospital. Staff knew how to contact the specialist care team if they were ever required. Staff had rarely contacted the pain team due to the nature of surgery undertaken at the day case unit.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Bowel Cancer Audit

The Dudley Group NHS Foundation Trust participated in the 2017 Bowel Cancer Audit.

In the 2017 Bowel Cancer Audit, 69.7% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 72.1%. However, due to changes in the methodology, performance against this metric should not be compared between reports.

The risk-adjusted 90-day post-operative mortality rate was 1.9% which was within the expected range. The 2016 figure was 5.0%.

The risk-adjusted 2-year post-operative mortality rate was 13.9% which was within the expected range. The 2016 figure was 22.1%.

The risk-adjusted 30-day unplanned readmission rate was 11.9% which was within the expected range. The 2016 figure was 6.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 64.1% which was worse than expected. The 2016 figure was 59.3%.

(Source: National Bowel Cancer Audit)

National Vascular Registry

The Dudley Group NHS Foundation Trust participated in the 2017 National Vascular Registry Audit.

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.4% for Abdominal Aortic Aneurysms. The 2016 figure was 0.4%.

Within Carotid Endarterectomy, the median time from symptom to surgery was 11 days, better than the audit aspirational standard of 14 days.

The 30-day risk-adjusted mortality and stroke rate was 3.3%, this was within the expected range.
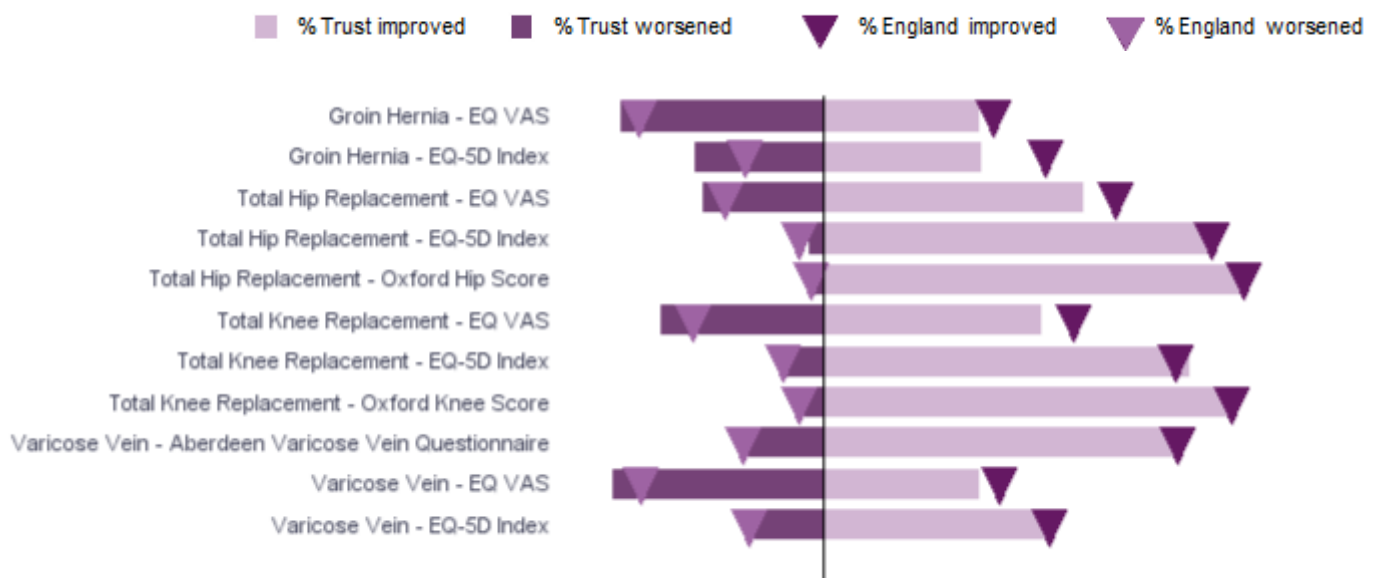
(Source: National Vascular Registry)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17, for groin hernias, the trust's performance was worse than the England average for

both the EQ VAS and EQ-5D Index indicators.

For hip replacements, the trust's performance was worse than the England average for the EQ VAS indicator but about the same as the England average for the EQ-5D and Oxford Hip Score.

For knee replacements, the trust's performance was about the same as the England average for EQ-5D score and Oxford knee score but worse than the England average for EQ VAS score.

For varicose veins, the trust's performance was worse than the England average for the EQ VAS score but about the same as the England average for the EQ-5D Index.

(Source: NHS Digital)

The Trust do not undertake groin hernias as these are deemed as a procedure of limited clinical priority.

All of the outcome measures above were related to surgery at Russells Hall Hospital and not Corbett Hospital.

The outcome measure with information provided to us by the trust was in relation to ophthalmology waits until the first injection:

Period (commenced Treatment)	No. Commenced Treatment	Wait to Treatment (weeks)
Jan - Dec 2018	480	6.2
Jan - Feb 2019	66	4.6

	No. Awaiting Treatment	Projected Wait to Treatment (weeks)
Patients Currently on Waitlist	37	4.7

The number of patients increased towards the end of 2018 which increased wait times. However, in the beginning of 2019 wait times have reduced.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Appraisal rates

For year to date, April to September 2018, 90.8% of required staff in surgery received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified nursing midwifery staff	1	1	100.0%	90.0%	Yes
Qualified healthcare scientists	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	235	250	94.0%	90.%	Yes
Qualified nursing & health visiting staff	275	306	89.9%	90.0%	No
Other qualified scientific, therapeutic & technical staff	28	32	87.5%	90.0%	No
NHS infrastructure support	11	13	84.6%	90.0%	No
Qualified allied health professionals	14	17	82.4%	90.0%	No
Support to scientific, therapeutic & technical staff	15	19	78.9%	90.0%	No
Total	**580**	**639**	**90.8%**	**90.0%**	Yes

Russells Hall Hospital / Corbett Hospital

For year to date, April to September 2018, 87.5% of required staff within surgery at Russells Hall Hospital / Corbett Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to scientific, therapeutic & technical staff	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	3	3	100.0%	90.0%	Yes
Qualified healthcare scientists	1	1	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	8	9	88.9%	90.0%	No
Other qualified scientific, therapeutic & technical staff	1	2	50.0%	90.0%	No
Total	**14**	**16**	**87.5%**	**90%**	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Nursing staff told us they always had their regular appraisals and supervision. Nursing staff and managerial staff told us that these were always worthwhile and of a good quality. Staff told us that

senior members of staff were always approachable for additional help if they needed it. Student nurses also told us that the support they received from mentors was positive.

Staff had the right qualifications, skills, knowledge and experience to do their job and continuously learnt whilst on the job. Staff members had regular training outside of mandatory training such as specialist diabetes training which staff members did on a three yearly basis. Staff had the right specialist knowledge for the procedures they did whilst on site. Such as Nurse led clinics where they carried out regular ophthalmic injections on patients.

Staff identified learning needs and had lots of opportunities to attend training and develop. Staff identified training needs through supervision, appraisals and new best practice. The surgery department ran audit afternoons once every six weeks where all surgical staff went to Russells Hall Hospital and had meetings, did training and shared learning through case studies.

Managers encouraged staff and provided them with opportunities to develop. Staff members completed a continuous professional development folder, which was monitored by senior development nurses at Russells Hall Hospital. Staff members told us managers were supportive when they asked for opportunities to develop.

Leaders on the unit managed identified staff performance issues and managed them appropriately. The ward sister provided an example of when poor staff performance was identified and the staff member involved was managed and supported appropriately to ensure they could improve.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All necessary staff were involved in assessing, planning and delivering patients care and treatment. The multidisciplinary teams contained both the nurses and the surgeon. Due to the type of surgery carried out other healthcare professional were rarely required but were available if needed.

The hospital had physiotherapists and occupational therapists on site. Due to the nature of the surgery provided physiotherapists and occupational therapists were rarely required in the day case unit. Staff could access pharmacy support over the phone if they had any questions.

There was a good relationship between theatre staff and staff on the unit. All staff we spoke told us that the two areas worked together as one team. Theatre staff communicated well staff on the rest of the unit and vice versa. Most nursing staff at the day case unit were multi skilled so had an understanding of what it was like to work across the whole unit.

Nursing staff led the discharge on the day case unit. The service has a discharge checklist which it used with all patients. Patients were always discharged at an appropriate time of the day. Due to the nature of the surgery provided patients did not need ongoing care in place prior to discharge.

Staff at Corbett Hospital had good links with staff at Russells Hall Hospital. If a patient needed to stay overnight for any reason they would be transferred to a ward at Russells Hall Hospital. Staff would provide both a verbal and written handover to staff at Russells Hall Hospital to make the transition as safe as safe as possible.

Seven-day services

The day case unit only carried out elective surgery and only operated Monday to Friday so there was no cover of any kind over weekends.

Nursing staff would cover the theatres if the operating lists overran.

Health promotion

Staff promoted good health in patients.

There were lots of health promotion leaflets available in the waiting and recovery area including stop smoking, diabetes, heart health, cholesterol and encouraging healthy eating. Staff told us they always spoke about health promotion during the pre-operation assessment if patients could benefit from a particular aspect of it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 82.4% of eligible nursing staff and 60.9% of eligible medical staff in surgery. The medical and nursing staff groups did not meet the target.

A breakdown of compliance by site for qualified nursing staff in surgery is shown below:

Site	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Russells Hall Hospital / Community	2	2	100.0%	90.0%	Yes
Russells Hall Hospital / Corbett Hospital	9	9	100.0%	90.0%	Yes
Russells Hall Hospital	158	194	81.4%	90.0%	No

In surgery the 90% target was met for the mental health law training module for which qualified nursing staff at Russells Hall Hospital / Community and Russells Hall Hospital / Corbett Hospital were eligible. Both of these sites had completion rates of 100.0% for the mental health law training module. The 90% target was not met for the mental health law training module for which qualified nursing staff at Russells Hall Hospital were eligible.

It should be noted that the data for nursing staff refers to two eligible staff Russells Hall Hospital / Community and nine eligible staff Russells Hall Hospital / Corbett Hospital, and so the performance should be taken in context when dealing with small numbers of eligible staff.

All staff had told us that they had completed mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us they felt the training was worthwhile and informative.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff had a good understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent. Staff demonstrated a good understanding of the Mental Health Act 2005 and DoLS and were able to give examples of where they had used it in practice.

Staff followed the correct procedures for consent and ensured patients provided informed consent. Staff asked patients if they understood the procedure to be undertaken prior to being given anaesthetic in theatre in order to double check consent. There were signed consent forms in all of the records that we reviewed whilst on inspection. Staff who did regular ophthalmology injections could get patients to sign three yearly consent forms rather than signing on a monthly basis. All patients we spoke with told us they had signed consent forms for the procedures they were about to have.

Staff followed best practice with regards to making best interest decisions when patients lacked capacity. Staff recognised when patients might lack capacity and held meetings with the patient, family members, nursing staff and surgeon. The trust had separate consent forms for patients who lacked capacity to make informed decisions at the point of care. These were well completed with family input collated where it was identified that a patient did lack the capacity to make decisions.

Is the service caring?

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Friends and Family test performance

From October 2017 to September 2018 the Friends and Family Test (FFT) response rate for surgery at Russells Hall Hospital was 35.5%. This was based on 21,345 responses.

A breakdown of FFT performance by ward for surgical wards at this hospital with total responses over 100 for the period from October 2017 to September 2018 is shown below.

A breakdown of response rate by site can be viewed below.

Friends and family test response rate at The Dudley Group NHS Foundation Trust, by site.

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	
Day case	16,039	33%	97%	96%	96%	95%	96%	95%	97%	95%	95%	95%	95%	95%	96%
Ward B4	1,079	46%	89%	87%	85%	94%	88%	86%	94%	90%	93%	90%	85%	87%	89%
Ward B5	938	48%	90%	90%	97%	87%	90%	78%	74%	89%	86%	87%	69%	79%	87%
Ward B1	851	54%	96%	98%	97%	96%	89%	94%	94%	88%	93%	86%	91%	93%	93%
Ward C6	817	45%	88%	91%	76%	91%	94%	93%	92%	92%	98%	94%	83%	91%	91%
Ward B3	681	35%	93%	90%	85%	85%	88%	86%	92%	88%	91%	96%	78%	90%	89%
Ward B2 (Trauma)	481	86%	90%	97%	93%	100%	100%	98%	97%	90%	94%	94%	94%	92%	95%
Ward B2 (Hip suite)	322	37%	96%	100%	92%	95%	97%	97%	100%	91%	100%	100%	93%	89%	96%
Ward B6	128	36%	100%						86%		86%	96%	95%	100%	95%

Key — Highest score to lowest score: 100% / 50% / 0%

[1] The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).

[2] Sorted by total response.

[3] The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

The above data relates to Russells Hall Hosptal surgery departments.

Between 1 April 2018 and 31 December 2018 the day case surgery unit at Corbett Hospital got 1996 responses, which was a response rate of 47%. Out of these responses, 98% would recommend the day case unit and 1% would not, with 90.5% of respondants 'extremely likely' to recommend the service.

(Source: NHS England Friends and Family Test)

Staff understood and respected people's needs and took these into account. Staff delivered patient centred care and always considered patients personal, cultural and social needs. Staff always treated patients with compassion. Patients told us they were always treated with kindness by all staff at the day case unit.

Staff always interacted with patients and those close to them in a respectful and considerate manner. Staff and patients told us that staff could always spend one to one time with patients if

they ever needed it. Staff were always seen to be having positive interactions and were always considerate of patient's feelings.

Staff were supportive of patients and those close to them. Staff were supportive of patients who felt anxious about surgery and did anything they could to ensure that patients felt as comfortable as possible throughout their time on the unit.

Staff would raise concerns about disrespectful, discriminatory or abusive behaviour and attitudes. Staff told us they would always report any concerning behaviour they saw on the unit. The ward sister told us she would always deal with any concerns and escalate any issues to senior management if needed.

Patients gave positive feedback about the service. The ward sister printed off all the day case units' patient comments on a monthly basis. In November 2018 there were 157 comments of which 150 were positive, three were negative and four were neutral. Some of the comments from patients were, 'Wonderful service. The staff are a credit to the hospital and the NHS', 'Exceptional, friendly and welcoming' and 'Staff are excellent. Cannot do enough for you' All the patients we spoke with were positive about the service.

Staff respected patient's privacy and dignity whilst they were on the unit. All patients we spoke with told us that staff respected their privacy and dignity at all time whilst they were on the ward. Staff were seen respecting patient's privacy and dignity, drawing curtains around the patient's beds when it was appropriate. Staff maintained patient's privacy and dignity at all time during the procedure in theatres, they also cleaned the patient immediately after surgery.

Staff responded to patient discomfort and pain in a timely manner. Patients told us staff responded as soon as they could when patients used the call bell or experienced any problems. There were enough staff to ensure staff could respond to any patient discomfort or pain quickly.

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff communicated with patients so that they understood their care and treatment. Staff were observed explaining the procedure to patients from start to finish. Patients who attended the unit both regularly and for the first time that day told us staff always explained the procedure to them fully.

Staff recognised when people who used services needed additional support and enabled them to access this. Staff recognised when patients were anxious and would provide additional support to those patients and any relevant adjustments that they could. Staff enabled patients to access additional services such as the patient advice and liaison service (PALS), translators and sign language interpreters when they were required.

Patients could get additional information on care and treatment if they wanted it. Staff would answer any questions patients had about their procedure. The hospital had lots of information on treatments that they offered on the unit.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

Staff gave patients appropriate information to cope with their care and treatment. Staff explained the procedure to patients. The day case unit had lots of leaflets available in the recovery and pre operation area of the ward, these included information on; local anaesthetic, recovering from general anaesthetic, preventing blood clots and corticosteroid injections.

Patients felt well informed about the care and treatment they were about to receive. Patients told us they felt fully informed about their care and described both medical and nursing staff positively in respect of keeping them up to date with information and updates. Patients we spoke with told us they felt fully informed to consent to any care or treatment and felt involved in decisions made.

Is the service responsive?

Service delivery to meet the needs of local people

The trust planned and provided services in a way that met the needs of local people.

The services provided by the trust at the unit reflected the needs of the local population. Staff at the service provided both regular and one off procedures for patients who required them. The service provided regular clinics for ophthalmology and pain management injections, which were used by patients on a monthly basis.

The trust had made very recent changes to the pre-operative assessment pathway to better meet the needs of elective patients. This involved including an anaesthetist, and other colleagues where required, as part of the pre-assessment consultation. Therefore, the patient could experience a 'one stop' appointment which enabled less journeys to the trust, and more time between first consultation and surgery to enable health optimisation. The aimed to include increasing theatre productivity, reducing on the day cancellations and improving the patient experience. Due to the infancy of this process at the time of our inspection, it was not possible to gather any data around this. However, a meeting was scheduled with the relevant Clinical Commissioning Group (CCG) in February 2019 to discuss long term funding.

Meeting people's individual needs

The service took account of patients' individual needs.

Staff delivered services in a way that took account of people's different needs. Staff had an awareness of cultural and religious needs, including nutritional preferences, dress code and dignity. Staff members were able to give examples of where they had carried out a procedure and did everything they could to ensure that patients preferences were met. The unit did not have a prayer room but the ward sister told us any spare room could be used as a prayer room if it was required. Staff on the unit could access the multi-faith chaplaincy service via the bleep system if it was needed.

Staff told us they had timely access to specialist teams when they were required. Staff could find the specialist teams they needed on the hub, specialist teams could also be accessed via a bleep system if it was an urgent referral. Staff told us the specialist diabetes team provided timely and beneficial support to the unit when it was required. Staff told us there was a specialist learning disabilities Nurse who provided timely and beneficial was contactable via a bleep if they were needed immediately.

Staff told us if patients had specialist needs they would allow carers or family members to be with patients throughout the whole process.

Staff cared well for patients living with dementia. Staff could access a specialist dementia nurse through the hub system. Staff had specialist dementia training. Staff saw elderly patients on a regular basis and would could often see a decline in the cognitive function of patients. Staff said that is this was the case they would organise meetings with the patient, family and multidisciplinary surgery team to discuss it.

Staff could provide specialist psychiatric support to patients if it was required. Staff could access a specialist mental health team if they were required to help. Staff could get information about this team from the hub on the intranet page or access them via a bleep system if they required urgent support.

Staff had access to translation and sign language services for patients who required them. Staff told us they regularly accessed translation services. The unit had a how do you communicate information leaflet for patients and carers to use.

The service is fully accessible so people living with disabilities could access and use services on an equal basis to others. The building was fully accessible for people with limited mobility. Staff had access to appropriate equipment on the unit to ensure people with limited mobility could access the procedures on offer.

Staff at the unit engaged with people in vulnerable circumstances to improve their access to other services. The ward sister gave an example of where they noticed a patient's health had deteriorated so they contacted the patients GP to arrange an appointment for them and potentially get them access to further help and treatment.
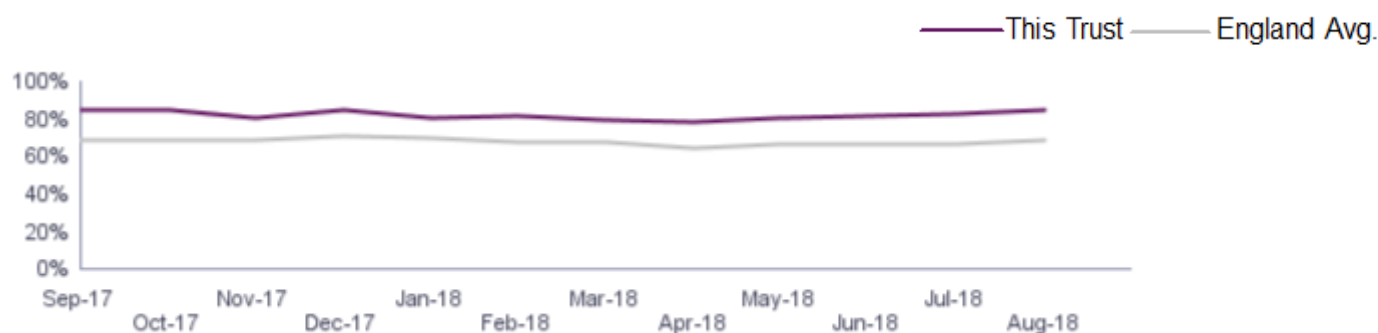
Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

The chart below shows the average length of stay for the top three specialties, based on count of activity for non-elective admissions:

Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for admitted pathways for surgery was better than the England average. It ranged from 78.3% to 85.2%, compared to the England average of 64.6% to 71.5%.

In the latest period, August 2018, 85.2% of this group of patients were treated within 18 weeks compared to the England average of 68.5%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Seven specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Trauma & orthopaedics	92.3%	60.0%
Plastic surgery	86.0%	81.1%
General surgery	80.7%	72.6%

Urology	80.3%	76.7%
Oral surgery	80.2%	59.4%
ENT	79.5%	63.1%
Ophthalmology	70.6%	68.2%

Two specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Neurosurgery	0.0%	69.9%
Cardiothoracic surgery	0.0%	79.6%

Cancelled operations

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two-year period from quarter 2 (Q2) of 2016/17 to Q1 2018/19, the percentage of last-minute cancellations at the trust where the patient was not treated within 28 days was consistently lower than the England average.

In Q4 2017/18, this trust cancelled 150 surgeries. Of the 150 cancellations 6% weren't treated within 28 days.

At Corbett Hospital day case unit in Q4 2017/18 there were 17 cancellations (excluding patient reasons and postponements). Of the 17 cancellations, one patient (5.9%) not treated or offered treatment within 28 days.

Percentage of patients whose operation was cancelled and were not treated within 28 days - The Dudley Group NHS Foundation Trust

Cancelled Operations as a percentage of elective admissions - The Dudley Group NHS Foundation Trust
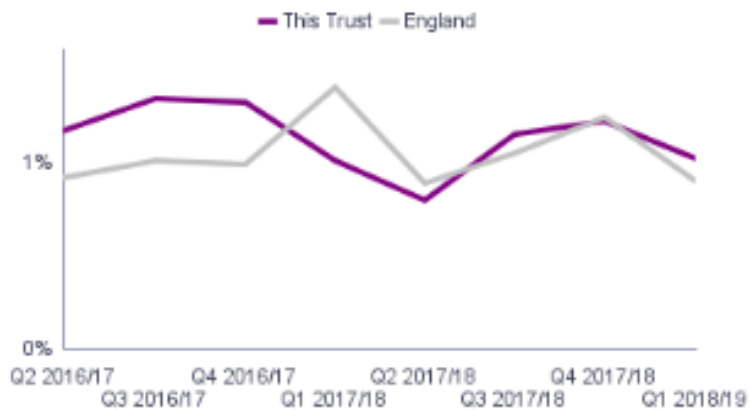
Over the two-year period, the percentage of cancelled operations at the trust was in the most part, worse than the England average. There was an improvement in the trust's performance in Q2 2017/18.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

The day case unit did not provide any emergency care or treatment.

Staff only cancelled or delayed care and treatment when it was absolutely necessary. Staff made sure they always explained the reasons for cancellations with patients and kept them up to date if there were any changes in the time of surgery. The most common causes of cancelled operations were notes not arriving at Corbett Hospital on time, patients arriving late and patients disclosing previously unknown information on the day. Staff immediately attempted to re-arrange any cancelled operations.

The service often over ran. Patients were always kept informed if the time of their care and treatment had changed.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Summary of complaints

From October 2017 to September 2018 the trust received 89 complaints in relation to surgery (18.2% of total complaints received by the trust). The main subjects of complaints were patient care (29) and communications (19).

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient care	29
Communications	19

Admissions and discharges (excluding delayed discharge due to absence of care package)	9
Values & behaviours (staff)	9
Other (specify in comments)	8
Appointments	5
Access to treatment or drugs	4
Waiting times	3
Admin/policies/procedures (inc patient record)	1
Privacy, dignity & well being	1
Facilities	1
Total	**89**

For the 46 complaints that had been closed at the time of data submission, the trust took an average of 83.4 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

The 43 complaints that had not yet been closed had been open for an average of 80.8 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

None of these formal complaints related to the day case unit at Corbett Hospital.

Number of compliments made to the trust

From October 2017 to September 2018 there were 712 compliments received for surgery (10.3% of all received trust wide).

Compliments were received in all 12 months of the period. November 2017 was the month where the most compliments were received (99).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

The trust did not separate the data, so it is not possible to see how many of these compliments relate to the day case unit at Russells Halls Hospital.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Patients knew how to complain and raise concerns. Most patients we spoke with were aware of how to complain and knew they could complain to the Patient advice and liaison service (PALS). Staff tried to deal with complaints immediately on the ward but if that was not possible they advised patients to make a formal complaint or told them they could contact PALS. PALS is an independent service which offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers or relatives. There are signs for PALS and information on how to use the hospitals complaints procedure in the hospital and on the day case unit.

Staff dealt with complaints in a compassionate manner. The ward sister, deputy matron or matron would deal with complaints for the unit. The ward sister told us they always took patient complaints seriously and responded to complaints in a compassionate and understanding manner.

Staff learnt lessons and made changes as a result of complaints from patients and relatives. Different staff members were able to provide examples of where the service had learnt lessons from complaints and as a result changes had been made to the unit. The service received a complaint regarding confidentiality as eye drops used to be administered in the reception area. The ward sister changed this practice, eye drops were delivered in a separate side room to protect patient's confidentiality. The service also had heaters available for the reception area as a result of complaints that patients were cold in the reception area.

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

A triumvirate senior management team oversaw the division of surgery, women and children under which surgical services fell. This included the day case unit at Corbett Hospital. They supported matrons to deliver the objectives and work of the surgery service.

The matron held regular meetings with the ward sister. The ward sister would then cascade information down to the remainder of the recovery and theatre staff via daily huddles, team meetings, email or notices up in staff areas. Staff told us they regularly received updates from local management.

The ward sister was a band six member of staff and the main leader based on the ward at all times. At the time of inspection discussions were underway to make the ward sister a band seven ward manager due to the responsibilities they undertook.

Staff told us local management were visible, supportive and willing to help out with day to day clinical duties over and above their management roles. Staff told us that management allowed flexibility towards working patterns where possible, for example to accommodate childcare needs. However, some staff members told us that they had not seen many of the senior management team visit the ward.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

The trust had an overall vision which was 'Trusted to provide safe, caring and effective services because people matter'. These were underpinned by;

1. Deliver a great patient experience
2. Deliver safe and caring services
3. Deliver service improvement, innovation and transformation
4. Be a place people choose to work
5. Make the best use of what we have
6. Deliver a viable future

These were supported by the trust values of care, responsibility and respect. We observed staff work in line with the trust vision and values during the whole time we were on inspection.

Staff were aware of the overall trust strategy, vision and values. Staff explained the strategy, vision and values to us whilst we were on site. Staff members had a clear priority of providing safe, personalised good quality to care to all patients who underwent procedures on the day case unit.

The surgery department did not have a separate strategy to the overall trust.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff were positive about the service. Morale amongst staff was generally good. Most staff members told us that the staff group were generally happy although at times morale could be varied when staff had a high workload, but staff all helped each other.

Staff felt valued by the trust and the senior management teams. Staff were aware of risks and challenges at both the day surgery unit at Russells Hall Hospital and presented as keen to improve standards where possible for patients. Staff told us of a 'non-hierarchical' approach where they felt that they could approach any colleague of any grade to receive support or share ideas. Staff interactions whilst on inspection demonstrated this 'non-hierarchical' approach. Staff also told us where they had been involved in specific projects or new practices, for example being part of interview panels for new staff.

Leaders were visible and approachable. All staff members told us the ward sister and matron were visible, always approachable and spent time on the day case unit. Staff said that they would approach staff members with any issues. Staff members said they would approach leaders with any issues they have without fear of victimisation. The day case unit had information about the freedom to speak out guardian displayed.

Leaders encouraged appreciative and supportive relationships. All staff members told us the ward sister created a positive work environment that made ensured staff got on with each other and were able to have positive supportive working relationships.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Clinical governance meetings were held monthly, which included the triumvirate leadership team and matrons from within the division. Through these meetings, a variety of topics were monitored and discussed including incidents, the risk register, complaints, patient falls and general concerns. This was a forum to raise any ongoing or new issues from ward level; as well as having information cascaded down from the senior management level and above. As these were division level meetings, matrons told us they gained a good overview of areas outside of surgery.

The matron would then hold a meeting with the ward sister at Corbett Hospital to share information from these meetings. The ward sister would then hold team meetings on the unit. All staff we spoke with told us they felt information was shared both up throughout management streams, and back through to ward level staff effectively.

The trust reviewed governance frameworks and made changes which improved the service. The trust had recently moved across a lead Nurse who had instigated some additional governance structures at Corbett Hospital. Staff at Corbett Hospital had recently started a Corbett Hospital specific governance group where they could discuss issues that came up that were specific to that hospital. The governance team were looking at issues such as getting more training at the Corbett Hospital site to improve training attendance amongst staff.

Systematic audits were undertaken and were used to improve the service. Quality audits were compiled on the wards, such as hand hygiene, and infection prevention and control. The results of

each wards monthly audit were fed up to the matron and divisional chief nurse via monthly meetings where results were challenged and action plans created.

The trust had not fully embedded the major incident plan at the unit. The Hospital had an in date Major Incident Plan that was ratified and finalised on 18 December 2018. Most staff members on the unit were not aware of the major incident plan. The unit did not have a copy of the major incident plan on site. The ward sister was aware of the major incident plan and believed that the unit would shut and the staff would move across to Russells Hall Hospital.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Staff had a robust process for recording and reporting risks. Staff on the unit would escalate risks through the ward sister, then on to the deputy matron or matron, who could discuss any risks at the appropriate clinical governance meetings. Staff concerns on the unit were mostly around staffing, due to the small core staff group if a few members of staff have extended periods of leave it could cause difficulties maintaining staffing levels.

Staff could access any new policies on the hub and these were updated along with national guidance. Updates following any changes or updates to national guidelines were discussed and ratified via clinical governance meetings. Any changes were implemented in a timely way in order to be introduced within patient care quickly. Senior management told us, and we saw, that medical staff monitored outcomes closely in order to take a proactive approach to improving performance where necessary.

Staff had a systematic approach to audits which could identify areas of risk. The deputy matron undertook nurse care indicators on monthly basis which included looking at a variety of areas including patient observations, manual handling, tissue viability, nutrition and medications. As well as separate audit processes relating to cleanliness and infection control

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The receptionist provided support to ensure that patient records were stored securely in line with data protection requirements.

We saw that patient records were stored in key-coded lockable cabinets. Where these were not functioning; we saw staff took immediate action to remedy this.

Information technology systems were used effectively to provide patient care.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The trust engaged staff at local level and at trust level. Staff members told us they felt engaged in decision making at the trust. Some staff members set up a staff experience task force which had been set up to improve staff experience; this included funded ongoing training. The task force included staff from all grades within the trust. A peer sub group had been set up to assess the applications for funding for additional training. We saw regular communications such as the Trust Safety and Experience bulletin being circulated and pinned up in staff areas. Messages and team meeting minutes were distributed to all relevant staff members.

Leaders and staff members understood the value of staff raising concerns. Both leaders and staff members told us that they would raise any concerns on the ward and understood that doing this would often lead to improvements in the service provided to patients.

All staff members continually sought out patient feedback and engagement in order to drive improvements in patient care. All staff members we spoke with told us they valued patient feedback and always took any concerns raised seriously. Staff gave examples of changes made to the service based on patients feedback.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

Staff strived for continuous innovation in the areas in which they work. The ward sister was developing a World Health Organisation (WHO) checklist that was tailored specifically for ophthalmology patients. Not all of the current standardised WHO checklist is relevant to ophthalmology patients so this checklist will remove some elements but add in some additional elements. The head of ophthalmology had approved this document and it was awaiting final approval by the documentation team.

Staff focussed on improving patient care. The ward sister developed a steroid injection pathway in order to get more details and have more interaction with patients who received this treatment. Prior to the introduction of this, patients were seen only by consultants.

Staff made changes to improve the recruitment process. The trust changed the recruitment processes whereby interview candidates were interviewed by a panel which included a peer from the same banding, and a member of staff from the relevant area of work. Senior managers told us they had received positive feedback from people who had taken part; and members of staff involved told us they felt this was a valuable and worthwhile strategy to help recruit new staff.

The hospital recognised good quality care. The day case unit staff team was nominated for the 'team of excellence' award at the yearly trust awards ceremony.

Outpatients

Facts and data about this service

The trust provides a range of outpatient services across three hospital sites:

- Russell's Hall Hospital
- Corbett Outpatient Centre
- Guest Outpatient Centre

The outpatient department sees approximately 500,000 outpatients each year. This includes both adult and paediatric outpatients appointments.

In addition, services are offered in community sites across the region, more recently expanding into the Wyre Forest area.

The trust provides the following outpatients clinics:

| Location	Clinic name	Service provided
Russell's Hall Hospital	Trauma & orthopaedics - elective clinics	Consultant led service, incorporating lower limb, upper limb, foot & ankle and back specialisms.
	Trauma & orthopaedics - nurse led elective clinics	Nurse consultant and ANP led lower limb arthroplasty clinics and virtual follow up clinics.
	Trauma & orthopaedics - fracture clinics	Consultant led face-to-face fracture clinic service and consultant-delivered virtual fracture clinic service.
	Ophthalmology clinic	Consultant delivered service, including specialist glaucoma, retina, corneal, oculoplastic and paediatric ophthalmology service. Urgent referral service provided during weekday hours.
	Low vision clinics	Dedicated low vision service provided by the orthoptist and optometrist team.
	ENT clinics	Consultants work alongside nurses and audiologists.
	Oral /Maxfax clinics	Consultants work alongside nurses, SpRs and trainees to deliver care.
	Orthodontics clinics	Management of teeth correction predominately for paediatrics.
	Plastics clinics	Consultants work alongside SpRs and SHOs to deliver care relating largely to skin cancer, hand problems, breast reconstruction and plastics urological concerns.
	Vascular	Consultant delivered regional vascular arterial network hub. Full range of index arterial procedures provided, and endovascular aneurysm repair service. AAA Screening programme hub.

Russell's Hall Hospital	Pain Management	Consultant led, specialising in pain management
	Anaesthetics	Consultant anaesthetists (including pain and intensivist posts)
	Haematology	Provides care to patients with problems including general and malignant haematology and thrombosis. Care is provided in outpatient clinics and the Georgina day case unit
	Immunology	Specialist immunology and allergy service for diagnosis and management of a range of primary and secondary immunodeficiency disorders as well as routine and complex allergy for both for both adult and paediatric patients. Consultants have regular outpatient and day case sessions each week. The clinical service is supported by an immunology lab and the medical day case unit where patients receive immunoglobulin replacement and attend for specialist allergy testing and immunotherapy.
	Anticoagulation Clinic	Nurse led team providing clinics at both RHH and in the community.
	Clinical Chemistry	Specialist referral for service lipid disorders and patients with metabolic abnormalities for Dudley. The team also provide a referral service for bariatric patients from the region.
	Adult Phlebotomy	Walk in service from 8am to 6pm from Monday to Friday and from 8am to 1pm on Saturdays. Booked appointments are available from 8am to 5.30pm from Monday to Friday and 8am to 12.30pm on Saturdays.
Corbett Hospital	Trauma & orthopaedics - elective clinics	Consultant led service, incorporating lower limb, upper limb, foot & ankle and back specialisms.
	Trauma & orthopaedics - nurse led elective clinics	Nurse consultant and ANP-led lower limb arthroplasty clinics and virtual follow up clinics.
	ENT clinics	Consultants work alongside nurses and audiologists.
	Anticoagulation clinic	Nurse led team provide clinics at both RHH and Corbett hospitals in the community.
	Phlebotomy	Walk in service from 8am to 6pm from Monday to Friday in addition to booked appointments covering all of these times.
Guest Ambulatory	Medical and surgical clinics.	
	Pain management	All day Friday pain clinic including MDT and Monday afternoon. PMPS assessment clinics, TENS clinics, acupuncture clinic.

(Source: Routine Provider Information Request (RPIR) – Sites tab; Acute RPIR – Context tab)

Clinics held at Corbett Outpatient Centre included dermatology, trauma and orthopaedics, rheumatology, chronic pain, gynaecology and urology. In addition, there was an outpatient physiotherapy and rehabilitation service and speech and language and dietetic clinics.

Total number of first and follow up appointments compared to England

The trust had 566,801 first and follow up outpatient appointments from July 2017 to June 2018. The graph below represents how this compares to other trusts.
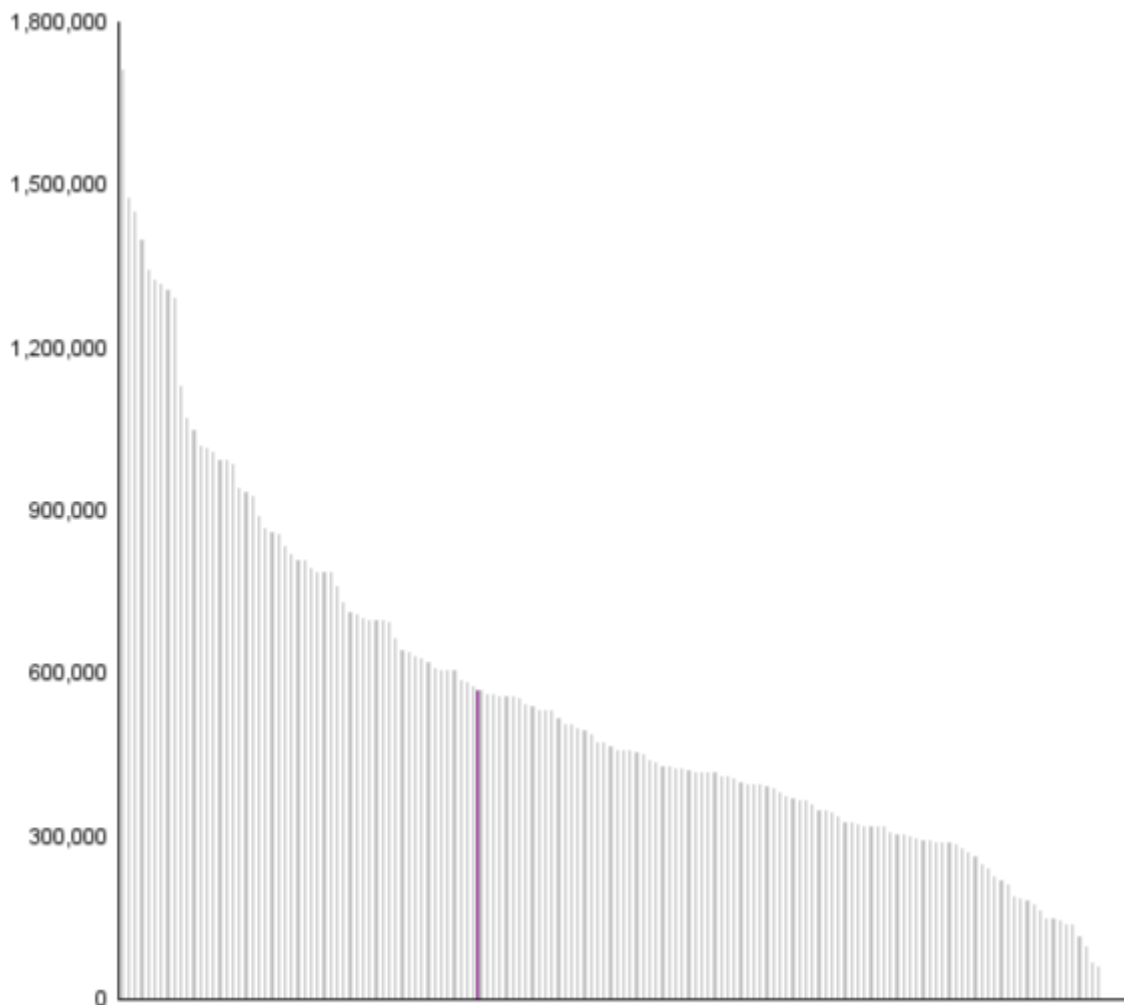
(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments

The following table shows the number of all outpatient appointments by site, a total for the trust and the total for England, from July 2017 to June 2018.

Site Name	Number of spells
Russell's Hall Hospital	791,321
Corbett Hospital	8,652
Guest Hospital	2,684
Halesowen Health Centre	1,490
Netherton Health Centre	1,283
This Trust	**806,630**
England	**106,661,135**

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from July 2017 to June 2018:

Number of appointments at The Dudley Group NHS Foundation Trust from July 2017 to June 2018 by site and type of appointment.
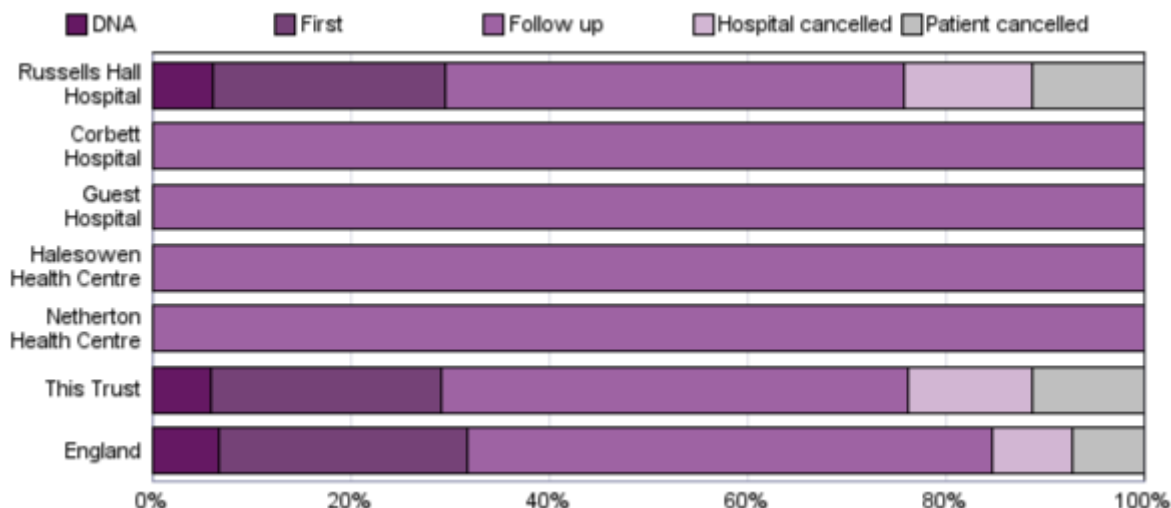
(Source: Hospital Episode Statistics)

As part of our unannounced inspection we visited the main outpatients' department; urology and gynaecology outpatients; the rehabilitation department; the trauma and orthopaedic clinic; phlebotomy (taking blood for testing); the dermatology clinic; and, medicine and surgery clinics.

The hospital provides outpatient services covering a range of specialities including but not limited to: rheumatology, dermatology, trauma and orthopaedics, urology, gynaecology and surgery. dental.

The service provided both consultant and nurse led outpatient clinics across a range of specialities. Outpatient clinics were held between 8am and 6pm.

During our inspection we spoke with eleven patients. We spoke with 27 members of staff including nurses, clinical support workers, nurse specialists, volunteers, reception staff, medical records staff, medical staff including consultants and registrars, physiotherapists, outpatient leads and managers, and divisional leads and managers. We reviewed three patient records and three complaint records. We reviewed performance information about the department and the trust.

Is the service safe?

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.

Mandatory training

Staff received effective training in safety systems, processes and practices.

Mandatory training compliance for qualified nurses was above the trust target overall.

The trust set a target of 90% for completion of mandatory training.

Trust wide

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 at trust level for qualified nursing staff in outpatients is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Manual handling (non-patient) / slips, trips & falls	1	1	100.0%	90.0%	Yes
Health & safety	36	36	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	36	36	100.0%	90.0%	Yes
Infection control – clinical	35	36	97.2%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	34	36	94.4%	90.0%	Yes
Information governance	33	36	91.7%	90.0%	Yes
Fire	32	36	88.9%	90.0%	No
Conflict resolution - level 1	32	36	88.9%	90.0%	No
Manual handling (patient) / slips, trips & falls	31	35	88.6%	90.0%	No
Resus – paediatric	12	14	85.7%	90.0%	No
Resus – adult	27	36	75.0%	90.0%	No

In outpatients the trust had an overall mandatory training compliance rate of 91.4% for qualified nursing staff. The 90% target was met for six of the 11 mandatory training modules for which qualified nursing staff were eligible.

No medical staff were reported to be working at the trust within outpatients.

Russell's Hall Hospital

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 for qualified nursing staff in outpatients at Russell's Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality & diversity (including autism awareness)	28	28	100.0%	90.0%	Yes
Health & safety	28	28	100.0%	90.0%	Yes
Infection control – clinical	27	28	96.4%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	26	28	92.9%	90.0%	Yes
Information governance	26	28	92.9%	90.0%	Yes
Fire	25	28	89.3%	90.0%	No
Manual handling (patient) / slips, trips & falls	24	28	85.7%	90.0%	No
Resus – paediatric	6	7	85.7%	90.0%	No
Conflict resolution - level 1	24	28	85.7%	90.0%	No
Resus – adult	20	28	71.4%	90.0%	No

In outpatients the trust had an overall mandatory training compliance rate of 90.3% for qualified nursing staff at Russell's Hall Hospital. The 90% target was met for five of the 10 mandatory training modules for which qualified nursing staff were eligible.

Russell's Hall Hospital / Corbett Hospital

A breakdown of compliance for mandatory training courses from April 2018 to September 2018 for qualified nursing staff in outpatients at Russell's Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality & diversity (including autism awareness)	8	8	100.0%	90.0%	Yes
Manual handling (non-patient) / slips, trips & falls	1	1	100.0%	90.0%	Yes
Infection control - clinical	8	8	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	8	8	100.0%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	7	7	100.0%	90.0%	Yes
Conflict resolution - level 1	8	8	100.0%	90.0%	Yes
Health & safety	8	8	100.0%	90.0%	Yes
Information governance	7	8	87.5%	90.0%	No
Fire	7	8	87.5%	90.0%	No
Resus - adult	7	8	87.5%	90.0%	No

Resus - paediatric	6	7	85.7%	90.0%	No

In outpatients the trust had an overall mandatory training compliance rate of 94.9% for qualified nursing staff at Russell's Hall Hospital / Corbett Hospital. The 90% target was met for seven of the 11 mandatory training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Where the trust target for mandatory training was not met, this related to one member of staff having not attended the training. Managers were aware of training compliance and had processes in place to monitor this and improve compliance.

There was a combination of on-line and face to face training. Leaders told us that adult resuscitation training figures had increased to 82% across all three hospital sites. Staff who had yet to complete their resuscitation training had been booked onto training in January and February 2019. There was an electronic mandatory training tracker in place making it easy to view if a staff members training was close to expiry.

Medical staff working in the outpatient department met the trust's target in relation to mandatory training in ten out of seventeen modules. Eight medical staff fell short of the trust's target ranging between 80% and 88%. Mental Health Law compliance rates were low at 57%.Dates had been set for this training throughout February 2019.These were arranged for the evening and designed to be tailored around the doctor's day.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The trust set a target of 90% for completion of safeguarding training.

Trust wide

A breakdown of compliance for safeguarding training courses from April to September 2018 at trust level for qualified nursing staff in outpatients is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	36	36	100.0%	90.0%	Yes
Prevent	36	36	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	35	36	97.2%	90.0%	Yes
W R A P	33	36	91.7%	90.0%	Yes
Safeguarding children level 3	28	32	87.5%	90.0%	No

In outpatents the trust had an overall safeguarding training compliance rate of 95.5% for qualified nursing staff. The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible.

Russell's Hall Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to September 2018 for qualified nursing staff in outpatients at Russell's Hall Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	28	28	100.0%	90.0%	Yes
Prevent	28	28	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	27	28	96.4%	90.0%	Yes
W R A P	25	28	89.3%	90.0%	No
Safeguarding children level 3	22	25	88.0%	90.0%	No

In outpatients the trust had an overall safeguarding training compliance rate of 94.9% for qualified nursing staff at Russell's Hall Hospital. The 90% target was met for three of the five safeguarding training modules for which qualified nursing staff were eligible.

Russell's Hall Hospital / Corbett Hospital

A breakdown of compliance for safeguarding training courses from April 2018 to September 2018 for qualified nursing staff in outpatients at Russell's Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
W R A P	8	8	100.0%	90.0%	Yes
Prevent	8	8	100.0%	90.0%	Yes
Safeguarding adults	8	8	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	8	8	100.0%	90.0%	Yes
Safeguarding children level 3	6	7	85.7%	90.0%	No

In outpatients the trust had an overall safeguarding training compliance rate of 97.4% for qualified nursing staff at Russell's Hall Hospital / Corbett Hospital. The 90% target was met for four of the five safeguarding training modules for which qualified nursing staff were eligible, with only one member of staff not completing the safeguarding children level 3 training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. All the staff in the general outpatient department had received safeguarding adult training. Staff working in more specialist areas of outpatients, where children may be treated routinely were trained to safeguarding children level three. For example, nurses we spoke with working in the trauma and orthopaedic clinic where children may be seen were trained to level three.

According to the Safeguarding children and young people: roles and competencies for health care staff Intercollegiate document, all non-clinical and clinical staff who have any contact with children,

young people and or parents and carers require level two safeguarding children training. In addition to this, staff should be able to access a level three trained professional at any time during their work.

Staff we spoke with had a good understanding of who the named safeguarding lead for the trust was and they could describe how they would raise concerns. For example, one member of staff told us of a referral to the safeguarding team for a vulnerable patient who had arrived for their appointment alone and with no shoes or socks. We were told that staff spoke with the patient's family due to concerns about their vulnerability and a lack of mental capacity. Information on safeguarding was visible throughout the department for staff, patients and visitors to see. This included the details of who to contact to raise concerns.

Female Genital Mutilation (FGM) leads were in place and there were processes for recording and reporting. The Head of Safeguarding attended external meetings whereby FGM featured in addition to other safeguarding subject matters including Child Sexual Exploitation, Modern Day Slavery and Trafficking.

Cleanliness, infection control and hygiene

Standards of cleanliness across the department were generally maintained, with systems to prevent healthcare associated infections. Staff kept the environment, premises and equipment clean.

Cleaning schedules were maintained in all clinical areas. For example, schedules for each consulting room were maintained. Those we viewed included details of the frequency and extent of cleaning within the room and were signed off as completed. Nursing staff took responsibility for monitoring the cleanliness of the rooms. Communal areas were monitored by contracted cleaning staff and we saw that cleaning schedules were maintained for bathroom areas and monitored closely by staff.

Toys used within the waiting area were subject to routine cleaning schedules and had been identified as an area of risk on the environmental risk assessment.

Regular cleaning audits were undertaken. We viewed a failure action list where individual failures to cleaning compliance were identified such as an accumulation of dust or marked privacy curtains. The contract with the cleaning provider included a target for cleaning compliance failures were addressed within an hour. Staff reported that they were satisfied with the cleanliness of the department and the responsiveness of the cleaning staff should concerns arise. All areas of the department were seen to be clean and tidy during the inspection.

We observed re-usable privacy curtains in treatment areas which had been changed in the last six months in line with national guidance. Nursing staff monitored the condition of the curtains within their own clinical area as part of routine checks. One staff nurse working within the department told us they had liaised with domestic staff about a curtain that had been marked. They told us that domestic staff changed the curtains as required. Domestic staff maintained records of six monthly curtain changes and laundering schedules. This complied with Hospital Building Note 00-09, infection control in the built environment. This demonstrated that staff regularly changed the curtains to minimise the risk of the spread of infection.

We observed staff following national guidance on infection control. For example, staff with long hair had tied it back and all staff were 'bare below the elbows' at all times to enable effective hand hygiene and minimise the risk of contamination. We observed staff following National Institute of Health and Care Excellence (NICE) QS61: Statement 3: People receive healthcare from

healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. Alcohol hand sanitiser was seen in some areas of the department and staff and visitors were observed using it.

Results of monthly hand hygiene audits showed that compliance was at 100% over a three-month period. At the time of our inspection hand hygiene audit results were displayed in patient waiting areas. These were 100% in both dermatology and general outpatient clinics.

There was sufficient personal protective equipment (PPE) available in line with trust policy. There were sufficient hand washing facilities available with sinks with lever arch taps in clinical/treatment areas. This was in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and hand towels were available next to hand basins to facilitate effective hand washing. Information was displayed by hand washing sinks, demonstrating the World Health Organisation (WHO) guidance (2009) 'Five moments for hand hygiene'.

Waste was seen to be handled in line with national guidance. Waste bins were emptied regularly and seen to not be overfilled. Sharps bins included completed labels with the signature of staff and the date they were assembled. Sharps bins were available in treatment rooms and areas where sharps may be used. Sharps bins were not overfilled and were managed in line with Health and Safety Regulations 2013 (the sharps regulations), 5 (1) d. This requires that appropriate and secure sharps containers for the safe disposal of medical sharps, be placed close to the work area where sharps are being used.

We spoke with staff in the urology clinic who could describe a process of decontamination of reusable medical equipment in accordance with Department of Health Decontamination of surgical instruments (CFPP 01-01) (chapter 6) and trust policy. We saw evidence of standard operating protocols for decontamination and completed checklists for cleaning of equipment. There were staff identified with lead roles for monitoring decontamination within the department.

Environment and equipment

The environment was not suitable for the number of patients seen. Leaders recognised the need to review patient flow through the department.

The outpatient service was provided within a single storey purpose built building that was accessible to patients with mobility issues.

Clinic and waiting areas were identified as a risk on the outpatient risk register. The risk included issues around increasing demand and a lack of consulting rooms across all sites including at Corbett Outpatient Centre. Other risks identified included a lack of bariatric equipment and issues with a lack of space in waiting areas. In addition, there were outstanding maintenance activities that had not been completed. For example, at Corbett we were shown a room that were carpeted that was unable to be used as clinical areas. Staff told us they were waiting for the carpet to be removed so that the room could be used more effectively. In addition, a lock on the treatment room door was broken and staff told us they were awaiting a key pad lock to be fitted but were unsure when this would be. The risk register identified outstanding maintenance issues at Corbett as an area of risk, indicating that funding had been agreed but that as yet there was no date for the work to commence.

Patient assessment areas in trauma and orthopaedics were in a bay area with curtained cubicles. Staff told us they tried to manage this by only having one patient in the treatment area at a time

rather than having patients waiting there. They acknowledged that this was difficult to manage at times.

Staff reported a lack of storage space throughout the department. In the trauma and orthopaedic clinic, we saw equipment stored in clinical bay areas as there was insufficient cupboard space, however we were informed by the service that this had been agreed with departmental leads in order to utilise the space available. There was insufficient storage space for medical records, with an increased risk of records not being stored securely. This was identified as a risk on the risk register.

There was no bariatric (for patients living with obesity) equipment at Corbett. Staff in the rehabilitation centre told us they could access this from Russell's Hall Hospital. In the outpatient waiting areas, seating was of a standard size with chairs with high arms so that bariatric patients may have found it difficult to sit comfortably. A lack of bariatric equipment was identified on the outpatient risk register, however, it was unclear what longer term action was being taken to address this issue.

In the urology department a patient with a history of seizures was having a cystoscopy. There were no sides on the trolley for safety so this was mitigated by nursing staff standing either side of the trolley in case of further seizures.

There was one resuscitation trolley available in the urology clinic that was to be used throughout the whole of the outpatient department. The trolley included tamper resistant seals on each of the drawers for additional security while ensuring that the emergency medicines and equipment were easily accessible to staff. Emergency equipment and medicines stored on the resuscitation trolley were subject to regular checks. This included checks that included ensuring that the seals were secure and that oxygen cylinders were sufficiently full, that expiry dates of medicines had not been reached and a detailed check of all equipment and single use items that may be required in a medical emergency. All resuscitation medicines and consumables kept on the trolley were in date.

Medical devices maintenance was carried out by the in-house medical engineering team. Medical devices were registered to an equipment management database where planned maintenance and demand maintenance work was recorded. One of the outpatient clinical support workers took the lead on checking the maintenance of equipment. We saw a log of regular equipment checks that indicated all equipment within the general outpatient department was within its maintenance due by date. We checked two items of equipment in general outpatients and found that all had up to date maintenance stickers attached, indicating they had been appropriately serviced as part of a preventative maintenance schedule. In the dermatology clinic we saw two phototherapy machines in treatment room 3 that had next service due stickers of December 2018. The dermatology CNS told us that the company had been contacted to ensure the service was carried out.

Disposable items were in use throughout the outpatient services. All disposable equipment was seen to be in date with arrangements for stock replenishment clear.

Assessing and responding to patient risk

Risks to people such as deterioration of patients and sepsis were not always adequately assessed and were not always managed safely.

The process for dealing with resuscitation situations was not clear. The service had one nurse bleep holder for resuscitation situations and were reliant on an anaesthetist in theatre and other medical staff on site but roles and responsibilities were not clear. A resuscitation trolley was kept in the urology department and staff said this would be collected by 'someone' but were not clear

who. Staff told us they would dial the internal emergency call number so that bleep holders would be alerted to the emergency and switchboard staff would put out an external call for a cardiac ambulance. However, one staff member told us they would call 999 themselves and request a cardiac ambulance without going through the internal switchboard. Following feedback from the first day of inspection, regarding the lack of clarity around the resuscitation process, senior staff updated the protocol. Action included adding additional bleep holders, including the senior urology nurse (who would collect the resuscitation trolley), the trauma and orthopaedic nurse (who also was trained in paediatric resuscitation) and the dermatology clinical nurse specialist (who would find the nearest doctor). Staff had practiced the resuscitation process in order to clarify the protocol and we viewed an updated copy on the staff notice board. This was led by a deputy chief nurse and the protocol also included that when the resuscitation call to switchboard was made there was a clear request for a cardiac ambulance to be called due to a cardiac arrest.

Senior staff told us they were aware there was some work to do on improving how they identify and monitor deteriorating patients in outpatients. We were told that discussions had been had at a senior level about how they could learn from the experience of staff in the emergency department around identifying patients at risk of deterioration. However, clear plans on how this would be developed were not yet in place. Clinical staff were trained in resuscitation and anaphylaxis. There was a hypoglycaemic kit held in outpatients that included glucose supplements, drinks and snacks. In general outpatients we were told that sometimes there were only clinical support workers on shift as once the registered nurse clinics had finished the registered nurse may then go over to Russell's Hall Hospital to help. However, there was no recorded risk assessment for support workers working without a registered nurse. Senior and nursing staff told us the support workers could seek help from registered nurses in dermatology and trauma and orthopaedic outpatients. However, we were told that there had been no scenario planning or rehearsals with support workers on the action to take and the current process was reliant on support worker assessment skills. Senior staff told us that ideally there would be a band 3 support worker on shift in this situation who was able to carry out activities such as blood glucose monitoring and electrocardiograms, however this was not guaranteed.

In the urology department a patient with a history of seizures was having a cystoscopy. There were no sides on the trolley for safety so this was mitigated by nursing staff standing either side of the trolley in case of further seizures. This was not identified on the urology risk register as a risk.

Patients in waiting areas were observed by the staff working in those clinics. Nursing staff told us they would periodically check the waiting area to ensure that patients were comfortable. We observed one patient who had experienced a delay in transport being supported by the nurse on duty. The nurse told us they had been due to travel to Russell's Hall in the afternoon as their clinic had been cancelled, however they delayed this until the patient's transport had arrived. Staff told us that patients identified as at risk of deterioration through general observations would be closely monitored and we saw this during our inspection. However, there were no formal monitoring processes for patients in waiting areas.

Reception staff who were not registered practitioners did not receive any training on how to recognise a patient was deteriorating. This was important as on induction reception staff were instructed to inform the nurse in charge if patients reported they felt unwell or if they witnessed deterioration. Reception staff told us they relied on their own experience to alert nursing staff to any concerns.

Nursing staff administering medicines in clinic had access to treatment for anaphylaxis (a serious allergic reaction) and had been trained to deal with this situation. Nursing staff we spoke to told us that adrenaline for use in this situation was locked in the treatment room and the keys held by the nurse on duty. However, nurses also told us that if there were administering a medicine for injection where there was a potential risk of anaphylaxis they would ensure that adrenaline was available in the room where they were administering the treatment. Following the inspection leaders told us that anaphylactic packs were now provided and stored on resuscitation trolleys.

Nurse staffing

The service did not consistently have enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and provide the right care and treatment.

The trust has reported the following qualified nursing staff numbers for the two periods below for outpatients.

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Nursing	61.4	55.7	90.7%	62.0	56.7	91.4%

The trust reported a qualified nursing staffing level of 90.7% in outpatients in March 2018 which increased to 91.4% in September 2018.

As at September 2018, there were 5.3 fewer WTE staff in post than planned for but 1.0 more WTE staff in post than in March 2018. There was an increase of 0.6 WTE planned posts between the two-time periods.

Staff told us there were times when support workers worked in general outpatients without the direct supervision of a registered nurse. This situation occurred when there was no clinic running in Corbett outpatients requiring registered nurse input, resulting in the registered nurse rotating to the Russell's Hall site. Staff told us this generally happened when clinics were cancelled and would likely be for part of the shift rather than the whole shift. We were also told that the risk was mitigated by support workers being able to access registered nurse input from the trauma and orthopaedic and dermatology clinics. However, there was no recorded risk assessment of this and the competence of the support workers to assess patient risk was not clear in relation to working without the direct supervision of a registered nurse.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From October 2017 to September 2018, the trust reported a vacancy rate of 7.7% for qualified nursing staff in outpatients. This was higher than the trust's overall target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018, the trust reported a turnover rate of 3.6% for qualified nursing staff in outpatients. This was lower than the trust target of 8.5%.

The breakdown by site was as follows:

- Russell's Hall Hospital: 1.4%
- Russell's Hall Hospital / Corbett Hospital: 11.1%

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018, the trust reported a sickness rate of 3.1% for qualified nursing staff in outpatients. This was lower than the trust's target of 3.5%.

The breakdown by site was as follows:

- Russell's Hall Hospital: 3.3%
- Russell's Hall Hospital / Corbett Hospital: 2.2%

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From October 2017 to September 2018, the trust reported 11,410.0 available hours in outpatients were filled by bank staff (5.1%) and 947.0 (0.4%) were filled by agency staff. In addition, there were 17,850.0 hours that needed to be covered by bank or agency staff but were unfilled (7.9%).

A breakdown of bank and agency usage by staff type is shown below:

	October 2017 to September 2018						
Staff type	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	3,206.0	2.7%	947.0	0.8%	10,002.0	8.4%	119,763.0
Non-qualified	8,204.0	7.8%	0.0	0.0%	7,848.0	7.4%	105,825.0
Total	11,410.0	5.1%	947.0	0.4%	17,850.0	7.9%	225,588.0

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency)

We asked the trust to provide us with details of bank and agency staff usage broken down by site. We reviewed the data for Corbett between October 2017 to January 2019 and found that bank and agency staff usage fell below the trust target of 18% in all months.

Medical staffing

The trust was unable to provide separate staffing data for medical staff in outpatients.

The trust clarified that the medical staff who work in outpatients, work across both inpatients and outpatients. Accordingly, in the trust's HR and training data these staff are mapped to the

relevant inpatient service.

(Source: Routine Provider Information Request (RPIR) – Medical agency locum)

Records

Records were not always available to all staff providing care. Records were not stored safely or securely within the department.

The service did not routinely monitor the proportion of patients attending an outpatient appointment without their full set of medical records being available. Staff reported that there were regular times when medical records were unable to be located prior to an outpatient appointment. We were told that when this happened a temporary set of medical records was produced, including copies of referral letters and any results such as radiological and haematological results on electronic systems. Reception staff told us they would sometimes contact the patient's primary care provider to request copies of referral letters and any other essential information. However, some administrative staff expressed concerns about the frequency that full sets of medical records were unavailable.

Leaders told us that staff reported missing healthcare records as a safety incident, however staff informed us that this was not always done due to the length of time it would take to complete and incident form. We asked for details of how many incidents had been raised about notes being unavailable for clinics in October/November and December 2018; the trust reported there were 14 across all three sites. Leaders recognised that due to the volume of unavailable notes it was unlikely that staff had time to report each missing set; they also told us that most notes were not missing but later found in other departments. Staff could not tell us how many notes were missing in any one day. We saw that one clinic for 15 patients had two sets of temporary notes prepared. Senior staff told us that the management of patient records had been a priority and identified as one of the main risks they had identified at the time of our inspection. However, this was not recorded on the outpatient risk register.

Systems and processes were being put into place to ensure notes could be located such as including a check box into booking in systems and an electronic note tagging system so notes could be located. Leaders confirmed there would need to be a manual audit of reported incidents to determine how often notes were unavailable.

Notes were seen to be stored in wire trolleys at the back of reception in a lockable room and behind the reception desk for clinics running at that time. The room was not locked at the start of the inspection, however when we returned on the second and third days this had been addressed. Access behind the reception desk was restricted by the presence of reception staff, however when standing at reception, notes for clinics being held were visible, including the name of some patients and the type of clinic they were attending. We flagged this with senior staff but no action was taken at the time of our inspection. Staff told us that notes trolleys had previously been stored in communal walkways but that this had been recently addressed prior to our inspection and we were told this no longer occurred.

We were told that records were retrieved from reception by support workers and administrative staff on an individual basis when patients arrived for their appointment and we observed this in operation. The records were then taken to the clinic and stored in

boxes before being returned to the reception area at the end of clinic. Staff told us that responsibility for this fell to domestic staff when clinicians had stayed beyond the end of clinic to complete the notes. This practice was stopped at the time of the inspection when this was raised with staff as a concern. However, at the end of the first inspection day we found two sets of notes left on a trolley in the clinic and while the domestic staff told us they had been told not to put the notes away, no other arrangement was in place to address this. Senior staff told us that the issue was due to medical staff staying in clinic when all other staff had left and not securing the notes before they left the department.

We saw that insufficient storage space for records had been identified as a risk on the outpatient risk register. However, control measures were identified as insufficient due to a lack of available storage space within the department.

The clinical audit team had audited outpatient documentation in 2018. Areas of good practice and concern were identified. As a result of the audit an action plan was devised. Actions included ensuring the patient full name, NHS numbers was in dictation of patient letters and ensuring complete recording of allergies in new patient letters. Positive findings included 975 of cases a clear diagnosis or differential diagnosis was recorded in the patient letter and 100% of letters in the sample contained a legible printed name and designation.

We reviewed three sets of notes. We found them to contain relevant information such as treatment plans, test results, diagnosis and follow ups. Records were legible, signed, dated and written in black ink.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines, with the exception of a treatment room within the general outpatient department that did not have a working lock.

In general outpatients medicines were kept in a treatment room that was usually locked when not in use, however at the time of our inspection we were told that the lock was broken and a new key pad lock was due to be fitted. Medicines were stored in locked cupboards within the treatment room. In urology, medicines were stored in a locked cupboard in a locked room. Cupboards containing medicines were locked, and the keys for these were held by a registered nurse.

FP10 prescriptions were used in urology. Prescriptions were stored securely in locked cupboards with serial numbers recorded so that all forms could be tracked throughout the department. This was in line with NHS Counter Fraud Authority Management and control of prescription forms: A guide for prescribers and health organisations, March 2018. FP10 prescription pads were not in use within the general outpatient department as medicines were generally issued using hospital prescriptions.

In the general outpatient department stock control was the responsibility of nursing staff. All medicines viewed at the time of our inspection were stored securely and in date.

Fridge temperatures were monitored to ensure that medicines were stored within the correct temperature range. We reviewed temperature monitoring records in general outpatients and saw that these were within range and that records were completed including checks of minimum and maximum temperatures. Staff were clear that any issues with the cold chain were to be escalated to pharmacy and advice sought about the storage of medicines.

Patient Group Directions (PGDs) were not used in general outpatients but were in use within dermatology and urology and gynaecology outpatients. These were reviewed, updated and approved by the Drugs and Therapeutics Committee and those we viewed were in date. PGDs are written instructions to administer medicines to patients in planned circumstances in place of an individual named patient prescription. Medicines for patients being seen in clinic were prescribed to take home or by prescribing clinicians in the patient's notes if medicines were to be administered in clinic. Patients were prescribed medicines to take home using a hospital prescription that could be filled at the outpatient pharmacy that was located next to the outpatient department. Controlled drugs were not in use within the department.

We reviewed the most recent ward/department medicines storage and handling audits dated September 2018. The audit at Corbett hospital found noncompliance in urology and gynaecology outpatients due to a medicines fridge being unlocked. Following feedback to staff a repeat audit in January 2019 showed that the medicines fridge was locked.

Incidents

Lessons were learned and improvements made when things went wrong. Staff understood their responsibilities to raise concerns, record safety incidents and report them internally and externally.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as a never event for outpatients.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in outpatients which met the reporting criteria set by NHS England from December 2017 to November 2018.

 A breakdown of the incident types reported is below:

- Slips/trips/falls meeting SI criteria

- Surgical /invasive procedure incident meeting SI criteria

(Source: Strategic Executive Information System (STEIS))

Staff we spoke with demonstrated a good understanding of their responsibilities for reporting when things went wrong. Staff were aware of the reporting system and knew how to use it. Daily safety huddles were held every morning at Russell's Hall outpatient department and we were told that

information from this was shared with all staff via email. Safety huddles were held at Corbett outpatient centre on a weekly basis and because the staff rotated across all sites nursing staff at Corbett had the opportunity to participate in the daily huddles when they were based at Russell's Hall.

A serious incident at Corbett outpatients involved a patient fall and a subsequent fractured neck of femur. The incident was under investigation and we saw that the patient had lost their balance while reaching for a ticket in the phlebotomy clinic and had not tripped or slipped. We saw that the duty of candour had been applied because of this incident. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. There were three incidents in general outpatients where the duty of candour applied.

We reviewed a summary log of all closed outpatient incidents and saw that 35 had been recorded between January and December 2018 across the trust. Six of these related to incidents at Corbett. Three related to slips, trips and falls, one to a delayed test, one to a health and safety incident and the other an appointment booking error. Incidents were investigated and actions recorded. Actions included those taken at the time of the incident and those as a result of the investigation.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance.

Policies and procedures based on such guidance were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and referred to the guidance used in their development.

We saw evidence of national guidance used within clinics. For example, in dermatology staff referred to the use of the British Association of Dermatology guidance and we saw relevant patient information leaflets used within the clinic. In general outpatients we spoke with nursing staff who supported rheumatology clinics. They told us that the National Institute for Health and Care Excellence (NICE) NG100 (Rheumatoid arthritis in adults) in relation to aspects of management such as diagnosis, assessment and treatments. We were also told that National Rheumatoid Arthritis Society guidance was in use, for example in relation to measuring disease activity within rheumatoid arthritis and the use of the DAS28 score.

Physiotherapists followed national guidance when supporting patients within stroke, rehabilitation and neurology pathways. For example, NICE guidance was followed for patients with conditions such as multiple sclerosis and Parkinson's disease.

Staff told us that clinical audits against national guidelines were carried out within specialisms rather than in general outpatients. The trust informed us that the clinical audit team worked closely with clinical leads to assess compliance of NICE guidelines.

There was a Local Safety Standards for Invasive Procedures (LocSSip) Audit (May 2018). The audit was to demonstrate compliance against the LocSSip policy. LoccSSips are based on the national safety standards (NatSSips). They were set up to enable the trust to review current local processes for invasive procedures. They are needed to make sure procedures and processes are in place that provide assurance that invasive procedures are recognised and managed safely. The audit identified there was a lack of knowledge in some areas about the standards and what they were for. However, it also showed that overall compliance with the policy was good.

Nutrition and hydration

People's nutrition and hydration needs were identified, monitored and met.

Water machines were available in the waiting areas. Patients could also access refreshments from a café close to the outpatient clinic. Staff told us that patients who were waiting for a long time or delayed due to transport issues were offered food and drinks. For example, we observed one patient waiting for more than an hour for transport following their appointment being offered refreshments by more than one member of staff.

Pain relief

People's pain was assessed and managed.

As part of outpatient assessment processes staff told us they would assess patient's pain level as appropriate depending on their condition and symptoms, or procedures they were having done.

Stocks of simple analgesia such as paracetamol were available in general outpatients. Staff told us that if a patient was in pain they were assessed and a one-off prescription was issued by a medical practitioner and analgesia supplied.

Pain clinics were held within the outpatient service. The service had implemented the faculty of pain core standards for pain management and was compliant for both acute and chronic pain. Key standards relevant to the outpatient department included no sole practitioner acting in isolation and specialist pain management services must have access to dedicated pharmacy input.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Follow-up to new rate

The trust provided their follow-up to new rate for November 2017 to December 2018 for all specialties together with the 'peer' rate of other acute NHS hospitals. This included both face to face and non-face to face attendances.

Twenty-one specialties had a rate higher than the reported peer group

Specialty grouping	Trust	Peer
Anticoagulant service	36.9	14.3
Nephrology	11.3	7.9
Orthodontics	10.8	9.4
Maxillo-facial surgery	9.8	1.5
Clinical oncology	9.2	7.5
Programmed pulmonary rehabilitation	8.8	6.6
Respiratory physiology	8.7	1.9
Clinical haematology	7.4	6.4
Rheumatology	7.3	4.2
Diabetic medicine	5.9	5.1
Chemical pathology	5.8	2.2
Endocrinology	4.6	2.9
Orthoptics	4.5	3.6
Dietetics	3.6	1.8
Dermatology	3.4	2.3
Physiotherapy	3.3	2.7
Urology	3.1	2.2
Audiology	2.1	1.3
Trauma & orthopaedics	1.9	1.8
Cardiology	1.3	1.3
Transient ischaemic attack	0.6	0.4

Twenty-three specialties had a lower rate than the reported peer group.

Specialty grouping	Trust	Peer
Medical oncology	7.6	8.7
Occupational therapy	2.4	2.4
Ophthalmology	2.3	3.1
Plastic surgery	1.8	2.5
Pain management	1.7	2.2
Optometry	1.7	2.7
Respiratory medicine	1.5	2.0
General surgery	1.4	1.5
Neurology	1.3	1.9
Vascular surgery	1.2	1.3
ENT	1.2	1.4
Clinical immunology and allergy service	1.2	1.4
Stroke medicine	1.1	1.3
Oral surgery	1.1	1.2
Gastroenterology	1.1	1.9
Breast surgery	0.8	1.2
Geriatric medicine	0.7	1.3
General medicine	0.6	1.2
Anaesthetics	0.4	1.8
Colorectal surgery	0.2	1.1
Interventional radiology	0.1	0.4
Clinical genetics	0.0	0.4
Clinical psychology	0.0	3.6

(Source: Data Request DR87)

Follow up to new data was reported trust wide rather than broken down per site. Dermatology, urology and trauma and orthopaedics, all of which had clinics based at Corbett, had a higher follow up to new ratio that the peer comparison.

A one stop breast clinic was in operation at Russell's Hall Hospital, there were no one stop clinics in operation at Corbett.

Outpatient services had processes in place to record patient outcomes after each clinic appointment. An outcome form was created for every outpatient appointment. The form was used to record the patient's referral to treatment status, the outcome of their appointment and where appropriate details of when their next appointment should be. Other outcomes recorded included any blood tests, scans, further investigations or discharge and was used to monitor patient follow up from consultation.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Appraisal rates

For the year to date, April to September 2018, 95.1% of required staff in outpatients received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to scientific, therapeutic & technical staff	3	3	100.0%	90.0%	Yes
Other qualified scientific, therapeutic & technical staff	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	54	55	98.2%	90.0%	Yes
Qualified nursing & health visiting staff	33	36	91.7%	90.0%	Yes
Qualified allied health professionals	7	8	87.5%	90.0%	No
Total	**98**	**103**	**95.1%**	**90.0%**	Yes

Russell's Hall Hospital

For year to date, April to September 2018, 98.6% of required staff within outpatients at Russell's Hall Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Other qualified scientific, therapeutic & technical staff	1	1	100.0%	90.0%	Yes
Support to doctors and nursing staff	45	45	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	27	28	96.4%	90.0%	Yes
Total	**73**	**74**	**98.6%**	**90.0%**	Yes

Russell's Hall Hospital / Corbett Hospital

For year to date, April to September 2018, 86.2% of required staff within outpatients at Russell's Hall Hospital / Corbett Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to scientific, therapeutic & technical staff	3	3	100.0%	90.0%	Yes
Support to doctors and nursing staff	9	10	90.0%	90.0%	Yes
Qualified allied health professionals	7	8	87.5%	90.0%	No
Qualified nursing & health visiting staff	6	8	75.0%	90.0%	No
Total	**25**	**29**	**86.2%**	**90.0%**	No

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

All new staff and volunteers attended a trust induction programme and were provided with additional role specific training as needed. The trust induction included mandatory training and an introduction to the trust as well as the individual hospital sites. The outpatient department had local induction processes in place for new staff.

Staff consistently told us they received support with their professional development within the service. Nursing staff working in the outpatient department worked as part of the medicine or surgery teams. Managers told us this was so that nurses were able to develop specific skill sets relevant to the clinics they worked in. For example, nurses working in the surgical team developed skills and competencies relating to areas of work such as compression bandaging and wound care. We viewed competency frameworks for both nurses and clinical support workers and saw that these were based on Nursing and Midwifery Council Guidelines.

Monthly audit meetings were held within the surgical division and outpatient staff attended these meetings. The meetings included training elements relevant to practice and incorporated learning from external speakers and case reviews.

Staff working in specialist clinics had access to relevant continuing professional development. For example, nursing staff working in rheumatology clinics had attended training in assessment processes. Physiotherapists had attended training courses to help patients with Parkinson's disease exercise in a way to promote neuroplasticity which had been shown to slow down the progression of symptoms.

Staff had access to clinical supervision.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.

Staff working within the outpatient clinics also told us there was a multidisciplinary approach to care across the different specialities. For example, physiotherapists we spoke with told us they worked within a multi-disciplinary approach to support patients on the stroke, rehabilitation and

neurology pathways. These meetings were attended by speech and language specialists, occupational therapists, physiotherapists, case managers and specialist nurses.

We observed multidisciplinary working in outpatient clinics where specialist staff worked with outpatient staff to provide care for patients. Staff working in different speciality clinics were accessible to each other. We observed all staff working together well to ensure the smooth running of the department. Staff spoke of good multidisciplinary working relationships. Clinical nurse specialists held nurse led clinics.

Seven-day services

General outpatient clinics were in operation between 8.00 and 6.00pm Monday to Friday.

Health promotion

The department took part in health promotion. Patients were supported to live healthier lives and were referred to other support services where appropriate.

There was a range of information available for patients such as information on how to manage their skin condition in the dermatology clinic. We also saw information around health and wellbeing and services such as stop smoking support.

Nursing staff told us that health promotion was a standard part of clinic activity. We observed nurses interacting with patients and giving them advice around nutrition and activity to improve health. One nurse we spoke with told us they routinely gave patients information on self-help methods to improve wound healing through good nutrition and skin care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trusts policy and procedures when a patient could not give consent.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 83.3% of eligible nursing staff in outpatients.

A breakdown of compliance by site for qualified nursing staff in outpatients is shown below:

Site	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Russell's Hall Hospital	24	28	85.7%	90.0%	No
Russell's Hall Hospital / Corbett Hospital	6	8	75.0%	90.0%	No

In outpatients the 90% target was not met by either site for the mental health law training module for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff demonstrated an understanding of the mental capacity act and followed the trust's assessing mental capacity policy which aligned with the key principles of the 2005 Act such as every adult has the right to make their own decisions, must be assumed to have capacity unless it is proved otherwise and that anything done on behalf of the person who lacks capacity must be done in their best interests.

Staff were aware of the importance of gaining patient consent and followed trust policy. Consent forms were drawn up in some areas such as for the UK refractory asthma registry information, other types of consent included verbal and non-verbal. The trusts policy on consent was up to date and version controlled It also recognised that consent could be withdrawn at any time. We asked the department for details of all the audits they completed, there were none specifically in relation to consent.

Is the service caring?

Compassionate care

People were treated with compassion, kindness, dignity and respect, when receiving care. Feedback from people who used the service, those who were close to them and stakeholders was positive about the way staff treated people.

Staff understood and considered people's personal, cultural, social and religious needs. We observed patients arriving in the department and being supported by reception and volunteer staff. Staff were observed to greet patients with kindness and respect. We also witnessed staff identifying and introducing themselves and asking patients if they needed help with anything when being collected from waiting areas. This is in line with NICE QS15 Statement 1: Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Staff interacted with patients and those close to them in a respectful and considerate manner. Patients throughout all outpatient areas consistently reported that staff were kind and respectful and that the service offered was good.

Staff were sensitive and supportive towards people using their services and those close to them. Patients reported that staff had been patient and kind and had taken the time to fully explain things to them.

Staff ensured people's privacy and dignity was always respected. During each appointment, a nurse or clinical support worker accompanied the patient and acted as their advocate during appointments. This was an area of development senior staff had worked on following a patient complaint where they had not been offered a chaperone. The trust's chaperone policy set out the requirement for all patients to have access to a chaperone of the same sex if required. Nurses or healthcare assistants acted as chaperones when necessary and they told us they had received training in this. Where a patient had a personal preference with regards to the sex of the person that was accompanying or examining them, staff would make every effort to accommodate the patient's request. There were chaperone signs in waiting areas, corridors and consulting rooms, informing patients of their right to a chaperone. Staff told us a chaperone was routinely offered to patients when undertaking intimate examinations.

Staff demonstrated the need to respond in a compassionate, timely and appropriate way to people's experience of physical pain, discomfort or emotional distress. Patients with a life changing diagnosis were offered specialist support from trained nurses. This was in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. However, in some outpatient areas there was limited space for such conversations to be held. For example, in the urology clinic we were told there was no quiet space for breaking bad news and that staff had to use office space for this purpose. We viewed the office space and saw that it was a working space and that patient records were also sometimes stored there. Staff told us this made breaking bad news more difficult as they aimed to enable patients and relatives the space to process information in their own time.

Emotional support

People were given appropriate and timely support and information to cope emotionally with their care, treatment or condition. Staff communicated well with patients so they understood their care, treatment and condition.

A clinical support worker or nurse was present with patients during their appointments. This ensured that the patient had an advocate during their appointment who would check that they understood what was being said. Staff we spoke with told us they would always check patient's understanding at the end of the appointment before they left the department. Staff told us they would try and take patients to a different area if they needed extra support or time, however this was sometimes limited by a lack of space within the department.

Written information was available for patients about their condition and the support services available to them. Patient information packs were given to patients who received a cancer diagnosis. The information included links to local cancer support services. Staff told us that counselling was offered where appropriate and that referrals to local charities providing support and companionship were made for patients who were alone.

Staff we spoke with demonstrated an understanding of the need to assess and support patients from a psychological and social perspective as well as a physical one. We saw that psychological input was available to patients within specific pathways, for example, for patients following a stroke pathway. Staff were able to refer patients for support through the Improving Access to Psychological Therapies (IAPT) services. This was in line with NICE QS15 Statement 10: Patients have their physical and psychological needs regularly assessed.

There was a team approach evident to supporting patients in the clinics. Reception staff told us they were aware to look out for patients who were struggling or distressed and nursing staff were aware of observing waiting areas to identify patients who may be in need of emotional as well as physical support.

We observed staff supporting patients emotionally. This included spending time with them answering questions or by offering additional support to those patients who may be isolated or attending their appointment alone. Staff were seen to be kind and caring and we saw that work schedules accommodated additional time spent with patients to provide extra support that was needed.

Understanding and involvement of patients and those close to them

Staff routinely involved people who use services and those close to them in planning and making shared decisions about their care and treatment.

Patients we spoke with told us they felt involved in their treatment and care. They told us that clinical staff were open in their approach and that information was readily available, both verbally and in written formats to help them understand their condition and treatment plans.

Patients told us they had the time and opportunity to talk to staff about any concerns or treatment options. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Patients were supported by staff who had the communication skills to ensure effective interactions with patients in line with NICE QS15 Statement 2: Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills. For example, a patient visiting the dermatology clinic told us they had received information about treatment options and had been given time to ask questions.

Staff could communicate with patients by using their own preferred methods of communication. Patients were asked to alert the department to any communication issues prior to their appointment so that staff knew in advance. Referral forms included information about the accessible information standard and we saw posters referencing this in waiting areas.

Patients we spoke with told us they felt listened to and respected by the staff working in the outpatient department.

Is the service responsive?

Service delivery to meet the needs of local people

The trust did not always plan services that took account of patient's individual needs. The facilities and premises were not appropriate for the services delivered.

The outpatient department environment was not appropriate to meet the needs of patients and did not provide comfortable seating. We viewed a number of waiting areas during our inspection. This included waiting areas for phlebotomy, dermatology, general outpatients and trauma and orthopaedics. We saw that there was insufficient seating during busy times and that some patients had to stand. There were signs on the notice boards requesting that those patients able to stand did so and gave up their seat to someone who needed it. It was also identified on the outpatient risk register that the design of the centre was not conducive to patient flow and that the subsequent issues with overcrowding in waiting areas could lead to an increased risk of slips, trips and falls. Leaders recognised that the environment needed improving to meet patient's needs and were motivated to try and find solutions to the issues. However, clear plans on how the environment could be improved had yet to be developed.

There were water machines in waiting areas and enough toilet facilities. There was also a café located near to the department which served a variety of refreshments. Information for patients who needed information in a different format or language was available through the trust's information office. There were notices in patient areas alerting people to support around accessible information.

General outpatient clinics operated between 8:00am and 6.00pm Monday to Friday. Patients had to check-in for appointments at the check-in booth with administrative staff completing the check-in process.

Patients told us that car parking could be an issue due to limited space and we observed people spending time waiting for a parking space to become available. Public transport to the hospital was available.

The department was clearly signposted and we observed staff and volunteers helping to direct patients to where they needed to go. Staff told us that signage within the department had recently been updated and improved. We observed staff and volunteers interacting with patients in a way that was supportive and helpful.

There were notice boards in clinic waiting areas advising who the relevant nurse and healthcare assistant attached to that clinic was. The notice boards displayed information advising patients of the potential for delays in clinics and staff apologised for this. Senior staff told us there were plans in place for a television screen in the waiting areas to keep patients more updated as the notice boards required staff to hand write updates on them.

Patients received text message reminders of their appointments and there was two-way texting in use.

A phlebotomy service was available in the main outpatient department for patients being seen in clinic. This was a walk-in clinic and no appointment was necessary.

We were told that a patient paging system was in use within the outpatient department at Russell's Hall for patients unable to wait in the waiting area, or for those with communication difficulties. There was no paging system in place at Corbett.

Meeting people's individual needs

The service took account of patients' individual needs although waiting areas were limited for patients in wheelchairs and there was no bariatric chairs in the waiting area.

The trust was aware of the Accessible Information Standard. The Accessible Information Standard came into effect in 2016 and requires that all NHS trusts offer reasonable adjustments to help support people with disabilities or sensory loss to fully understand the information given to them. Staff had access to communication resources and multiple language and British Sign Language (BSL) interpreting for appointments.

Staff told us they could access interpreters on the same day if needed. Staff knew about translation services for patients who did not speak English as a first language and interpretation services could be arranged either to be face to face or via a telephone device.

There was no bariatric equipment held in general outpatients, however, staff told us they could access equipment from other locations as needed, including transferring equipment from Russells Hall Hospital following individual risk assessments. However, it was identified on the risk register that bariatric equipment was not always able to be used within outpatients due to the narrowness of corridors and small doorways.

Staff working in outpatients had access to a learning disability liaison nurse and mental health liaison, including for support for patients with dementia. They would contact the liaison nurses for advice and input about how best to support the patient.

Waiting area facilities were limited for patients in wheelchairs and had been identified by staff as needing revision to improve access for patients.
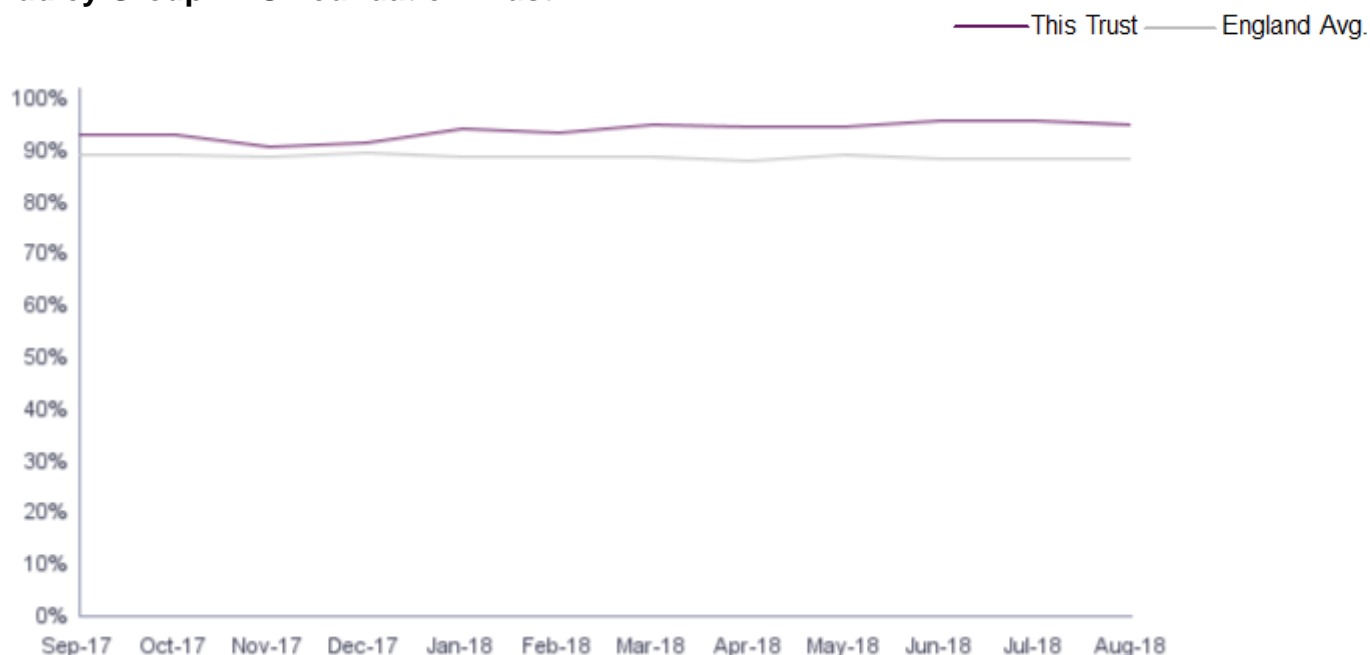
Access and flow

People could access the service when they needed it. Most waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice, action plans were in place for those that were not.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for non-admitted pathways was consistently better than the England average. The latest figures for August 2018, showed 94.9% of this group of patients were treated within 18 weeks versus the England average of 88.4%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, The Dudley Group NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Twelve specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Plastic surgery	100.0%	90.6%
Ear, nose & throat	98.9%	85.2%
Thoracic medicine	98.8%	87.0%
Geriatric medicine	98.4%	95.5%
Oral surgery	97.0%	83.5%
Neurology	96.1%	79.8%
Cardiology	95.0%	86.3%
Trauma & orthopaedics	94.8%	86.3%
Gastroenterology	94.7%	83.8%
Other	94.6%	91.0%
Urology	94.3%	87.2%
General Surgery	94.2%	88.9%

Three specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Dermatology	87.9%	89.1%
Ophthalmology	87.1%	89.2%
Rheumatology	86.2%	88.3%

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From September 2017 to August 2018 the trust's referral to treatment time (RTT) for incomplete pathways was consistently better than the England overall performance. The latest figures for August 2018, showed 93.6% of this group of patients were treated within 18 weeks versus the England average of 86.8%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, The Dudley Group NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Fifteen specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
General medicine	100.0%	92.7%
Geriatric medicine	99.4%	96.1%
Thoracic medicine	99.0%	88.8%
Ear, nose & throat	97.6%	84.8%
Trauma & orthopaedics	97.4%	82.1%
Rheumatology	97.1%	92.6%
Gastroenterology	96.7%	90.1%
Oral surgery	96.4%	84.5%
Other	96.4%	90.1%
Dermatology	95.8%	90.7%
Cardiology	94.9%	89.7%
Neurology	94.4%	87.3%
General surgery	92.8%	84.3%
Plastic surgery	91.5%	83.0%
Urology	89.7%	86.6%

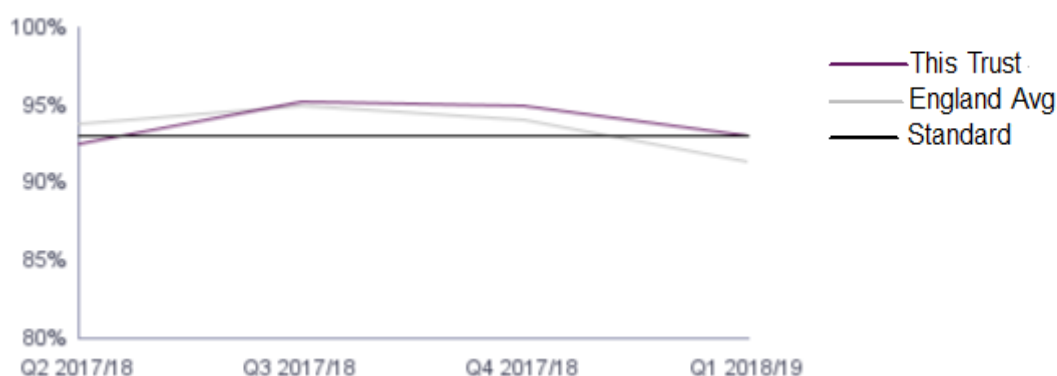One specialty was below the England average for incomplete pathways RTT (percentage within 18 weeks).

Specialty grouping	Result	England average
Ophthalmology	83.2%	88.2%

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is performing better than the 93% operational standard for people being seen within two weeks of an urgent GP referral. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers), The Dudley Group NHS Foundation Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust is performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat). The performance over time is shown in the graph below.

Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), The Dudley Group NHS Foundation Trust
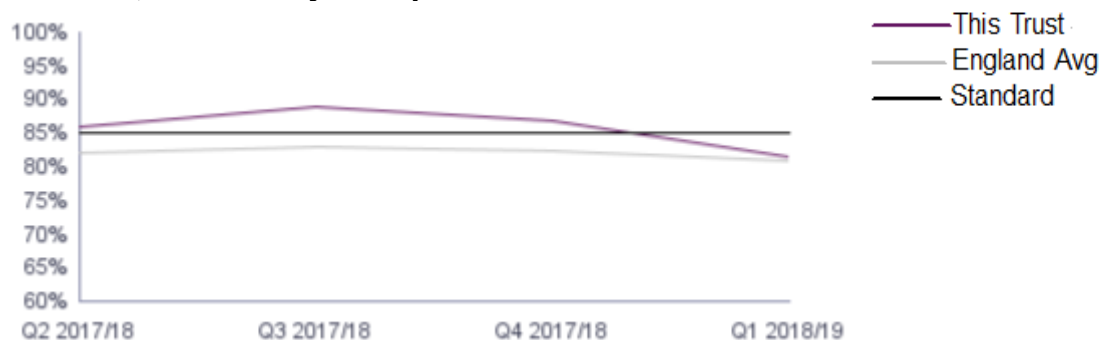

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP

referral to first definitive treatment

The trust is performing better than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. The performance was better than the standard and England average from Q2 17/18 to Q4 17/18 but then dipped below the standard, although still above the England average, in Q1 18/19.

Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment, The Dudley Group NHS Foundation Trust

(Source: NHS England – Cancer Waits)

There were referral to treatment (RTT) action plans to address areas where RTT times were below average. Leaders told us that the rheumatology department who were below average for non-admitted pathways percentage within 18 weeks had not met targets of 95% in August and September 2018 but had achieved the target in October, November and December 2018.

There was a choose and book system for outpatient appointments. Choose and book enables patients to choose the hospital they would like to attend and book a convenient date and time for their appointment. On arrival patients presented to the main reception desk; hospital volunteers waited near the main reception area to direct patients to the correct area. There were several waiting areas depending on which clinic patients were waiting for. Nurses or clinical support workers called patients in for their appointment. The doctor or outpatients booking team would make any further referrals.

The trauma and orthopaedic department held virtual fracture clinics. Leaders told us that this had reduced hospital attendance and that feedback had been positive. In the phlebotomy department there was a number of systems in place, a pager system alerted the phlebotomist when the next patient was due.

Staff in dermatology told us that waiting times had been delayed due to a lack of consultant availability. This was identified on the dermatology risk register. Figures provided by the trust showed that between October and December 2018 the average wait for a dermatology follow up appointment was 55.9 days. The trust reported that this figure was also impacted by patient choice. At the time of inspection, a new consultant was in post and staff were positive about the impact this would have on improving waiting times. We were told of a recent complaint from a patient who was unable to get an appointment within the agreed timescale and that this would result in a break in treatment. Nursing staff told us that while this treatment delay would have not been of clinical significance they contacted the dermatology registrar and arranged for the patient to be added onto a clinic.

Some reception staff reported that delays in booking follow up appointments meant that some patients did not always get an appointment within the timescale agreed with their clinician. Staff reported that they would liaise with the relevant secretarial staff to book patients in if there was limited availability. Reception leads told us that the key performance indicator for booking follow up appointments was within 24 hours although this was not always achieved. They told us that

the 'cashing up' process at the end of clinic had recently been reviewed to match referral to treatment figures to individual clinic areas and that they received regular performance information to monitor each outpatient location. At the time of inspection there were 344 outpatient appointments yet to be booked for Corbett. The longest wait at that time had been 72 hours.

Did not attend rate

From July 2017 to June 2018 the 'did not attend' rate for Russell's Hall Hospital was lower than the England average. The rate remained consistently lower than the England average, except for December 2017, where the rate was similar to the England average.

The chart below shows the 'did not attend' rate over time.

Proportion of patients who did not attend appointment, The Dudley Group NHS Foundation Trust.
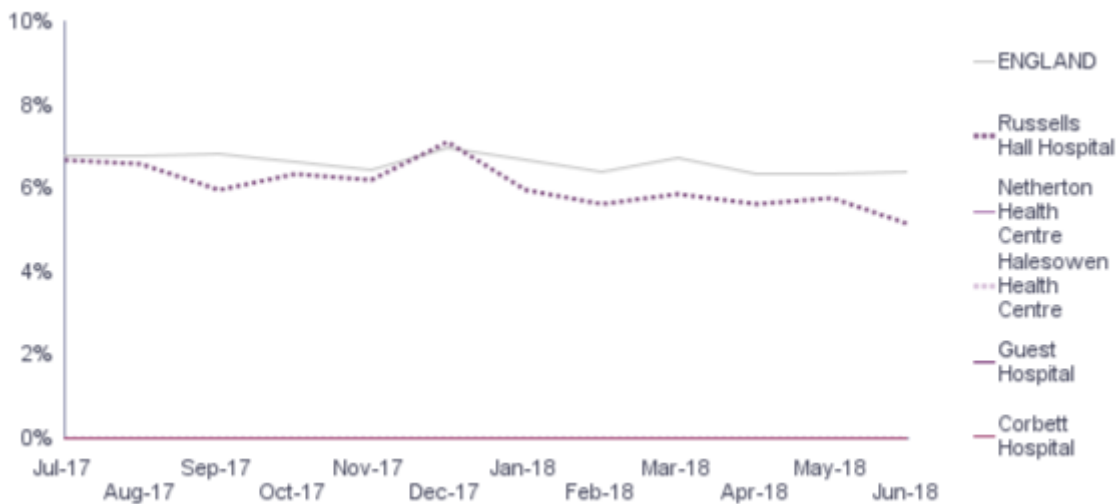
(Source: Hospital Episode Statistics)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared those with staff. However, complaints were not closed in line with the trust's complaints policy timescales.

Summary of complaints

From October 2017 to September 2018 the trust received 56 complaints in relation to outpatients (11.4% of total complaints received by the trust). The main subjects of complaints were patient care (15) and communications (13). We were told that of these 56 complaints, nine related to Corbett outpatients.

A breakdown of complaints by subject is shown below:

Subject	Number of complaints
Patient care	15
Communications	13

Appointments	13
Values & behaviours (staff)	8
Other (specify in comments)	2
Access to treatment or drugs	1
Admissions and discharges (excluding delayed discharge due to absence of care package)	1
Waiting times	1
Prescribing	1
Transport (ambulances)	1
Total	**56**

For the 40 complaints that had been closed at the time of data submission, the trust took an average of 74.9 working days to investigate and close these. This is not in line with their complaints policy, which states complaints should be closed within 40.0 working days.

The 16 complaints that had not yet been closed had been open for an average of 83.0 working days at the time of data submission.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Senior staff investigated complaints and concerns and we viewed evidence of action plans as a result. For example, we viewed an action plan following a complaint from a patient relating to an examination that had taken place without a chaperone. We saw that as a result of this learning had been cascaded to all staff around offering chaperones to patients. We saw that action included raising awareness of offering chaperones and recording this in the patient notes. We saw evidence of chaperone signs throughout the outpatient department during out inspection.

We reviewed three recent complaints responses (August to December 2018) and found they had details of the investigation, an apology, and when appropriate offered patients the opportunity to see a different consultant for any future appointments. Details of how to complain to the Public Health Service Ombudsman if they remained dissatisfied were also included. Leaders recognised the importance of good communication with patients who had made a complaint.

Information was readily available in waiting areas on how to make a compliant and details of the patient advice and liaison service (PALS). Complaints and compliments were an agenda item in confirm and challenge quality meetings and were discussed in weekly huddles. Staff were able to give an example of a complaint and how practice had changed as a result.

Number of compliments made to the trust

From October 2017 to September 2018 there were 234 compliments received for outpatients (3.4% of all received trust wide).

Compliments were received in all 12 months of the period. May 2018 was the month where the most compliments were received (47).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The outpatient services had the leadership capacity and capability to deliver high-quality, sustainable care. Leaders had the skills, knowledge, experience and integrity needed and there were clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership.

The outpatients and urology departments operated within the structure of the trust surgery, women and children division. The leadership structure included the chief of surgery, the director of operations, divisional chief nurse, matron and lead nurses. Leaders rotated across all three hospital sites.

The outpatient department at Corbett Outpatient Centre was managed by a general outpatient matron who worked across the trust-wide outpatient services. The matron post had been a recent development in the months before our inspection. Staff were positive about having a dedicated outpatient matron in post, telling us that they had previously felt there had been a lack of leadership and that outpatients had not been viewed as a priority by the trust. Staff reported improved visibility of leaders at all levels, including regular visits from the divisional chief nurse and directorate managers.

An outpatient senior nurse was also in post across all three trust hospital sites and a lead nurse had recently been appointed within the urology department. In addition, there were senior administrative roles such as team leader and management roles for health records and administration.

Staff were consistently positive about the leadership of the service and the division. They told us that both the matron and senior nurse were based at Corbett Outpatient Centre at least once a week and that communication was effective.

Vision and strategy

There was a clear vision and set of values, with quality and sustainability as the top priorities.

The service had a clear vision to be a highly regarded healthcare provider where people matter. Staff told us that the values underpinning the vision included care, respect and quality.

There was an annual outpatient plan in place which was aligned with the trust wide six strategic objectives. The plan contained goals such as staffing and environmental improvements, increasing productivity and the digitisation of health records. There were key actions and timescales identified alongside the goals.

Leaders were able to consistently articulate the vision and strategy for the service.

The trust wide vision and values were displayed in outpatient waiting areas and staff had a good understanding of these. We consistently observed staff providing care with a focus on improving the patient experience which was part of the trust's strategic objectives. Patients fed back that their experience had been positive and that staff had been caring. This evidenced that staff were observing the values and objectives of the trust.

Culture

Managers across the service promoted a positive culture that supported and valued staff, created a sense of common purpose based on shared values.

The culture within the outpatient department was centred on the needs and experience of people who use the service and staff felt supported, respected and valued. Staff reported recent improvements in the management structure as having a positive impact on the culture of the service. Nursing staff working in the outpatient department told us they rotated across all three sites which meant that they got to work with different team members in all locations. They told us there was a positive team culture across all sites.

Staff spoke of a supportive culture, which was open and where they felt confident to raise concerns; staff felt respected and valued. Staff spoke of enjoying their role in the department.

Mechanisms were in place to provide staff with the development they needed such as appraisals, training and development opportunities.

We observed cooperative, supportive and appreciative relationships amongst staff. Staff worked collaboratively.

Governance

There were examples of ineffective governance systems in some areas such as risk registers and audits.

Some areas of governance needed improvement. For example, risks were not always recognised or mitigated within risk registers and risks had limited movement from the initial risk rating to the current risk rating.

There was a lack of effective systems of audit in some areas and a clear disconnect from what we were told and what data showed. For example, in relation to missing/unavailable patient notes staff told us there were notes missing for clinics on a daily basis. We asked for details of how many incidents had been raised about notes being unavailable for clinics in October, November and December 2018; the service reported there were 14 across all three sites. This meant there was a clear disconnect between the numbers of missing/unavailable notes staff were telling us about and the amounts actually recorded. Leaders recognised that staff would not have the time to complete incident reports for all missing and unavailable notes.

At the time of the inspection there were no quality dashboards in the outpatient's department, this would form part of an ongoing roll out of dashboards across the trust.

Leaders gave examples of working with external professionals such as the local clinical and commissioning groups (CCG) and NHSI to improve the patient experience. For example, outpatient staff were involved in working with NHSI to plot the patient journey through the service with the aim of redesigning the service to improve the experience for patients.

The monthly nursing governance section of the assurance report in December 2018 contained information on formal complaints, compliments, trends and themes which included clinic waiting times, car parking and late arrival of doctors. These were included on the agenda within confirm and challenge quality meetings.

There were structures in place to ensure information was passed from ward to board and back again. There were daily huddle meetings held at Russell's Hall Hospital outpatient department. As most staff rotated across sites they would attend a meeting at some point during the week.

However, huddle meetings were not held at Corbett Outpatient Centre. We were told that issues such as safety, compliments and complaints and learning from incidents were discussed at the meetings. Staff told us that any outcomes from the meetings would be shared via email so that staff working at Corbett would receive relevant information.

Lead nurses reported into confirm and challenge meetings on a monthly basis. These were led by the divisional chief nurse. A presentation was produced for this, including key areas relating to areas such as workforce, finances and quality and governance; the meeting was also attended by the matron. Each department fed into their departmental governance meetings.

The directorate manager and chief nurse reported into the surgical divisional management team where they fed up risks from confirm and challenge meetings, governance and huddle meetings. Each speciality provided an update to the governance assurance meetings. Presentations from key speakers were cascaded down to departments by the matron. The governance assurance meeting chair produced a highlight report which was presented to clinical quality, safety and patient experience committee (committee of the board).

Management of risk, issues and performance

The organisation had the processes to manage current and future performance and there was a system in place to identify, understand, monitor and manage current and future risks. However, not all risks were fully recognised and mitigated.

Risk registers were maintained where risks were identified and mitigating actions used to manage the level of risk. However, there were some areas where the risks had not been fully mitigated or recognised. For example, action taken to mitigate the risks associated with the storage of health records exposed the service to potential breaches of confidentiality and information governance. For example, domestic staff had been given the responsibility of returning health records to the reception storage area, and while this practice was stopped in response to the concerns we raised, we then found notes on a trolley in an unlocked area of the clinic as they had not been returned to the storage area. In addition, we highlighted that patient names and the clinic they were attending were visible from the reception desk as health records were stored there with information visible. This practice was not stopped during the time of our inspection. We saw that the storage of health records was included on the outpatient risk register and the service had identified health and safety and information governance impacts of the risk. However, gaps in control remained in relation to a lack of storage space. In addition, it was not clear from the risk register which location it related to. However, a peer review that had been undertaken at Corbett in early January 2019 included some additional actions to mitigate risk that were not recorded on the risk register.

Risks were identified using a red, amber, green (RAG) rating system. Risks were rated using initial, current and target rates. Of the nine risks identified one had seen a reduction in risk rate since the initial assessment, this related to signage at Corbett which had been updated. The other risks had not yet been re-assessed as having an improved risk rate. One risk, relating to slips, trips and falls had been given a higher risk rating currently than when it had been initially identified. There were gaps in control identified including that the design of the department was not conducive to patient flow although it was not clear what action was being taken to address this or which site the risk specifically related to. None of the risks had clear dates recorded on the risk register, including dates relating when target rates were to be achieved by.

Not all risks were included on the risk register. Staff in urology at Corbett were seen to take mitigating action at the time of inspection in response to the risk of a patient with a history of seizures having a procedure on a trolley with no sides. However, this risk had not been identified on the urology risk register as a potential risk to patients.

At Corbett Outpatient Centre a peer review had been undertaken in early January 2019 within a risk management framework. The review identified areas of environmental risk throughout the whole hospital. Specific actions included improving the visibility of records relating to cleaning of public areas, making better use of storage space, control of substances hazardous to health and the storage of records. Each action had a lead allocated and a date set for review. As part of the management of risk, a site specific governance group had been set up and at the time of our inspection two meetings had been held. The matron told us they were planning on carrying out monthly reviews as part of the management of risk and quality assurance with the aim of improving the environment and the efficiency of services provided.

Information management

The service did not always collect, analyse, manage and use information as well as it could to support all its activities.

We viewed a risk on the risk register identifying that computers within the department across all three sites did not have the capacity to run up to date software. Staff reported that there were concerns that they did not have the systems in place to support the use of an electronic patient record. The trust had plans in place to roll out the electronic patient record across the trust in 2019, however it was recorded on the outpatient risk register that there was no budget for new computers to support this. Following the inspection service leads told us that as part of a programme of new computer installation throughout the trust, the installation of new equipment was completed within the outpatient department in April 2019.

Space was limited for the storage of patients' health records. During our inspection we saw that efforts were being made by leaders to identify solutions to the issue of records storage. However, we saw several instances of health records that were not stored securely or where patient identifiable information was visible.

Clinical staff had access to pathology results, imaging results and referral letters via the electronic systems currently in use. Staff told us that the systems worked well generally and that the information was accessible when they needed it. However, some reception staff reported that when patient health records were not available they had to make up temporary notes using information from other sources. This sometimes required them to contact the patient's GP to request information such as referral letters.

There were no quality dashboards in use within outpatients at the time of our inspection. Leaders told us that a dashboard roll out had commenced in January 2019 and that this would eventually include the outpatient department. Not all areas of performance relating to quality were monitored. For example, the service did not monitor data relating to the availability of health records for patients in outpatients other than through the reporting of incidents. Staff and leaders told us that it was likely not all incidents relating to notes availability were recorded in this way due to the time it would take to complete the reporting.

Where the service collected data it was used appropriately, for example to produce assurance reports. Data was discussed in confirm and challenge meetings, assurance reports contained data

on quality, governance, finance and workforce. Data collected included friends and family test, complaints and outstanding follow up rates.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

There were various ways the service engaged with staff including the use of patient safety bulletins, the trust governance newsletter, team briefs and emails. Staff we spoke with in the department told us they regularly attended team meetings.

Patients views were collected through the family and friend's data. Patient stories took place at board level. The NHS friends and family test is a nationwide initiative to gain feedback from patients about the care and treatment they receive in hospital. Patients were asked whether they would recommend

NHS services to their friends and family if they needed similar care or treatment. Test results were not recorded or displayed within the outpatient department at the time of our inspection. November 2018 results showed that 89% of patients would recommend the trust wide outpatient service to their friends and family. Senior staff we spoke with told us they wanted to increase the proportion of patients who completed the questionnaires and had requested the allocation of volunteers with online questionnaires to spend time in the department, supporting patients to complete the surveys. However, this had not yet been agreed. Senior staff told us they had developed action plans to address issues raised by patients, including the use of 'you said, we did' feedback boards in patient areas.

Most staff we spoke with told us that leaders engaged appropriately with them and they felt involved in changes going on within the department. Leaders acknowledged that the service was going through a period of change and that staff had demonstrated a very supportive approach to this and were receptive to changes. However, some staff reported that they didn't always feel involved in decisions that directly impacted on them, for example in relation to uniform changes and rotating posts across all outpatient sites.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

Leaders strived for continuous improvement; learning from incidents and complaints was embedded in the departments culture. In recent months the leadership to the outpatient department had increased, both in general outpatients and urology at Corbett. Leaders we spoke with had clear aims for developing improvement methodologies and were committed to improving the experience of patients. Staff consistently reported that since this time there was a greater focus on improvement across the department.

Leaders we spoke with told us of changes over the course of the last year where there had been an increased focus on developing processes to make improvements within outpatients. For example, in relation to supporting staff to reflect on practice to increase learning and improve quality.

There was evidence of active participation in research within speciality clinics, for example within dermatology in relation to the care and treatment of patients. One of the dermatology nursing

team was nominated for the British Dermatology Nursing Group nurse of the year for psoriasis.

Diagnostic imaging

Facts and data about this service

Diagnostic and imaging services at Corbett out patient centre

- Plain film – two x-ray rooms.

- Ultrasound imaging – one ultrasound room. The service provides musculoskeletal to include both diagnostic and therapeutic, general, gynae and small parts scans.

- DEXA imaging – one DEXA room.

Opening hours for all services are 8 am to 5.30pm Monday to Friday.

Is the service safe?

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.

Mandatory training

The service provided mandatory training in key skills to staff but had failed to meet their target for allied health professionals and medical staff in diagnostic imaging.

The training figures below are for Corbett and Russell's Hall as most staff working in diagnostic imaging rotated between the two sites.

Manual handling (non-patient) / slips, trips & falls training for allied health professionals was 40%, manual handling (patient) / slips, trips & falls training was 68.4% and Infection control training was 65.4% all against a trust target of 90%.

Adult resuscitation training for allied health professionals was at 70.7% against a trust target of 90%. We found that staff were unaware of the process and procedures to follow in respect of resuscitation including some staff being unaware where the resuscitation trolley was kept.

Staff felt they needed more time to complete training and found this difficult and said they had to do a lot of training in their own time.

There were no training figures or matrix available on the diagnostic imaging unit.

The trust had an action plan in place to improve mandatory training figures.

Mandatory training completion rates

The trust set a target of 90% for the completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Resus - adult	6	6	100.0%	90.0%	Yes
Information governance	6	6	100.0%	90.0%	Yes
Health & safety	6	6	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	6	6	100.0%	90.0%	Yes
Conflict resolution - level 1	6	6	100.0%	90.0%	Yes
Fire	5	6	83.3%	90.0%	No
Equality & diversity (including autism awareness)	5	6	83.3%	90.0%	No
Infection control - clinical	5	6	83.3%	90.0%	No
Manual handling (patient) / slips, trips & falls	4	6	66.7%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	2	3	66.7%	90.0%	No

In diagnostic imaging the trust had an overall mandatory training compliance rate of 89.5% for qualified nursing staff. The 90% target was met for five of the ten mandatory training modules for which qualified nursing staff were eligible.

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A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Information governance	19	19	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	19	19	100.0%	90.0%	Yes
Health & safety	19	19	100.0%	90.0%	Yes
Conflict resolution - level 1	19	19	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	17	19	89.5%	90.0%	No
Fire	17	19	89.5%	90.0%	No
Infection control - clinical	16	19	84.2%	90.0%	No
Resus - adult	16	19	84.2%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	3	4	75.0%	90.0%	No

In diagnostic imaging the trust had an overall mandatory training compliance rate of 92.9% for medical staff. The 90% target was met for four of the nine mandatory training modules for which medical staff were eligible.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified allied health professionals in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Clinical governance (including incidents, complaints & claims investigations)	77	81	95.1%	90.0%	Yes
Health & safety	77	81	95.1%	90.0%	Yes
Equality & diversity (including autism awareness)	73	81	90.1%	90.0%	Yes
Conflict resolution - level 1	65	81	80.2%	90.0%	No
Information governance	65	81	80.2%	90.0%	No
Resus - adult	53	75	70.7%	90.0%	No
Fire	56	81	69.1%	90.0%	No
Manual handling (patient) / slips, trips & falls	52	76	68.4%	90.0%	No
Infection control - clinical	53	81	65.4%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	2	5	40.0%	90.0%	No

In diagnostic imaging the trust had an overall mandatory training compliance rate of 79.3% for qualified allied health professionals. The 90% target was met for three of the 10 mandatory training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Russells Hall Hospital / Corbett Hospital

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Equality & diversity (including autism awareness)	3	3	100.0%	90.0%	Yes
Information governance	3	3	100.0%	90.0%	Yes
Fire	3	3	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	3	3	100.0%	90.0%	Yes
Resus - adult	3	3	100.0%	90.0%	Yes
Conflict resolution - level 1	3	3	100.0%	90.0%	Yes
Health & safety	3	3	100.0%	90.0%	Yes
Manual handling (patient) / slips, trips & falls	2	3	66.7%	90.0%	No
Infection control - clinical	2	3	66.7%	90.0%	No

In diagnostic imaging the 90% target was met for seven of the nine mandatory training modules for which qualified nursing staff at Russells Hall Hospital / Corbett Hospital were eligible.

A breakdown of compliance for mandatory training courses from April to September 2018 for medical staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Information governance	16	16	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	16	16	100.0%	90.0%	Yes
Health & safety	16	16	100.0%	90.0%	Yes
Conflict resolution - level 1	16	16	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	15	16	93.8%	90.0%	Yes
Fire	14	16	87.5%	90.0%	No
Infection control - clinical	13	16	81.3%	90.0%	No
Resus - adult	13	16	81.3%	90.0%	No
Manual handling (non-patient) / slips, trips & falls	0	1	0.0%	90.0%	No

In diagnostic imaging the 90% target was met for five of the nine mandatory training modules for which medical staff at Russells Hall Hospital / Corbett Hospital were eligible.

A breakdown of compliance for mandatory training courses from April to September 2018 for

qualified allied health professionals in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Health & safety	66	69	95.7%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	65	69	94.2%	90.0%	Yes
Equality & diversity (including autism awareness)	64	69	92.8%	90.0%	Yes
Conflict resolution - level 1	57	69	82.6%	90.0%	No
Information governance	56	69	81.2%	90.0%	No
Resus - adult	49	68	72.1%	90.0%	No
Manual handling (patient) / slips, trips & falls	49	69	71.0%	90.0%	No
Fire	49	69	71.0%	90.0%	No
Infection control - clinical	47	69	68.1%	90.0%	No

In diagnostic imaging the 90% target was met for three of the nine mandatory training modules for which qualified allied health professionals at the hospital were eligible.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff had training on how to recognise and report abuse and they knew how to apply it.

We saw local safeguarding pathways and contact details for relevant people displayed. Staff knew who the safeguarding lead was and how to get in touch with them.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	19	19	100.0%	90.0%	Yes
Prevent	19	19	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	18	19	94.7%	90.0%	Yes
W R A P	16	19	84.2%	90.0%	No
Safeguarding children level 3	12	15	80.0%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 92.3% for medical staff. The 90% target was met for three of the five safeguarding training modules for which medical staff were eligible. Safeguarding adults and prevent training modules both had completion rates of 100.0%.

It should be noted that 66.7% of allied health care staff had attained WRAP training and 61.1% of staff had attained level 3 children's safeguarding against a trust target of 90%.

A breakdown of compliance for safeguarding training modules for qualified allied health professionals in diagnostic imaging is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	76	80	95.0%	90.0%	Yes
Safeguarding adults	74	81	91.4%	90.0%	Yes
Safeguarding children level 1 & 2	74	81	91.4%	90.0%	Yes
W R A P	54	81	66.7%	90.0%	No
Safeguarding children level 3	11	18	61.1%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 84.8% for qualified allied health professionals. The 90% target was met for three of the five safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

A breakdown of compliance for safeguarding training modules from April to September 2018 for medical staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Safeguarding adults	16	16	100.0%	90.0%	Yes
Prevent	16	16	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	15	16	93.8%	90.0%	Yes
W R A P	14	16	87.5%	90.0%	No

In diagnostic imaging the trust had an overall safeguarding training compliance rate of 92.4% for medical staff at Russells Hall Hospital / Corbett Hospital. The 90% target was met for three of the four safeguarding training modules for which medical staff were eligible. Safeguarding adults, prevent and safeguarding children level 1 & 2 training modules all had completion rates of 100.0%.

A breakdown of compliance for safeguarding training modules from April to September 2018 for qualified allied health professionals in diagnostic imaging at Russells Hall Hospital / Corbett Hospital is shown below:

Name of course	Number of staff trained (YTD)	Number of eligible staff (YTD)	Completion rate	Trust Target	Met (Yes/No)
Prevent	66	69	95.7%	90.0%	Yes
Safeguarding adults	65	69	94.2%	90.0%	Yes
Safeguarding children level 1 & 2	64	69	92.8%	90.0%	Yes
W R A P	49	69	71.0%	90.0%	No
Safeguarding children level 3	11	17	64.7%	90.0%	No

In diagnostic imaging trust had an overall safeguarding training compliance rate of 87.0% for qualified allied health professionals at Russells Hall Hospital / Corbett Hospital. The 90% target was met for three of the five safeguarding training modules for which qualified allied health professionals were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Equipment was cleaned by radiographer's morning and afternoon and domestic staff cleaned the environment each evening. "I am clean" stickers were attached to equipment and dated.

Cleaning schedules were in place for equipment and diagnostic imaging staff and domestic staff worked together to ensure cleanliness. For example, domestic staff had left instructions for diagnostic staff, "Please leave table raised for cleaners on Fridays".

Hand hygiene audits were carried out monthly by a senior radiographer. These were recorded but not displayed for staff to see. A cleanliness audit carried out by the trust from August to December 2018 identified a scoring of between 93-96%.

There was guidance in place for staff on how to manage clinical waste, general waste, laundry and sharps and we saw that waste was managed appropriately.

Hand washing sinks and hand gel were available for staff in each room and we saw staff washing their hands between patients.

Environment and equipment

The service had suitable premises, environment and equipment.

General risk assessments regarding the environment were available for staff on the trust's electronic (computer) system. These included risks around Control Of Substances Hazardous to Health (COSHH). We saw COSHH guidance displayed and substances falling under COSHH were locked away.

There were stickers on portable electrical equipment to say this had been tested (PAT) and was safe to use and a log of when equipment was due for PAT testing was maintained by estates staff.

Other equipment such as scanners were serviced and maintained by a maintenance company contracted by the trust and a log of this was maintained. The sticker on the equipment displayed the next due date of service. We saw equipment testing was up to date within the unit.

There was information displayed for staff with telephone contact details of who to ring for each piece of equipment if there was a fault. Staff knew what to do if equipment was faulty and explained what they had done in the past in order to enable the equipment to be repaired quickly.

Personal Protective Equipment (PPE) was available for staff to use and staff were aware of when to use this for example if attending a patient with an infection.

Staff wore lead aprons when carrying out x-rays as there was a risk of exposure to radiation

In respect of DEXA scanning staff were not sure where safety information had come from. A staff member could not recall who had specified the safety zone for DEXA scanning but said it was "someone in Medical Physics who said it was safe to stand behind the yellow line on the floor without wearing a led apron for protection." The trust had a written protocol in place for this.

However, one of the scanning machines should have had daily quality checks carried out and these had been done weekly not daily.

Assessing and responding to patient risk

The service did not always plan for emergencies nor did staff understand their roles if one should happen. The service had not recognised risks to patients.

The resuscitation trolley for the diagnostic imaging department was located nearby in the outpatient's urology department.

Four staff members we spoke with were unsure where the resuscitation trolley was located.

Staff were confused about the procedure for resuscitation and which staff members were responsible for each specific task. Each of the staff members we spoke with gave different accounts of the Resuscitation procedure.

There had been no recorded scenarios (drills) in relation to resuscitation.

Relevant daily checks had been carried out on the resuscitation trolley and staff had signed for these.

We raised concerns with the trust during the inspection about the resuscitation procedure and the trust introduced a new protocol for resuscitation and care of the deteriorating patient. This included

three staff members holding a bleep and clear instructions on who was responsible for each task. The trust also organised three scenarios during the inspection.

We could not be assured that staff had sufficient and up to date knowledge of the regulations and protocols they were working to.

Staff working in a diagnostic imaging department worked under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. Staff had limited knowledge of these regulations and did not know that these had been updated in 2017.

The folder containing information for staff about IR(ME)R regulations contained out of date information.

The folder containing protocols for staff to work to were out of date and some were incomplete.

There were no staff signatures to confirm staff had read protocols and/or IR(ME)R regulations.

A senior staff member did not know where in the department the 'Local Rules' were displayed, these were found on the doors to an x-ray room.

Staff were unsure who key staff members were for example staff could not articulate who the Radiation Protection Advisor and the Radiation Protection Supervisor were.

There were no up to date risk assessments in place in respect of diagnostic imaging.

We spoke with three key members of staff who did not know how to access specific risk assessments relating to diagnostic imaging and we could not locate these. The trust said risk assessments were being developed.

We saw that Dose Reference Levels (DRL's) were measured, but staff were unsure whether these were benchmarked against National DRL's. The trust sent evidence to confirm they did carry out this benchmarking.

There was no clinical dashboard or monitoring of clinical indicators.

Staff did not know what was on their risk register or how to add to raise awareness of risk.

Following the inspection, the trust sent us a detailed action plan of the how they planned to address the above risks.

Major Incident Plan

There was a major incident plan in place but staff were unsure what this contained. The plan was detailed and included planning for such events as terrorism, major disasters, rising tides (infectious disease epidemics), chemical exposures, planning for severe weather disruption and cyber-attacks. Staff were unclear of their roles if an emergency should happen.

Nurse staffing

There were no planned qualified nurses employed at Corbett Hospital in Diagnostic Imaging.

The unit at Corbett hospital was usually staffed daily Monday to Friday 8.30am to 5pm with a senior radiographer, two other radiographers, a third radiographer in the operating theatre and a radiographer aide. There was also two reception staff and a volunteer.

There was a shortage of reporting radiographers and the trust had an action plan in place to review what additional reporting staff were required. This would include reviewing how this would work in terms of recruitment/training, along with what backfilling was required for the current reporting radiographers and any trained within the department in the future.

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 20.0% for qualified nursing staff in diagnostic imaging. This was greater than the trust's 8.5% turnover target. This relates to one member of qualified nursing staff leaving over the 12 month period.

It should be noted that the high rate for qualified nursing staff is partly due to the small number of nursing staff in diagnostic imaging so each leaver represents a large proportion of the total staffing level.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 3.6% for all staff in diagnostic imaging. This was just above the trust target for sickness of 3.5%.

For the same time period, the trust reported an overall sickness rate of 1.6% for qualified nursing staff in diagnostic imaging. This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From October 2017 to September 2018 the trust reported no nursing bank or agency use in diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

Two Radiographers had at the Corbett site each week as part of their Job Plans. There was an on-call rota should medical staff be required for advice.

Total staffing: planned vs. actual

The trust reported the following staff numbers for the two periods below for diagnostic imaging;

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Medical staff	19.1	19.9	104.3%	22.3	18.1	81.3%

Staff fill rates for medical staff in September 2018 have seen a reduction from March 2018. There were 0.8 more WTE staff in post than planned for in March 2018, in September 2018 there were 4.2 less WTE staff in post than planned for.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported an overall vacancy rate of 4.3% for medical staff in diagnostic imaging. This was less that the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported an overall turnover rate of 9.4% for medical staff in diagnostic imaging. This was greater than the trust's 8.5% turnover target. This relates to 1.6 members of medical staff leaving over the 12 month period.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 1.1% for medical staff in diagnostic imaging. This was lower than the trust target for sickness of 3.5%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

From September 2017 to August 2018 the trust reported 4,579.0 of the 41,877.0 available medical staff hours were filled by bank staff (10.9%) and 1,212.3 hours were filled by locum staff (2.9%) in diagnostic imaging.

A breakdown of bank and locum usage in diagnostic imaging is shown below:

Core service	September 2017 to August 2018						Total Hours
	Bank		Locum		Unfilled		
	Hours	%	Hours	%	Hours	%	
AC - Diagnostic imaging	4,579.0	10.9%	1,212.3	2.9%	0.0	0.0%	41,877.0

(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)

Qualified allied health professionals staffing

Total staffing: planned vs. actual

The trust reported their qualified allied health professional numbers for the two periods below in diagnostic imaging;

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified allied health professionals	97.3	75.0	77.1%	97.2	72.3	74.4%

The trust reported a qualified allied health professionals staffing level of 77.1% in diagnostic imaging in March 2018. This dropped to 74.4% in September 2018.

(Source: Routine Provider Information Request (RPIR) –Total staffing tab)

Vacancy rates

From October 2017 to September 2018 the trust reported a vacancy rate of 22.5% for qualified allied health professionals in diagnostic imaging. This was greater than the trust target of 6.3%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From October 2017 to September 2018 the trust reported a turnover rate of 6.1% for qualified allied health professionals in diagnostic imaging. This was lower than the trust's 8.5% turnover target. This

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From October 2017 to September 2018 the trust reported an overall sickness rate of 3.8% for qualified allied health professionals in diagnostic imaging.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Records

Staff kept appropriate records of patients' care and treatment.

Records were clear, up-to-date and available to all staff providing care.

We observed that the use of paper records in the department was minimal. X-rays were stored electronically as this was a filmless hospital with a system known as Picture Archiving and Communications Systems (PACS). PACS allows x-rays to be viewed by relevant medical staff on the trust's computer network. Staff said that PACS did not always work effectively and that the system needed to improve. The trust was in a process of procuring a new PACS system at the time of the inspection..

Letters were sent back to GPs in a timely way for example we saw a GP who worked three days a week within the department analysing bone density results and writing letters to the patients' GPs.

Patients undergoing DEXA scanning were asked to complete a health declaration.

All patients were asked to sign a consent to treatment.

Notes were stored securely whilst patients were undergoing diagnostic imaging tests.

Medicines

The Diagnostic Imaging department at Corbett Hospital did not routinely manage medication for patients.

Patients brought their own medicines with them as an outpatient.

Incidents

The service did not manage incidents well and incident management was not robust.
Staff knew how to report incidents on the hospital's electronic incident reporting system but said they did not receive feedback from incidents they had raised.
A senior staff member gave an example of having sustained a fall at work and had raised this as a safety incident but had not had any communication back.
Staff said the types of incidents they raised were usually about having the wrong patient details so having to hold up diagnostic imaging lists could be a problem but this didn't happen very often.

The risk register identified a need for discussion at staff meetings to try and reduce the number of incidents and encouragement for staff to report incidents so they could be rectified.

Staff did not know how many incidents there had been within the department, what they were nor if lessons had been learned.

This was escalated to the trust during the inspection and the trust responded with an action plan for improvement.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018 the trust reported no incidents classified as never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from December 2017 to November 2018.

Both of these were diagnostic incidents including delay meeting SI criteria (including failure to act on test results) and resulted in unexpected / potentially avoidable injury causing serious harm. One incident occurred in July 2018 and one in August 2018.

(Source: Strategic Executive Information System (STEIS))

Safety thermometer

The Corbett hospital did not use a safety thermometer to measure safe care and treatment in the diagnostics department.

Is the service effective?

We report on this section but we do not rate it

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance and evidence of its effectiveness. Managers did not check to make sure staff followed guidance.

For example, the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 replaced the 2000 regulations (including amendments made in 2006 and 2011). The Regulations available to staff at Corbett diagnostic imaging department were the 2000 regulations (and 2006 and 2011 amendments.). We raised this with the Executive at the end of our inspection visit. The trust informed us the following week that procedures had been re written in line with the 2017 Regulations.

Nutrition and hydration

As an outpatient diagnostic imaging department, the service did not routinely offer patients food and drink.

Patients could access drinks and food from the café close by opposite the department.

Pain relief

Patients were not routinely offered pain relief because the procedures undertaken were non-invasive. Staff made sure patients were comfortable during procedures by helping them with positions and pillows and providing blankets to keep them warm.

Patient outcomes

The service monitored the effectiveness of most aspects of care and treatment but there was limited evidence of the use of findings to make improvements.

IR(ME)R requirements stipulate routine audits should be undertaken in order to seek improvement in outcomes of patient care through structured reviews.

Some audits were routinely undertaken by senior staff on the unit for example hand hygiene audits. These had been at 100% for the last six months. Cleanliness audits were completed by interserve.

Local Safety Standards for Invasive Procedures (LocSSip) Audit May 2018 identified that there were 10 LocSSip forms in total audited in from Radiology. The results demonstrated that the LocSSips were embedded within Radiology.

We had seen that there was a lack of leaflets and posters around for patients. There was an action plan developed on 7/11/18 following an environmental review of Corbett hospital. This included providing more posters and information for patients.

Audits of DEXA scans were carried out routinely by GPs in the community. The GP who was working at Corbett hospital gave an example of how forms for DEXA scanning had changed as a result of audits and how new referral criteria was now contained within the Fracture Risk Assessment Tool (FRAX) which had helped with risk assessing patients.

Competent staff

The service could not demonstrate that staff were competent for their roles.

Staff were not supported to complete continual professional development (CPD) training. Staff told us there was no time allocated to do this. There were no records of CPD available. This was identified as a risk on the trust's risk register.

There was no continuity nor structure for training staff and no process for signing off competency checks.

A staff member told us they had had an induction period of two weeks in each area. However, they had not received any IR(ME)R training.

Staff said they would like some 'refresher training' particularly in radiation as this was 'a vital component in patient safety'.

Staff told us nobody checked the quality of their work. The trust had an action plan in place to introduce competency checks for staff working in diagnostic imaging.

Appraisal rates

All staff we spoke with confirmed that they received annual appraisals and that these were helpful and an audit showed 100% compliance with staff appraisals.

For year to date, April to September 2018, 92.6% of required staff in diagnostic imaging received an appraisal compared to the trust target of 90.0%.

A breakdown of appraisal completion by staff group for April to September 2018 is shown below:

Staff group	Individuals required	Appraisals completed	Completion rate	Trust Target	Target met
Support to doctors and nursing staff	5	5	100.0%	90.0%	Yes
Qualified healthcare scientists	23	5	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	5	23	100.0%	90.0%	Yes
NHS infrastructure support	27	28	96.4%	90.0%	Yes
Qualified allied health professionals	75	81	92.6%	90.0%	Yes
Support to ST&T staff	28	34	82.4%	90.0%	No
Total	**176**	**163**	**92.6%**	**90.0%**	**Yes**

All staff aside from support to ST&T staff met the 90.0% target. Last year (April 2017 to March 2018) 64.7% of all staff in diagnostic imaging received an appraisal.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Russells Hall Hospital / Corbett Hospital

For year to date, April to September 2018, 91.9% of required staff within diagnostic imaging at Russells Hall Hospital / Corbett Hospital received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Support to doctors and nursing staff	1	1	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	2	2	100.0%	90.0%	Yes
NHS infrastructure support	27	28	96.4%	90.0%	Yes
Qualified allied health professionals	65	69	94.2%	90.0%	Yes
Support to ST&T staff	18	23	78.3%	90.0%	No
Total	**113**	**123**	**91.9%**	**90.0%**	No

Last year (April 2017 to March 2018) 65.9% of all staff in diagnostic imaging at Russells Hall Hospital / Corbett Hospital received an appraisal.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients.

Doctors, consultants, radiographers, radiologists, aides, reception staff and volunteers worked together and supported each other to provide good care.

Two GPs worked alongside DEXA scanning staff and interpreted scan results and gave advice to patients' GPs for on-going treatment.

Staff at Corbett hospital could liaise with professor Neil Gittoes at the Queen Elizabeth Hospital for specialist advice on osteoporosis.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment though PACS electronic system.

Seven-day services

The service was provided Monday to Friday from 8:00am to 5:30pm

Health promotion

When DEXA scans were reviewed by the GP working in diagnostic imaging, advice regarding health promotion was suggested to the patient's GP and/or Consultant. For example, commencing calcium supplements and other medication.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Consent was obtained before patients underwent X-rays and/or scans. We heard staff explaining to patients what procedures were and how they were required to sign a consent form. We saw consent forms signed by patients.

Staff said if a patient lacked capacity to sign a consent form then there would have to be a 'best interests decision' in place before undergoing procedures.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, the trust reported that mental health law training was completed by 80.0% of all staff in diagnostic imaging compared to the trust target of 90.0%.

Qualified nursing and health visiting staff did not meet the 90.0% target for mental health law training with a completion rate of 66.7%. It should be noted that the data for nursing staff refers to three eligible staff and so the performance should be taken in context when dealing with small numbers of eligible staff.

Both allied health professionals and medical staff met the trust target for mental health law training with a completion rate of 100.0%. It should be noted that the data for allied health professionals and medical staff refers to one member of eligible staff each and so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff cared for patients with compassion

All of the patients and accompanying visitors we spoke with told us all staff treated them warmly and kindly. We saw staff of all ranks approaching people who appeared unsure of their way and offer help. Staff maintained a warm and cheerful disposition in their contact with patients and going about their work generally

A patient spoke of the "excellent service" that they and their relative had received at Corbett diagnostic imaging unit.

Staff we spoke with were open, honest and demonstrated a caring attitude.

Staff demonstrated a non judgemental attitude in conversation about mental ill health, learning disability, autism and dementia. Staff were able to describe examples of how they positively responded to patients who might be frightened, confused or phobic about imaging procedures.

Although the reception area was open reception staff spoke in a quiet way with each patient and music was playing so patients could speak to the receptionists without being overheard.

Staff took the time to interact with patients and those close to them. We saw receptionists were friendly and welcoming and this helped to put patients at ease.

Patient's privacy and dignity was maintained as all x-rays and scans took place in private x-ray rooms.

Emotional support

Staff provided emotional support to patients to minimise their distress.

A staff member said if a patient became distressed they would be offered a private room where a staff member would sit and talk to them.

We saw where a patient had sustained a fall outside of the hospital doors and hurt their ankle. Staff provided emotional support to the patient and their relative. However it was some time before the patient was taken to a private room and away from other patients waiting in reception.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

We heard staff communicating with patients and explaining what was happening and why.

Where patients did not speak English as their first language then interpreters could be used (language line) or other staff members could be called upon to speak with them. Staff said they usually found that patients who could not speak and understand English were accompanied by a family member who could communicate for them.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided services in a way that met the needs of local people.

The trust had recognised the fact that one in two women and one in five men over the age of 50 would break a bone.

The trust had met an increase in people developing osteoporosis (with an aging population). Dual Energy X-ray Absorptiometry (DEXA) scanning measures the density of peoples' bones. The trust had won a Gold standard award for diagnosing osteoporosis and other related conditions.

Patients were referred for DEXA scans from GP surgeries and outpatients.

The trust had specially trained radiographers to carry out the scans and most patients were scanned within a month of referral.

Two GPs worked part time at the diagnostic imaging unit at Corbett hospital to interpret DEXA scans and report back to the patient's GP or Consultant. We observed a GP examining scan results and writing letters to the patient's GP and giving advice as to treatment. This helped patients to avoid sustaining further fractures.

The trust was reviewing staffing levels within the diagnostic imaging services. Local managers told us 21 Radiologists were required to meet the current demand for services.

Meeting people's individual needs

The service took account of patients' individual needs.

The trust had a Dementia Strategy in place and said the strategy was an important part of the overall trust strategic objectives and linked with the trusts Vision and with the Trusts Nursing and Midwifery Strategy

Adequately supporting patients attending the Imaging Department who had learning disabilities/autism was on the trust's Risk Register. The trust had identified inadequate provision of appropriate resource to meet the needs of patients with learning disabilities/autism, both within the environment of the department and the staff expertise.

Diagnostic Imaging staff attended mandatory training for safeguarding children/adults levels one and two.
Forensic champions attended safeguarding level three.
Imaging staff attended DOLS and mental health capacity act training and there was proactive engagement with learning disability lead and Identified patients were 'fast tracked' through the department.

Staff usually knew when a patient was attending with special needs before they arrived. The learning disability nurse specialist for the trust would be involved and a plan in place to help meet the needs of the patient. More time was allowed for patients with any special needs for example three slots were planned for a patients with bariatric needs and staffing organised so that enough staff were on hand to assist.

Children were accompanied by their parent/guardian and were encouraged to stay with the child throughout the procedure.

Carers were encouraged to stay throughout the procedure with patients with any special needs.

Although the changing rooms were small, patients who could not manage these would be able to change in the x-ray room.

The changing rooms posed a risk for patients with special needs who were confused or suddenly became ill. A scenario was carried out where an inspector locked themselves in a changing room and summoned help and it took five minutes for staff to open the door using a coin in the lock. The trust were risk assessing/reviewing the changing rooms set up.

Bariatric equipment could be ordered for patients requiring these but this would be planned prior to admission.

The unit also had a hoist to help anyone who could not weight bear.

There were disabled toilet facilities available.

Leaflet racks were empty and there was a lack of information/posters for patients in the areas. There was an action plan developed on 7/11/18 following an environmental review of Corbett hospital. This included providing more posters and information for patients.

Access and flow

At Corbett hospital diagnostic imaging waiting times and arrangements to treat and discharge patients were in line with national good practice.

Patients waited an average of one month for a DEXA scan and were below the national waiting times for general diagnostic imaging.

Four patients we spoke with told us that they had been referred by their GP very quickly and were happy with the waiting times.

Diagnostic waiting times (percent waiting 6+ weeks)

From September 2017 to August 2018 the percentage of patients waiting more than six weeks to see a clinician was consistently lower than the England average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England.

The chart below shows 6+ weeks percentages over time
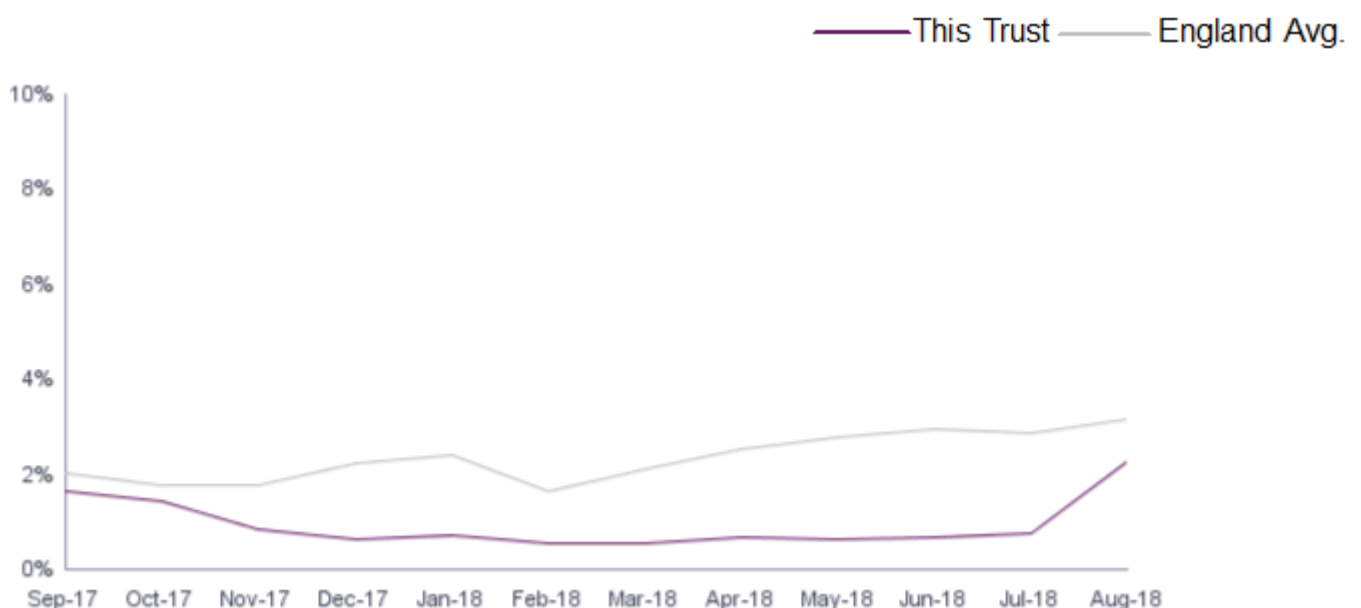
(Source: NHS England – Diagnostic Waits)

Learning from complaints and concerns

The service treated concerns and complaints seriously but did not always investigate them in a timely manner. Lessons learned from complaints were not routinely shared with all staff.

For the eight complaints that had been closed at the time of data submission, the trust took an average of 69.8 working days to investigate and close these. This was not in line with their complaints policy, which states complaints should be closed within 40.0 working days. Two of the nine complaints were closed within the 40.0 day target.

The one complaint that had not yet been closed had been open for 28.0 working days at the time of data submission.

The trust did not reflect, and staff did not know how improvements had been made in diagnostic imaging as a result of complaint investigations.

Following this inspection the trust sent us an action plan of how they planned to improve their management of complaints.

Summary of complaints

From October 2017 to September 2018 the trust received nine complaints in relation to diagnostic services (1.8% of total complaints received by the trust). Diagnosis and tests was the main subject of complaint, with five of the nine complaints relating to this. Patient care was the main subject of two of the nine complaints.

A breakdown of complaints by subject is shown below:

Subject	**Number of complaints**
Other (Diagnosis and tests)	5
Patient Care	2
Values & behaviours (staff)	1
Communications	1
Total	**9**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From October 2017 to September 2018 the trust received 38 compliments about for diagnostic imaging (0.6% of all received trust wide).

Compliments were received in all 12 months of the period. November 2017 was the month where the most compliments were received with seven.

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care). The trust did not provide a breakdown by subject for compliments received.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

There was insufficient managerial oversight and leadership presence at Corbett hospital to ensure high quality sustainable care.

Staff were unsure who their manager was and told us they didn't see managers very often and "never saw directors".

Staff told us they missed having the support of a manager and sometimes radiographers had to suspend lists to chase up tasks which a manager would normally do. For example, the radiographers were not allocated a chaperone and they had to ask X-Ray for assistance. This was something a manager could sort out if there was one.

Managers were unsure who was leading and who had managerial responsibility for diagnostic imaging.

Vision and strategy

The service had a vision and strategy for what it wanted to achieve with diagnostic imaging but staff did not feel involved and/or informed about this.

There was no evidence of the involvement of patients, and key groups representing the local community.

At Corbett hospital diagnostic and imaging unit there was a poster displaying the 'National Osteoporosis Society's vision' which included:

A mission to improve the lives, treatment and care of people with osteoporosis and to maximise prevention for those at risk.

A vision for a society where prevention, treatment and care of people with osteoporosis was of the highest standard and consistency available.

Staff were familiar with this vision but did had not had the support of a manager to ensure they understood the vision and their roles in ensuring it's delivery.

The trust told us that future plans included the introduction of a new, more effective PACS System and more reporting radiographers would be introduced.

New equipment competencies mandatory training and radiation protection lectures had slipped and there was an action plan in place to improve in these areas.

The plan going forward included embedding updated IR(ME)R regulations so that all staff would be aware of these.

The Modality Lead weekly meeting had been in place since October 2018. Radiation protection group meetings were planned for every six months.

A staffing review within Imaging on 09/01/19 had highlighted the need to recruit more reporting radiographers due to the lack of staffing within the department amongst other issues. Corbett hospital diagnostic imaging was not too badly affected by this although most of the staff rotated between Russels Hall and Corbett.

In Radiology the trust carried out research and attended the annual National Osteoporosis Conference.

The trust had met an increase in people developing osteoporosis (with an aging population). Dual Energy X-ray Absorptiometry (DEXA) scanning measures the density of peoples' bones. The trust had won a Gold standard award for diagnosing osteoporosis and other related conditions.

Culture

Managers did not promote a positive culture that supported and valued staff. There was no sense of common purpose based on shared values.

The culture of high-quality sustainable care was not embedded and staff did not feel they were well supported.

The lack of consistency in management of the service had had a negative effect on how staff felt and some staff were unsure who to go to for support.

Not all levels of governance and management functioned effectively and some staff were unclear what their roles were, what they were accountable for and to whom.

Governance

The service did not use a systematic approach to continually improving the quality of its services and the systems in place (to ensure that high standards of care were safeguarded) were ineffective. There was limited evidence that excellence in clinical care would flourish within diagnostic imaging.

Some staff were unsure of their roles and responsibilities in respect of the management of the unit. Staff were unsure who they could go to for support and when we asked who was managing the unit a staff member said, "Well I suppose its me".

Governance systems were new and were not fully embedded.

We saw there was a programme of clinical auditing in place run by a 'trust audit group'. Audits included monitoring of DRLS, quality of images and LOCSIPS compliance.

However this had not filtered down to the staff working on the diagnostics imaging unit as they had no knowledge of these audits.

Regulations governing diagnostic imaging (IR(ME)R) were out of date. Not all staff were aware there had been changes to these regulations in 2017. The trust had an action plan in place to update these.

A Governance meeting was held for Corbett hospital on 26/11/18 which did not identify any issues for diagnostic imaging. On 4/12/18 a 'Imaging Governance Group Highlights Summary to CSS Meeting' was held where Standard Operating Procedures (SOPS) for standing spine x-rays were agreed amongst other items.

The trust had reviewed all incident categories and themes from imaging for the last 12 months, along with detailed view of November 2018; and were continuing to do on a monthly basis. Although the trust reviewed incidents there was little feedback to diagnostic imaging staff about outcomes and/or learning from incidents. An action plan was in place to make contact with all speciality leads to book suitable times for this to take place with all staff from the department.

The meeting also identified that COSHH, Risk Assessments and Stress Assessment training would take place to ensure that the department was up to speed. The minutes would be sent to the Divisional Group for ratification.

The trust had recently appointed a head of governance person and were confident that this would help improve governance, risk management and quality measurement in diagnostic imaging services.

Management of risk, issues and performance

The service did not have clear and effective processes for managing risk, issues and performance within the service.

There was no comprehensive assurance system in place and performance issues were not routinely escalated.

There was a limited programme of clinical and internal audit to monitor quality and identify where action should be taken.

There were no recorded risks to align what staff said was on their worry list. For example, staff could not articulate what was on the departmental risk register and did not know how to add any newly identified risks.

Information management

The service used secure electronic systems with security safeguards but did not routinely collect, analyse, manage nor use information to support diagnostic activities.

There was no understanding of performance through gathering and integrating people's views and information was not routinely used to measure improvement.

There were no clear service performance measures monitored and information systems were not used effectively to monitor the quality of care.

Engagement

The service did not always engage effectively with patients, staff, the public and local organisations to plan and manage appropriate services.

There was poor attendance at staff meetings and staff said this was due to the times that meetings were scheduled which did not fit in with staff working rostas.

There was a staff hub on the hospital intranet and a staff newsletter circulated with information for staff.

The trust ran an "employee of the month" which motivated staff and celebrated their achievements.

We saw Friend and Family Test cards and boxes in place for patients to use. We did not see reception staff encouraging patients to use them however and this was a missed opportunity.

The trust told us they would be starting a "You said and we did" programme to demonstrate improvements as a result of public consultation.

The trust were engaging with another local NHS trust to provide a joint MRI breast reporting service.

Learning, continuous improvement and innovation

In diagnostic imaging the trust did not demonstrate a strong commitment to improving services by learning from when things went well and when they went wrong. There was little evidence of training, research and innovation.

Staff did not regularly take time out to work together to resolve problems and team objectives, processes and performances. Therefore this did not encourage improvements and innovation.

Community health services

Community end of life care

Facts and data about this service

End of life care (EoLC) at the trust is provided by a specialist inpatient and community palliative care service, led by dedicated palliative care consultants. Advice, guidance, education and treatment is provided by these teams to support patients with complex pain management needs. The trust works in partnership with other local hospices.

In community end of life care, The Dudley Group NHS Foundation Trust works in close liaison with both district nursing services and GPs. The Dudley Specialist Palliative Care team is a multidisciplinary team consisting of consultants in palliative medicine, clinical nurse specialists in palliative care, clinical psychology, occupational therapy and physiotherapy. The team provides specialist advice alongside the patient's own medical team or GP whether that be in hospital or at home. The team continuously provides educational opportunities to the generalist workforce aiming to up-skill colleagues and ensure patients' needs are met whatever stage of their illness.

The team work with the local and other hospices in the surrounding area. The team are also active members of local Dudley economy strategy groups, reginal palliative care physicians meeting, the palliative and end of life care expert advisory groups, local networks and local sustainability and transformation partnerships.

The service aims to provide specialist palliative care to patients and their families in all care settings, the patient's own home, hospital, care homes and hospice, working closely with other health and social care professionals to help patients and their families cope with adjusting to living with a life limiting illness.

The service aims to:

- Provide a holistic assessment of all patients and their family's needs; identifying any physical, psychological, spiritual or social needs.
- Work closely with health and social care professionals to ensure clear referral pathways to help patients and their families cope with living with a life limiting illness.
- Support all members of the healthcare team in making end of life care decisions, including anticipatory prescribing, supportive care and if appropriate rationalisation of interventions.
- To support patients and their carer's in making clinical decisions about their own care including preferences for place of care and to support the patient with advance care planning where appropriate.

(Source: Routine Provider Information Request (RPIR) – Context CHS, EOLC networks and sites tabs)

Is the service safe?

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.

Mandatory training
The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff we spoke with told us they had completed or were booked to complete their mandatory training. Updates were completed as often as directed. Staff told us that there were systems in place to remind them when their training was due. This was in the form of an electronic recording system. Reminders were sent and monitored through supervision with managers. Some of the training was face to face and some eLearning. Staff told us that trainers were often flexible and would attend alternate venues for staff convenience.

In addition to the tabled mandatory training below, there was mandatory end of life training for all end of life staff. Depending on role, staff completed up to five palliative care modules. For example, end of life training, symptom control, end of life care planning and advanced communications. Nursing staff also completed mandatory sepsis training and a 3-yearly update training on syringe drivers. Syringe drivers contained medicines to help manage pain, sickness, fits, agitation or breathing problems.

Staff worked closely with their colleagues in the local mental health acute trust who provided them with mandatory training to make them aware of the potential needs of people with mental health conditions, learning disabilities, autism and dementia. This meant that staff received training to help them work effectively with patients with additional specialist needs.

Mandatory Training completion
The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April to September 2018 for qualified nursing staff in community health services for end of life care is shown below:

Name of course	April to September 2018				
	Number of staff trained	Number of eligible staff	Completion rate	Trust target	Met (Yes/No)
Resus - adult	9	9	100.0%	90.0%	Yes
Equality & diversity (including autism awareness)	9	9	100.0%	90.0%	Yes
Clinical governance (including incidents, complaints & claims investigations)	9	9	100.0%	90.0%	Yes
Health & safety	9	9	100.0%	90.0%	Yes
Fire	8	9	88.9%	90.0%	No
Infection control - clinical	8	9	88.9%	90.0%	No
Information governance	8	9	88.9%	90.0%	No
Conflict resolution - level 1	8	9	88.9%	90.0%	No

Manual handling (patient) / slips, trips & falls	7	9	77.8%	90.0%	No

In community health services for end of life care the 90% target was met four of the nine mandatory training modules for which staff were eligible.

It should be noted that for the staff groups not meeting the target, this was due to only one or two eligible staff not having completed the training so the performance should be taken in context when dealing with small numbers of eligible staff.

The trust did not provide any data for medical staff working in community health services for end of life care. Please see Acute End of Life Care for medical staffing mandatory training information.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received safeguarding adults and children training at the level required for their role. They worked closely with safeguarding teams and understood safeguarding systems, processes and practices. Staff provided us with examples of when they had identified safeguarding concerns relating to both children and adults and referred on to the safeguarding teams.

Staff had good links with other professionals, for example, health visitors and general practitioners at regular multi-partnership meetings and shared information to work together to keep patients safe. There were local safeguarding champions, a trust safeguarding lead and continued education for staff to ensure those who came in to contact with the service were safeguarded. We saw related documentation and staff gave us examples of joint working with other professionals.

Staff could access mental health teams 24 hours a day, seven days a week for support in identifying mental health needs and providing guidance and training to ensure those patients were safeguarded.

A psychologist played a key role in supporting staff and those who were engaged with the service to receive the best possible care. The psychologist worked alongside community staff to support them working with patients with additional mental health needs. The psychologist and nursing staff told us that if a patient was assessed as having a primary mental health diagnosis or chronic mental health condition, the patient would be assessed as appropriate to be care co-ordinated by the specialist mental health team. Nursing staff would then care plan to support those staff in managing the end of life aspect of a patients care.

Patient's assessed to be at risk of suicide or self-harm were referred to the mental health team or the psychologist to help them to remain safe. Information was also shared with the patient's GP. Staff provided us with examples of challenging incidences. Staff understood their limitations and knew when they should involve mental health teams and the psychology team to help keep patients safe. This was recorded in patient records and meeting minutes.

Safeguarding Training completion
The trust set a target of 90% for completion of safeguarding training.
A breakdown of compliance for safeguarding training courses from April to September 2018 for qualified nursing staff in community health services for end of life care is shown below:

Name of course	April to September 2018				
	Number of staff trained	Number of eligible staff	Completion rate	Trust target	Met (Yes/No)
Prevent	9	9	100.0%	90.0%	Yes
Safeguarding children level 1 & 2	8	9	88.9%	90.0%	No
W R A P	8	9	88.9%	90.0%	No
Safeguarding adults	7	9	77.8%	90.0%	No

In community health services for end of life care the 90% target was met one of the four mandatory training modules for which staff were eligible.

It should be noted that for the staff groups not meeting the target, this was due to only one or two eligible staff not having completed the training so the performance should be taken in context when dealing with small numbers of eligible staff.

At 31 December 2018, 100% of qualified nursing staff had completed levels 1, 2, and 3 safeguarding adults and children. This meant that all staff had received their mandatory training to help keep people safe.

The trust did not provide any data for medical staff working in community health services for end of life care. Please see Acute End of Life Care report for medical staffing mandatory training information.

Safeguarding referrals
A safeguarding referral was a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern was raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children's Services, Adult Services or the police should take place.

The trust reported no adult or children safeguarding referrals for community end of life care from October 2017 to September 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

All staff were required to complete mandatory infection prevention control training. Staff followed infection control principles and were audited to ensure they were compliant. This meant that standards of cleanliness and hygiene were maintained using infection prevention control techniques, for example, hand washing and carrying hand gels to prevent and protect people from healthcare-associated infections.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Staff had access to equipment to help them to safely care for patients in the community. The equipment we looked at was within date and safe to use, for example calibrated, which meant they would give accurate results. Extra equipment was carried in the event of errors. For example, staff carried extra syringe drivers with them to ensure patients had access to spares should they be needed.

Assessing and responding to patient risk

Staff focused on risk for each patient. They kept clear records and asked for support when necessary.

Patients had comprehensive assessments that identified their individual needs. We saw this documented in records, in discussions with staff and observed in practice while staff were visiting patients in their home. Each patient's plans were reviewed regularly to identify and respond appropriately to changing risks. Staff gave us examples of where changing risks had been identified and how they responded to it. This included deteriorating health and wellbeing, medical emergencies or behaviour that challenged. Staff shared this information in a timely way with involved professionals. For example, the patient's GP. Staff discussed these issues in their weekly meeting with the service psychologist to help them discuss and share concerns and learn where possible.

Staff knew about and dealt with specific risk issues, such as pressure ulcers. We looked at eight care records, all of which demonstrated an assessment of pressure areas. Where there were risks identified, we saw evidence of provision of bed and pressure relieving equipment. Staff told us the service they used to access equipment were prompt in their delivery. This meant that patient risks were appropriately assessed and managed in a timely manner to reduce risks. Patients and their carers were provided with a guide to pressure area care leaflet that clearly outlined ways to manage and reduce pressure ulcer risks.

Patients had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff, including the service psychologist gave us examples of when they had supported patients and their families in these circumstances. Staff could contact the teams via telephone, email and met with them face to face on a regular basis through joint meetings. Staff told us that the specialist teams responded promptly to support patients when there were difficulties.

Staff worked closely with ambulance services to ensure joined up assessment and management of risk. There were joint meetings and regular contact between the agencies when managing patients. Ambulance staff had access to patients advanced care planning and Do Not Attempt CPR (DNACPR) decisions. A DNACPR decision was made in advance to indicate whether attempted CPR would not be likely to be appropriate for a patient in the event of cardiac arrest.

Staff from the service provided training to ambulance staff to educate them on positively managing patient risk. A DNACPR decision was crucial to ensure the patient had a peaceful and dignified death. Decisions about when to apply DNACPR involved the most senior clinician available.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. The specialist community palliative care team were made up of two consultants and a lead nurse. There were eight qualified nurses. Seven of the nurses were band 7 and one a band 6. There was

a band 6 vacancy. This meant that all registered nurses were qualified to a senior level. There were two occupational therapists and a part time physiotherapist and psychologist. The palliative care support team were made up of a band 6 team leader who supervised a team of eight clinical support workers.

Staff shortages were managed by substantive staff with experience of palliative care and worked on the trust bank. There was no agency or bank use in the previous 12 months. There was joint working with the district nursing team and the local authority staff to ensure adequate staffing with the right skills to provide the right care and treatment.

Staff discussed patients at shift changes to ensure that the right staff were available to meet the individual needs of patients.

Planned v Actual Establishment

Details of staffing levels within community health services for end of life care by staff group as at March and September 2018 are below:

Community health services for end of life care – Qualified nursing staff

Staff Group	March 2018			September 2018		
	Planned WTE staff	Actual WTE staff	Fill rate	Planned WTE staff	Actual WTE staff	Fill rate
Qualified nursing staff	7.2	8.2	113.9%	9.2	7.2	78.3%

The trust reported an over established staffing level of 113.9% for qualified nursing staff in community health services for end of life care in March 2018. This over establishment related to 1.0 more whole time equivalent staff in post than planned for. The staffing level for qualified nursing staff dropped to 78.3% in September 2018.

As at September 2018, there were 2.0 fewer whole time equivalent staff in post than planned for and 1.0 less whole time equivalent staff in post than in March 2018. There was an increase of 2.0 whole time equivalent planned posts between the two time periods.

The trust did not provide any data for medical staff working in community health services for end of life care. Please see Acute End of Life Care report for medical staffing under medical staffing information.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

The trust set a target of 6.3% for vacancy rate.

From October 2017 to September 2018, the trust reported an overall vacancy rate of 1.1% for qualified nursing staff in community health services for end of life care. This was below the trust's target.

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

Turnover

The trust set a target of 8.5% for turnover rates.

From October 2017 to October 2018, the trust reported an overall turnover rate of 0.0% for qualified nursing staff in community health services for end of life care. This was below the trust's target.

Sickness

The trust set a target of 3.5% for sickness rates.

From October 2017 to October 2018, the trust reported an overall sickness rate of 11.6% for qualified nursing staff in community health services for end of life care. This did not meet the trust's target. We were told that there was one staff member on long term sick which affected the overall sickness rate.

Nursing – Bank and Agency staff usage

From October 2017 to September 2018, the trust reported of the 14,404.0 available hours in community health services for end of life care, none were filled by bank or agency staff to cover sickness, absence or vacancy.

In the same period, 211.0 (1.5%) hours needed to be covered by bank or agency staff but were unfilled.

A breakdown of bank and agency usage by staff type is shown below:

October 2017 to September 2018

Staff type	Bank		Agency		Unfilled		Total Hours
	Hours	%	Hours	%	Hours	%	
Qualified	0.0	0.0%	0.0	0.0%	211.0	1.5%	14,404.0
Non-qualified	0.0	0.0%	0.0	0.0%	0.0	0.0%	0.0
Total	0.0	0.0%	0.0	0.0%	211.0	1.5%	14,404.0

Medical locums

The trust did not provide any data for medical staff working in community health services for end of life care. Please see Acute End of Life Care report for medical staffing information.

The consultant and manager told us that despite efforts, they could not recruit locum cover for the consultant on maternity leave. The consultant told us they could absorb the share of patients across the medical team to ensure patients continued to have their medical needs met. The consultant on maternity leave was due back in February 2019 which would relieve the caseloads of the other medics.

Suspensions and supervisions

During the reporting period from October 2017 to September 2018, the trust did not report any cases where staff have been either suspended or placed under supervision in community health services for end of life care.

Quality of records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The service was in the process of setting up a secure electronic palliative care co-ordination system. The principle was to share records with key details about their treatment choices to be updated and accessible to those delivering their care. With a patient's consent, the system allowed rapid access to key information across services about patients at the end of life. This included their expressed preferences for care, making sure they receive the right care in the right place, by the right person, at the right time. The deadline for full implementation was January 2019. This meant that the service would have a paperless system and patient records were accessible.

Patient records included, where possible all relevant information. Where there were identified gaps, staff would ring the referrer for additional information. Patient files included outpatient letters, diagnosis and prognosis.

All eight patient records we looked at had advanced care plans. Advanced care planning was process of discussion between patients and their care providers. All records we looked at clearly indicated the patient's wishes. Do Not Attempt CPR (DNACPR) records were held at patient's home. Records we looked at were appropriately completed. There was evidence of verbal consent documented in the text of the records where there was not a signature.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

Staff qualified to prescribe medicines followed national guidance and best practice when prescribing and administering medicines. This included prescribed anticipatory medicines with individualised indications for use, dosage and route of administration. We saw this demonstrated in conversations with patients, families and staff.

All injectable medication was checked and recorded by the district nurses throughout the patients care episode and at discharge. Controlled drugs were checked, recorded and disposed of by 2 nurses. If required, a family member could countersign. Other medications were taken to pharmacy for disposal. Staff ensured safe storage of medication. They ensured it was understood that medication should be locked away from children and out of reach. Sharps bins were available in patient's homes and disposed of appropriately. District nurses took syringe drivers and all other medicines needed with them to the patient's home. Once set up, the syringe drivers were monitored by staff twice daily. This meant that staff had good medicines management systems in place to keep people safe.

Safety performance

A safety thermometer was not completed for the community end of life care specifically. However, staff were aware of the need to monitor pressure ulcers and urinary tract infections to keep people safe.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff followed policy. They recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff had used an electronic incident reporting system. The electronic incident reporting system flagged up safeguarding category incidents to the team, and information governance breaches. The leads from each team would pick up those incidents and use the information to improve practice.

The leadership team had oversight of reported incidents. They looked at themes, for example around communication and timely medications. Where possible they would complete incidents reports on the day they happened. All incidents were electronically sent to the manager and depending on the issue it would be investigated or discussed with staff. Incidents of significance were shared and discussed at team meetings and if required at a one to one basis. Staff understood duty of candour. The duty of candour is a duty that, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.

We looked at incident reports where there had been reflection and learning by staff. Staff provided us with examples of where they had raised incidents and used the learning to improve practice and outcomes for patients. Staff looked at trends, for example, a regular review of how many people died in their preferred place.

Management told us that the trust was involved in an improvement practice group. End of life care was an area of focus for the group. A value stream analysis was completed alongside primary care, care commissioning groups, local ambulance service, 111 and care homes with the aim of learning and improving.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From December 2017 to November 2018, the trust reported no incidents classified as a never event for community health services for end of life care.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community health services for end of life care, which met the reporting criteria, set by NHS England from December 2017 to November 2018.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From October 2017 to September 2018, trust staff within community health services for end of life care reported no serious incidents.

This is comparable with that reported to Strategic Executive Information System (STEIS) data. This gives us more confidence in the validity of the data.

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Prevention of Future Death Reports

In the last two years, there have been no prevention of future death reports sent to the trust relating to this core service.

(Source: Universal Routine Provider Information Request (RPIR) – P76 Prevention of future death reports)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service took a holistic approach to assessing, planning and delivering care and treatment to all people who used services. This included addressing, where relevant, their nutrition, hydration and pain relief needs.

Staff were familiar with up to date evidence based guidance. For example, Care of the Dying guidelines dated November 2018 to ensure delivery of care to dying adults were within an up to date, evidence-based framework that reflected local and national guidelines. Staff demonstrated an understanding of the 'One Chance to get it Right'. This was an approach to caring for people in the last few days/hours of life that focused on the needs and wishes of the dying person and those closest to them.

The trust introduced the Gold Standards Framework (GSF) in April 2018 to improve the consistency and quality of care within the community. The GSF is a model of good practice that enabled a 'gold standard' of care for all people who are nearing the end of their lives. The GSF involved staff across the trust, not just the specialist palliative care team. Partner agencies knew and understood the principles and value of it. We saw good engagement from staff. 90% departments had a lead consultant.

Staff carried out audits to determine if patients died in their preferred place of death. For example, how many died in hospital and how many died within few weeks of having surgery or within 12 months. As a result, education initiatives were introduced. For example, training and education with ambulance services and district nurses to ensure they worked with patients and their families to ensure patients continued to receive their care at their requested place of death.

A specialist palliative care cell was being set up by adapting the electronic recording system. The aim was to pull data to create a baseline and to continue to audit data to help make service improvements.

Nutrition and hydration (only include if specific evidence)

The district nursing team were responsible for the nutritional and hydration needs of patients.

Pain relief (only include if specific evidence)

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff used recognised tools to support patients with difficulty, for example pain scales they use for those unable to verbalise. Staff used the West Midlands Palliative Care Physicians Guideline. This was accessed by a link on the specialist HUB pages and a central document page.

Staff gave us examples of when they communicated effectively and compassionately with patients

to manage their pain. Staff were innovative in the approach to pain management. This was demonstrated by the safe use of innovative and pioneering approaches to care and how it was delivered. We were provided with a practical example of how a patient with particularly challenging pain management was supporting in remaining in the community using a drug that would ordinarily only be used in hospital. A collaborative approach by a specialist team meant that the patient's

wishes to die at home were met and their pain safely and effectively managed. The positive outcome was acknowledged by the patient and their family.

Staff demonstrated an excellent understanding of managing very complex pain. Staff worked alongside a consultant when increasing medication to reach the right level for patients. Staff followed national guidance and best practice when prescribing and administering pain relief. This included prescribed anticipatory medicines with individualised indications for use, dosage and route of administration. We saw this demonstrated in conversations with patients, families and staff.

Patient outcomes

The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

All patients assessed as being at end of life were referred to the GP end of life register. Key staff met and recorded patient details at the Gold Standard Framework (GSF) consultation once a month. In addition, staff met with GP's weekly and attended multi-agency meetings to discuss all palliative care patients. They discussed preferred place of care, if there was a need for anticipatory medication and who would be the best person to give support, for example, the district nursing team. This meant that the patients preferences were discussed, shared and recorded.

Staff attended monthly GP meetings held at surgeries and discuss people on the GSF register. The meetings with the GP's were an opportunity to speak about people on the team's caseload and how effectively they were being managed in their last 12 months of life.

Staff told us that the new seven-day service, which was introduced in November 2018 was vital in preventing inappropriate admissions to hospital. One staff member told us that over the course of two weekend shifts they had prevented two admissions to hospital. They provided us with one example of how joint working with the acute hospital and ambulance service meant that the patient was seen and discharged within a four-hour period to ensure care continued in the patients preferred place. The staff member worked with the district nurse in educating them on how to support the patient's wishes and worked with the ambulance team in supporting a swift turnaround for the patient. This meant the patient's wishes were carried out, the district nurse and ambulance staff learned from the experience and how to improve their practice to support future patients in similar circumstances.

Audits – changes to working practices

The trust had participated in no clinical audits in relation to the community end of life care core service as part of their Clinical Audit Programme.

Monitoring of compliance was carried out using an audit programme, facilitated by a palliative care team clinical lead on annual basis.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

We saw evidence of trust audits being discussed and addressed in quarterly specialist palliative care quality and practice development team meeting minutes. For example, a consultant informed the attendees that they were taking part in The National Care of the Dying Audit in August 2018. The consultant told us that audits were discussed at quality meetings, the minutes of which were distributed to staff members via email and discussed in local meetings. We also saw a list of local audits listed in the Annual Report and actions because of outcomes.

Consultants carried out procedures in the last week of life audit. This referred to inpatients, however, the audit referenced improvements related to how the introduction of the Gold Standard

Framework enabled more patients to die at home. The audits linked with community end of life services and staff spoke of how they worked closely with hospital staff to make use of audit outcomes for learning purposes.

Staff had access to an operational policy, work programme, annual report and annual plan of audits, which fed in to the audit programme within the trust. We were given an example of a local audits were there was learning as a result. For example, a historical complaint about practice around syringe driver prescribing which resulted in a registrar helping with syringe audit. To assure themselves, staff completed a review of anticipatory prescribing audit. There were yearly trust mandatory audits for care. Staff completed internal audits around caseload reviews. This meant they were part of a continuous quality improvement process that focused on specific issues or aspects of health care and clinical practice.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The team were made up of specialist palliative care nurses. The specialist palliative care nurses worked alongside district nurses and other specialist professionals to carry out joint visits to give advice, symptom management, and psychological support. For example, if a patient had a primary diagnosis of a mental health condition, the specialist palliative care nurses would support mental health staff in managing their specialist wellbeing and physical health needs. Staff knew and understood the principles of working with people with specialist needs. We saw this documented in records and in discussions with staff across disciplines.

Staff in the specialist palliative care team provided end of life education for all health care professionals. This included medics (hospital based and GPs), nursing staff (qualified/unqualified), allied health professionals and non-clinical staff, including admin, ward clerks, porters and volunteers. The education programme included training, education courses and resources, and aims to ensure all health and social care staff had the necessary skills, knowledge and attitude to care for the dying. We spoke with staff from inpatient services, district nurses, heart failure nurses and all of them spoke highly of the education they had received to help them work well with the patient group.

Staff in the specialist palliative care team were provided with specialist training to help them identify and manage mental health conditions, suicide and risk factors, and dementia. Staff training needs were identified in one to one meetings with managers. There were specialist palliative care team champions within the acute hospital. Charitable funds were available for the specialist palliative care team champions. They met as a group on a quarterly basis to discuss competencies, priorities in education and other educational events. These meetings had an agenda and were documented. We saw good knowledge and understanding of key principles of working with patients at end of life on the wards at the acute hospital.

In addition to an education programme to promote learning, staff received one to one management and clinical supervision and a yearly appraisal. One to one supervisions were recorded and signed off in a staff folder, however clinical supervision was not documented formally. Annual and 6 monthly staff reviews were documented and nurses held revalidation folders to further ensure they were competent in their roles.

All qualified staff had completed relevant post graduate qualifications. One nurse we spoke with had a degree in palliative care. There were two nurse prescribers in the team. All staff we spoke with told us that they were encouraged to complete nurse prescribing training.

The occupational therapists and allied health professionals delivered aspects of the education programme. For example, occupational therapy ran a fortnightly programme for acute therapists. This was a one day training programme that included communication, priorities of care, advanced care planning, do not attempt resuscitation. Staff on acute respiratory wards, renal and oncology wards had been provided with training in prognostication to help reduce repeat admissions.

Clinical Supervision

The trust provided the following information about their clinical supervision process:

"The trust offers clinical supervision to all staff which is accessed either by accessing their locally trained supervisors or alternatively the Professional Development Team. Posters are in place to inform community nursing teams of how to do this."

Clinical supervision was not mandated within community nursing, staff were able to access this when they felt it was required.

The approach to clinical supervision was varied across allied health professional services. Some services had well-established clinical supervision structures that followed the guidance of their respective professional bodies. This included regular scheduled meetings on a one-one basis with a more senior member of staff, within a group setting with peers or with professional colleagues within a speciality, for example, consultants and psychologists. Clinical supervision may include caseload discussion, case history discussion, multi-disciplinary discussion and peer review. Other areas follow the approach of the community nursing.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clin Supervision)

Appraisal rates

For year to date, April to September 2018, 85.0% of required staff in community health services for end of life care received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	Staff who received an appraisal	Individuals required	Completion rate	Target	Met Yes / No
Qualified allied health professionals	1	1	100.0%	90.0%	Yes
Qualified nursing & health visiting staff	8	9	88.9%	90.0%	No
Support to doctors and nursing staff	8	10	80.0%	90.0%	No
Total	**17**	**20**	**85.0%**	**90.0%**	No

It should be noted that for the staff groups not meeting the target, this is due to only one or two eligible staff not having received an appraisal so the performance should be taken in context when dealing with small numbers of eligible staff.

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

Multidisciplinary working and coordinated care pathways

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Staff worked alongside other agencies to assess patient's individual needs and preferences to ensure delivery of tailored services. Patient needs were assessed using a range of individual professionals who put the patient at the centre of delivery of care.

The single point of access team filtered all referrals through to the team and an allocation nurse (off duty) would sit with a consultant each morning to jointly agree allocation of referrals dependent on individual need, GP, locality, appropriateness and fact finding to establish the best fit.

Staff attended a twice weekly multi-disciplinary meeting facilitated by the psychologist. Weekly meetings with GP's, local authority social care teams, school health visitors and other involved partner agencies. This meant that different disciplines worked together to support each individual patient, their families and carers and meet tailor their care to meet their specific needs.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. There was a clinical psychology pathway for palliative care, end of life and bereavement. The service focused on ensuring that the End of Life Strategy (2008) and NICE guidance (2004) was implemented to provide coordinated and high-quality interventions to support emotional wellbeing. The service was flexible and offered a service in hospital, in the community or at home. The psychologist, specialist palliative staff and moving patient and carer testimonials demonstrated a gratitude for the integrated specialist service.

The services were flexible, provided informed choice and ensured continuity of care. For carers of patients there were respite services available, for example a volunteer service that offered two hour sitting service once a week and Marie Curie who offered overnight respite.

The palliative care support team were integrated and half funded by social services and half by health. This was a service for patients deemed to have less than three months before reaching

active dying. Staff carried out all personal care and could offer up to four visits a day depending on need. These staff were well trained and worked closely with district nurses if there were additional clinical needs. They were managed by a dedicated team leader.

For patients with specific needs, for example, patients with an existing neurological condition, there were external agencies who worked alongside the specialist palliative care team. There was a specific carers and family support service, a dementia service and a service specifically for the elderly. This meant that there was wraparound service to provide care to support positive outcomes.

The service had a personal care team of specialist care support workers, led by a registered nurse. The team worked side by side with the local authority social care team to co-ordinate health and social care needs. Patients were rapidly assessed for a package of care, and the care implemented by the joint teams the next day.

The specialist palliative care nurses helped manage the patient, their families and their journey. They carried out holistic assessments and looked at physical, emotional, spiritual and financial needs. To assess whether they were getting it right, they launched a questionnaire to evaluate visits. This was a work in process and incomplete at the time of inspection. The plan was to use this feedback to help tailor services for those who used the service.

Staff could access allocated beds at a local nursing home with the right expertise for palliative patients. Staff told us they were very flexible and patients were allocated beds urgently if families were in crisis at home. A robust plan was put in place to ensure continuity of care. There was an assigned care home nurse which meant that specialist palliative care nurses did not need to visit daily unless necessary.

Staff attended fortnightly multi-disciplinary team meetings to focus on learning. This meeting included the chaplain, a consultant, two occupational therapists, the psychologist, team leader, and nurse specialists from acute services. These meetings had an agenda and were minuted by an administrator. The minutes were shared with all staff at local team meetings.

Staff attended a team building gold standard framework event every 4 weeks. The occupational therapists also attended generic multi-disciplinary team meetings for elderly and frail. Staff also attended a palliative care register meeting to making sure people who should be on the register were.

Health promotion

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. We saw evidence of consent contained within patient records. Staff also gave us examples of how they would support a patient's best interests when they were unable to consent.

Staff had good links with the local mental health team. The team psychologist was substantively employed by the local mental health trust. This meant they could access to up-to-date, accurate and comprehensive information on patients' care and treatment.

Mental Capacity Act and Deprivation of Liberty training completion

For year to date, April to September 2018, mental health law training (including deprivation of liberty safeguards training) was completed by 77.8% of eligible nursing staff in community health services for end of life care. It should be noted that the data for nursing staff refers to nine eligible staff, and so the performance should be taken in context when dealing with small numbers of eligible staff.

The trust did not provide any data for medical staff working in community health services for end of life care. However, please see Acuter End of Life Care report for medical staffing training information.

(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

From October 2017 to October 2018, the trust reported that 81 Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority. None of these were pertinent to community health services for end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Is the service caring?

Compassionate care
Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

Staff cared for patients with compassion. Staff were discreet, respectful, and responsive when caring for patients. Patients said staff treated them well and behaved kindly. Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treat people.

People fed back that they thought staff went the extra mile and their care and support exceeded their expectations. We spoke with and observed interactions with patients and carers. We spoke with specialist staff who worked alongside the team, for example, the district nurses and the heart failure team. They each told us how much they valued the service, how there was a culture of support, education, learning and putting patient care at the centre of what they do.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

There was a strong, visible person-centred culture displayed by every member of the team and those who worked in partnership with them. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service,

those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. This was displayed in support provided to patients and their families before and after death. For example, the psychologist supported a remembering group facilitated by staff to support people after their loved ones had died. Condolence cards were sent following death clearly outlining an invitation to access support after a loved one had died.

Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account, and found innovative ways to meet them. For example, we were told about a patient who had requested a hymn. Staff arranged this to be facilitated and sung by the chaplaincy service. People's emotional and social needs were seen as being as important as their physical needs. We observed this in all our observations, in discussions and using feedback directly from people who used the service.

Emotional support

Staff provided emotional support to patients to minimise their distress. Staff were trained, passionate and highly motivated to provide emotional support to patients and their families to minimise their distress. We saw and heard of care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. We saw examples of gratitude in varying forms. For example, in thank you cards that clearly outlined gratitude to staff who people felt were like members of their own family.

Staff told us it was their aim to make people feel at ease and at peace to facilitate being in their own home if that was their wish. Staff recognised the needs of those caring for the dying and could make referrals for night sitters through charity organisations. This meant that families were supported in achieving some respite to replenish their emotional and physical energy.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Each patient had priorities for the care of the dying person communication document. Contained within the document was guidance on how to communicate if there were barriers. For example, what to do if patient did not have capacity. For example, involve an advocate if there was no family.

The document also included the needs of the family and those important to them. At this point in their assessment, patients' families and those important to them were provided with an end of life guide. The guide was developed because feedback from patients was that it was important to know what to expect when someone is near the end of life.

Staff told us, in discussion with the multi-disciplinary team, family and patient, if appropriate, they gave careful consideration when it was appropriate to withhold, withdraw or rationalise unnecessary treatments in the best interests of the dying patient. For example, we discussed when a patient might develop an infection while actively dying and in other circumstances, might require intravenous antibiotics. Staff told us that the focus of care was symptom management, comfort care and dignity.

Patients and their families could give feedback on the service using an easy to complete questionnaire with attached free post self-seal envelope. The feedback was used for service improvement purposes by the specialist palliative care team. There was a specific friends and family question contained within the questionnaire. This meant that the survey could also be used to inform the trusts national return to NHS England to ensure high standards of healthcare and sharing of findings with the public.

Staff supported patients to make advanced decisions on their care. Staff had conversations with patients about the future and provided them with a planning for your future care leaflet. These conversations helped people explore options, identify wishes and preferences, appointment someone to make decisions relating to using Lasting Power of Attorney. The process was entirely voluntary and staff were careful to steer patients at their own pace and under their specific direction.

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and provided services in a way that met the needs of local people. The teams were separated in to five locality hubs which meant that staff could manage patients in line with GPs and other professional agencies involved in care and treatment of those who were at the end of life.

Staff, patients and carers had a single point of contact through which they could refer, access assessments and other resources. For example, arrange a home-based assessment for home-based equipment by a qualified professional, such as an occupational therapist, and be trained to use it as necessary. Staff told us they could be flexible in all that they offered and that they worked hard to ensure they met the needs of those who used the service.

The service employed a palliative support nurse as part of a new initiative to help support the specialist palliative care nurses. The palliative support nurse held 12 patients on their caseload based on referral rates. Complex patients would be seen alongside a more senior nurse if needed. This meant that there was an additional capacity to support more patients with less complex requirements in the community.

Meeting the needs of people in vulnerable circumstances

Patient's preferred place of care was prioritised and specific needs explored and delivered if possible. Specific spiritual, cultural and religious needs were addressed. When requested, a referral to the hospital chaplaincy team or to a patient's own religious leader was supported. This was recorded in patients' individual records.

People's individual needs and preferences were central to the delivery of tailored services. There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The service was flexible, provided informed choice and ensured continuity of care. Staff gave us numerous examples of how they did this. For example, educating and supporting district nurses in avoiding radiotherapy if this was assessed as appropriate for patients. Staff completed advanced care planning with patients which clearly stipulated where the patient wished to die, for example, in a hospice rather than at home, staff also explored preferred alternatives in the event that the patients first wishes could not be met.

Staff consistently told us they sought to maximise quality of life and independence. We spoke with two occupational therapists who were fully integrated to the specialist service. They gave us examples of how they helped keep patients in the community if it was their wish. One occupational therapist told us that they had helped to fast track a patient with complex needs to continue to live independently in their home which was their wish. The occupational therapist told us a seamless service supported this process. They taught the palliative care support worker moving and handling techniques, hoisting and special seating with pressure relief. In addition, there were psychological issues. These were promptly picked up and managed by psychology. This meant that the patient and their spouse could stay at home and the patient died according to their wishes.

The service physiotherapist was on maternity leave and due back early 2019. The service had recruited a temporary physiotherapist, however they left. Staff raised this as a concern and kept a record of physiotherapy specific issues, for example, breathlessness. The team tried various methods of filling this gap, however they were not always suitable. For example, there was the choice for patients to be seen by the hospital physiotherapist but patients did not always have

mobility that meant they could attend. This meant patients did not always have access to a physiotherapist during this period.

Access to the right care at the right time

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
Patients had access to a seven-day service in the community. Staff told us this helped reduce hospital admissions. Only the senior band 7 nurses covered the weekend service. Nurses covering weekends worked alongside the district nurses at a community Hub. Out of hours services at the weekend was covered by staff at a local hospice, which was the main centre for district nurses and GP's. The hospice was a consultant and palliative led service covered by the trust consultants. This meant staff and patients had a relationship with them and could call them directly for guidance and support. Patients would only be discharged if the service was no longer required.

We saw evidence in records of patient's relatives being contacted on the day of referral, patient being seen two days after allocation meeting. Rapid response and timeliness was demonstrated by all staff involved in patient care.

Accessibility
The largest ethnic minority group within the trust catchment area is Pakistani with 3.3% of the population.

	Ethnic minority group	Percentage of catchment population (if known)
First largest	Pakistani	3.3%
Second largest	Indian	1.8%
Third largest	White and Black Caribbean	1.1%
Fourth largest	Other white	1.0%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals
None of the data provided by the trust for days from referral to initial assessment or from referral to treatment for patients related to their community end of life care service.
(Source: CHS Routine Provider Information Request – CHS10 Referrals)

The single point of access team filtered all referrals through to the service. An allocation nurse received and agreed allocation of referrals every morning. A consultant supported decisions about allocation of referrals dependent on individual need, GP, locality, appropriateness and fact finding to establish the best fit.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The service had a complaints policy and process for people to raise concerns. There were several ways that people could raise concerns. We saw easy to use leaflets given to people with information outlining how to complain and what to expect. People could also complain online or over the telephone. There were processes for exploring and investigating complaints. Advocacy

and Patient Advice and Liaison services available to people to help them when they were unhappy. Themes from complaints were recorded and shared with staff to help make improvements.

Staff learned from surveys. For example, the Modified Voices survey highlighted a theme around communication. People reported not always being aware that their loved ones were dying. As a result, a strategy was developed jointly with other key stakeholders. The service self-assessed against the strategy and came up with recommendations, one of which was to agree a common language. For example, definitions for palliative care was agreed for organisations and similarly a less technical approach to language used with people using services.

Complaints

From October 2017 to September 2018, there were no complaints about community health services for end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From October 2017 to September 2018 there were 35 compliments received for community health services for end of life care (0.5% of all received trust wide).

Compliments were received in four months of the 12 month period. September 2018 was the month where the most compliments were received (16).

The trust reported key themes emerging from the compliments supported the information found in other surveys that have been undertaken and include care and treatment (medical, nursing, other, general nursing care) and staffing (medical/nursing, general nursing/care).

The trust did not provide a breakdown by subject for compliments received.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The specialist palliative care lead nurse had overall responsibility for the specialist palliative care teams. This included the acute specialist palliative care team, community specialist palliative care team and palliative care support team.

Two specialist palliative care consultants worked alongside the specialist palliative care lead nurse and clinical nurse specialists, palliative care nurses and the palliative care support team.

Staff told us they had very good relationships with the leadership and management team. They had frequent meetings and interactions with them. Staff told us that the manager was accessible throughout the week and at the weekend, even if they were off duty. Staff received emails regularly with updates from senior leadership team.

The leadership team supported a philosophy of reflection. This was facilitated by the service psychologist and among peers. Staff were encouraged to attend clinical supervision and other means of support to improve their practice and encourage wellbeing. This meant that staff received facilitated support and worked closely to support each other to provide the best possible care to patients.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The trust vision and values posters were displayed and staff told us that they felt part of the overall trust vision and values.

There was an end of life and palliative care strategy implemented 2017; the review date was 2020. The strategy was a collaboration between the trust, the commissioners and the local hospice to help support delivery. The strategy clearly sets out the outcomes for meeting the needs of patients who required the specialist service. For example, to ensure staff were suitably trained.

Staff were trained and in addition to mandatory training, they were supported in achieving additional evidence based specialist training to meet the needs of the patient group. The strategy sets out advanced personalised care planning, co-ordinate care, equity of access and person-centred outcome measurements. All of which were seen to be embedded in practice.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was a culture of fostering a workplace that encouraged and promoted the well-being of all staff. The leadership team provided protected time for education, training and meetings. Staff told us they felt the leadership teams understood and valued and encouraged to provide the best care for patients above all else. This was evidenced in our interactions with staff and in our observations.

Staff felt safe to discuss concerns in an open and transparent way. They understood the whistleblowing process and felt confident in using it if needed.

There was culture of education, learning and collaboration in all aspects of end of life care. It was demonstrated across disciplines and directorates within the trust and externally with partner agencies. There was evidence in the number of multi-professional and multi-disciplinary meeting minutes. In discussions with staff and the joint working with partners, for example, joint visits and working with local authority health and social care teams. Education and learning was evidenced in the education programme, feedback from partners, for example, West Midlands Ambulance Service. End of life care was an integrated partnership among professionals who worked to provide the best possible end of life care to patients in the community.

All staff we spoke with told us they felt proud to work in the service. Many of the staff we spoke with told us it was a privilege to be part of patient's end of life care. Staff clearly put patients and their wishes at the centre of all of the work they carried out with patients, their families and carers in the community.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

The end of life care steering group, who met quarterly, maintained oversight the service. The group reviewed the quality of the service being provided and monitored performance against set objectives, for example, recruitment and the introduction of the Gold Standard Framework. The directorate manager for haematology and oncology attended divisional integrated governance meetings. The reports from these meetings were fed in to team meetings to keep staff up to date with plans and outcomes.

The specialist palliative care consultants and specialist palliative care lead nurse reported quarterly to the Quality Committee, which reported to the quality executive. The service sat within medicine and integrated care. The end of life care executive, non-executive and clinical lead played an active role in end of life plans for continuous improvement.

Staff could access the 2018 annual report for the service. The report was discussed and agreed in the Specialist Palliative Care meeting in September 2018. It was used to identify areas of good practice and plan future improvement. For example, key achievements were audits completed during the year and presented to appropriate teams, continued support for palliative care champions and a rolling education programme. Challenges included provision of 7-day service for Specialist Palliative care inpatient service. This provided an opportunity to reflect achievements and areas of continued improvements for the future.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a service risk register. It was up to date and staff knew how to escalate any concerns. The risks on the risk register reflected the risks raised by staff. For example, the inability to recruit a locum consultant. Mitigation was in place for the risks and action taken was reported and reviewed at regular governance meetings and shared with trust directors.

The service had a quality assurance dashboard. This was used to monitor service related performance and make improvements. It recorded data such as referral times, where people died and time between admission and death. The data was used to target education across the service and beyond. For example, education programmes were rolled out to external agencies such as ambulance services and other directorates such as heart failure services.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Leaders had access information systems to facilitate the management of data in line with data security standards.

Staff could access an electronic record and data system across the community service. This helped staff coordinate patients alongside other professionals to provide person-centred care. The service had a dedicated page on the trust's website where patients and relatives could access the service's policies and information.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

The service supported end of life care champions. Champions encouraged talk about end of life care. Staff were encouraged to talk openly and sensitively about death and bereavement to improve support for both patients nearing the end of their lives and those involved in their care. They assisted with sharing information with patients and relatives and engaged the wider staff team in new developments.

The hospital had an awards system for staff aimed to reward and recognise both teams and individual staff members who had 'made a difference' for patients, visitors or colleagues.

The service conducted a bereavement care questionnaire 'Voices' which gave the public an opportunity to suggest improvements. An analysis of returns received between July 2018 to August 2018 showed a high level of satisfaction.

There were a number of initiatives to support patients and the bereaved. For example, groups facilitated by the psychologist. One group, which was evidence based, was called a remembering group. This gave the bereaved an opportunity to talk about their loved ones in a supportive and caring space.

Wide ranging agencies and key stakeholders engaged regularly to improve services. For example, staff met with commissioners regularly for palliative care and continuing healthcare funding to support good quality care.

The introduction of the Gold Standard Framework meant that there was regular staff engagement. There were members events that were attended by the trust and public. There were community initiatives, for example, dying matters event, which was a week-long event to raise awareness of end of life. All staff told us that there had been significant focus and improvements in the service over the past couple of years. We saw this evidenced in the high level of engagement and related initiatives to promote improvements.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
The service was fully integrated with key partnership agencies to work to a common set of standards. For example, the palliative care support team worked in two's, with one member of the team substantively employed by the local authority. The palliative care support team were established following an initiative piloted originally by an occupational therapist in the team. This was supported by the leadership team in its inception. The service was fully embedded and valued by people who used the service and other key staff.

Training initiatives were on a continuous programme for all people involved in end of life services; internal and external stakeholders. All staff were involved in facilitating the education and training programme and feedback from trainees was positive. We were told by staff that because of the continued education and joint working, an improved service had been developed. Staff were proud of their achievements and passionate about the service being a learning and improving one.

Accreditations

NHS Trusts can participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not report any accreditation schemes for community health services for end of life care that have been awarded. However, they were working towards Gold Standard Framework Accreditation with one more year of a two-year process to complete.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)