The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Quality Report

Twympath Lane
Gobowen
Oswestry
Shropshire
SY10 7AG
Tel: 01691 404000
Website: www.rjah.nhs.uk

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	Requires improvement
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is one of the UK's five specialist orthopaedic centres. It provides specialist and routine orthopaedic care to its local catchment area, and specialist orthopaedic care regionally and nationally.

At the time of our inspection, the trust's executive team was experiencing a period of significant change. The Chief Executive had resigned her post one week prior to the inspection and the Director of Finance was covering this role on an interim basis. The Interim Director of Operations had been in post for three weeks and the Director of Nursing was due to leave her post at the end of the month.

In March 2015, it was identified that the trust had been over-stating its position against the referral to treatment (RTT) target of 18-weeks. An external review was commissioned to look at the processes, controls and governance arrangements around some of the criteria for inclusion and exclusion that had been used by the trust. The report determined that the exclusions applied by the trust were not in line with practice at other organisations and there were gaps in roles and reporting arrangements. This was the second time that the trust had been investigated for issue relating to RTT. A second report was commissioned which focused on the operational context, leadership and cultural issues around the RTT misreporting. This report had not been published at the time of our inspection.

We inspected this hospital in October 2015 as part of the comprehensive inspection programme. We inspected all of the core services provided by the hospital. We visited the hospital on 6, 7 and 8 October as part of our announced inspection. We also visited unannounced to the hospital on Thursday 15th October 2015.

Overall we have rated this hospital as requires improvement. We saw that services were caring and compassionate and staff were prepared to go that extra mile for patients. We saw a number of areas that required improvement for them to be assessed as safe, effective and responsive. We saw that leadership of services in some areas also required improvement.

Our key findings were as follows:

- Staff were proud of the hospital and its national and international reputation. There was good team working within and across disciplines, staff groups recognised and understood the importance of each other's roles. Staff told us they felt supported by their managers.
- There was a culture of reporting incidents and good local learning, however, not all non-clinical and zero harm incidents were being routinely reported and there was limited learning across the organisation.
- The hospital performed well against the safety thermometer targets and had not reported a case of Clostridium Difficile since June 2014.
- Staffing levels on the wards reflected national guidelines and there was very limited reliance on agency workers.
- There was good use of guidelines and patients were very positive about their outcomes.
- We were concerned that not all staff were following recognised national best practice in infection control, particularly bare below the elbows and the use of hand gels, although we did observe staff washing their hands
- There were qualified Paediatricians on duty during the day, but medical out of hours cover for paediatric services was not provided by staff with paediatric training, not all staff had life support training to the appropriate level to respond to paediatric patients.
- There was no oversight of the planning of outpatient clinics, this meant that at times, support services such as x-ray were stretched and patients were subject to excessive waiting times for tests and clinic appointments.

We saw several areas of outstanding practice

- Award winning leadership of MCSI by the ward manager which had positively impacted on the team and anecdotally reduced reports of stress related sickness.
- Exceptional compassionate care by staff on the MCSI who showed high levels of support for individual patients.
- Outcomes for patients attending the hospital with complex orthopaedic problems were consistently

Summary of findings

good. A higher proportion of patients undergoing hip and knee replacements reported an improvement in their condition following their surgery compared to the average of the other specialist orthopaedic trusts.
- The proactive approach taken to support patients living with dementia, particularly on the HDU
- Innovative ways of engaging with children and young people about services in collecting views about services and using young volunteers to assist in interviewing for new staff.
- The Orthotic Research & Locomotor Assessment Unit provided innovative interventions to improve patient mobility, including occupational and physio therapies, as well as mechanical aids which were designed and manufactured on site.

However, there were also areas of poor practice where the trust needs to make improvements:

Importantly the trust must:

- The hospital must ensure that all incidents, including non-clinical incidents are reported by all staff. Learning points from complaints and incidents should be shared across directorates and all action plans monitored to improve the quality of care and develop services.
- The hospital must improve hand hygiene standards and ensure that all staff in all areas are adhering to trust policy. The trust must also audit hand hygiene practices, using methods that are robust and improve signage of isolation procedures, hand washing instructions, and use of hand sanitisers in all clinical areas and corridors.
- The hospital must ensure that there are robust and suitable arrangements to provided paediatric medical cover during the evenings, overnight and at the weekend to ensure that they can respond in an appropriate, safe and timely way to deteriorating and seriously ill children.
- The hospital must ensure that staff caring for children are able to identify, report and treat deteriorating and seriously ill children. This includes being familiar with the SBAR technique and its use in alerting the medical team to emergencies.
- The hospital must ensure that patient's medical notes in HDU include a record of all doctor visits and any revision to the patient's treatment plan.
- The hospital must ensure that there is at least one team member with up to date paediatric resuscitation training on duty at all times on Alice ward and all staff that may be required to respond to a paediatric medical emergency also have up to date paediatric resuscitation training.
- The hospital must ensure that resuscitation equipment is fit for purpose and urgently seek to provide battery-powered suction machines for Alice ward.
- The hospital should ensure that paediatric care pathways are routinely audited in order to monitor compliance with nationally recognised best practice.
- The hospital should ensure that outpatient clinics are planned in such a way to prevent excessive demand on support services or other clinic areas which in turn impacts adversely on patient waiting times.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The trust is very proud of its long history of providing orthopaedic care since the early 1900's, although it has been officially named the Robert Jones and Agnes Hunt Orthopaedic Hospital since 1938. The organization became a foundation trust in 2011.

The trust is one of the UK's five specialist orthopaedic centres. It provides specialist and routine orthopaedic care to its local catchment area, and specialist orthopaedic care regionally and nationally. As it is located close to the Welsh border, it provides local services to people in in England and Wales. Health indicators for Shropshire are similar or better than the national averages.

The trust employs over 1,000 staff and has 219 inpatient beds. There were 15,512 inpatient admissions between April 2014 and March 2015 and 152,471 outpatient attendances in the same period.

The trust is a specialist centre for the treatment of spinal injuries and disorders and also provides specialist treatment for children with musculoskeletal disorders. There are eight inpatient wards including a private patient ward; ten operating theatres, including a day case surgery unit; and full outpatient and diagnostic facilities. They work with partner organisations to provide specialist treatment for bone tumours and community based rheumatology services. The hospital at Oswestry also hosts some local services such as maternity services.

Our inspection team

Our inspection team was led by:

Chair: Michael Marrinan, Executive Medical Director at King's College Hospital

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

consultant orthopaedic surgeon, paediatric orthopaedic nurse, consultant paediatrician, rehabilitation nurse, orthopaedic surgery nurse, consultant anaesthetist, radiographer, consultant radiologist, outpatients nurse, director of nursing, medical doctor, physiotherapists. The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

How we carried out this inspection

We inspected this service as part of the comprehensive inspection programme and visited the hospital on 7 and 8 October 2015 as part of our announced inspection. We also visited unannounced to the trust on Thursday 15 October 2015.

We held two public listening events prior to this inspection in Oswestry and Shrewsbury on 30 September and 5 October respectively. Approximately 20 people attended across both sessions to share their views and experiences of the hospital.

During our visits to the trust we held seven planned focus groups to allow staff to share their views with the inspection team. These included all of the professional clinical and non-clinical staff. Through these groups we spoke to well over 150 members of staff.

We met with the trust executive team both collectively and on an individual basis, we also met with ward managers, service leaders and clinical staff of all grades. We also spoke to patients and their relatives and carers we met during our inspection.

Summary of findings

We visited many clinical areas and observed direct patient care and treatment.

What people who use the trust's services say

The Friends and Family test (inpatient) for the period August 2014 to July 2015 showed that more people consistently would recommend the trust than the England average.

The CQC adult inpatient survey for 2014, found the trust performed better than other trusts on three questions about help with eating, getting questions answered by the nursing staff and finding someone to talk to when worried. The trust was comparable with other trusts on all the other questions.

At our listening events held in Oswestry and Shrewsbury, most members of the public were very positive about their experience of the hospital. People told us that staff were very caring and attentive. They told us doctors and nurses were willing to listen to their concerns and explain procedures to them in a way they could understand. However, some people who attended also expressed concerns about their treatment and care.

We used all of this information to help direct the inspection team and focus the inspection on areas important to all service users.

Facts and data about this trust

As at April 2015, the trust employed 1,131 whole time equivalent staff. Of these, 110 are medical staff and 268 are nursing staff. There are 5 high dependency care beds, 16 paediatric beds, 67medical beds and 104 surgical beds. There are a further 15 day surgery beds. There were 15,512 inpatients admissions between April 2014 and March 2015 and 152,471 outpatient attendances. As a specialist orthopaedic centre the trust provides services locally, regionally and nationally.

The trust had revenue of £93 million with a budget surplus in 2014/2015 of £1 million.

During 2014/2015 there was one Never Event reported by the trust relating to wrong site surgery.

There were a total of 7 serious incidents reported between May 2014 and April 2015, two were unexpected death of inpatient, others included slips, trips and falls and surgical errors.

There were a total of 1,428 incidents reported via the NRLS (national reporting and learning service), 91% of these were classified as "no harm" or low harm incidents. The trust reports a similar number of incidents per 100 admissions when compared to other specialist orthopaedic trusts.

There has been no MRSA Bacteraemia cases reported by the trust since August 2006 and no Clostridium Difficile cases reported since June 2014

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Requires improvement

Hand Hygiene best practice was not embedded in all parts of the organisation and we observed many staff (including consultant medical staff) who were not bare below the elbows or washing their hands/using hand gel between patients. The trust had an established process for reporting incidents however, we found some inconsistencies in its application and reporting of incidents to national bodies was slow.

Nursing staffing levels reflected safer staffing guidance and national requirements where applicable. There were sufficient numbers of doctors but we were concerned that out of hours arrangements could put some patients at risk.

The trust understood its responsibilities under Duty of Candour regulations and had taken steps to ensure staff were aware and systems and processes were in place. Staff had been received training in safeguarding adults and children and there were policies and procedures in place to assist staff in ensuring patients were protected from potential abuse.

Duty of Candour

- The Duty of Candour is a legal duty on hospital trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The trust's Being Open policy incorporates the requirements under these regulations.
- We spoke with a range of staff about their understanding of the regulations concerning Duty of Candour. They generally understood the concept, and where staff were not as aware of the terminology, they were able to describe a culture of openness and transparency with patients and their families. We were told about a number of specific examples where Duty of Candour regulations had been applied.
- We saw information displayed on the wards informing staff about the Duty of Candour and actions they needed to undertake.
- Staff told us about attending 'Being Open' training provided by the trust. Data provided showed that 82% of staff at the trust had completed this training. In addition, the trust had held in-depth discussions with consultant staff as part of their awareness training.

Safeguarding

- The trust policies and procedures were in place for safeguarding children and vulnerable adults which reflected relevant legislation.
- The trust had a named safeguarding lead that was available for guidance and support.
- The staff we spoke with understood their responsibilities and they were able to explain the safeguarding policies and procedures. They knew how to access safeguarding policies and procedures on the trust's intranet and were aware who were the adult and children's safeguarding leads for the trust were.
- All staff we spoke with confirmed they had completed relevant safeguarding training. The trust had a target that 90% of all staff should have completed training on safeguarding children and adults. Data provided by the trust showed that 99% of staff had completed level 1 adult safeguarding training and level 1 children's safeguarding training. Eighty-seven percent of staff had completed level 2 training for adults and 85% had completed level 2 training for children.
- Safeguarding children lead staff should had level 4 safeguarding training, 100% of required staff had completed this training.

Incidents

- The trust had an established process for reporting incidents and near misses through an electronic reporting system. Incidents that could have or did harm a patient were appropriately reported. We saw that there was local learning from incidents and any necessary action was taken to prevent similar incidents from occurring in the future.
- At the time of the inspection, the trust had reported 11 serious incidents between March 2014 and May 2015. Slips/trips/falls and unexpected death of inpatient (not in receipt) were jointly the most reported type of serious incident, three of each type.
- One Never Event was reported in September 2014 as wrong site surgery. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. This event related to a spinal procedure whereby the patient had to return to theatre to correct the error. A specific standard operating procedures had been written in response to the Never Event but had not been signed off and therefore was not formally in use.
- We saw that locally, staff knew of the never event and had reflected on changes. When we spoke to senior staff in other areas, they were less clear on its relevance to them.

Summary of findings

- Between September 2014 and August 2015, 1,428 incidents were reported to the National Reporting and Learning System (NRLS). NRLS is a central database of patient safety incident reports. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care. Of the these incidents, 125 (9%) were reported as moderate harm, 1303 (91%)were reported as low harm or no harm.
- The reporting of incidents, investigation and feedback should be undertaken in a timely way to ensure that patients were protected from further harm. The trust had a target that 100% of incident reports and any investigations should be completed within 14 days of the incident. Data showed that between September 2014 and August 2015 only 240 (17%) of incidents were reported to NRLS within 14 days and 5% of incidents were reported more than 90 days after the incident.
- We identified some inconsistency around the incident reporting systems regarding staff access to the system and that not all incidents were being reported. The trust does not routinely report patient related, non-clinical incidents into NRLS; this could include: any booking problems, cancelled clinics, information governance issues, bed capacity or staffing shortages.
- Where incidents were reported, analysis of the root causes was undertaken and an action plan produced from the evidence. Most staff told us they received feedback on incidents in their areas but they did not get to hear of incidents that occurred in other wards or departments.
- Between October 2014 and September 2015 the mortality rate for the hospital was below the national average. There were no unexpected deaths and 10 expected deaths.
- All patient deaths within the hospital and all deaths post operatively within 30 days were reviewed. The findings of the investigation were reported at the trust-wide 'Deteriorating Patient Group' and reports were discussed within the multi-disciplinary clinical effectiveness group and the quality and safety group.
- Staff we spoke with told us that the last mortality and morbidity meeting specifically for medical care services was held in December 2014. This was confirmed when we requested morbidity and mortality review meeting minutes for the service and were informed the trust do not hold separate meetings for Medicine. This meant that reviews and findings from deaths that had happened in the service were not formally discussed by junior and senior medical staff.

Summary of findings

- The trust had committed to 'Sign up to Safety', an NHS England National Patient Safety Campaign. Sign up to Safety was launched in June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

Cleanliness, infection control and hygiene

- There has been no cases of methicillin-resistant staphylococcus aureus (MRSA) Bacteraemia reported by the trust since August 2006 and no Clostridium Difficile (C.Diff) cases reported since June 2014. From April 2014 to August 2015 MRSA screening was recorded as 100%.
- The trust reported an increase in surgical site infection rates in quarter 2 of 2015. The rate jumped from 0.2% in quarter 1 to 1.3% in quarter 2 for knee replacements, this is a six-fold increase. There was a three-fold increase over the same time period for hip replacements from 0.7% to 2.0%. At the time of our inspection, the trust were investigating the reasons for the increase but were unable to confirm the source.
- We saw that all areas of the hospital we visited appeared clean and mostly tidy. There were cleaning plans in place and we saw that these were being followed. Wards and departments had side rooms that could be used to isolate potentially infectious patients to prevent cross-infection or to protect patients with low immunity if needed.
- The trust infection and control policy required that uniforms and work wear should not impede effective hand hygiene, and should not unintentionally come into contact with patients during direct patient care activity. Bare below the elbow and hand washing procedures during the provision of care was not embedded and our observations confirmed this.
- We observed a patient return from theatre on Ludlow ward and not once did the three staff members wash or gel their hands. Two consultants on Ludlow ward were observed to not be bare below the elbows. We observed two staff on Powys ward move between patients in two bays and no gel was applied at any time. We observed staff entering and exiting all surgical wards and at no time did the staff wash their hands or apply hand gel. On the medical wards we observed three doctors on a ward round and two managers, none of whom cleaned their hands. In outpatients we saw a number of consultants and registrars wearing long sleeved shirts and jackets as they moved between consultation rooms and waiting rooms.

- During our discussions and observations, it was clear that senior consultant staff were not engaged in the infection control agenda and did not role model the behaviours required to ensure that junior staff followed nationally recognised good practice.
- Hand hygiene audit results consistently demonstrated 100% compliance all areas. When we investigated this we heard that the results related to a observing a sample of staff over a 20 minute period, who knew at the time they were being watched. The weekly observation audits were in the process of being developed to include bare below the elbows as it was not currently included.
- There were adequate hand washing facilities in clinical areas. Hand sanitising gel was available at entrances to the hospital and treatment areas. However we did not always see accompanying signs to draw attention to their purpose or provide instructions for staff, and observed that staff and visitors were not routinely using the sanitising gel. During one period of observation in outpatients, 23 people entered the waiting area 'B' none were seen to use the gel dispensers in that area.
- We did observe staff were bare below the elbow in the HDU and children's ward. In these areas we saw staff washed their hands, used hand gel and personal protective equipment (PPE) appropriately. Hand sanitising gel was available and used in both areas.

Staffing

- Staffing levels and the skill mix were planned in line with safer staffing tools and national guidance where applicable. Nursing staffing levels were displayed in each ward area. We looked at duty rotas and saw that staffing levels were consistent.
- When shifts could not be fully staffed from their own staff working within contracted hours, staff worked additional hours through the hospital bank (temporary contract). Bank and agency usage was low and there was no evidence that agency nurses were used on a regular basis on any of the wards.
- We saw that nursing and multidisciplinary handovers occurred at shift changeovers and throughout the day. "Safety huddles" took place at each shift change on each medical ward. A safety huddle is a brief face to face meeting attended by different health professions to exchange information about predicted ward activity and safety. This kept staff informed of safety issues and action required of them.

Summary of findings

- There was a higher proportion of consultants and lower proportion of junior doctors compared to the England average and also for the average of specialist orthopaedic trusts.
- Medical staff attended all wards at least once a day and on some wards there was a weekly comprehensive consultant led multidisciplinary ward round. In addition there was a handover between shift changes and to the 'onsite' night time medical cover where necessary.
- Out of hours medical cover was provided on an on call rota basis by a middle grade doctor who was on site. This included providing cover for HDU and the children's ward. Although there were both medical and nursing staff available with European Paediatric Life Support (EPLS) training, the arrangements at the time of the inspection did not reflect nationally recognised best practice. To support the doctor on site, a consultant anaesthetist was on call from home and if needed could be in the hospital within 30 minutes and on-call paediatric support was provided from a local acute hospital.

Are services at this trust effective?

Requires improvement

Local policies and guidelines were based on nationally recognised best practice, however, there was limited audit to demonstrate their application or effectiveness. There was evidence that some outcomes for patients were good, particularly in surgery and on the spinal wards but in other areas there was limited evidence of benchmarking against other providers to demonstrate good outcomes for patients such as the Intensive Care National Audit and Research Centre database.

We saw and were told about good multidisciplinary working on all the wards and in the departments we inspected. Patients benefited from good team working where interventions were based around the patient. Consent was consistently obtained and recorded throughout the trust and staff were able to demonstrate they had a good understanding of the Mental Capacity Act.

Evidence based care and treatment

- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. Staff were aware of national guidance and information available from the National Institute for Health and Care Excellence (NICE), and the Royal Colleges.

- We reviewed local policies guidance and standards and saw they were aligned with current best practice and national guidance. These were available on the trust intranet system. Staff could locate policies when requested.
- Adherence to local policies and procedures was largely evident. Pathways were consistently followed and there was evidence that staff received and acted upon specialist advice where appropriate.
- Surgical services were managed in accordance with the set principles such as NCEPOD and the NHS Institute for Innovation and Improvement, which closed in March 2013.
- There was evidence of some local audits to assess compliance with best practice and an audit forward plan. Although the number of audits was limited. On the children's ward, staff were unable to provide us with examples of which care pathways were in use and how they were assured they were being met.

Patient outcomes

- The spinal cord injury specialised service quality dashboard for quarter 4 2014/2015, showed the service's performance was consistent with the national picture on 13 out of 18 rolling indicators reported. For two indictors relating to patients acquiring pressure sores, the service performed much better than expected as they scored zero. For three indicators the trust was worse than expected. These were; mean length of stay in acute phase for level of injury; percentage of bed days occupied by non-clinical delayed discharge patients for newly injured and further admission patients.
- Enhanced recovery programmes were in place for hip and knee joint replacement surgery for those patients identified as suitable candidates. The programme is shown to produce fitter patients, fewer postoperative complications, accelerate the recovery from surgery and improve the quality of the patient experience.
- In the Patient Reported Outcome Measures (PROM's), a higher proportion of patients undergoing hip and knee replacements reported an improvement in their condition compared to the average of the specialist orthopaedic trusts. The Oxford Hip Score reported that performance was similar to average
- HDU did not contribute data to Intensive Care National Audit and Research Centre (ICNARC), to benchmark the service against other similar hospitals and we were not made aware of any local audits carried out by the unit in respect of patient

outcomes. Following our inspection, we were informed that the trust had contacted ICNARC and was in the process of applying for inclusion to enable the service to be bench marked against similar services.
- We saw evidence of local and national audit engagement. Between June 2014 and May 2015 eleven audits had been completed, nine of which were local audits including two physiotherapy audits.
- At the time of our inspection the trust were not participating in the Imaging Services Accreditation Scheme (ISAS). Clinicians reported that accreditation had been discussed but the system had yet to be engaged with as it was thought that sufficient quality assurance measures were already in place but these were not shared with us during the inspection.
- Standardised relative risk of readmission was much lower than the England average for elective and non-elective care; however, it was higher than the average for elective rheumatology. Risk of readmission for elective care was similar to the average for specialist orthopaedic trusts.

Multidisciplinary working

- There was good multi-disciplinary team working. Assessment, planning and delivery of people's care and treatment was coordinated to involve all the necessary staff including members from other teams.
- Patients had access to physiotherapists, occupational therapists, psychologists, dieticians, nurses orthopaedic doctors, pharmacy staff, speech and language therapists and a social worker.
- A multi professional resettlement and community liaison team supported and facilitated the discharge process up to and after the patient's discharge. We saw that they identified care and equipment requirements, and acted upon them.
- The ORLAU provided exemplary multi-disciplinary working. The service had dedicated staff from a number of specialities, including orthopaedic surgeons, bioengineers, physiotherapists, gait laboratory technicians, orthoptists, engineers and administrative staff. Multi-disciplinary meetings took place in relation to all patients which ensured patient pathways through the service were managed appropriately and tailored to meet individual needs.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- We saw patients being asked for their agreement to care and treatment. All the records we reviewed clearly showed that

patients had consented to the treatment they received. Patients gave written consent during the pre-admission process for surgery. This was checked and reviewed on admission. Staff told us that they always asked for consent before carrying out any examination or procedure.

- Staff we spoke with were clear about their responsibilities in relation to gaining consent, including those people who lacked capacity to consent to their care and treatment. They were able to demonstrate an understanding of the MHA Code of Practice by describing examples of how it would be applied.
- When people lacked the mental capacity to make a decision, we saw that staff made 'best interests' decisions in accordance with legislation including referral to the mental health team.
- Staff were also knowledgeable regarding Deprivation of Liberty Safeguard (DoLS) applications. We saw no instances of where a DoLs application or best interest assessment was required during our visit.

Are services at this trust caring?

Good

Patients attending the trust were very happy with the care and treatment they received and this was reflected in survey results.

We observed that staff were very compassionate towards their patients and committed to ensure they were well looked after.

Patients and their relatives reported that they felt engaged in their care and were party to the decision making process. We saw many examples of good emotional support.

Compassionate care

- The NHS friends and family test asks people if they would recommend the services they have used and offers a range of responses. The trust has consistently received better ratings than the England average on this test. In July 2015, 99% of patients said they would recommend the services; it had been at that rate (or higher) since February 2015.
- Out of 38 comments cards received from the Trust as part of this inspection, 35 were extremely positive. Comments included, "treated with respect and dignity", "staff were first class and treated me with utter respect".
- Throughout our inspection, we saw some many examples of compassionate care for patients and observed staff to be professional in their manner whilst in the ward areas, protecting people's privacy and dignity in a discreet manner.

- Patients told us they had been well cared for and staff were sensitive to their needs and treated them with kindness, compassion and respect.
- NHS choices website gave the hospital five stars for the feedback given from patient responses.

Understanding and involvement of patients and those close to them

- Patients told us they and their relatives were aware of what was happening to them and felt included in decisions and were given relevant and timely information. We saw evidence of this in patient records.
- Patient's relatives told us they felt informed about the plan of care and that all the staff had been supportive. There was evidence written in care records and discharge plans when a patient's family or those close to them had been involved.
- We observed staff during our visit to the HDU hand over the unit's portable phone to a patient to speak to their loved ones. The patient said they really appreciated this and having spoken to those close to them had put assured their loved ones that they were alright.
- In outpatients, patients told us that they had been able to make informed choices about treatment options, where possible and had been able to ask, and were told in terms they could understand what the benefits and disadvantages might be for each option. They felt that they had been able to make the final decision about what treatment to undertake.

Emotional support

- We saw that staff were reassuring with patients and sensitive to their emotional needs. We observed encouragement and reassurance being given to post-operative patients when mobilising. One patient told us they and their partner were particularly well supported during some more difficult days and experiences.
- A clinical psychology service was provided for patients in the spinal unit that included assessments for anxiety and depression, and counselling. This service was also available to other patients in the hospital.
- Chaplains were available 24 hours a day seven days a week. They represented different denominations and had contact with all the major faith communities.
- A full time specialist nurse for children with muscular dystrophy was available for advice, education and bereavement support for children and their families.

Summary of findings

- A clinical nurse specialist in the tumour unit was able to describe the emotional support they are able to offer patients who were anxious to understand their condition.

Are services at this trust responsive?

Requires improvement

Patients told us and we observed long waiting times in outpatients. Clinics were not planned in a co-ordinated way to ensure that demand for support services was managed. This impacted in the patient experience.

Privacy and dignity was well maintained although there were some areas which were not compliant with guidelines on mixed sex accommodation. New facilities being built on site would remedy this situation. We saw good support for patients with learning disabilities and people living with dementia. The trust had adopted a hospital-wide scheme to ensure staff were aware of the needs of patients

The trust provided care and treatment to people locally, regionally and nationally. Services were planned to meet the needs of people and the service was responsive to patients travelling long distances.

Bed occupancy was below England averages and at the time of our inspection, the trust told us they were meeting referral to treatment (RTT) time targets. There had been issues with the RTT in recent months which they were continuing to work on. Following our inspection we became aware that the data was not accurate and the trust was not meeting the 92% target.

Service planning and delivery to meet the needs of local people

- The hospital is one of the UK's five specialist orthopaedic centres, providing both specialist and routine orthopaedic care. The hospital was one of the main referral centres for the treatment of difficult and complex joint replacement surgery and is one of 11 units in the UK designated to receive and treat spinal cord injured patients. This meant there was demand for services locally, regionally and nationally.
- A significant proportion (27%) of patients who attend the hospital have their services commissioned by Welsh Health Boards. Commissioners in Wales and England are working to different metrics regarding the length of time a patient waits for treatment. This means that the hospital has to plan to ensure these targets are adhered to.

- We saw that the trust operated to three separate commissioning standards for the same condition. This meant that one patient attending hospital for the same condition might wait three times as long as another patient with exactly the same problem. We saw this posed significant operational issues for the trust.
- Staff were aware that patients would travel significant distances to attend the hospital and planned services to meet their needs. We saw how many patients were able to engage in several interventions during each appointment.
- The type and frequency of clinics was determined by individual consultants. Consultants would ask their secretaries to arrange a clinic for a number of patients on a particular day, this was communicated to the booking clerks who would then contact the patients and arrange appointment times. These were then passed to the outpatients department for them to allocate rooms. There was no oversight of the system which enabled consultants to see what activity was already occurring and thereby assess the impact of the clinic on the required support services.

Meeting people's individual needs

- Privacy and dignity were upheld in the in-patient areas and in the departments. We observed a lack of privacy in the rehabilitation area (gymnasium), where patients were undergoing a range of treatment and one to one consultations. The gym was used as a thoroughfare to other areas. There were no screens between patient areas which meant that visual and auditory privacy was not always achieved. We reported this to the trust who took action following our inspection.
- We saw a wealth of advice/information leaflets available for patients and relatives regarding care and treatment produced by the trust as well as national organisations and associated charities and support groups.
- The wards provided mixed sex accommodation; bays were separated on a gender basis with separate bathroom facilities. The current HDU did not comply with Department of Health guidelines regarding mixed sex accommodation. There was no toilet or shower facility on HDU, although a toilet and shower would be available in the new HDU.
- The HDU mainly provided care for adults. Although since 1 April 2015 seven children between 13 and 17 years of age had been cared for in there. Staff told us that children were cared for in

the side ward and were always accompanied by a children's nurse who was supported if required by HDU staff. Paediatric intensive care standards are clear that children and adults should not be cared for on the same unit.

- Support for people with physical disability, learning disability and dementia was available if needed. We saw that patient passports were used. A patient passport provides immediate and important information for doctors, nurses and administrative staff in an easy to read form, promoting a positive experience for people with learning disabilities.
- A communication box was held in the outpatients department which contained various cards and pictures which staff used to help them communicate with patients who had a learning disability or could not express themselves verbally. Staff explained that patients with complex needs usually came with carers or relatives who were able to assist with communication and understanding for the patient.
- Staff in surgery undertook an audit on the compliance with national guidelines for the care of adults with learning disabilities between April and August 2015. The results showed that 100% of the notes reviewed had a clear entry that the patient had a learning disability, including one that made reference to the use of a care passport.
- Data provided by the trust showed that 88% of all staff have completed equality and diversity training against a trust target of 90%.
- A patient told us that following a discussion with the ward staff they had been admitted the night before their surgery as it would have been difficult to attend for 7am (normal practice). They told us that the staff were very caring and responsive to their needs.
- Parents and carers were encouraged to stay with the children at all times during their stay. There were rooms on the ward for parents to sleep and camp beds were also provided for those parents who wanted to sleep next to their child.
- Translation services were available through a telephone service and face to face interpreters could be arranged if required. Some staff working in the hospital were able to translate basic issues; however during medical consultations specialist translators were booked when appointments were arranged.

Dementia

- The trust have adopted "The Butterfly Scheme", which is a system of hospital care for people living with dementia or requiring memory support. The scheme teaches staff a targeted care response to offer to patients along with support material

to implement and run the scheme. Butterfly stickers and magnets could be added to patient's notes including x-ray forms to ensure that all staff were aware that the person was living with dementia. The patients received more effective and appropriate care, reducing their stress levels and increasing their safety and well-being. There are link nurses working in each area of the hospital who lead on the butterfly scheme in their area.

- A new facility on Sheldon Ward, known as The Poppy Lounge, was opened in December 2014, to mimic the home environment as much as possible to assist people requiring memory support. We saw that the lounge was used for group activities as well as providing a quiet area for people to relax. We also saw that Sheldon ward had been decorated in a way to assist people with memory loss to identify specific areas.
- Patients living with dementia were encouraged to bring their carer with them to clinic appointments and on admission.
- Both clinical and non-clinical staff had undergone training to enable them to support patients with dementia.
- We saw there were boxes of aids to help communication with people living with dementia or a learning disability. Staff also told us that whenever possible they involved families in the care of people who were living with dementia of a learning disability.

Access and flow

- The trust target for bed occupancy was a maximum of 87%. We saw that the average bed occupancy for quarter 4 in 2014/2015 (January –March 2015) was 84%. This was below the England average and the average for specialist orthopaedic trusts. Although we saw that bed occupancy had increased since April 2013, it was consistently below the trust target and below national averages. Higher rates of bed occupancy impact on the efficient running of the hospital.
- The average length of stay at the hospital was shorter than the average at other specialist orthopaedic trusts.
- At the time of the inspection, the trust reported that 92% of patients with English commissioners were treated within the 18 week target period (RTT), this is the target for all English trusts. Following our inspection, we were made aware by the trust that there were some inaccuracies in the data and the actual figure was 87.4% and the trust had not met the RTT target.
- As at July 2015, patients referred from English commissioners waited on average 8.9 weeks from referral to treatment (RTT). At the time of our inspection, this had increased to 16 weeks. Due

to commissioning differences between English and Welsh bodies, Welsh RTT times were in some instances in excess of 52 weeks. Twenty-five patients from English Commissioners had been waiting over 52 weeks for treatment.

- In September 2015, the cancer 'two week' wait time for referral and '31 day to treatment' was recorded as 100%, and had been so since June 2014.
- Diagnostics waiting time for patients referred from Welsh commissioners had a target of 90% of patients to be seen within eight weeks. We saw that the trust had achieved this target between April and September 2014. In October the rate fell below 90% and continued to fall throughout November, December and January when it fell to 67%. However by February 2015 the service was again performing within target, and by April 100% of patients were being seen within eight weeks.
- Diagnostic waiting times for patients referred from English commissioners was six weeks with a target of 99%. We saw that the service achieved 99% or 100% compliance between April 2014 and June 2015.
- From February 2015 to September 2015 there were 47 patients who experienced a delay in their discharge. The 47 patients were delayed 769 days in total. Of the 47 patients 42 were referred from English commissioners.
- All patients whose operation was cancelled received treatment within 28 days. The trust's performance against this target was better than the England average and the average for specialist orthopaedic trusts for every quarter.
- The trust did not routinely record and monitor the time patients waited in outpatients for their appointment. Staff told us that all appointments were scheduled to last the same amount of time however some ran over this time, but this was balanced by the number which took less time. We saw this in action where at one point waiting times had been posted on the waiting room notice board as 40 minutes. A few hours later we were in the same area and it was noted that the waiting time had been changed to 20 minutes.
- The trust had set a target of 90% of x-ray patients to be seen within 30 minutes. Data provided by the trust showed that between April 2014 and April 2015, the target was only achieved during three of the twelve months. Three further months achieved over 85%.
- Staff in outpatients and imaging told us that in addition to the usual clinics there is a scoliosis clinic which is held twice monthly. Patients attending the scoliosis clinic often require

Summary of findings

extensive imaging procedures during their visit. This usually means that patients waiting for imaging in all the clinics find their waiting times are extended. Staff told us that it was not unusual for patients to experience waiting times over an hour and half when scoliosis clinics were running.
- Overall we saw a lack of productivity measurements other than those nationally required.

Learning from complaints and concerns

- Data received from Trust showed that between July 2014 and June 2015, the trust received 82 formal complaints. The average length of time taken to respond to a complaint was 34 days. The trust policy on complaints did not specify a timescale for responses but that it would be agreed on an individual basis with the complainant.
- Nine complaints were analysed as part of our inspection. All demonstrated, as far as could be ascertained appropriate, considerate and proactive responses from the Trust and that actions were taken as a result. Feedback was provided to the areas involved but learning from patients complaints was not routinely shared across other wards and directorates.
- All staff we spoke with correctly described the trust complaints and concerns policy and their role in responding. Staff told us that if someone wanted to make an informal complaint, they would attempt to resolve any issues immediately or direct them to the nurse in charge.
- Patient information leaflets were available throughout the hospital, which included information on how to make complaints. The trust patient advice and liaison service (PALs) were available to advise and assist patients who wished to make complaints.
- Complaints information was included on the scorecards which were discussed at departmental meetings. On a monthly basis, senior leadership received a report detailing any complaints received.

Are services at this trust well-led?

Requires improvement

The chairman of the trust had a clear vision for the organisation but it was not universally shared and not all staff were aware of it or their role in achieving it. The strategy for the trust was dominated by surgical services.

Governance arrangements were in place but not applied in a systematic and consistent manner. A recent external report had identified issues with the governance arrangements around referral to treatment target times

Summary of findings

The leadership of the organisation was in the midst of significant change at the time of the inspection. The trust executives were almost all in an interim position or about to move to other organisations. It was difficult to assess the capability and capacity of the executive team going forward but there was a willingness to do the right thing and support the staff at the trust.

Communication with staff and the public had not always been as open and transparent as it could be but there was a change occurring and the executive team were prioritising the involvement of staff and patients.

Staff spoke positively about working at the trust and valued their colleagues and the patient care they delivered.

Vision and strategy

- The trust chairman felt the trust had developed a clear vision and strategy for services at the hospital. Staff awareness of the vision and strategy was mixed. In some parts of the organisation staff were clear about the role they had to play in achieving the vision and strategy, other less so and were concerned about the future sustainability of their service. During interview, the chairman of the trust acknowledged there was a need for greater sharing of the vision to reduce uncertainty amongst the staff.
- The strategy for the organisation was focused on surgical services, this meant that other services such as paediatrics or medical services were less clear about the future of their services. The trust vision did not give staff a clear picture as to the trusts aims for the next five to ten years.
- Most staff were aware of and understood the values of the trust and the behaviours that would achieve these values. Senior executives felt that these core values were starting to be used to challenge negative behaviours.

Governance, risk management and quality measurement

- There were some systems in place to identify record, manage and mitigate risks but these were inconsistently applied.
- In March 2015, it was identified that the trust had been over-stating its position against the referral to treatment (RTT) target of 18-weeks. An external review had been commissioned to look at the processes, controls and governance arrangements around some of the criteria for inclusion and exclusion that had been used by the trust. The report determined that the

exclusions applied by the trust were not in line with practice at other organisations and there were gaps in roles and reporting arrangements. This was the second time that the trust had been investigated for issue relating to RTT.

- By the time of our inspection, the trust was reporting that it was back to achieving the RTT targets. However the interim Director of Operations was reviewing all of the data and systems available to determine the validity of this position. It was not clear if the trust yet had full control on RTT issues.
- Quality measurement of services and patient outcomes was absent in some services, during focus groups staff told us they felt quality was measure by comments cards.
- Where there was non-compliance with policies and procedures we saw this was not being challenged or questioned, particularly where staff were not following infection prevention and control procedures for hand hygiene on the ward areas. Audits were not sufficiently robust to reflect actual practice.
- The integrated performance report had been developed in order to assist the service in monitoring the delivery of key performance metrics against local and national targets and communicating any issues to the trust board. The report covered the five key domains of patient safety, patient experience, resources, efficiency and external perception.
- Locally there were monthly department meetings where complaints, incidents, audits and quality improvement projects were discussed and reviewed and when needed increased risks were identified and actions put in place to minimise any identified risk.
- The clinical lead for HDU had explored the possibility of applying to submit data to the Intensive Care National Audit and Research Centre (ICNARC) to ensure that the trust was able to bench performance and identify any potential risks of the service. The unit manager told us that they were developing a business case to fund the submission of ICNARC data.
- There were 20 risks identified on the corporate risk register. Of these, six were categorised as moderate risks and 14 were high risks. The top two that were rated as most likely to happen were:
  - Adverse publicity due to incidents, performance or disruptive behaviour. Adverse publicity due to external scrutiny from Monitor in relation to governance arrangements in the Trust.
  - Failure to embed RTT management processes. Pressure on a number of subspecialties due to national lack of capacity.

Increase in demand identified. Resource constraints preventing commissioners investing in sufficient activity to sustain waiting times. On-going delivery of activity at sub-specialty level to achieve waiting times.

Leadership of the trust

- At the time of the inspection, the trust was in the midst of significant leadership change. A week prior to the announced inspection the Chief Executive resigned their post and the Director of Finance was acting in that role. An interim Director of Operations had been in post a few weeks and the Director of Nursing was leaving at the end of the month, to be replaced on an interim basis by the deputy.
- Staff we spoke with told us they felt well supported and listened to by local line managers and leaders. They also felt supported in their learning and development.
- The leadership structure of the organisation had been described as "top down", a number of managers at different levels within the organisation told us they had limited capacity to make decisions without authorisation further up the organisation. Staff told us they felt managers did what they could but "their hands were tied".
- Staff considered executive leaders as supportive but not visible. The new leaders acknowledged that the change in personnel had created an opportunity to provide leadership in a different way that ensured staff felt a better connection with senior leaders.
- The vacancy of clinical director for the medical care services had not been filled since the previous post holder left in December 2014. This had meant that there was no representation of medical care services at trust meetings and that accountability for some clinical governance lacked clarity on occasions.
- We saw that the trust had a predominately medically led model of leadership. Where staff were not following infection prevention and control procedures for hand hygiene we saw that senior medical leaders were not modelling behaviours that would lead other staff to follow the policy.
- The clinical lead for children's services was one of three consultant paediatric orthopaedic surgeons. Day to day decisions about the ward and children were made by the orthopaedic team. Although there were close working relationships, paediatricians did not appear to have been able to influence key issues such as decisions about paediatric early warning scores and the use of electronic monitoring for

children. These decisions had been made by the orthopaedic consultants and anaesthetists. The West Midlands Quality Review Service report said, "The role taken by the consultant paediatricians in leading the development of services for children was not clear to reviewers". Our findings supported this view.

Culture within the trust

- Staff spoke positively about working within the service. All staff told us they would recommend it as a place to work or for treatment. They described it as friendly and most told us they would feel confident to raise and escalate concerns but there had been a culture of not sharing "bad news" and some staff described negative responses from managers when they did raise incidents. Staff and local line managers described to us some of their frustrations with senior management and that they did not always listen.
- Staff and managers we spoke to were patient focused and as a small organisation, we found that staff were very familiar to each other and were prepared to work hard for the benefit of the patient.
- Newly employed staff told us they had received a warm welcome and quickly felt part of the ward team. We heard that staff teams were friendly, sociable and morale was generally good.
- Medical staff told us that training and education opportunities were excellent, not only in a teaching environment but also incorporated into day to day practice. Many clinical staff we spoke to described a strong learning culture. We did find though that this did not extend to all parts of the organisation and some staff groups felt that opportunities for training and development could be improved.

Fit and Proper Persons

- The board were aware of the principles of the Fit and Proper Person test and were aware of their responsibilities.
- The board had appointed an interim Director of Operations who took up post a few weeks prior to our inspection. We saw that the Fit and Proper Person process had been followed during the recruitment process.
- We chose and reviewed a sample of executive director's personal files in relation to the Fit and Proper Person test. We found all the documentation to be satisfactory.

Public engagement

- The trust used a range of local and national surveys to engagement with its patients and the wider public. The trust had a number of patient groups which held regular meetings which were attended by hospital staff including members of the executive team.
- It was clear from our listening events and other feedback that patients were overwhelmingly supportive of the organisation and very tolerant of any issues that may arise. We saw that patient stories were not routinely part of the trust board meetings.
- The Foundation Trust had 13 governors. They told us they felt they had a good relationship with the non-executive directors and they were increasingly able to challenge them.
- Some governors who attended the Council of Governors meetings felt these were too infrequent at four per year. Some governors also attended the public board meetings but told us that timeliness of papers is a problem and they often receive them two months after board meeting, when they are made public. This meant that the governors were not sighted on the RTT problem.
- Governors were unable to robustly discharge their duties without timely access to the board's papers.

Staff engagement

- The trust used a range of tools to engage with staff. This included a monthly newsletter, distributed to all areas of the hospital. Staff were encouraged to send in stories, events or feedback from training to cascade good news and positive working practices.
- Most wards and departments held monthly team meetings where information was cascaded and staff were given the opportunity to provide feedback.
- Staff we spoke to were mixed about the level of communication and engagement from managers. Some teams felt that their managers kept them well informed, others felt they were kept in the dark. Some staff expressed concerns about the instability of leadership and how this would impact on them and the future of the organisation but there was limited communication to reassure them.
- Some staff described management communication to us as 'like a layer of permafrost'. We saw the current management team were taking significant steps to improve this; but more remains to be done.
- The NHS Staff survey for 2014 found that of the 29 indicators measured, the trust scored worse than other orthopaedic hospitals on 13 and better than other orthopaedic hospitals on

16. The overall response rate was worse than the average for other orthopaedic hospitals and the England average. The overall engagement score (3.84) was worse than other orthopaedic hospitals (3.87) but better than the England average (3.75).

Innovation, improvement and sustainability

- There was a positive approach towards innovation and improvement and we saw a range of innovations across the service.
- The development of new prostheses and grafting techniques continue to be progressed with a speciality utilising a range of donor bone grafts and titanium implants.
- Staff told us about being accepted as part of the "Vanguard Scheme": a joint programme led by NHS England and NHS Improvement designed to spread excellence in hospital services and management across multiple locations. It aims to formalise the way organisations work together on a clinical basis and furthers the work of the Specialist Orthopaedic Alliance. Due to the infancy of this development it remained in an aspirational phase at the time of our inspection.
- Nuclear medicine was under review in relation to the viability of its continuing to function from the trust. The department saw in the region of 1,000 patients per year. The cost of renewal and maintenance of equipment together with the high skill level of staff required to work in the department meant that expenditure far outstripped the income generated. Senior managers were in consultation with neighbouring trusts and planned ultimately to transfer patients who required this service to the nearest alternative hospital based on patient's location and hospital location.
- ORLAU had explored innovative approaches to service delivery through service level agreements with NHS and charity partners and by supporting services off site. The department was active in the translation of research into clinical practice through funded research projects and academic partnerships. Staff had been involved in International/National collaborations in service development, training (ESMAC teaching and National School of Health Science (NSHCS) MSc delivery) and quality standards implementation (ISO 9001/CMAS/iCEPSS). ORLAU has developed local models for translating trust policies into practice, for example evaluating local stress levels and assessing developments against trust values.

Overview of ratings

Our ratings for The Robert Jones & Agnes Hunt Orthopaedic Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Outstanding practice and areas for improvement

Outstanding practice

- In July 2015, a National Patient Safety Award for clinical leadership was won by the Ward Manager of MCSI for building sustainable systems and processes.Staff sickness levels on MCSI had reduced from 27% to 0.2%during 2014-2015. This was largely attributed to the strong leadership of the ward manager which had positively impacted on the team and reduced reports of stress related sickness.
- Staff on the MCSI had shown exceptional compassionate care in supporting a patient who was bereaved during their admission period and in practical assistance to help a patient to maintain contact with their employer.
- In the High Dependency Unit, staff enabled patients to maintain contact with their loved ones via the unit's portable phone which was brought to the patients' bedside. This enabled patients to keep in touch especially if the patient lived some distance from the hospital and relatives were not able to visit.
- The HDU had proactively taken steps to support patients living with dementia. For example, individual clocks within HDU which identify the time and day of the week which helps with orientation.
- On the children's ward, to reduce the risk of an allergic reaction, a toaster had been set aside for gluten free bread and was clearly marked as such.
- The children's ward had used innovative approaches to collecting children's views about services including, 'Pants and Tops' and the seedling to flower display .
- The Orthotic Research & Locomotor Assessment Unit was outstanding, providing innovative interventions to improve patient mobility, including occupational and physio therapies, as well as mechanical aids which were designed and manufactured on site.

Areas for improvement

Action the trust MUST take to improve

- The hospital must ensure that there are robust and suitable arrangements to provided paediatric medical cover during the evenings, overnight and at the weekend to ensure that they can respond in an appropriate, safe and timely way to deteriorating and seriously ill children.
- The hospital must ensure that all incidents, including non-clinical incidents are reported by all staff. Learning points from complaints and incidents should be shared across directorates and all action plans monitored to improve the quality of care and develop services.
- The hospital must improve hand hygiene standards and ensure that all staff in all areas are adhering to trust policy. The trust must also audit hand hygiene practices, using methods that are robust and improve signage of isolation procedures, hand washing instructions, and use of hand sanitisers in all clinical areas and corridors.
- The hospital must ensure that staff caring for children are able to identify, report and treat deteriorating and seriously ill children. This includes being familiar with SBAR and its use in alerting the medical team to emergencies.
- The hospital must ensure that patient's medical notes in HDU include a record of all doctor visits and any revision to the patient's treatment plan.
- The hospital must ensure that there is at least one team member with up to date paediatric resuscitation training on duty at all times on Alice ward and all staff who may be required to respond to a paediatric medical emergency also have up to date paediatric resuscitation training.

Outstanding practice and areas for improvement

- The hospital must ensure that resuscitation equipment is fit for purpose and urgently seek to provide battery-powered suction machines for Alice ward.
- The hospital should ensure that paediatric care pathways are routinely audited in order to monitor compliance with nationally recognised best practice.
- The hospital should ensure that outpatient clinics are planned in such a way to prevent excessive demand on support services or other clinic areas which in turn impacts adversely on patient waiting times.

Action the hospital SHOULD take to improve

- The hospital should re-establish mortality and morbidity meetings in the medicines division to review deaths as part of professional learning for doctors.
- The hospital should make arrangements to improve privacy in the therapies gym and ensure there is a regular programme of environmental audits and facilities and address non-compliance in a timely way.
- The hospital should arrange and monitor attendance at trust wide medicines safety committee meetings to enable discussion of best practice and share learning from concerns, risks and incidents
- The hospital should review and update PGDs in line with national guidance through the approved trust processes.
- The hospital should ensure that HDU contribute data to Intensive Care National Audit and Research Centre (ICNARC) or a similar organisation to benchmark the service against other similar hospitals.
- The hospital should be aware of where children are seen and treated. Where possible, children should be seen in the paediatric outpatient department, where the environment is suitable and where staff have appropriate training in caring for children.
- The hospital should review arrangements for therapy provision at weekends to ensure patients have adequate access a seven days a week.
- The hospital should review the leadership arrangements for the children's services to ensure the ward manager has sufficient managerial and professional support