

University Hospitals Dorset NHS Foundation Trust

Quality Report

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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.

Summary of findings

Overall summary

Inspected but not rated

University Hospitals Dorset NHS Foundation Trust was formed on 1 October 2020 from the merger of Poole Hospital NHS Foundation Trust and The Royal Bournemouth and Christchurch NHS Foundation Trust. The organisation serves its local population as well as the influx of tourists who visit the area predominantly in the summer months. The trust has a fully-established board of executive and non-executive directors along with a Council of Governors drawn from local public and staff representatives.

To manage this large organisation and its governance, the trust has established three care groups: surgical, medical, and specialties, and a further group for operations. Within each of these groups are the different sub-specialties, directorates and teams covering the whole organisation. During this inspection we met with 31 members of staff from across most of the care groups and teams as well as members of the executive leadership team.

We carried out this announced focused inspection of the leadership, culture, governance, information management and learning at this trust within our well-led key line of enquiry because we had concerns about the safety and quality of some areas. Our concerns were around:

- The high number of never events the trust (and its predecessor organisations) had reported in the period from March 2020 to January 2021. Never events are serious, largely preventable patient safety incidents that should not happen if the available preventative measures have been used. Any 'never event' reported could indicate unsafe care. The trust had reported 13 of these events which was a high number over these 11 months when comparing this organisation with other similar NHS trusts. These incidents were reported by the trust through the serious incident reporting platform for NHS England and NHS Improvement – the Strategic Executive Information System (known as StEIS).
- A small number of patients (eight cases we reviewed) had been referred to the trust (and predecessor

organisations) for emergency admission or outpatient consultation, diagnosis and subsequent treatment. Not all treatment had been carried out in a timely way or the patient had not been followed-up within their treatment. This concern arose from a CQC review of incidents reported by the trust through the National Reporting and Learning System (known as NRLS).

- An incident of a breach of information governance where staff access to request certain clinical tests had not been made in line with trust rules around data security. This incident was reported to CQC through our Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) reporting system as it related to requests for X-rays.
- An incident which gave rise to concerns around employment of temporary staff and how the scope of practise was managed within the competence and experience of the individual. This incident was raised with us directly by the trust.

As this was a focused inspection of some individual elements of the well-led question, we did not rate the trust at this time. The trust was formed on 1 October 2020 and has yet to receive a rating by CQC for its services or hospital locations.

Our findings

At this inspection we found leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for their staff. The service had an open culture where staff could raise concerns and discuss incidents without fear. New developments were already streamlining governance processes to bring consistency within the care groups and sub-speciality groups.

Staff were clear about their roles and responsibilities to governance. All staff were committed to continually learning and improving services. There were significant developments in patient information systems and data security underway and in future plans.

However, the concern around access rights of staff in one area of the organisation's IT systems did suggest an area

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of culture and staff accountability which needed further attention. The high number of never events also suggested some areas where a sub-optimal culture or human factors were less well understood or unresolved from previous corrective actions and had played a role in things that went wrong.

Leaders operated mostly effective governance processes, although this new organisation recognised there were gaps being addressed in some areas, and processes to be improved. There were some failings in patient treatment pathways for cancer where staff had not adhered to process, and this had not been discovered at the time through governance systems. The information systems were mostly integrated and secure, but improvements were needed (and were planned) to address the recognised risks around access rights and systems operating safely and effectively.

How we carried out the inspection

This inspection was announced to the trust with just under two weeks' notice. The trust was given the scope of the inspection and told of our four areas of concern. This was to give senior staff time to arrange for relevant staff and teams to meet with us. It was also to ensure a safe environment was provided within COVID-19 infection prevention and control measures for all involved.

As we had four specific areas of concern, we met with a range of key staff in interviews at the trust on 20 April 2021. In our interview around never events, we met with 14 staff from across the trust, including senior staff from the care groups. In our interview around information governance, we met with 10 staff from across the trust with responsibility for data and information security and technology. In our interview around the cancer pathway, we met seven staff in senior operational and performance roles. Finally, in our interview around recruitment, we met six staff with responsibility for human resources (known as 'people' officers) and senior clinical staff. A number of these staff joined multiple interviews and we spoke with 31 different members of staff overall.

As our visit remained within the period of COVID-19 lockdown in England, the leadership team and all the support staff made sure all those present at interviews were safe and protected under the rules of social-distancing and infection prevention and control.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

Because this was a focused inspection around aspects of leadership, culture, governance, information management and learning (well-led) we did not on this occasion speak with people who use the service for their views.

Is this service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for their staff.

The leaders we met during this inspection demonstrated to us an insight into the areas of concern and their leadership in the learning and improvement needed. This extended from executive board members through to care group clinical directors (operations, medical and nursing). There was evidence of collective leadership where staff found strength in shared priorities and values. We recognised in the new organisation a clear desire from senior staff to be visible and approachable and provide support and guidance. Senior staff wanted their teams to come to talk with us directly and provide their own evidence. They therefore arranged for a wide range of staff to be able to attend our inspection.

The 2020 NHS staff survey was conducted for the two NHS legacy trusts, but when extracted and combined, gave the new organisation a high rating of staff engagement which put the trust among the top 10 in England. However, this was within the context of a lower than usual response rate from staff which was around 10% below the England average and around 10-15% fewer staff responses than the previous year. Staff engagement is made up from a number of key indicators in the survey around culture and commitment.

Culture

The service had an open culture where staff could raise concerns and discuss incidents without fear. However, the concern around access rights of staff in

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one area of the organisation's IT systems did suggest an area of culture and accountability which needed further attention. The high number of never events also suggested some areas where a sub-optimal culture or human factors were less well understood or unresolved from previous corrective actions and had played a role in things that went wrong.

We recognised an organisation and staff who worked in and embraced an open culture. There was strong evidence to show staff were encouraged to or felt safe to speak up and say when things had gone wrong or may have led to failure. This was evident from our conversations with members of staff who reflected on what they felt was a good reporting culture among their colleagues. It was noted that all the incidents of concern had been raised to us directly or indirectly through one or more CQC or NHS reporting protocols. The trust had a well-established and embedded freedom to speak-up guardian who had been in the role for a number of years (and covering both predecessor organisations for a time). Regular reports were provided to and presented to the trust board by the guardian who was supported by a team of trained staff. The trust had a number of testimonials on its website from staff who had spoken up about concerns.

The 2020 NHS staff survey was conducted for the legacy organisations, but when extracted and combined, gave the new organisation a similar or above average rating for those questions relating to the safety culture. In the question asked of staff about feeling secure about raising concerns, 74% of staff said they did against a sector average of 71%. An above average level of respondents said staff who were involved in an error, near miss or incident were treated fairly. The positive response rate was 68% against a sector average of 62%.

Senior staff agreed that staff or teams would speak up to them when they needed to and would be heard. When we talked about the never events, the chief medical officer reflected on how there was no hesitation by staff involved to report these events internally so they could be investigated. Each of the events were quite different and there was no specific theme or key similarity with the exception of the effective use of safety checks and the culture associated with those. Staff told us each event was seen as multifaceted key learning in the organisation.

Staff did not feel they were blamed for errors, but these were recognised as often multi-factorial, and where learning was needed to address shortcomings where they were found.

However, one theme which did have more frequency than others was around culture. Human factors were known to be one area in never events, along with cultural issues, which needed some further work. Human factors relate to the behaviour of individuals and their interactions with each other in specific environments. The risk of these areas needing some work had been recognised by the executive team and a number of the clinical leadership we spoke with. One area of action was to produce a scorecard where some of the early indicators of potential problems or cultural risks might be flagged. This included areas, for example, such as a high staff turnover in a division or team, or high levels of staff sickness. These scorecards would be available to care group senior leaders with the intention of addressing possible cultural or human factor risks before they escalated.

Staff we met in our interviews talked with us about how the trust would share learning and take action when a never event, serious incident, or near miss occurred. This included an urgent review of issues of safety should they need to be quickly addressed. A full investigation would then take place. We were provided with an example of four SBAR-C reports (structured reports which look at: the situation, background, assessment, recommendations and conclusion of any event). Each of these described a series of recommendations to be acted upon, and how learning was to be shared and with whom. Following all serious incidents, there would be a post-event review after three months. The trust guidance for the post-event review was to establish the impact of the root-cause analysis approach, review lessons learned, and to gain assurance any remaining risks were being managed.

In terms of the event which led us to ask questions about information governance, there was an issue with culture here where, despite training and the trust policy statement (IT Security Policy v3.8 s8.1), staff had not followed guidance and trust policy around accessing systems. We noted and recognised this event was in a time of extreme pressure for the organisation in the early stages of the COVID-19 pandemic. It was part of a solution intended to reduce paperwork being used in favour of

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electronic administration. There had never been any intention of the organisation for staff to breach access rights to the specific system, but this had unfortunately ended up in common practice in this one situation.

The trust was in the final stages of investigating the specific incident. It had so far determined after examining medical records that no harm had arisen from staff not using correct access rights to a diagnostic system. The trust told us it had found no tests had been ordered for patients which were not indicated in their treatment pathway or by anyone unauthorised to request them. However, the trust recognised the assurance process it relied upon did not happen on this occasion. Due predominantly to the COVID-19 pandemic restrictions on processes and limiting staff movement, not all the various audits and spot checks were undertaken. However, the issue, which was identified by chance, was reported as soon as discovered.

There was therefore a breakdown in the understanding by staff of being trusted and accountable, unless in an unavoidable emergency, to act both according to trust policy and legal requirements in access rights to trust systems. The trust will provide CQC with the completed investigation report into this incident when it has been through the governance process and approved.

Governance

Leaders operated mostly effective governance processes, although this new organisation recognised there were gaps being addressed in some areas, and processes to be improved. There were some failings in patient treatment pathways for cancer where staff had not adhered to process, and this had not been discovered at the time through governance systems. However, new developments were already streamlining governance processes to bring consistency within the care groups and sub-speciality groups. Staff were clear about their roles and responsibilities to governance.

The chief executive of the new organisation told us effective governance was key to the strategic goals of the trust, particularly quality of care and transforming and improving services. Being well-governed was also one of the five pillars of the trust's strategy. The governance system was through a trust-board structure with board committees and sub-committees encompassing the

trust's assurance and responsibilities. We met with members of these groups throughout this inspection and could see how they were well represented throughout the system of governance.

In relation to our concerns around never events, the trust had governance processes which reviewed these events at sub-committee level both individually and collectively. Each had been investigated and action plans approved to look at how to prevent these occurring in future. As a process of assurance through the governance system, the investigations were brought to the trust's care group governance meetings (quality risk group), and then reported to the quality governance group. This group was chaired by the associate medical director for patient safety. Oversight was then provided by the quality committee, which was a sub-group of the trust board. This committee was chaired by a non-executive director of the trust with the chief medical officer and chief nursing officer as executive clinical leadership.

This committee produced a quality report to the board each month. However, the board papers did not demonstrate recognition of the rise in these events to become a statistical outlier over the 11 month period where 13 events took place. These were highlighted and investigated by the board sub-committee and noted in the board's integrated performance report. However, the board papers did not take account of the rise in the events in order to pursue further assurance of action being taken to address these incidents.

Any learning, improvement or change resulting from discussion at these committees came back down to ward level (a process known as 'board to ward') through cascading actions or information using the same route as they were escalated to the board (a process known as 'ward to board'). We saw a number of examples of different ways of informing staff through formal governance processes, committees, informal staff meetings (huddles), the trust's intranet, and more general communications to staff.

In relation to the concern around recruitment of temporary staff, the trust had recognised a gap in process which needed to be strengthened. Action had been taken following an incident where the scope of practise for a member of the trust's bank staff had not been well managed. Some documentation required under trust policy and employment regulations had not been

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received. The investigation into this incident was not yet completed but the trust had taken quick action to address some of the gaps in process which had been identified.

All recruitment of temporary staff now went through a single team. We met the head of the 'temporary staff' team, and senior members of the human resources team who explained the process for recruitment of temporary or bank staff. This included the authority given to the team to insist all documentation was gathered and assessed before employment commenced. Executive approval was required to enable employment to start for key staff when documentation was unavoidably delayed. This followed trust policy and the circumstances were risk assessed before any approval was given. Any senior staff who would be working unsupervised, as was entirely appropriate for some senior roles, would first have the approval of the senior leadership in their care group with that proposal and scope of practise evaluated. Other staff would be supervised in their practise through the usual mentoring and supervision arrangements.

The trust will provide CQC with the completed investigation report into this incident when it has been through the governance process and approved.

Although the new organisation had only been established for just over six months, staff we met were clear about their responsibilities and roles. The trust had set clear and defined structures around its governance systems and operational processes. This had been a gradual process which was itself structured to work down through the senior appointments in tiers and appoint directors and managers. These directors and managers would then in turn report to the staff who would manage sub-specialties and directorate.

Governance processes were being rolled-out with consistency to enable teams to understand what was expected and provide a structured response to incidents and learning opportunities. There were regular meetings held mostly monthly and then quarterly throughout the system of governance in the care groups. This gave staff regular opportunities to meet, discuss and learn from the performance of their part of the service and the overall organisation.

However, in relation to our concern about patients being delayed in cancer treatment or the pathway not completed in error, the procedures for managing patients with unexpected diagnosis of cancer were not always being correctly followed.

The governance system did not have sufficient assurance to recognise these breaks occurring in a patient treatment pathway, or delays through failings in paperwork. Following our inspection, the trust investigated the incidents we raised, which considered eight specific events, and was able to report that all but one showed some failure by staff to follow process as a contributory factor. None of the incidents gave rise to concerns about any specific team or speciality. The incidents reported did not show similar themes, so there were a number of possible points of failure recognised in the system.

We acknowledge the trust had plans laid out to further address this area of concern within a large-scale improvement and restoration programme for cancer services. This included the 'elective and cancer operational performance, assurance and delivery programme'. This programme had been designed around the restoration of services following the COVID-19 pandemic. Within the programme of work will be individual projects which include, among others:

- Development of single patient administration system (known as PAS) across the organisation.
- A clinically-led validation programme – the validation of the waiting list by speciality clinicians.
- Completion of a single patient treatment list for the trust.
- Using innovation to reduce patient waiting times.

The trust leadership team also acknowledged how paper-based systems created a potential for unintentional human error, but systems available to the organisation still required some paper-based processes on occasion. The long-term plan for the trust was to computerise all stages of the process and fully integrate systems to work together.

Nevertheless, staff had reported the incidents when they were identified and had investigated the failings in

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process. In the cases where harm had come to patients, the trust told us it had contacted the patients or relatives in line with the obligation under the duty of candour to apologise and explain.

In the NHS 2020 staff survey, in the question asked of staff whether they would be happy about the standard of care provided to a relative or friend by the organisation, 84% of staff said they would. This was against a sector average of 75%. Also, 76% of staff said they would recommend the organisation as a place to work. This was 9% above the sector average.

Information management

The information systems were mostly integrated and secure, but improvements were needed (and were planned) to address the recognised risks.

In terms of the concern around information governance, the trust processes for assurance around data security and staff access rights had not identified the reported incident. Not unlike many large NHS organisations, the trust was operating over 400 different IT systems of various functions and sizes from very large to very small. There were a number of processes adopted to determine if access to systems was secure and only for those entitled to it. However, due predominantly to the COVID-19 pandemic restrictions on processes and limiting staff movement, not all the various audits and spot checks were undertaken, and the breach was not identified for around 11 months. New standard operating procedures and audit tools being developed by the trust in relation to information governance would be more likely to recognise unusual access patterns in systems, but these were in development.

The trust provided us with a presentation around the future of information systems and governance of data. This described a clear pathway to making improvements in areas such as security of systems and replacing systems to enable better communication for shared information. It also described the responsibility and accountability for key members of staff for system oversight.

The trust also provided its overall risk framework for data security which demonstrated how the organisation complied with legislation around data protection. A 'confidentiality and audit procedure' paper had been prepared for approval at a meeting of the information

governance steering group in mid-May 2021. The purpose of this audit work was to strengthen the organisation's assurance around controls for access to confidential information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

In the concern around the never events, the trust was able to demonstrate staff held both a responsible attitude to recognising an error had been made and a desire to learn from that. The 'safety check list', which was an issue in some of the never events reported, was one of the trust's four quality priorities for improvement for 2021/22. The trust provided a paper presented to its transformation and improvement group in February 2021 which gave the rationale for the safety check list to be one of the four quality priorities. This identified the areas which needed to be addressed and how the work would be supported through a quality improvement project.

Following never events or serious incidents, the trust would circulate a notice to all staff titled: "trust wide learning from a serious incident." We saw examples of those from two of the events we reviewed. Furthermore, if the investigation into the event determined staff needed more training, this was organised. We were given an example of this from one of the other events around incorrect use of medical gases. There was also an opportunity to use the trust's screensaver system on staff computers to post messages around learning which would be received by a large number of staff at one time.

In the issue which related to employment, scope of practise and responsibility for temporary staff, the organisation had already recognised learning and how to improve its processes. Although the final investigation was not yet complete, and actions therefore not fully completed or audited, positive change had already taken place.

In the issue which related to the information governance breach, the investigation had not yet been completed. We were therefore not able to judge if the actions taken were effective or mitigated future risks. However, we recognised, as did the trust, that all systems required a degree of staff trust in order to secure data unless the systems had highly sophisticated access. The trust strategy for information governance was to roll out

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identity card access and single sign-in capability in order to further strengthen security. A business case had been approved in August 2019 to progress to a single sign-in for 1,000 staff at first through a series of trials and pilot projects. On the evaluation of the pilot a further 9,500 licenses had been purchased to cover the rest of the

trust's system users. There were also plans to use software to flag unusual activity or access attempts in future IT infrastructure. Both these improvements were underway in strategic plans for IT and should address the issue of failure of access rights.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with one legal requirement.

Trust wide

- Ensure governance systems are effective in determining patients' pathways of care and treatment and these are being completed safely while new systems are developed and made available. In a small number of cases of patients being treated for cancer at Poole Hospital, the system used did not prevent treatment pathways being missed, delayed or terminated in error. We recognised the trust had taken steps to address these gaps, but until the system is tested and these fully investigated, the risk to patient care and treatment still remains. Regulation 17 (1) (2) (b)

Action the trust SHOULD take to improve:

We told the trust that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

Trust wide

- Consider whether the culture around information governance accountabilities and issues of trust are sufficiently recognised and understood to prevent a breach of information access rights. Consider also whether culture is a continuing problem area, as already recognised, in the prevalence of some never events despite some concerns already being acted upon but appearing not entirely resolved.
- Review how events which become statistical outliers for the organisation, as was the case with the 13 never events over the 11 month period, are collectively highlighted to the board over time for effective assurance. Although these were reported as required to the board through the integrated performance report, the high prevalence was not clearly identified for any further discussion or analysis.