

Burton Hospitals NHS Foundation Trust

Sir Robert Peel Community Hospital

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital

Good



Minor injuries unit

Good



Medical care

Good



Surgery

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The Sir Robert Peel Community Hospital is part of Burton Hospitals NHS Foundation Trust. The hospital provides a number of services to the local population of Tamworth, working closely with neighbouring hospitals and NHS trusts.

We inspected this hospital in July 2015 as part of the comprehensive inspection programme.

Overall, we have rated this hospital as good. We saw that services were caring and compassionate. We also saw that people had good outcomes because they receive effective care and treatment that met their needs. Systems and processes were in place to ensure patients were kept safe and were able to respond to local need.

Our key findings were as follows:

- Staff were caring and compassionate towards patients and their relatives. Patients' dignity and privacy was ensured and we saw many examples of good care right across the trust from staff at all levels.
- The hospital delivered an effective and responsive service that met the needs of the local community.
- The numbers of patients using the day case unit had declined and there were concerns regarding the long term sustainability. A decision to close the unit was postponed until 2016, following consultation with staff and the local community.
- There was a strong open culture and staff were encouraged and supported to report incidents. There were clear systems in place to ensure lessons were learnt and services developed as a result

We saw several areas of good practice:

- There was good joined up working in the minor injuries unit with other specialists such as the mental health crisis team and the mental capacity service team within the hospital.
- The five steps to safer surgery (part of the World Health Organisation (WHO) surgical safety checklist) was said by staff to be well embedded and the latest audit report showed high levels of compliance.
- Staff told us senior leaders and the executive team were approachable and visited the hospital on a regular basis.
- The surgical team were working towards Joint Advisory Group (JAG) accreditation for gastrointestinal endoscopy services.

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

Importantly the trust must:

- The trust must review arrangements for access to x-ray imaging after 5pm weekdays and on Saturday afternoons and Sundays for MIU patients.
- The trust must support the MIU to audit its performance in order to assess the effectiveness of their own practice and to identify and manage risks.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Minor injuries unit

Rating

Good



Why have we given this rating?

Staff reported and learned from any incidents or mistakes. There were good systems in place to keep patients safe. The MIU was led by experienced emergency nurse practitioners. There was a high rate of staff sickness and maternity leave absence this was covered by other staff working extra shifts. Treatment and care was provided through nationally agreed ways and pain relief was offered as needed. There was good joined up working with other specialists such as the mental health crisis team and the mental capacity service team within the hospital. There was no access to x-ray imaging after 5pm week days or on Saturday afternoons or on Sundays. Patients had to go to other local hospitals. Patients were seen on a 'first come, first served' system but reception staff could send patients with particularly risky symptoms and all children under a year old straight through to see a nurse. All staff treated patients with respect and warmth. Patients told us they were satisfied with the care they received. We found leadership required some improvement. The trust did have monthly meetings about how the MIU was performing, but it was not using some of the important monitoring information that was being collected to make sure all the risks were known about and managed safely.

Medical care

Good



We found that medical services at the Sir Robert Peel Community Hospital provided an effective rehabilitation service to the local community and surrounding hospitals. The staff were trained and competent to provide a safe service in a positive friendly environment. The ward was found to be clean and we saw that the staff followed infection prevention and control policies and procedures. We saw that learning from incidents was embedded and had improved care and practices; especially relating to falls and falls prevention. A strong multi-disciplinary team worked together to enhance the patients experience and enabled people to safely return home or to a community setting within a reasonable time scale. Risk assessments and individualised care plans ensured that patients received the optimum experience for their

Summary of findings

needs. Patients and those close to them told us they had received good care from friendly, professional staff. Staffing levels were supported by bank or agency staff; a rolling programme of recruitment was in place to address vacancies. Staff told us they felt valued and listened to.

Surgery

Good



Staff were caring, professional and friendly. Patients were involved in their care and treatment and encouraged to ask questions. We reviewed patient care records, these were appropriately completed with sufficient detail. We saw systems were in place to monitor patient risk and maintain a safe service. Staff were confident in reporting incidents and were aware of the importance of duty of candour, informing the patient when things go wrong. Staff displayed good compliance results with the NHS safety thermometer. Medical and nursing staff felt as though they had safe staffing levels. All staff that we spoke with told us they worked well as a team. We saw there was joint working with the Queen's Hospital surgical division. All medical staff worked across both sites. We saw the team were working hard to complete all audits in order to gain accreditation for the endoscopy unit. The unit had experienced a reduction in its utilisation in recent years and the trust were concerned over its long term sustainability. A decision to close the unit was postponed until 2016, following consultation with staff and the local community.

Outpatients and diagnostic imaging

Good



Patients, visitors and staff were kept safe as systems were in place to reduce and monitor risk. Services followed recognised pathways of care and were completed by trained and skilled staff. Patient outcomes were audited and benchmarked against national standards. Staff were caring and involved patients and their carer's and family members in decisions about their care. The service was responsive to the local community. Local leadership was good. Managers understood their staff and provided an environment where they could develop. Formal complaints processes were embedded however we did not see evidence that informal complaints were being recorded in line with the trust complaints policy.

Sir Robert Peel Community Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Outpatients and diagnostic imaging

Detailed findings

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Background to Sir Robert Peel Community Hospital

The Sir Robert Peel Community Hospital is part of Burton Hospitals NHS Foundation Trust. The hospital provides a minor injuries unit, medical care and rehabilitation on one ward, day-case surgery and endoscopy services and outpatient clinics. The hospital is based in Tamworth, 20 miles from the main trust site in Burton Upon Trent.

The trust serves a population of more than 360,000 people in Burton upon Trent and surrounding areas, including South Staffordshire, South Derbyshire and North West Leicestershire.

Our inspection team

Our inspection team was led by:

Chair: Mr Mike Lambert, Consultant, Norfolk & Norwich University Hospitals NHS Foundation Trust.

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

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

director of nursing, emergency department head of nursing, matron for surgery, senior nurses, senior paediatric nurse, critical care consultant nurse,

supervisor of midwives, staff nurses, lead paramedic, chartered physiotherapist, operational managers, governance and quality experts, consultant in clinical oncology, consultant physicians, consultant paediatrician, critical care consultant, specialist gynaecology consultant, consultant urologist, consultant general and vascular surgeon and medical registrar.

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 in July 2015 as part of the comprehensive inspection programme.

We visited the hospital on 7, 8 and 9 July 2015 as part of our announced inspection.

We did not hold a public listening event prior to this inspection, we did meet with Staffordshire Healthwatch and a number of people contacted CQC directly to share their views and opinions of services.

Detailed findings

During our visit to the hospital we held eight 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 over 300 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.

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

Facts and data about Sir Robert Peel Community Hospital

As at April 2015, the hospital employed 119.94 whole time equivalent staff. Of these, 45.25 were nursing staff, medical staff were not routinely based at the hospital. There were 24 general medical beds and 15 day-case surgical beds. There were 326 total inpatients admissions between April 2014 and March 2015 and 23,404 outpatient attendances. There were also 23,782 attendances at the minor injuries units.

The trust serves a population of more than 360,000 people in Burton upon Trent and surrounding areas,

including South Staffordshire, South Derbyshire and North West Leicestershire. East Staffordshire district was ranked 124th of 326 local authorities in the English indices of deprivation in 2010.

The trust had revenue of £183 million with a budget deficit in 2014/2015 of £10.6 million.







There were a total of 77 incidents reported at the hospital between January and April 2015. Nine were categorised as moderate harm, all others were near miss, no harm or minor harm.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Minor injuries unit	Good	Good	Good	Good	Requires improvement	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Minor injuries unit

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

Information about the service

The Minor Injuries Unit based within Sir Robert Peel Community Hospital is a 24 hour nurse-led service for those suffering from minor injuries or minor illnesses, no appointments are necessary.

Patients are assessed, diagnosed, treated and discharged by Emergency Nurse Practitioners (ENPs). There is no on-site Doctor or GP within the unit

Patients may be re-directed to their GP, or to Accident and Emergency, if that would be the best and most appropriate healthcare for their condition

Between April 2014 and Mar 2015, emergency and urgent care services at the Sir Robert Peel Hospital saw 23,782 patients. There was an overall drop of 1.4% in attendances between 2013/14 and 2014/5.

We visited the MIU announced on 9 July 2015. During our inspection, we spoke to three patients and six staff including NHS Ambulance Trust crew. We followed the care and treatment of two patients through from arrival to discharge.

Summary of findings

Staff reported and learned from any incidents or mistakes. There were good systems in place to keep patients safe. The MIU was led by experienced emergency nurse practitioners but there was a high rate of staff sickness and maternity leave absence this was covered by other staff working extra shifts.

Treatment and care was provided through nationally agreed ways and pain relief was offered as needed. There was good joined up working with other specialists such as the mental health crisis team and the mental capacity service team within the hospital. There was no access to x-ray imaging after 5pm week days or on Saturday afternoons or on Sundays. Patients had to go to other local hospitals.

Patients were seen on a 'first come, first served' system but reception staff could send patients with particularly risky symptoms and all children under a year old straight through to see a nurse. All staff treated patients with respect and warmth. Patients told us they were satisfied with the care they received.

We found leadership required some improvement. The trust did have monthly meetings about how the MIU was performing, but it was not using some of the important monitoring information that was being collected to make sure all the risks were known about and managed safely.

Minor injuries unit

Are minor injuries unit services safe?

Good



We found services were safe. Staff understood the trusts incident reporting policies and procedures and used the system to report and to learn from incidents and errors. There were systems in place to ensure safety such as the good practice around hygiene and infection control, record keeping, safeguarding and medicines management and staff complied with these.

The hospital had no security personnel on overnight however. There were agreed procedures in place to respond to very unwell or deteriorating patients. There was no resuscitation team on site within the hospital. The MIU was led by experienced emergency nurse practitioners. Bank staff were being used to cover a high sickness and maternity absence rate.

Incidents

- The trust's emergency and urgent care directorate incident reports cover the ED at Queens Hospital Burton and the two minor injury units in the community including the Robert Peel Hospital MIU.
- Across these services there were five serious incidents from May 2014 to April 2015; with very few category 2-4 pressure ulcers, falls with harm or C.U.TIs
- Staff told us they reported incidents using the trusts electronic system and that the staff group reflected on incidents that had been investigated to learn lessons for improving practice.
- Local leaders gave us an example of openness and candour good practice. They had reported an incident retrospectively, when it came to their attention through media coverage, that a person who staff recognised had attended the MIU as a patient, had soon after died.

Cleanliness, infection control and hygiene

- The trust had policies and procedures for hygiene and infection control.
- We noted the emergency nurse practitioners (ENP) staff were bare below the elbow in keeping with policy and wore uniforms.
- There were hand cleansing dispensers on the walls around the unit and we saw staff using them. We saw

supplies of aprons and gloves available at the point of treatment for staff to wear. Hand hygiene audit results for 2014/2015 showed the unit achieved 100% compliance throughout the year.

- We noted that the MIU was fitted with cloth fabric curtains in each treatment room and this is not best infection control practice.
- All treatment rooms and areas of the MIU including the sluice room were clean and tidy and well organised.

Environment and equipment

- There was no personnel security on site. Local leaders told us overnight porters acted in the role of security if necessary. This was noted on the trust's risk register. The MIU was monitored internally by CCTV. Local managers told us the MIU had a good relationship with local police.
- The MIU was well laid out although we noted the reception and waiting area was cramped. Staff told us patients waiting to see the GP service that ran in an adjacent space also used this waiting area. It led to the x-ray department of the hospital.
- We saw an adequately equipped resuscitation room and evidence of regular checks made of resuscitation equipment.
- Treatment rooms were multi-functional and this allowed for flexibility. We noted there was a child friendly treatment room. There was also an eye treatment room and a plaster room.

Medicines

- We noted the medicines cupboard was securely locked and all drugs were stored correctly.
- Administration of controlled drugs was properly recorded and the records balanced with the remaining supplies.
- We noted one patient specific proforma in place that was agreed with a GP for a local patient.

Records

- Patient records and notes kept locked in a trolley within the reception area.
- Nurses had access to patient's x-ray images through desk top monitors

Safeguarding

Minor injuries unit

- We heard reception staff checking what relationship accompanying adults had to the child patient when they booked in.
- We observed an ENP carrying out a full safeguarding assessment as a matter of course when treating a nine year old child during our visit.
- ENP's understood their responsibilities to safeguard vulnerable adults and the trusts policies and procedures.
- The trust provided data on safeguarding training which was for the whole of the Emergency services across the trust. This meant we could not determine how many staff at this MIU were up to date. All nursing staff across the service (100%) had completed safeguarding adults training at level 1 and 93% had completed level 2. All nursing staff (100%) had also completed child protection training at level 1, 87% had completed level 2 and 66% had completed level 3.

Mandatory training

- Staff told us they were up to date with their mandatory training. The Trust sent training records which combined included all staff working in the ED at Queen's Hospital and both MIU's, so we could not confirm the compliance rate for this MIU. However, across the service, 100% of nursing staff had updated their advanced paediatric life support training, 97% had completed fire safety training, 95% had done infection control training and 61% of nursing staff had updated their advanced life support

Assessing and responding to patient risk

- The MIU had no triage but a see and treat arrangement was in place.
- We noted the reception desk had an alert list of presenting symptoms that triggered priority access to an ENP.
- Ambulance crew we spoke with confirmed they didn't routinely bring patients to the MIU but do a lot of transfers out to ED's, particularly for patients with cardiac symptoms.
- Deteriorating patients, those presenting with chest pains or a 'floppy baby' were stabilised by the ENP's and the procedure was to call a 999 ambulance allow paramedics to continue care.
- We noted from information on display that on the three days before our visit there had been five transfers made.

- There was no resuscitation team on site in the hospital to support the ENP's in an emergency however. Local managers told us there was a plan for the MIU staff to undertake on site resuscitation simulation training.
- We noted NICE risk assessment protocols on large posters around the walls of treatment rooms including assessing the risk of serious illness in a child.

Nursing staffing

- The MIU was led by Emergency Practitioner Nurses (ENP) and managed by a senior sister.
- There were 20 nurses employed in total, four on duty on any one day shift and two on duty overnight. Local leaders told us some staff work nights permanently and others rotate.
- Local managers told us due to long term sickness and regular maternity leave it had been some time since the unit was fully staffed. Vacant shifts were covered by bank staff.
- We saw four nurses on duty on the afternoon of our visit. We noted from information on display in the corridor that on Monday 6 July 2015 there had been three nurses on sickness absence; on Tuesday 7 July 2015 it was the same and on Wednesday 8 July 2015 two nurses were on sickness absence.

Medical staffing

- There were no medical staff working at the MIU it was a nurse practitioner led service.

Major incident awareness and training

- There was a major incident policy. Staff were aware of the major incident and business continuity policy, and understood their roles and responsibilities in the event of a major incident.

Are minor injuries unit services effective?
(for example, treatment is effective)

Good



We found services were effective. Treatment and care was provided through nationally agreed pathways and pain relief was offered as appropriate. Local managers audited some of the units performance such as following up

Minor injuries unit

patients that they transferred by 999 to emergency departments at other hospitals. However the trust did not monitor this information so it could be used to manage risks.

The MIU was led by emergency nurse practitioners and there was good joined up working with other specialists such as the mental health crisis team and the mental capacity service team within the hospital.

Evidence-based care and treatment

- We observed the assessment treatment and care of two patients including a child and noted they were given the appropriate treatment and advice for their conditions.
- We noted large posters on the walls of treatment rooms describing NICE treatment pathways including paediatric life support, ocular referrals, a choking algorithm and guidelines on management of asthma.
- ENP's described protocols that they followed for specific injuries and conditions and we observed these in practice with two patients whose consultation and treatment we followed.

Pain relief

- We noted pain relief offered as appropriate to the two patients whose treatment we followed, including a child.

Nutrition and hydration

- Most patients attending the unit are not there for a significant period of time which might impact on their nutritional or hydration needs, however, the trust assured us that patients would be provided refreshments if required, for example if there was a delay in transfer to another unit.
- We noted there was a water dispenser in the waiting room. The hospital had an on-site café and out of hours, patient had access to vending machines.

Patient outcomes

- The trust had previously taken part in several College of Emergency Medicine College of Emergency Medicine (CEM) audits including ones into assessment and treatment of feverish children, fractured neck of femurs and vital signs. However, these are related to care prior to April 2013.

- The unplanned re-attendance rate remained at 6% for December 2014 to March 2015. This is above the target of 5% but below the England average of 7.5%.
- We noted that the MIU held a register of all patients transferred out to ED's. Local leaders undertook a regular audit of their transfer of patients in order to assess the effectiveness of their own practice.

Competent staff

- Nursing staff were qualified emergency nurse practitioners and this meant they could prescribe some types of medication for patients.
- Local managers told us that a persistent shortage of nurses did allow for some development opportunities within the unit but it also restricted the staff available to gain experience at the trust ED in Queens Hospital. Staff rarely worked at the trust's other MIU in the Samuel Johnson Hospital Lichfield.
- ENP's told us they received on going daily clinical supervision from seniors and practice managers.
- Ninety-three percent of staff had completed their appraisal in the previous 12 months.

Multidisciplinary working

- We noted a senior ENP was a mental health liaison nurse for the unit and they worked with the crisis team that was based on site within the hospital.

Seven-day services

- The MIU was open 24 hours a day on seven days a week.

Access to information

- Staff had access to information, policies and procedures via the trusts intranet.
- A monthly assurance report for the MIU was made available to staff and they met with senior staff to discuss this.
- We saw patient treatment information cards on display and information about local voluntary help agencies including for domestic violence and alcohol abuse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A trust wide audit of the dementia care strategy in July 2015 had recommended improvements within the ED across the trust, in recording the involvement of carers in medical decisions for patients with dementia.

Minor injuries unit

- We saw a notice about the IMCA service on site within the hospital including photographs, names and contact numbers.

Are minor injuries unit services caring?

Good



We found services were caring. Staff in all roles treated patients and their relatives/friends with respect and warmth and patient's privacy and dignity was upheld. Patients told us they were satisfied with the care they received and where appropriate relatives were involved in decisions about treatment. Patients had access to the full range of support provided at Queens Hospital Burton.

Compassionate care

- Patients we spoke with told us staff were kind and treated them with respect.
- We observed only positive interactions between staff in all roles and patients and saw no breach of a patient's privacy or dignity.
- We saw staff at all levels and in all roles treating patients and their relatives/friends with respect, warmth and kindness and communicating with them well.
- National data sources reported the Friends and Family test scores as consistently better than England average between December 2013 and November 2014. We had no data about the MIU results specifically.
- The Care Quality Commission inpatient survey result for November 2014 showed the ED performance "about the same" as other trusts. We had no data about the MIU results specifically.

Understanding and involvement of patients and those close to them

- We spoke with three patients whose care and treatment we followed on the day of our inspection including a child and their parents. They all told us they were satisfied with the care they received and the staff who provided it.
- We observed staff interacting with patients and family members. Staff talked to them in a way that patients could understand and described what they were going to do. Staff also checked with the patient that they understood what they'd been told and where they were.

- We observed parents being involved in the decisions about treatment of children.

Emotional support

- We observed reassurance being given to patients and nurses offering emotional support. Relatives were able to remain with patients throughout their time in the MIU to ensure they were supported.
- Patients had access to the full range of support provided at Queens Hospital Burton.
- Chaplains were available 24 hours a day seven days a week. They represented different denominations and had contact with all the major faith communities.

Are minor injuries unit services responsive to people's needs? (for example, to feedback?)

Good



We found services were responsive. The MIU was situated within a district general hospital and there was no ED within the hospital. Patients presenting with major injuries or illness were taken by the ambulance services to the trust ED at Queens Hospital Burton or to Good Hope ED Sutton Coldfield, which was closer. The ENP's could also refer patients directly to Good Hope Hospital for x-ray imaging out of hours although it was provided by a different trust.

The MIU responded to meeting individual patients needs such as people with mental health issues and young people. Patients were seen on a 'first come, first served' system but there was a 'first contact protocol' on for reception staff to consult. It listed a range of symptoms and presentation for which immediate action was required and included all children between 0 and 12 months old. Complaints were investigated and the MIU used the outcomes to improve the service.

Service planning and delivery to meet the needs of local people

- The MIU was situated within a district general hospital. There was no ED within the hospital.
- Patients presenting with major injuries or illness were taken by the ambulance services to the trust ED at Queens Hospital Burton or to Good Hope ED Sutton Coldfield.

Minor injuries unit

- Although Good Hope Hospital ED was nearest to the MIU and ENP's could refer there it was provided by a different trust.
- The MIU saw an overall drop of 1.4% in attendances between 2013/14 and 2014/5. These drops were sharpest during August 2014 and in February 2015 (-9.8% and -9.0% respectively).
- Although the MIU was open seven days a week and 24-hours a day, x-ray imaging services based within the hospital were available only Monday to Friday, 9:00am to 5:00pm and Saturday mornings, 9:00am to 12:00 noon. Patients requiring an x-ray outside of these times had to travel to another location. ENP's could send patients directly to the imaging services at Good Hope Hospital for x-ray.

Meeting people's individual needs

- We spoke with a senior ENP who was a mental health liaison nurse for the unit. They told us the crisis team was based on site within the hospital but they worked over a wide geographical area.
- We noted the mental health assessment tool and staff talked us through how they used it.
- We saw well organised information available on display to staff and patients on various mental health conditions aimed at young people.
- The population of Tamworth was predominantly white European and we noted that all written information was in English only.
- The trust had a dementia care policy in place and had audited its compliance within the ED generally and made recommendations about pain relief and involving carers in medical decisions. We noted no evidence of a particular focus on supporting patients with learning disability or dementia.

Access and flow

- The MIU had no triage arrangement in place; patients were seen on a first come first served basis.
- We noted there was a 'first contact protocol' on the wall for reception staff to consult. It listed a range of symptoms and presentation for which immediate action was required, including overdose/poison, any difficulty breathing, unwell floppy baby, all children between 0 and 12 months old.
- There were instructions for reception staff to follow to bring these patients to the attention of a nurse practitioner.

- Reception staff told us that patients who went for x-ray imaging were placed at the front of the queue again when they returned with their x-ray docket.
- We noted at 2pm on the afternoon of our visit the waiting room was busy with 15 people including children.
- At the time of our visit we noted there was a paramedic on training placement in the unit. Their role was to move patients from the waiting room to another area, assess them, devise a plan, discuss this with an ANP then either act or revise the plan. They told us the experience was very valuable to them and they felt more confident about making better use of the MIU as a safe alternative to the ED's.
- Performance on MIU for waiting times and compliance with national targets such as seeing, treating and discharging or admitting patients within four hours of arrival were not separately identified within data provided by the trust and not monitored by the trust.
- Data shows the ED across the trust as having consistently low and lower percentage of patients leaving before being seen compared to England average, from April 2013 to Sept 2014. We had no specific data for the MIU.
- Ambulances did not bring patients to the MIU but the unit did use 999 services to transfer very sick patients on to Queens Hospital Burton ED (19 miles away) or to Good Hope Hospital ED (6 miles).

Learning from complaints and concerns

- Staffing levels and names for that day and photographs of team leaders were on display in the reception area so patients could see who was in charge.
- Local leaders told us they had received only two complaints since December 2014. They gave us an example of how one complaint was investigated as an incident by the clinical director for emergency and urgent care services and the department was working towards improving the pathway for that particular presenting condition.

Are minor injuries unit services well-led?

Requires improvement



Minor injuries unit

We found leadership required some improvement. Governance arrangements were not monitoring the performance that was being audited by local leaders. The trust was therefore not sighted on some risks.

The MIU and the trust had an open culture and staff and local managers felt confident about reporting anything they had concerns about, including when something had gone wrong. Staff were made aware of the trust's strategic objectives, the unit was well led locally and senior leaders were visible. Patients told us the MIU had a good reputation locally. Friends and Family Test data was put on display.

Vision and strategy for this service

- Patients and staff told us the service was valued by the local community.
- Staff confirmed they the ED matron regularly came to the MIU and the lead nurse community and clinical support services were visible and approachable.
- We noted the trust's strategic objectives on display in the nurses' office.

Governance, risk management and quality measurement

- Community and clinical support services leaders reported they were involved in governance meetings each month that rotated around the three sites of emergency and urgent care services in the trust. The ED matron reported to this meeting and incidents, FFT results and ward assurance were discussed. Nursing staff we spoke with were not aware of any governance meeting held in respect of the service.
- We were not assured that patient outcomes were monitored by ED governance, for example the audit undertaken regularly of transfer of patients to ED's. Community and clinical support services leaders reported the policy as being, once a patient was handed over to paramedics for a transfer; it was the end of the

MIU responsibility. This meant there was no governance monitoring of the number of times the MIU was transferring out patients or of MIU outcomes for patients.

- Risks, for example any gap in resuscitation need in the MIU and out of hours access to x-ray imaging were not being identified and managed by the trust.

Leadership of service

- The MIU was well led locally and staff told us they felt well supported to carry out their role.

Culture within the service

- Staff and local leaders told us the MIU and the trust had an open culture and they felt confident about reporting anything they had concerns about, including when something had gone wrong.

Public engagement

- Patients we spoke with told us the MIU had a good reputation locally.
- We saw a stack of completed Friends and Family Test (FFT) forms ready to go off to the trust headquarters, 19 were adults and 6 from children for that week.
- We observed reception staff methodically clipping a FFT test form to each set of patient details when they checked in including a child friendly form.

Staff engagement

- The ENP's told us they enjoyed working in the MIU and felt proud of providing a good service to the local community.

Innovation, improvement and sustainability

- We did not see any specific examples of innovation at the MIU. We noted the service was well valued by the local community but also that attendances had decreased during 2014/15.

Medical care (including older people's care)

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

At the Sir Robert Peel Community Hospital medical services were provided on a 24-bedded ward which provided care of older people, general medical care and rehabilitation.

Inpatient services were provided with support from local General Practitioners (GP's) who visited the ward twice a week and provided on-call support at night. Consultant physicians and other specialist clinicians also visited the wards to provide care.

Summary of findings

We found that medical services at the Sir Robert Peel Community Hospital provided an effective rehabilitation service to the local community and surrounding hospitals. The staff were trained and competent to provide a safe service in a positive friendly environment.

The ward was found to be clean and we saw that the staff followed infection prevention and control policies and procedures. We saw that learning from incidents was embedded and had improved care and practices; especially relating to falls and falls prevention.

A strong multi-disciplinary team worked together to enhance the patients experience and enabled people to safely return home or to a community setting within a reasonable time scale.

Risk assessments and individualised care plans ensured that patients received the optimum experience for their needs. Patients and those close to them told us they had received good care from friendly, professional staff. Staffing levels were supported by bank or agency staff; a rolling programme of recruitment was in place to address vacancies. Staff told us they felt valued and listened to.

The community hospital offered a service that the trust vision described; to provide community and secondary healthcare services close to and for local people.

Medical care (including older people's care)

Are medical care services safe?

Good



People are protected from avoidable harm or abuse. Reporting of actual and possible patient harm incidents was encouraged by the ward manager. Staff we spoke with told us they knew how to report them. Learning from incidents was fed back to staff to improve safety for patients and changes of practice were acknowledged.

We observed safe storage of patient records. Records were used to support safe discharge. We saw safe storage and administration of medicines on the ward.

Infection prevention and control processes were found to be effective. The ward was clean and tidy and the manager showed us the ward performance was compliant against safety targets.

Incidents

- There had been no Never Events reported, these are wholly preventable, serious incidents that have the potential to cause serious patient harm or death.
- We found that incident reporting and learning was embedded within the ward environment. Staff told us they reported all types of untoward incidents, including near misses to ensure similar incidents were avoided in the future and that lessons were learnt. There was one serious incident reported in January 2015 when a patient sustained a fracture following a fall on Philip Ward. We saw that lessons had been learnt from this incident and changes made to practice as a result.
- Feedback from mortality and morbidity meetings feedback was shared with staff where relevant. There was a higher number of deaths during 2014/2015 year when compared to the previous 12 months. Eight deaths occurred during the winter months and were in the older age group (>75yrs). This reflected the national picture and West Midlands crude mortality trends that showed that excess winter deaths were 33% higher especially in the older age group. The winter's excess mortality in the older age group was almost certainly related to increased numbers of patients with influenza who subsequently developed respiratory infection and complications. The influenza vaccine was only partially effective this year.

- We spoke with the staff about their responsibilities under duty of candour requirements in relation to reportable patient safety incidents. We heard that a serious incident which occurred on the ward was fully discussed with the patient's relatives, and the matron had met with the patient's family. The case had been presented at a governance meeting to share lessons learnt and to demonstrate candour.

Safety thermometer

- The ward assurance data was displayed on the ward notice board. During May 2015 there had been no complaints and five compliments.
- NHS national safety date was recorded as 98% for this site. There had been no pressure ulcers reported in May 2015.
- The health and safety score was 98% and MEWS (Modified Early Warning System) was 100%. MEWS showed early recognition of deteriorating patients to give timely support when required.

Cleanliness, infection control and hygiene

- The ward areas we visited were all found to be clean and tidy. Staff were seen to be using protective personal equipment including specialised clothing such as gloves and aprons. Hand hygiene was observed and signage was visible. Hand gel dispensers were sited at the entrance of the ward and in the patient bays.
- Hand hygiene audits had been consistently compliant; the May 2015 score was 100%.

Environment and equipment

- Resuscitation equipment was found to be accessible and in good working order; this had been checked daily and checks were documented. Staff training in this area was 100%.
- To support the patients with their independence we saw that adaptable equipment was in place such as high/low beds, moving and handling aids and accessible toilets and bathrooms. The trust had a central equipment store which we were told made accessing equipment easy and quick.
- Recently the manager had secured funds to purchase an air assisted patient handling system to safely lift patients who have fallen, in a safe and secure way. Delivery was expected in July 2015.

Medical care (including older people's care)

- Equipment had been serviced and tested in accordance with the trust policy and procedure. We were told that when equipment was faulty this was labelled and returned to the equipment store or supplier for repair or replacement.

Medicines

- Medicine issues had occurred which related to supply delays or non-availability of medicines when some patients had been admitted or transferred to the ward. When this occurred, the ward manager gave feedback to the staff at the referring hospitals or hospital wards. We were told that the improved communication had reduced the medicine issues.
- The ward had a designated pharmacist prescriber which meant that once patients were on the ward no issues were identified.

Records

- A combined risk assessment was used to assess manual handling risk scores, falls risk, nutritional assessment scores and the patient's level of mobility and pressure ulcer risk scores. These documented assessments supported the patient in their holistic plan of care enhancing their rehabilitation and leading to safe discharge.
- Records we looked at were fully completed, dated and signed. Records were audited monthly to ensure they met the trust policy for record keeping. In April 2015 the audit scored 96%; two records had not been appropriately signed.
- Records were appropriately stored to ensure patient confidentiality.

Safeguarding

- Staff we spoke with were fully aware of the trust's safeguarding policy and procedures; 98% were trained to ensure they were up to date with current practices. Staff knew the name of the trust safeguarding lead. They told us they felt well-supported and would seek advice if they had safeguarding concerns.
- There was one Deprivation of Liberty Safeguards (DoLS) reported on the ward. This is part of the Mental Capacity Act 2005 that aimed to make sure that people were looked after in a way that did not inappropriately restrict their freedom. The safeguard ensured that a person was only deprived of their liberty in a safe and

correct way, and it was in the best interests of the person. The mental health team and the trust safeguard lead were fully involved and one-to-one care had been initiated.

Mandatory training

- Mandatory training, induction and update training are a means of providing staff with the knowledge and skills to enable them to comply with key trust policies, ensuring improved safety levels and lower risk. Trust mandatory training target levels was 90%. The mandatory training level at Robert Peel was 94% compliant; two members of staff had been unable to complete the required training as they were on maternity leave, and one person was on long term sick leave. Mandatory training included fire safety, moving and handling, safeguarding, first aid, resuscitation, equality and diversity and health and safety.
- Nurses and nursing assistants we spoke with told us that the ward manager monitored staff attendance to ensure staff had completed all their mandatory training. The manager showed us that they logged all the training data on line.

Assessing and responding to patient risk

- MEWS scores showed early recognition of deteriorating patients to give timely support when required. The ward rarely used the process as its purpose was rehabilitation and patients were normally discharged into the community. Staff told us that when a patients' condition deteriorated they supported the patient until the emergency ambulance service transferred the patient to the acute hospital.

Nursing staffing

- Nurse handovers were carried out at the start of each shift to communicate patient information. Multi-disciplinary board rounds occurred daily attended by a range of health professionals. Staff held a printed handover sheet to ensure they had the patient details close at hand so that they could refer to a summary of peoples care requirements and personal choices.
- Actual versus establishment staffing levels were displayed. The ward was staffed with a ratio of one registered nurse to eight patients during the day shift and one registered nurse to twelve patients during the night shift.

Medical care (including older people's care)

- The charge nurse was supernumerary for each shift which meant that they were able to observe care delivery and advice staff as necessary. Skill mix was one trained nurse and two nursing assistants for the day shift and one trained nurse and one nursing assistant at night.
- Agency and bank nursing staff were currently being used due to cover one trained nurse vacancy.

Medical staffing

- The ward was supported by local GP's who completed a daily ward round. We were told that access to GP's out of hours had proved difficult on more than one occasion; however we saw no evidence that this had a detrimental effect of patient safety or care.
- Speciality consultants and doctors from Queen's hospital attended the ward weekly or as required. They reviewed patients with neurological conditions, stroke, dementia and palliative care needs.

Major incident awareness and training

- A revised business continuity plan had been introduced and was available in a paper copy and on the intranet. The staff were informed when the level of need at the trust was high.
- We were told that beds on the ward had been utilised during the winter pressure arrangements. During this time the suitability of patients for discharge was reviewed more frequently to allow early, safe discharge of some patients allowing increased bed space movement.

Are medical care services effective?

Good



People have good outcomes because they receive effective care and treatment that meets their needs. Care was provided in line with national guidelines and the trust's policies and procedures.

Patients were well-supported with their individual nutrition and hydration needs by suitably trained, competent staff.

Multidisciplinary working was embedded in the ward and patient's rehabilitation was enhanced by the service.

Evidence-based care and treatment

- Policies were based on The National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- Health and safety, environment and documentation audits were completed by other ward managers; the results and learning points were fed back to the manager who cascaded this to the staff.
- We were told that adherence to local policies and procedures were discussed at staff induction, and ward meetings. We saw that they were easily accessible on the intranet.

Pain relief

- Pain relief was considered as part of patients medicine regimes, to enhance their mobility and rehabilitation as necessary. Patients were provided with pain relief according to their individual needs and prescriptions and we saw evidence that nursing staff were vigilant when monitoring patients' pain levels.
- A member of the ward staff was an independent medicine prescriber. Nurse and pharmacist independent prescribers are able to prescribe any medicine for any medical condition within their competence. This system ensured that timely supply and administration of medicines avoided delays.

Nutrition and hydration

- Each patient had a Malnutrition Universal Screening Tool (MUST) completed on admission to the ward and this was monitored on a daily basis; including dietary and fluid intake. We saw that patients who had fluid balance charts were being monitored and their records were completed and signed.
- Referrals to the dietician were carried out promptly and patients' weights were recorded weekly or as necessary. Patients were referred to the speech and language team (SALT) when swallowing problems were identified; they assessed patient's safety whilst eating and drinking and recommended suitable consistencies of food and fluids.
- Protected meal times allowed patients to eat their meal without interruption. Relatives and carers were encouraged to support those close to them when appropriate. We saw hot and cold drinks were offered to patients at regular intervals between meal times. We were told that the meals generally looked appetising and we served in good portions.

Patient outcomes

Medical care (including older people's care)

- The average length of stay for 2014 was 24 days. The trust 'planned length of stay target' was 21 days.
- Following an incident where a patient sustained a fracture following a fall, the frailty team introduced a mapping strategy and undertook an investigation to determine any trends or safety issues. This piece of work resulted in the introduction of individual patient sleep diaries known as 'sleep hygiene', along with other 'promotion of sleep strategies' implemented by the night staff. The introduction of care footwear documentation was commenced whereby the staff identified a patient's footwear and included them in the risk assessment. Falls had reduced by 60% within the previous six months. When falls did occur they were mapped on to a picture of the ward to identify key locations and times.
- Patient outcome data was not divided between sites; data relates to the trust medical service overall.
- Sentinel Stroke National Audit Programme (SSNAP) allows comparison of key indicators that contribute to better outcomes for patients. Overall performance is rated from A (highest) to E. It is acknowledged by the audit that very stringent standards are set; however, data shows that performance level between October 2013 and September 2014 was grade D. Scanning and occupational therapy were both graded A with physiotherapy and multidisciplinary working both graded B.
- Myocardial Ischaemia National Audit Project (MINAP) looks at how the NHS cares for patients with heart attack in England. During 2013/2014 177 patients were seen by a cardiologist or a member of team and were admitted to a cardiac ward which scored 96%, above the England average of 94%. Of the 177 patients 116 were referred for or had angiography which scored 97%, above the England average of 77%.
- The trust had a mixed performance in National Diabetes Audit (NaDIA) from September 2013 which showed the trust was worse than the England & Wales median for prescription errors, insulin errors and the 'foot assessment' indicators. However, performance was better than the England & Wales median for food/meal indicators and staff knowledge indicators. Overall satisfaction was 93%, compared to the England & Wales median of 86%. Data for this hospital only was not available.
- There was a mixed performance against the latest heart failure audit; 50% of patients had input from a specialist

against the England average of 78%. Evidence from clinical trials demonstrates that patients with heart failure, due to left ventricular dysfunction, show an improvement in symptom control and a reduction in morbidity and mortality when treated with an ACE inhibitor (ACEI). 95% of patients were discharged on ACEI against the England average of 73%.

- Standardised risk of readmission for elective patients was reported as good. There was variable performance compared to England average for elective length of stay.

Competent staff

- Annual staff appraisals were based on the trust vision of aiming to deliver care that was consistently safe, consistently effective and perceived by patients in a positive way. Completion of staff appraisals was 93%. The appraisals included role specific tasks to ensure staff were suitably qualified, competent and had suitable knowledge to care for the patients on the ward.
- Staff told us they were given the opportunity to develop their skill through relevant training and attend local link meetings.

Multidisciplinary working

- Multi-disciplinary working was embedded in the ward. The ward based physiotherapist and occupational therapist (OT) staff supported the nurses in the patient rehabilitation pathway.
- Daily "board rounds" encouraged collaborative 'multi-disciplinary' planning and strong working relationships. There was an obvious professional respect between nurses and therapists which made communication of patient information at handovers, ward rounds and multidisciplinary team meetings effective and efficient.
- The physiotherapists worked closely with the OT's to promote safe patient independence during their rehabilitation programme. We saw that the team discussed patient's progress and reviewed and updated documentation as necessary. The therapists joined the consultant ward rounds to give valuable progress feedback.
- Patients had access to specialist support from the mental health team.

Seven-day services

- The trust consultant responsible for rehabilitation, visited the ward once a week along with other specialist

Medical care (including older people's care)

doctors as required. Medical support for local patients was given by six local GP's who visited the ward twice weekly. Patients who were not registered with the local service received medical input from another GP who attended the ward daily, Monday to Friday. All out of hour's needs were covered by the on-call GP service. Patients were able to transfer back to their referring hospital, in the case of an emergency.

- The onsite x-ray service offered a full five day service and short hours at weekends. If a patient required an x-ray outside of these hours then they would have to be transferred to a neighbouring acute hospital.
- The pharmacy service, OT's, and physiotherapists offered a six day service (Monday to Saturday) with an on call system in place on Sundays. The physiotherapist team prioritised those patients to be seen on a Saturday. The dietician and SALT team worked Monday to Friday.

Access to information

- The trust used electronic patient records, which meant that information was accessible.
- Trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust. They could access guides to policies and procedures to assist in their own role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of their responsibilities around the Mental Capacity Act and deprivation of liberty safeguards. They were able to demonstrate a good understanding of the process. 94% of staff had completed the training which was included in the safeguard training session.
- The mental health team attended the wards on request to support patients to make decisions if needed.
- We observed patients being asked for verbal consent prior to procedures being carried out.
- We saw evidence that people's mental capacity was assessed as part of a best interest process.

Patients are supported, treated with dignity and respect, and are involved as partners in their care. Patients we spoke with were complimentary about the care they had received, the staff on the ward and their overall experience.

We heard how the staff encouraged the patients to be independent; reducing their time spent on the ward and promoting a safe discharge back to their own home or community setting.

Compassionate care

- Patients we spoke with were happy with their care and the attention from the staff. We saw kind, responsive interaction between the staff and patients.
- We observed compassionate care and attention being delivered. For example a nurse spoke with a patient with loss of hearing in a sensitive manner. Patients told us they had been well cared for.
- We observed staff protecting patient's privacy and dignity, shutting curtains around the bed area securely and lowering their voice to discuss personal information.
- Staff were observed to be kind and caring when supporting people's mobility and we saw staff introduce themselves to patients and relatives.
- Five stars had been awarded to the hospital based on 24 ratings with NHS Choices.

Understanding and involvement of patients and those close to them

- We heard how patients were encouraged to be independent and live as they would at home as part of the rehabilitation plan. We saw that patients, and relatives when necessary, were included in the discussions about the plan of care during the ward round. They were given the opportunity to ask the medical and nursing staff questions.
- One visiting relative told us they felt fully informed about the plan of care and future discharge.

Emotional support

- Nurse specialists were available for advice related to conditions such as dementia, diabetes, safeguarding and mental health.
- Staff had recently accessed mental health services to ensure a patient's safety was considered and their rehabilitation plan was appropriate.

Are medical care services caring?

Good



Medical care (including older people's care)

- We observed a registered nurses, healthcare workers, therapists and student nurses assisting patients demonstrating respect and kindness, maintaining their dignity at all times.
- We observed reassurance and advice being given to patients and we saw that patients had their call bell within reach. Patients told us that they thought the call bells were responded to within good time scales and they had not had to wait an unreasonable amount of time for attention.

Are medical care services responsive?

Good



Patients' needs are met through the way services are organised and delivered. We found the ward to be responsive to the individual patient needs within their rehabilitation pathway. Full assessments were completed on admission which were monitored for their progress during the patients stay on the ward.

Service planning and delivery to meet the needs of local people

- The ward offered a rehabilitation service to local people and patients referred from surrounding areas. Patients were assessed by the ward staff prior to their admission. The commissioners have been instrumental in promoting the provision of frail elderly pathways, intermediate care and long-term conditions. The trust aimed to extend the patient pathway to benefit patients through the delivery of joined-up care and commissioners through more efficient and effective provision.
- The outcome of the review of the Staffordshire health economy review had not been finalised but will have implications for the hospital and commissioners. The early indications were that the review will confirm the hospital has an essential role in providing services to the local population.

Access and flow

- Admissions were received from the community and the acute setting. Patients were admitted directly to the ward for assessment and diagnosis.
- 18 week referral to treatment for those patients admitted was 100% for this service on this ward.

- Patient discharges were generally to a community setting such as their own home or a care home. The GP's were informed of the arrangements to continue support of the patient in a timely manner.
- Weekend discharge rate was currently 7% on this site.
- The discharge nurse worked closely with the ward staff to ensure patient flow was optimum. We were told that discharge plans commenced on admission to the ward however delays occurred when the patient progress slow, they became unwell or the community setting was not available.

Meeting people's individual needs

- Although the ward did not currently offer an 'end of life' service, they had been in a position to support one patient and their family in recent times. The staff felt they were able to offer a seamless service and the family had praised them for their kindness, support and overall care. The ward manager had provided the staff with ward based training to work towards accepting direct referrals in the future.
- Patients with complex needs were risk assessed by specialist nurses, physiotherapists and OT's. The patients care plan was then based on the risk assessments and professional advice.
- 'About Me' documentation supported individualised care and personal preferences for patients with learning disabilities and dementia. Carers of patients with special needs were encouraged to be present on the ward to assist with rehabilitation process.
- The trust had a specialist liaison nurse for patients with learning disabilities based within the community; they worked collaboratively with all wards in relation to learning disabilities and was a member of the adult safeguarding operational group. The liaison nurse followed the patient journey from the community into the acute trust.
- Interpreting services were available, when required for those patients whose first language was not English.
- A ward leaflet was available explaining the 'Ask Me' campaign which had been created to improve communication between staff and people using the service, and their families. It also included uniform recognition details, contact numbers, and other patient and visitor information.

Medical care (including older people's care)

- Information and advice notice boards were sited around the wards and entrance to the hospital. Advice leaflets were available on the ward for patients and carers offering disease/condition related advice and support.

Learning from complaints and concerns

- The ward manager told us that when a complaint was received the ward staff were informed about the issues and the findings of the investigation were discussed at ward meetings and documented in the meeting minutes. No complaints had been received between March and July 2015. How to make a complaint leaflets were displayed along with information on how to contact PALS.

Are medical care services well-led?

Good



We found the ward to be well managed and staffed by friendly, caring nurses and nursing assistants. The manager fed back governance data to the team when necessary and had been influential in improving patient safety on the ward.

The staff told us they felt valued and listened to and able to share their ideas and thoughts. We were told that the senior leadership team were visible and approachable.

Vision and strategy for this service

- Staff told us that the trust's vision was to become the local healthcare provider of choice, providing excellent community and secondary healthcare services close to and for local people. The community hospital offered a service that the trust vision described.

Governance, risk management and quality measurement

- The ward manager attended the medical governance meetings. The manager told us they now felt that the staff and the rehabilitation service were valued by the trust. They had successfully been involved with the winter pressure management of beds, patient flow and planning meetings.
- Following any incident on the ward the manager worked with the staff to complete a trust action plan, which was

drawn up as a result of the root cause analysis. The progress with action plans was monitored by senior management until completed and then signed off during the risk management meetings.

Leadership of service

- Staff told us that the ward manager was approachable and listened to the staff. They were visible on the ward and very much part of the team. They told us they welcomed visits from senior leadership and that they had seen executives in the hospital. We were told that the executives were approachable and welcomed staff views and ideas.

Culture within the service

- We heard from staff how knowledge was shared and staff ideas were valued. There was a caring attitude displayed between the staff and patients on the ward. We heard of the strong emphasis on good communication and on-going enhancement of the skills of the staff.

Public engagement

- Patients and visitors were encouraged to share their experience on the NHS website and through the friends and family process. The hospital had a welcoming entrance with a café and open seating areas which visitors were encouraged to use during their visit.
- Friends and Family Test was currently 97% for inpatients who would recommend using the hospital on this site.

Staff engagement

- Staff received a monthly, medicine division, newsletter which could be accessed on the intranet and was available as a paper copy. This updated staff on recent events, training dates, incident data and staffing issues. Staff were encouraged to send in information to be included in the following months.
- Staff told us they felt valued and listened to. They were encouraged to complete the NHS staff surveys and local surveys. The NHS staff survey showed results were within expectations. Staff told us that they valued the managers input to continually enhance their individual skills and personal development. Key findings from the survey showed that staff results were better than the national average in staff appraisal and stating that the







Medical care (including older people's care)

trust listened to patient feedback; they had not been subjected to physical violence from patients and the public, not witnessed harmful errors or incidents and had not experienced bullying or harassment.

Innovation, improvement and sustainability

- The ward manager told us how they aimed to provide a distinct end of life service in the future. This was to offer a seamless and calm experience for the patient and those close to them and to reduce bed pressures in the acute trust. They had established meetings with the palliative care consultant on to the ward who had provided relevant training for the staff.
- The ward manager told us they were continually looking to improve the service. An example of this was the mapping of falls to reduce the occurrence and this had so far proved successful.

Surgery

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

Information about the service

Sir Robert Peel Community Hospital is one of the three locations from which Burton Hospitals NHS Foundation provides care. The day case surgical unit saw on average around 2,801 patients in the past year. The unit had 15 day-case beds with a waiting room. The service provided day case surgery offering a range of minor and intermediate surgical procedures, a nurse-led pre-assessment clinic and an endoscopy service. Forty-seven percent of all activity were general surgery procedures; 28% were urology and 24% were trauma and orthopaedics.

We spoke with three patients, seven nursing and healthcare assistant staff, a manager, one non-clinical staff and a medical consultant. In total we reviewed four care records. We visited the anaesthetic room, theatres, the recovery area and the ward in order to observe care provided both pre- and post-operatively.

Summary of findings

Staff were caring, professional and friendly. Patients were involved in their care and treatment and encouraged to ask questions. We reviewed patient care records, these were appropriately completed with sufficient detail. We saw systems were in place to monitor patient risk and maintain a safe service.

Staff were confident in reporting incidents and were aware of the importance of duty of candour, informing the patient when things go wrong. Staff displayed good compliance results with the NHS safety thermometer. Medical and nursing staff felt as though they had safe staffing levels. All staff that we spoke with told us they worked well as a team. We saw there was joint working with the Queen's Hospital surgical division. All medical staff worked across both sites. We saw the team were working hard to complete all audits in order to gain accreditation for the endoscopy unit.

The unit had experienced a reduction in its utilisation in recent years and the trust were concerned over its long term sustainability. A decision to close the unit was postponed until 2016, following consultation with staff and the local community.

Surgery

Are surgery services safe?

Good



Staff were confident in reporting incidents and were aware of the importance of duty of candour, informing the patient when things go wrong.

Staff displayed good compliance results with the NHS safety thermometer. Medical and nursing staff had safe staffing levels.

Medicines were stored correctly and in line with trust policies. Staff adhered to infection control guidelines and maintained a clean environment.

We reviewed patient care records, these were appropriately completed with sufficient detail. We saw systems were in place to monitor patient risk and maintain a safe service.

Incidents

- No 'Never Events' had occurred within the service between April 2014- March 2015.
- There had been 32 serious incidents at the hospital (April 2014- March 2015). We saw reviews of root, cause and analysis reports had been completed.
- Staff reported incidents via electronic information systems, managers were clear about their responsibilities for reviewing and escalating incidents. All staff told us they knew how to report an incident and that they felt confident in raising concerns. Staff told us they always received feedback. They confirmed learning was shared about incidents from the matron via e-mail.
- We reviewed details of general incidents and saw they contained a cause, details of actual impact and an action plan/outcome.
- We saw evidence that staff logged near misses and learnt from them. We saw staff had changed their practice after one patient had almost been missed for a follow up appointment. This was fully investigated as to why and staff found that some were unclear of the process. The process was revised to ensure this did not happen again and learning was disseminated by one to one teaching.
- The duty of candour regulations require a provider to be open and transparent and follow specific requirements such as when things go wrong with care and treatment, informing the person and or family. Staff were able to

explain the importance of duty of candour. Duty of candour was detailed in the outcomes of the incidents we reviewed. A policy of "Being open when patients are harmed" (2015) policy was in place incorporating requirements of duty of candour.

Safety thermometer

- The trust used the NHS Safety Thermometer which was a tool for measuring, monitoring and analysing harm to patients and harm free care. Monthly data was collected on pressure ulcers, falls, urinary tract infections for people with catheters and venous thromboembolism (VTE or blood clots). We noted nursing staff conducted audits on harm-free care, patient experience and the environment. The hospital calculated the NHS safety thermometer percentage of harm free care for the community division was 97% (April 2014- March 2015) complaint with a target of 95%.
- Hospital data showed that 99% (April 2014- March 2015) of all patients had received a VTE risk assessment on admission, against a trust target of 95%

Cleanliness, infection control and hygiene

- The unit and theatres appeared to be very clean and well maintained. One patient told us they thought the area was "Immaculate", we substantiated this. The area underwent an annual deep clean as per policy. We noted cleaning rotas were displayed and completed regularly.
- Guidelines on infection control were in use. Personal protective equipment, such as gloves and aprons were available for use in all clinical areas.
- Staff were 'bare below the elbows' in line with trust policy and national guidelines for best hygiene practice.
- We observed staff in the endoscopy unit regularly washed their hands between patient interventions. Hand hygiene audits were maintained on the endoscopy unit, theatres and the day case unit. Figures showed all areas were consistently 100% over the past year.
- Hand gel dispensers were well placed throughout the departments; we observed visitors and patients using them.
- We observed staff in the endoscopy unit adhering to guidance for the safe disposal of different types of clinical and domestic waste and used needles (sharps).

Surgery

- There were no methicillin-resistant staphylococcus aureus (MRSA) infections within the hospital and eight reported cases of Clostridium difficile (C. difficile) within the past year. We were told patients were only screened for MRSA if they were deemed to be of high risk.

Environment and equipment

- On inspection we found equipment was regularly checked and maintained, stickers indicated the next check due date.
- Theatre staff understood their responsibilities for preparing and handling surgical instrumentation at all stages of the operative procedures. Staff reported having sufficient equipment to enable them to carry out their duties.
- Full tracking and traceability of surgical instrumentation was provided which offered a full audit trail ensuring that each decontamination process was followed correctly and according to international standards.
- Records showed that resuscitation trolley checks were completed each day. There were effective systems to ensure that resuscitation equipment, including emergency drugs, were readily available.
- The environment was visibly clean and bright. Areas had been repainted in the past year. Patients told us they thought the environment was calm and pleasant.
- The area had ten rooms which were gender assigned to avoid mix sex breaches. There was a bay of five beds which were mixed sex but we saw patients were organised into rooms as a first priority to better ensure privacy and dignity.
- We saw some rooms were more spacious, these were dedicated for wheelchair user access.

Medicines

- Pharmacy technicians visited the wards daily to support the management of patient medicines and stock control. Stock balances of medicines were regularly audited and confirmed to be correct.
- Correct storage arrangements were in place for the different types of medicines, including items which required refrigeration. We saw temperature checks had been carried out on fridges, ensuring correct, safe storage. Suitable disposal arrangements were in place for medicines that had expired.

Records

- We reviewed four paper patient care records. We saw these were appropriately completed with sufficient detail. Staff completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and VTE.
- Records were safely stored in a locked trolley to ensure confidentiality. We saw accounts were clear, signed, dated and no abbreviations or short hands were used.

Safeguarding

- There were safeguarding policies and guidelines for the protection of vulnerable adults and children. The trust had a designated safeguarding lead who provided advice for staff.
- Nursing and medical staff were knowledgeable about what actions they would take if they had any safeguarding concerns, and had an awareness of the hospital safeguarding systems and processes.
- Training data provided by the trust was for all surgical services and so we could not determine compliance levels just for this location. However, 100% of nursing staff had completed level one adult safeguarding training and 94% had completed level two. One hundred percent of nursing staff had also completed child protection level training.

Mandatory training

- Most staff had completed a programme of mandatory and statutory training which included fire safety, information governance, equality and diversity, infection control, advanced life support and conflict resolution.
- Resuscitation training compliance was monitored regularly for the whole of the hospital we found the figures were 94% (June 2015).
- Staff from the hospital completed adverse incident reporting training, 92% (June 2015).

Assessing and responding to patient risk

- Pre-operative assessments were completed for all patients prior to scheduled surgery.
- Early Warning Score (EWS) observations were monitored for patients and we saw evidence of staff responding to deteriorating patients.
- We saw the service monitored their use of VTE risk assessments and patients confirmed they had been informed about how to reduce risks of blood clots for example, by staying mobile and wearing stockings.

Surgery

- The five steps to safer surgery (part of the World Health Organisation (WHO) surgical safety checklist) was said by staff to be well embedded after being identified as a concern from the Keogh report (2013). The WHO clinical checklist compliance audit report (June 2015) showed the rates for the past two months were between 95% and 100%. We were unable to observe the checklist being completed as there were no operations on the day of inspection only endoscopy procedures. Staff told us they felt confident in challenging senior staff if they did not comply with safety procedures and the checklist.
- We spoke to the nurses who led the pre-operative assessment clinic and they told us examples of how they assessed and responded to risks appropriately, for example one nurse was seeing a patient that started to deteriorate and they acted appropriately, had taken observations and accessed the minor injuries unit at the hospital. Nursing staff told us medical staff were very supportive when they needed a consult during the assessment.

Nursing staffing

- All ward managers completed an acuity tool to ensure their established nursing numbers reflected the needs of the patient. The service has been using one regular agency staff member due to long term sickness. Managers had submitted a business case for a permanent operating practitioner in order to permanently fill this role.
- Regular bank staff were utilised by the unit, many of whom had previously been permanent staff. We were told by staff that they had recently filled all their vacancies and employed three whole time equivalent nurses.
- All seven nursing and healthcare assistant staff that we spoke with were happy with the nursing staffing levels on the unit.
- Nurse handovers were carried out at the start of each shift to communicate patient information.

Surgical staffing

- Procedures were led by consultants and where appropriate anaesthetist. According to managers the medical rota was said to be well-organised and planned far in advanced with the doctors. The consultant we spoke to said they were very happy working at the hospital and had no concerns.

Major incident awareness and training

- Staff were aware of the major incident and the business continuity policy, and understood their roles and responsibilities within a major incident.
- Staff were aware of the major incident policy (reviewed May 2015) and who the identifiable responsible person to lead on ensuring staff followed the procedures and protocols for a major incident was.

Are surgery services effective?

Good



Surgical specialties treated and cared for patients in accordance with national guidance. We saw the team were working hard to complete all audits in order to gain accreditation for the endoscopy unit.

Patient's pain was controlled during procedures. All patients confirmed they gave consent to treatment.

Staff ensured they were competent to do their job and engaged in further development.

All staff that we spoke with told us they worked well as a team. We saw there was joint working with the Queen's surgical division. All medical staff worked across both sites.

Evidence-based care and treatment

- Surgical specialties managed the treatment and care of patients in accordance with a range of guidance from the National Institute for Health and Care Excellence (NICE) and Royal College of Surgeons.
- Policies and procedures mirrored those of the Queen's Hospital surgical division as medical staff worked across both sites this made adhering to them easy. We saw that they were easily accessible on the intranet. Staff told us they were involved in the development of local policies, across both Hospital sites. All policies would be sent out to senior staff prior to publishing to ensure a consultation process was followed.
- The team were working hard to receive Joint Advisory Group (JAG) for Gastrointestinal Endoscopy Accreditation. This is the formal recognition that an endoscopy service has demonstrated that it has the ability to deliver against the measures in endoscopy standards. Several audits need to be in place to ensure

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they meet the standard. We saw the unit had a very clear action plan in place to work towards this and had already undertaken many of the required audits with good results.

- Care pathways were in use for patients undergoing elective surgery. The pathway incorporated the patient journey from pre-assessment, admission, surgery, recovery and discharge. Staff ensured a safe discharge and completed a range of checks for example to ensure care was in place for dependents and they had an escort to drive them home.

Pain relief

- Patients confirmed they were regularly asked about their pain levels. We observed staff regularly monitored non-verbal signs for pain and reassured patients when undergoing procedures.
- Pain scores were recorded on a pain scoring tool. Pain relief for patients was documented.

Nutrition and hydration

- Patients received fasting instructions according to the Royal College of Nursing pre-operative fasting guidelines, 2005. Patients did not receive food due to the unit only being for day case procedures. Although we saw patients were offered tea and toast before they were discharged.

Patient outcomes

- The service took part in all the national clinical audits they were eligible for, and had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- The hospital took part in various clinical audits. This included a WHO checklist audit, colonoscopy pathway audits and an audit of glaucoma new patient referrals

Competent staff

- All staff had regular appraisals; the compliance rate was 91% for the hospital, staff on the day case unit told us they had all had their appraisal in the previous 12 months.
- Staff completed supplementary courses to ensure their competency, such as conscious sedation and venepuncture training.

- Newly qualified staff told us they had an excellent preceptorship programme and felt very supported. Staff told us practice development nurses supported newly qualified staff.
- Nurses were developing competency programme for staff wanting to support in the nurse led pre operation assessment. They told us this would help junior nurses with their continuous professional development.

Multidisciplinary working

- Staff engaged in 'morning huddles' in which they discussed any formal and informal issues.
- The unit told us they engaged in monthly team meetings and last discussed the rota and vacancies. All staff that we spoke with told us they worked well as a team.
- Staff gave us an example that they have been working across professions to gain Joint Advisory Group (JAG) for Gastrointestinal Endoscopy Accreditation. This is the formal recognition that an endoscopy service has met certain endoscopy standards. We saw regular meetings were held by the gastroenterology consultant.
- We saw evidence of working with GPs ensuring information was shared with the patient's GP.
- We were told some staff like operational managers worked across all three sites and was able to disseminate information.

Seven-day services

- Pre assessment clinics were open from 8.00am-4.00pm.
- Patients started to arrive at the unit at 7.30 am at the earliest and the last patient was discharged at 7.00pm. If patients required an inpatient bed after a procedure this would be arranged by the consultant with bed managers' at the Queens site. Handover of the procedure and patients details would be given over the phone.

Access to information

- All local policies and guidelines could be accessed electronically on the trust's intranet system. The trust used electronic patient records, which meant that information was accessible. All staff had access to email systems.
- Paper patient records were available on the unit and were held in lockable cupboards. The key was held with the senior nurse.

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- Patients confirmed they received information about the services provided from the waiting list department (booking) and in outpatients. Staff confirmed they would give patients leaflets to take home on the aftercare post procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records showed that patients gave consent to treatment during the pre-assessment stage and this was reconfirmed on the day of surgery. We reviewed four consent forms and found that all of these were completed in line with Department of Health Guidelines.

Are surgery services caring?

Good



All staff we observed were caring, professional and friendly. Patients told us reception staff were courteous and helpful. Patients were involved in their care and treatment and encouraged to ask questions. We saw patients were supported emotionally before, during and immediately after their procedure.

Compassionate care

- The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. The recommender score for the NHS FFT for the day case surgical unit was 100% (April-May 2015) saying they would recommend the unit. The staff displayed several comments such as “Home from home”, “Professional” (staff), “Exceptional service” and “If only every hospital was like this, could not have better care.”
- All staff we observed were caring, professional and friendly.
- Patients told us reception staff were courteous and helpful. We saw the main reception was manned by a volunteer and we confirmed they were consistently polite and kind when directing patients where to go.
- One patient described nurses as “Lovely”. One patient described the consultant as “Very kind and nice”. One patient told us “Staff are courteous” and “The best thing about this place (Hospital) is the staff”.

Understanding and involvement of patients and those close to them

- We observed staff talking with patients, they explained procedures and allowed the patients time for any questions. We saw staff explained the procedure before, during and after. They reassured patients on when they were likely to receive test results and how the hospital would contact them.

Emotional support

- Staff told us they were experienced in dealing with anxious patients and would emotionally support them by providing reassurance. Due to the nature of the unit staff would refer back to the GP if they felt the patient required any further mental health support.
- We observed one young patient who was undergoing an invasive procedure staff adapted their responses accordingly and alleviated their fears.

Are surgery services responsive?

Good



We saw the service was being planned with staff to ensure it met the demands of the patient. We saw the service was being continually reviewed by the operations team which worked closely with the day case unit. We saw the teams held very high standards for the unit and ensured they met their targets. However we saw little evidence of staff improving the access to the service. We saw the utilisation of the unit was lower than expected. This was said to be down to poor access to the service. Some GPs did not know procedures were carried out at the hospital.

We noted that work needed to be done to improve complaint response time figures.

Service planning and delivery to meet the needs of local people

- In 2014, the trust proposed closure of the day case unit at the hospital as utilisation of the unit was lower than expected. There was a significant response from the local population and so the trust asked a local community interest group to collect local views on the

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services provided. Many patients commented that the hospital is not given as a choice by their GP. One respondent commented "...there is not going to be a demand, if you don't offer people the chance to go."

- This finding was confirmed by a trust survey of patients which showed that 62% of patients were not provided a choice when they were referred to have minor surgery by a consultant.
- The service did not participate in the NHS 'Choose & Book' service, this did not allow surgical patients to choose the most convenient place and appointment for them. We saw little evidence of the hospital actively increasing the profile of the service within the community to improve utilisation.
- The operations staff worked closely with the unit in planning the service and ensuring it met the demands of the local community. For example, the operations team told us they would be involved with any complaints about the unit and ensured the service was reviewed.
- Managers were currently looking at the informatics infrastructure and were planning the implementation of this with staff with a view to being more aligned to the Queen's hospital system, making cross site working easier. This would also ensure the booking system was more robust so "patients did not fall through the net".
- Staff told us they had recently been working on the pathway for endoscopy patients ensuring the process is more streamlined for patients. Over the past year staff told us they had used this experience on the pathway for patients who were admitted to Queen's Hospital following minor surgery. Staff told us they made allocating a bed more in line with the Queen's Hospital policy for example, involving the bed manager. They told us they had also improved the way in which they communicated and handed the patient over to the medical staff on that site.

Access and flow

- The target is that patients should not wait longer than 18 weeks from referral to treatment. At the hospital, 99% of patients were seen within this time against a target of 95%
- The operations team told us they had been in line with their targets for the past year. Staff told us they were proud of their high standards and did not work to targets but worked to exceed the targets.

- Lists of procedures were said to be planned far enough in advance with doctors that they haven't cancelled a list in the past year. They saw cancelling lists was just not an option and did not reflect good patient care.
- One patient who had to cancel their appointment told us the hospital staff were very accommodating in re-booking it at a more convenient time. One patient had been told there was a cancellation so their appointment had been brought forward which they thought was very efficient.
- The service took a proactive approach to discharge planning, starting this process at the patient's admission. GPs were all informed of the procedure, 94% (June 2015) of letters were sent within the five day target, the target was 95%.
- We saw there were fewer risks of readmission at the hospital in comparison to the England average (June 2013-May 2014).

Meeting people's individual needs

- Interpreters, including British Sign Language, could attend with patients at all points, pre and post-surgery. Arrangements were also in place for those with dementia or other cognitive impairment to have a family member or carer with them.
- Staff told us that one interpreter who was assisting a deaf patient interpret had told the staff during a pre operation assessment that they were so good at speaking to the patient, explaining and involving them in their plan of care that they almost felt as though they didn't need to be there.
- Staff told us reception staff were effective in ensuring they always arranged an interpreter to attend appointments with the patients.
- Staff were aware the trust had implemented a dementia strategy.
- Friends and Family cards are issued in Urdu and Polish as well as English language
- Patient information leaflets were available for patients being discharged to alleviate any fears they may have of after care and how to manage dressings. Patients were encouraged to contact the ward if they had any concerns once home.

Learning from complaints and concerns

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- We saw the hospital had received 38 complaints and the complaint response time was 53%, the target was 90% (April 14- March 15). We noted the need to improve these figures.
- The patient liaison service was visible near the entrance of the unit. Staff encouraged feedback from patients and comment cards were handed out during the discharge process.
- The hospital received 118 compliments (April 14- March 15).

Are surgery services well-led?

Good



Leadership of the service was good. Leaders were described as supportive and approachable and staff felt engaged with senior leadership. There were clear governance arrangements in place to manage risk and assess quality.

Concerns over the long term sustainability of the service had led to the trust deciding to close the day case unit and the theatre, this decision has since been postponed as a result of staff and public engagement.

Vision and strategy for this service

- In 2014, the trust proposed to close the day case unit and the theatre at Sir Robert Peel Community Hospital due to declining utilisation and concerns about clinical sustainability. The decision was communicated to the staff in the hospital and the public.
- Burton Hospitals Foundation Trust were called to the Department of Health (DH) to demonstrate why they had taken the decision and to seek evidence of public consultation. The public consultation revealed that the public felt it was underused due to poor access from GPs and consultants. The public shared concerns over the difficulties this will cause for the more vulnerable groups that use the service.
- At the time of the inspection, the trust had decided to delay any decision over the units future, pending further work on why utilisation was dropping. A further decision would be made in February 2016.
- The trust were able to demonstrate that if closure went ahead, plans were in place to mitigate the impact of the changes on the local community.

Governance, risk management and quality measurement

- We saw that robust clinical governance and risk management arrangements were in place.
- From the trust wide 2015/16 surgical business plan we saw staff developed an analysis of the teams' strengths and weaknesses. One weakness was community hospital Sir Robert Peel was not JAG accredited but they were working towards this.
- Senior staff told us they joined the Queen's Hospital monthly governance meetings in order to disseminate learning trust wide.

Leadership of service

- Staff were aware of the divisional structure and who their local and senior managers were.
- Nursing staff felt as though their ward managers were all supportive and approachable.
- Staff commented that the executive management team engaged and were visible. We saw several changes in practice based around recommendations from Keogh (2013) and the last CQC inspection (2014). We saw strong leadership from the board to divisional managers to local managers.

Culture within the service

- We saw the culture on the wards was positive. All staff told us they loved working at the hospital. All staff felt comfortable in raising concerns and challenging those who did not adhere to guidelines and policies.

Public and staff engagement


- Staff developed leaflets for patients on what procedures were available at the hospital in order to increase utilisation and publicity.
- As part of the decision making around the future of the unit, the trust a local community interest group to collect local views on the services provided. In addition, focus groups were held at the groups and staff and the public were invited to attend and express their views.
- Staff developed a newsletter which went out to GPs on a monthly basis in order to keep them informed of any changes at the unit. The last letter encouraged them to refer to the unit and outlined the procedures that they offered.

Innovation, improvement and sustainability

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- Staff shared their concerns regarding the long-term sustainability of the service. Staff told us investment in new equipment was needed which required a substantial investment.
- We saw endoscopy were working on their accreditation to attempt to better secure a service at the hospital.

Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

Outpatient and diagnostic imaging services are provided at all three hospital sites at the trust. Each hospital was visited as part of the inspection process and each is reported upon separately. However; services on all three hospital sites were run by one management team. As such they were regarded within and reported upon by the trust as one service, with some of the staff working at all sites. All the data provided by regarding out patients services was at trust level.

Outpatient services at Sir Robert Peel hospital were provided between 9am and 5pm Monday to Friday, and on Saturday mornings. A full range of medical and surgical clinics operated through the week supported by therapy services. Diagnostic services were available between 8am and 5pm and provided services to the minor injuries unit and the outpatient department.

Between April 2013 and June 2014 Sir Robert Peel hospital had 16,247 planned outpatient appointments.

In order to make our judgement we visited the outpatients department and we visited the diagnostic imaging services. We spoke with patients, their relatives or carer's, medical staff including focus groups of consultants, junior doctors, nurse groups and allied health professionals.

Summary of findings

Patients, visitors and staff were kept safe as systems were in place to reduce and monitor risk. Services followed recognised pathways of care and were completed by trained and skilled staff. Patient outcomes were audited and benchmarked against national standards.

Staff were caring and involved patients and their carer's and family members in decisions about their care. The service was responsive to the local community. Local leadership was good. Managers understood their staff and provided an environment where they could develop.

Formal complaints processes were embedded however we did not see evidence that informal complaints were being recorded in line with the trust complaints policy.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



Systems were in place to record, assess and share learning from incidents. Infection prevention and control measures were effective. Equipment was maintained well, provision had been made for the replacement of major pieces of equipment as they aged or became less reliable.

Safe staffing levels were achieved through the use of bank and agency staffing. Staff were up to date with mandatory training and aware of their safeguarding responsibilities.

Incidents

- We found incidents in the outpatients department were reported in line with the trust's policy.
- Staff we spoke to told us they were familiar with the electronic reporting system and knew how to report an incident.
- There was evidence that lessons were learnt following incidents. One member of staff told us about an incident where a patient was not followed up. Following the investigation, lessons learnt included changes to some records management and developing a safety netting system of appointment booking.
- As a consequence of this incident, the trust looked back over three years and sixteen patients were recalled for tests, an explanation was given to them all and an apology. This showed that the trust was aware of its responsibilities under duty of candour.
- The trust produces a regular briefing called 'Sharing for Caring' to share the learning from serious incidents, we saw evidence of this briefing paper at this hospital.
- 17 incidents were reported by the out patients department in the first four months of this current year. All were categorised as low or no harm incidents. There were no serious incidents reported. From 1 May to 30 June 2015, no incidents were reported by the radiology department at the hospital.
- No never events had been linked to outpatient specialties at the hospital.

Cleanliness, infection control and hygiene

- We looked at all the areas in outpatients and diagnostics and found them to be clean and tidy.

- Cleaning schedules were evident in radiology. We saw that equipment and tables were cleaned after every patient. Deep cleaning was completed every week.
- Hand gel dispensers were well placed throughout the departments; we observed visitors and patients using them.
- We observed staff following hand hygiene procedures, using hand sanitizing gel and hand washing.
- We observed a phlebotomy drop in session. The sharps box was clearly being used correctly, gloves and hand gel were visible and also in use. The trust needle stick injury policy was in place, no needle stick injuries had been reported at the hospital in the last 12 months.
- We were shown evidence of hand washing audits for April 2015 which showed that outpatients achieved 91% compliance and radiology achieved 100% compliance.

Environment and equipment

- We found that all out patient and diagnostic areas including consulting rooms were well laid out with spacious areas for patients to wait.
- At the time of our inspection there was plenty of seating for patients. We were told that the anti-coagulation clinic on Mondays can be particularly busy, especially after a Bank Holiday, but waiting space is not usually a problem.
- We examined the records of all resuscitation trollies and all were found to be up to date with daily checks.
- We were told that all equipment is tested by a medical engineer every 12 months. Medical equipment we examined was clearly labelled and within the timescales for testing.
- The outpatients department carried out monthly environmental check. We saw that at the last check in April 2015, the department achieved 100%.
- Local rules for radiological safety arising from the use of diagnostic x-ray equipment were in view and accessible and on the 'S' drive which all staff had access to.
- Radiology had a policy for identification in place, we saw how this was used and staff explained how this had been effective.
- There were panic buttons in the radiology cubicles to enable staff to summon assistance if required.

Medicines

- We examined drug cupboards and refrigerators. Drugs were kept securely, audited in terms of stock and expiry date. All drugs were properly accounted for.

Outpatients and diagnostic imaging

- Radiology staff wore 'film badges' these monitored the exposure of staff potentially harmful radiation. The badges were changed every three months and exposure rates were collated by the trust radiation protection supervisor (RPS).
- The trust had developed strategies in consultation with consultants and nurses which enabled nurses in certain circumstances to administer medications without the need of an individual patient prescription. This had been developed in respect of seven patient groups.
- Pharmacy support was available at the hospital between 9am and 5pm Monday to Friday. If clinics ran over or on Saturday mornings, if advice was required; pharmacy support was available from Burton on an on-call basis.
- The trust had a safeguarding lead and link nurses were available to support staff at the hospital. Training was provided in adult safeguarding and in children's safeguarding.
- The trust was not able to provide us with data on levels of training for outpatients and diagnostics just for this hospital. However, trust-wide data showed 100% of radiology, administration and nursing staff had completed safeguarding adults level 1 training. Eighty-nine percent of nursing staff had completed level 2 safeguarding adults training along with 95% of radiology staff.
- All (100%) of radiology, administration and nursing staff had completed child protection level 1 training. Sixty-seven percent of administration staff had undertaken level 2, along with 89% of radiology staff and 91% of nursing staff. One hundred percent of nursing staff had completed child protection training to level 3.
- PREVENT training was provided and compliance with completion was 93% of above for all staff groups. PREVENT is part of the Governments counter-terrorism strategy and raising awareness of it in healthcare is a key component of it.

Records

- Data provided by the trust showed that between July 2014 and June 2015, on average less than 1% of patients notes were not available on request for the clinic. The trust has a policy and procedure in place for clinic staff to follow if records are unavailable.
- During our inspection we checked a number of records regarding the general running and administration of the outpatients and diagnostic services departments. We saw that records were complete, clear and precise which enabled audit of processes to be completed effectively.
- Entries in patient registers, and individual records were appropriate and appeared accurate. Patient notes were individualised and included appropriate assessments to help keep people safe. We examined entries in relation to the phlebotomy service and saw that they were clear and concise.
- The trust told us they do not conduct any audits on outpatient notes.

Safeguarding

- Nursing and healthcare staff we spoke with understood their role in relation to protecting people from abuse and how to report suspicions of abuse.
- Reception staff were aware of the safeguarding process to follow should children not attend for their appointment. This was in line with the trust's procedure 'Management of children and young people who do not attend planned appointment'.

Mandatory training

- Individual staff were responsible for ensuring they attended mandatory training. Electronic reminders informed staff when training was due. If staff did not attend within the correct timescale their line manager would receive notification and would challenge staff as to why the training had not been completed.
- The trust was not able to provide us with data on levels of training for outpatients and diagnostics just for this hospital but trust-wide training logs showed that compliance with mandatory and statutory training was good. For example. 100% of radiology staff had completed equality and diversity training, 92% of administration staff had completed manual handling training and 92% of nursing staff had completed information governance training.
- Radiology staff told us that attending continuing professional development (CPD) events was difficult due to staffing issues. CPD is a requirement of registration and re-validation in some specialities. CPD events such as lectures can form part of staff evidence for the CPD.

Outpatients and diagnostic imaging

- Reception staff told us that it was difficult to attend training as a group because the reception desk could not be left unmanned. They said they were given time to carry out training and that most of their training was computerised e learning.

Assessing and responding to patient risk

- We observed the outpatient department end of day summary file which showed that every patient booked in to a clinic had an outcome recorded.
- Consultations always included assessment appropriate to the clinical need to monitor any change in health.
- Staff told us they did not follow any set procedure for recognising and managing the deteriorating patient but clinic nurses were observant of the waiting patients and clinic doctors could be called in an emergency.
- Part of the outpatient process including advising patients that should they become ill or feel that their condition had deteriorated between outpatient appointments they should return to their GP.
- MRI screening included a section to ensure that women who may be pregnant were identified.
- The Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000, require employers to establish diagnostic reference levels (DRLs) and to undertake appropriate reviews if these are consistently exceeded. We saw that each x-ray room at the Sir Robert Peel hospital displayed local DRLs in respect of set procedures. Reporting procedures were in place should the levels be consistently exceeded in line with the guidance.

Nursing staffing

- We saw how staffing of clinics was based on the acuity of patients and numbers of patients booked. Clinic daily templates recorded the number and type of clinics running, the medical staff attending and the nursing skill mix required.
- Nursing and healthcare staff numbers were based on national guidance.
- Nursing staff were managed by one senior nurse who worked between this hospital and the Samuel Johnson hospital. As a result staff worked flexibly between the two hospitals moving between the hospitals and swapping shifts to cover for staff absence. This meant that bank and agency staff were not required and the skills and expertise of the staff was shared across the two hospitals.

Medical staffing

- Eleven out of twelve of the general surgeons who held clinics at the hospital had job plans. Job plans assist managers and support staff to understand consultant availability and plan services.
- Locums were used to cover clinics where specialities could not be covered by trust doctors such as dermatology.
- At the time of our inspection radiology had one whole time equivalent vacant post in the department.
- Consultants did not see every patient at every appointment but were supported by members of their team. Most junior doctors described being supported by the consultants, and how they were able to seek advice if necessary during a consultation. Clinic debriefs took place which allowed cases to be discussed.

Major incident awareness and training

- The trust had a major incident and business continuity plan. The plans were available to all staff on the electronic shared drive. Major incident action cards were available for individual staff.
- Radiology services formed part of the major incident planning. We saw evidence of major incident planning being discussed in diagnostic imaging safety meetings.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate



Both outpatients and imaging services provided effective care and treatment. Patients received effective pain relief and support. Multidisciplinary working was evident throughout the departments. Staff training and re-validation were effective, as were supervision and appraisal systems.

Evidence-based care and treatment

- We found that there was a consistent approach to policies and procedures across the trust which extended to the Sir Robert Peel hospital.
- We saw effective interaction between different staff groups and departments. A good network of link nurses

Outpatients and diagnostic imaging

was in place across the trust with nurses meeting regularly to share best practice and exchange knowledge and information. This includes link nurses for tissue viability, safeguarding and dementia.

- Radiology used the radiology information system (RIS) computer based programme to monitor and audit activity in the department.
- We saw that Administration of Radioactive Substances Advisory Committee (ARSAC) guidance was followed in line with the Medicines (Administration of Radioactive Substances) Regulations 1978.
- In 2013, the Royal College of Radiologist's undertook a review of the service at Burton Hospitals. Thirty-one recommendations were made, of which 95% have since been implemented. Radiologists told us that they welcomed the reviews findings as at the time they felt that executive level support could have been improved as could the IT system. As a result of the review, there had been an improvement in conditions and better team working. Staff stated that they now felt part of the hospital team.
- The trust is part of the east midlands radiology group which encourages exchange of best practice and benchmarking.

Pain relief

- Patients we spoke with whose condition involved pain or discomfort, described how they had been able to discuss these symptoms and they had been prescribed drugs or recommended over the counter remedies which enabled them to control their pain.
- Pain assessments were completed at each appointment to enable clinicians to monitor effectiveness of treatment.
- A patient told us how they had contacted the clinic due to the amount of pain they were suffering. As a result their appointment for a pain relieving injection had been brought forward.

Patient outcomes

- Whilst Sir Robert Peel hospital had planned 16,247 outpatient appointments during the period April 2013 to July 2014, we saw that only 63% or 10,236 of these actually took place. 10% of patients did not attend, 17% cancelled their appointments and a further 10% had their appointment cancelled by the hospital.
- The trust had clear pathways for the admission of patients from outpatient clinics if this was required. The

guidance had specific pathways dependant on the clinical needs of the patient. Provision was included to provide addition nursing staff to the relevant outpatient clinic whilst the transfer of the patient was arranged, if it could not be arranged immediately.

- Radiology services for the trust were working towards membership of the Imaging Services Accreditation Scheme (ISAS) which is jointly run by The Royal College of Radiologists (RCR) and the Society and College of Radiographers (SCoR). This involves peer review and assessment of services. The department had been assessed as 86% compliant with the scheme. The trust aims to have achieved accreditation by 2017.
- Diagnostic imaging staff had all completed training in The Ionising Radiations Regulations 1999 (IRR'99).

Competent staff

- All staff we spoke with informed us they had a current annual appraisal in place. We saw matrix which showed that 100% of outpatient staff had received an appraisal during the current year.
- Senior members of staff told us they were proud of the number of nurse led clinics in place. For example nurse practitioners for urology, ophthalmology, bowel cancer follow up and a colorectal nurse specialist, all of whom had undertaken additional training to increase their knowledge and skills.
- We observed a phlebotomy drop in session. Registered nurses and health care assistants were trained and assessed as competent to take blood samples. The trust had a venepuncture policy.
- We saw evidence of competency reviews being completed, for example the venepuncture assessment record for one member of staff dated 28 April 2015, marked as competent.
- We spoke with one member of staff who ran a cytology clinic, carrying out 20 smear tests per clinic session. The nurse described how in order to carry out this clinic they had attended in-house training and they had been signed off as competent following supervision and assessment. In order to maintain their expertise in this field they attend a twice yearly nurse colposcopy forum and special events held at Birmingham Queen Elizabeth Hospital for nurse colposcopy practitioners three times a year.
- We examined personal development records. Close examination of two records showed that appraisals had

Outpatients and diagnostic imaging

taken place within correct timescales, objectives set and documents signed satisfactorily. A senior nurse at this hospital informed us that appraisal objectives were linked to the PRIDE values.

Multidisciplinary working

- Policies and procedures were common across the trust. At Sir Robert Peel hospital we spoke with a senior sister who showed us common documentation for policies, procedures and appraisals.
- Administrative support for consultants was provided from Queen's Hospital. On average support consisted of one secretary per two consultants. Secretaries understood their role in achieving targets for letters and appointments to patients and worked closely with the patient Access Centre to enable outpatient appointments to be made on time.
- There was opportunity for radiology staff to rotate between the departments in the three hospitals. However this appeared to be utilised more by junior staff who wished to expand their experience.
- Outpatients and imaging service described excellent relationships with local GP services. GP's were able to ring the departments and arrange services to meet the needs of individual patients.
- Imaging services worked closely with staff from the minor injuries unit.
- Therapies staff were based in the hospital and interaction with outpatient clinics was well planned, to prevent patients having repeat trips to the hospital.

Seven-day services

- Outpatient services at Sir Robert Peel hospital operated Monday to Friday 9am to 5pm. Occasionally clinics ran on Saturday mornings.
- Imaging services operated between 8am and 5pm weekdays and Saturday mornings. This meant that patients who attended the minor injuries unit outside these hours could not receive a timely service if imaging was required. Patients were either re-directed to Queens A&E or to other hospitals.

Access to information

- All department protocols for diagnostic imaging were in view in the magnetic resonance imaging (MRI) and computed tomography (CT) rooms. Staff could also access information on the trust computer shared drive.

- Outpatient staff had access to patient records electronically and from their written notes. We were assured that if patients written notes were not available at the time of their appointment, patients were still able to be seen as medical staff could access the required information by reviewing the electronic system.
- A learning disability pack was available to staff which included pictures and flash cards. A full communication toolkit was available from the Medical Library which was aimed at patients with visual and hearing impairments and for those with learning disabilities.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had a good knowledge of the mental capacity act. They understood how to support patients and their carers or family when they attended appointments. There was clear guidance available for staff to follow if a patient did not have capacity to make important decisions about their health care. Documentation was available in the department which enabled staff to follow the guidance and ensured correct procedures would be followed.
- We did not encounter any patients in the outpatients or diagnostic imaging services who did not have capacity. Staff described how capacity issues occasionally arose in relation to elderly patients living with dementia or other memory problems, and with people with a learning disability. They described how most patients who were living with dementia or similar issues were accompanied by relatives or carers which meant there was usually someone who could assist in ensuring that decisions were made in the patients best interest if this was required.

Are outpatient and diagnostic imaging services caring?

Good



Patients were very complimentary about the care and support they received in both outpatient and imaging departments.

Staff took a pride in how they dealt with people and understood how to support patients and family members or carers when dealing with bad or unwelcome news.

Outpatients and diagnostic imaging

Patients were fully involved in discussions and decisions about their care.

Friends and family test results for outpatient services across the trust showed that between January and May 2015 an average of 90% of patients would recommend the service. During the same period 3% of patients said they would not recommend the service.

Compassionate care

- We were informed by one patient that staff in the outpatient clinic had responded in a compassionate and flexible way by rearranging her outpatient appointment. She said that staff take time to listen and don't rush patients and that they are kind.
- We witnessed radiology staff being professional and caring with patients. Staff took steps to ensure privacy and dignity was maintained through the use of gowns and staff being mindful to close doors until the patient was ready. Radiology undertook regular privacy and dignity checks both by nursing leads and lay people.
- One nurse told us how they had sat with an anxious patient until they were called in to their appointment. The nurse described how they had noted that the patient would not wait for longer than 10mins in the waiting area before becoming anxious. She sat and talked with the patient until it was time for them to see the consultant. If it were not for this intervention the patient would have left the department without a consultation.
- The hospital has developed a 'Warm Welcome Group' made up of different staff. The group have a particular focus on customer care. Training is being developed which mainly focuses on communication skills. They plan to roll out the training to all staff but are starting with receptionists as they are the first contact people have each time they arrive.
- Imaging services conducted patient surveys in addition to friends and family tests. We saw how the results were reviewed monthly. Weekly informal staff meetings took place to discuss 'patient's best views to take'.

Understanding and involvement of patients and those close to them

- Patients we spoke with described how they had been involved in discussions about their care with doctors and nurses. They told us they had been encouraged to ask about procedures and had been told about and given information about proposed treatment.
- Family members and carers were involved in the process. All those we spoke with described positive encounters with staff.

Emotional support

- We were told that if bad news needed to be given to patients or family members this was usually undertaken by the consultant or specialist nurses.
- Chaplaincy services were available if required, staff could be called to the department or patients, carers or family could be directed to multid denominational facilities if they preferred.

Are outpatient and diagnostic imaging services responsive?

Good



Services were planned to meet the needs of local people. Staff had received training and understood how to support vulnerable patients and their carers. In almost all instances referral to treatment times exceeded national targets.

Service planning and delivery to meet the needs of local people

- The trust had positive working relationships with community services and local GP's. If the patient access team wanted to communicate any changes or developments in the referral process they could place an article in the GP Newsletter. This process was also used for reminders such as indicating that an interpreter is required for the consultation.

Access and flow

- Overall performance for the trust in relation to referral to treatment times was good. The standard is that 95% of non-admitted patients should start consultant led treatment within 18 weeks of referral. We saw that between April 2013 and November 2014 the trust average was consistently between 98% and 99%, whilst the England average over the same period saw a fall from 97% to below 95% by November 2014.

Outpatients and diagnostic imaging

- Referral to treatment times were reported at trust level, however the trust were able to provide information broken down into main site (Queens hospital) and community hospitals. The following data therefore relates to Sir Robert Peel and the Samuel Johnson hospitals. The data showed that between January and June 2015 the seven specialities within the surgical division all exceeded the 95% target referral rate with a divisional total of 97%. Urology, paediatrics and gynaecology all achieved 100%. Orthopaedics and ophthalmology achieved 99% and 99% respectively. The nine specialities which fell within the Medical division achieved a divisional total of 95%. Clinical Neuro Physiology, Haematology, Nephrology and Neurology achieved 100%. Three specialities had failed to meet the target, Dermatology 93%, Rheumatology 91% and Respiratory 87%.
- Incomplete pathways of care have a standard of 92% of patients starting consultant led care within 18 weeks of referral. The trust as whole has been over target throughout April 2013 to November 2014 and overtook the England average in December 2013. As of November 2014 the trust performance was at 94% whilst the England average was 93%.
- All cancer referral targets at the trust exceeded national targets, urgent GP referrals, six week and 31 day referral targets.
- Seventeen percent of patients did not attend (DNA) their appointment. This is significantly higher than the England average of 6%. We asked the trust for details of analysis of hospital cancelled appointments. They were unable to provide any details but assured us that this analysis was 'a work in progress'.
- Figures showed that a total of eleven patients did not attend clinics held the previous day. The hospital was introducing or using a number of strategies to reduce the number of DNA patients, for example, reminder letters were sent to colposcopy patients 10 days before the appointment date.
- We asked the trust for their analysis of waiting times, they advised that this information was not yet captured in the outpatients department but systems were being developed which would enable the analysis to be done in future.
- We observed an excellent service for some general surgery patients who were assessed as suitable for surgery at this hospital. The patients were seen by the consultant in outpatients, consent to carry out the

procedure was agreed at the time and an appointment for the surgery was given by the operating theatre booking staff. In summary the patient was examined by the consultant, diagnosed, treatment discussed, consent to operate given and a date for the surgery to take place all in one visit.

- Radiology report turnaround times all met national guidance. Reports for patients from the minor injuries unit were completed within 24 hours. GP referral reports were completed in the department within three days, however the reports could take a further 3 to 5 five days to reach the GP. Urgent reports were faxed on the day of the report.

Meeting people's individual needs

- Interpretation services were available, initially through a telephone service, but face to face services could be arranged if advance notice were given. The most commonly used services were for Urdu and Polish. Patient information sheets were available and could be translated into other languages if required.
- British Sign Language (BSL) interpreters were also available and could be booked for consultations between patients and clinical staff.
- Staff were trained in mental health awareness to help them identify and support patients appropriately. Advocacy services could be arranged for vulnerable patients.
- A learning disability pack was available to staff which included pictures and flash cards. A full communication toolkit was available from the Medical Library which was aimed at patients with visual and hearing impairments and for those with learning disabilities.
- Appointment letters could be typed in large font for patients with a visual impairment.
- We spoke to a patient who had not been due their appointment until the end of July. The patient required a pain relieving injection. They had contacted the department as they were experiencing pain. They described how staff had been flexible in slotting her in to an earlier appointment.
- Rheumatology and Neurology patients were able to ring the clinic nurse during clinic times to discuss any concerns or urgent matters they had. If necessary the nurse can arrange for them to attend and be seen in the out patients department.

Outpatients and diagnostic imaging

- The hospital had a high volume of patients whose first language was Polish. A set of regularly used phrases has been translated into Polish in the radiology department. This was a local initiative and although staff had found it very useful, it had not been quality checked by the trust.
- Some services had been reduced. A member of staff informed us that there was a restriction on the removal of lumps and bumps and the repair of asymptomatic hernias. This meant that patients with these conditions were unable to receive treatment at this hospital.
- The trust had invested a lot of time and resources into dementia care. This extended to the Sir Robert Peel hospital. We found that most areas had dementia champions to assist staff with their understanding and promote the care required to support patients with dementia or similar memory issues.
- Bariatric services were available, with specialist equipment available if required.
- Seven patient group directives have been developed to enable nurses to administer medications in certain circumstances without the need of an individual patient prescription. This made best use of both nurse and consultant time in addition to reducing waiting times for patients.

Learning from complaints and concerns

- Staff in the outpatient clinics and reception staff understood how to support people if they wished to make formal complaints. They described the process for referring people to the patient advice and liaison service (PALS). PALS leaflets were available on the reception counter.
- Staff said that wherever possible they would try to resolve issues for people before they reached the level of a complaint.
- Staff informed us that very few complaints were made and that most related to waiting times in clinics or cancelled appointments. In response to the complaints about waiting times, a review of the booking slots has taken place and adjusted to avoid the bottle necks. This action is awaiting review to assess the impact of the change.
- We were told by the patients we spoke with that the parking system is complicated and that if clinics overrun they often have to go out to the car park and put more money in the meter. Many patients said they try to avoid the hospital car parks by parking on the private roads.

- Radiology staff said that most issues raised by patients related to the car parking system. Comments about the service itself were generally complimentary.

Are outpatient and diagnostic imaging services well-led?

Good



Local leadership was seen to be good.

Managers and staff understood their role and were supported by the organisation.

Systems were in place to monitor and respond to issues. Evidence of interventions to address issues was seen.

Staff felt engaged and able to challenge. There was an open culture of learning and progression.

Vision and strategy for this service

- Staff we spoke to understood the values of the organisation and were able to articulate their meaning.
- Staff understood their role within the organisation and how they contributed to the trusts vision and strategy. Staff at all levels were keen to show and explain their work.
- The service had established an outpatient efficiency project in June 2015, to address a number of strategic issues facing outpatients such as clinic utilisation, DNAs and booking processes.

Governance, risk management and quality measurement

- There were systems in place to enable department managers to identify and respond to issues affecting the service. Regular team meetings took place where staff were able to raise concerns or receive feedback or updates. Good work or items of concern were taken forward to senior staff meetings and where necessary escalated to quality assurance groups, operations meetings or to board level.
- Outpatient staff described to us a variety of meetings and the methods used to cascade information. Senior staff attended trust wide meetings, divisional meetings and governance meetings. Information from these was

Outpatients and diagnostic imaging

cascaded at a monthly team meeting which included sharing of learning from patient feedback, complaints and incidents. A standard template was in use for the cascade of information.

- Diagnostic imaging services held monthly clinical governance meetings and monthly staff meetings. We saw how information from clinical governance meetings was disseminated at the staff meetings from minutes of the meetings.

Leadership of service

- There was evidence of strong nursing leadership. Managers understood their staff and were able to support them in their role and in achieving the trust goals.
- The nursing services at the Sir Robert Peel hospital were jointly managed with those at the Samuel Johnson community hospital. This had advantages in that processes were similar, however also brought challenges as managers had to share their time between two locations. Additionally managers had responsibilities to attend quality meetings and management meetings at Queens hospital. Despite this staff told us that managers were accessible and available.
- Staff we spoke to said they felt supported by management and that they could raise any issues or concerns and that they would be listened to and taken seriously.
- More senior managers and executive staff were visible on site, this was confirmed by staff in outpatients and imaging services. We were told that

Culture within the service

- The culture of the staff working at this hospital was very much aligned to the local community but at the same time recognising they are part of a larger organisation.
- Staff within the radiology department told us that they felt there was disengagement between what happened at the trust main site at Queens hospital and the smaller

units at Sir Robert Peel and Samuel Johnson hospitals. Junior staff did move between sites for experience of the different environments but there was little opportunity for established staff to do so. There is a perception that the smaller units are looked down upon.

- The radiology department had regular group meetings which the assistant director attended. The integration between services at the three hospitals has formed part of these meetings.
- Radiology have a standing agenda item at their meetings, a 'Great/Brilliant' item to celebrate innovation and sharing of knowledge and perceptions.

Public and staff engagement

- The trust in partnership with the Seisdon Peninsular Clinical Commissioning Group had commissioned Staffordshire Healthwatch, Engaging Communities, to carry out a public consultation in relation to local services. This identified the strong feeling within the community to retain and expand on services at the community hospital.
- The trust had a volunteers team of over 200 members. Volunteers worked at all three sites, and in a number of roles including assisting in the outpatients department at Sir Robert Peel hospital.
- The trust governors had staff representatives who represented both staff and public issues.
- Information was cascaded to staff through team meetings and events. Personal email accounts, and news articles and newsletters posted on the trust intranet.
- Staff told us they were encouraged to complete the NHS staff surveys and local surveys. The NHS staff survey showed results were within expectations.

Innovation, improvement and sustainability

- There was a focus on continuous learning and staff were encouraged and supported to develop themselves and services.

Outstanding practice and areas for improvement

Outstanding practice

- There was good joined up working in the minor injuries unit with other specialists such as the mental health crisis team and the mental capacity service team within the hospital.
- The five steps to safer surgery (part of the World Health Organisation (WHO) surgical safety checklist) was said by staff to be well embedded and the latest audit report showed high levels of compliance.
- Staff told us senior leaders and the executive team were approachable and visited the hospital on a regular basis.
- The surgical team were working towards Joint Advisory Group (JAG) accreditation for gastrointestinal endoscopy services.

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must review arrangements for access to x-ray imaging after 5pm weekdays and on Saturday afternoons and Sundays or MIU patients.
- The trust must support the MIU to audit its performance in order to assess the effectiveness of their own practice and to identify and manage risks.

Action the hospital **SHOULD** take to improve

- The trust should review the use of cloth fabric curtains in MIU treatment rooms to improve infection control.
- The trust should review the arrangement of overnight porters acting in the role of security for the MIU.
- The trust should routinely monitor the time patients wait for their appointment in out-patients to ensure services are responsive to peoples' needs and identify any issues and/or associated risks.