The Royal Orthopaedic Hospital NHS Foundation Trust

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Please note that the overall rating for the trust remains requires improvement; the follow up inspection ratings have been taken into account and this has resulted in no change to the overall hospital rating.

We undertook this inspection 28 and 29 July 2015 as a focused follow-up to an inspection we completed in June 2014. At that inspection the core services of Critical Care, which was a High Dependency Unit (HDU) at this trust and Outpatients Department (OPD) both had an Inadequate rating in one domain. This was within Safe for HDU and Responsive for OPD. Both services were rated as Requires Improvement overall. The trust received a follow-up inspection of those services to provide assurance that improvements had been made. Although diagnostics and imaging forms part of the OPD inspection the main issues had been in OPD, therefore the focus of this report was there. The inspection took place at this trust's one site which has the same name as the trust.

At the end of 2014 there were some issues relating to staff and medications, which the trust shared with us at the time. This resulted in some changes in staffing in governance and a wholesale review and change of processes regarding controlled medication. For this reason a pharmacist inspector joined the inspection team. We wanted to review the governance and the controlled medication processes. We received some whistle-blower allegations prior and during the inspection which we also had an opportunity to review within the remit of this inspection.

A further visit was arranged to view documents relating to Duty of Candour (Regulation 20). During that visit on the 05 August we visited OPD, X-ray waiting area, and the previously private ward.

At this inspection the two core services were rated as Required Improvement. However, we did see improvements in both core services. We noted that the trust responded to our concerns raised at the previous inspection, but we found that other issues impacted on their ability to meet the regulations. This has been reflected in the ratings.

Within HDU all the ratings remained the same as the previous inspection. Although the issues identified were different this time they had a significant impact across a number of domains.

Within OPD the result for safe remained the same. The responsive domain had improved from inadequate to requires improvement. This demonstrated that the trust had worked hard to improve the services for people and where the rating is requires improvement there is still some improvement work to be done. We have recognised within the reports that the trust has identified work streams to address the on-going improvement work. As part of the improvement work within OPD the trust had upgraded the patient administration system, to ensure it was compatible with the planned management information system due winter 2015.

Our key findings were as follows:

- Staffing of HDU with regards to children was not suitable. We found that children were being cared for within the unit but not always by a paediatric trained member of staff, nor were the facilities suitable for children.
- Within both core services we found that infection control practices were well embedded, and staff followed trust policy and procedures.
- We found that although the trust and its staff worked to the essence of the regulations of the Duty of Candour, in being open and transparent when things went wrong, they did not meet all of the requirements of that regulation.
- Multi-disciplinary working was effective in improving patient experience within the hospital.
- 100% of staff in both core services had received their appraisals, which was higher than the hospital's overall rate.

We saw several areas of outstanding practice including:

- The unit manager had ensured that staff were both aware and understood the values of the trust. A post box had been put on the unit to enable staff to identify what the values meant to them in their work on HDU. Staff views on the values displayed on a noticeboard and had also been discussed during staff meetings.

Summary of findings

- Within Outpatients we observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient left the clinic.

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

- Safeguarding training compliance rate needed to be improved in OPD, for both adults and children only reaching the trust target for awareness training.
- Privacy and dignity was compromised with the unacceptable arrangements regarding the toilet and washing facilities available for patients in HDU. There was only one toilet available for patients (adults and children, staff and visitors).
- The trust needed to ensure it could upload the information in the Intensive Care National Audit & Research Centre, so it could be benchmarked against other similar trusts.
- Within OPD management reports needed to be available to monitor clinic wait times and cancellations. There needed to be an agreed process which all staff followed in the event of a clinic being cancelled.

We were very concerned about care of children in the HDU, therefore have followed our processes to ensure that the trust takes appropriate action to improve the situation we found at inspection. Our specific concerns relate to:

- Medical and nursing cover must be improved on HDU when children are accommodated.
- Children must be cared for in an appropriate environment when requiring HDU care.

Importantly, the trust must:

- The trust must improve local leaders' understanding of the processes involved in exercising the duty of candour, in particular what they should expect beyond ward level and at a practical level, including record keeping.
- The trust must ensure sufficient staff are trained in safeguarding adults and children in OPD.
- The trust must improve the flow through the OPD so patients are not kept waiting for appointments.
- The trust must embed management arrangements within the OPD to ensure a firmer grip on the process of clinic booking and patient flow to improve waiting times for patients.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to The Royal Orthopaedic Hospital NHS Foundation Trust

The hospital was established in 1817. The existing hospital is situated in the south of Birmingham.

The hospital is a tertiary centre treating not only local people but people from across the UK and internationally.

The trust specialises in planned treatments of joint replacement, spinal and hand surgery as well as paediatrics. Nationally recognised as a centre of excellence for the treatment of bone tumours and for having a specialist bone infection unit.

Our inspection team

Our inspection team was led by:

Team Leader: Tim Cooper, Head of hospital Inspection, Care Quality Commission

Inspection Manager: Donna Sammons, Inspection Manager Hospitals Birmingham, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a Deputy Medical Director, two Consultant Anaesthetists, a Head of nursing with critical care experience, a Head of Outpatients, a Consultant Radiologist, a Medical Director and Deputy Chief Executive and a Head of Clinical governance and quality.

There were three experts by experience who were part of the team; they had experience of using services and caring for a person who used services.

How we carried out this inspection

We analysed the information we held about the service, which included national data submissions and information which people had shared with us. In addition to this we reviewed the information the lead inspector had regarding the service.

We visited the service as part of an announced inspection. The trust had 12 weeks' notice of our inspection start date.

We spoke with patients and visitors during the inspection. We also spoke with staff both clinical and non-clinical. We interviewed the executive team about their roles and responsibilities and the strength and weaknesses of the trust. We spoke to staff individually and in focus groups arranged in advance.

To reach our ratings we also reviewed documents in use at the time of the inspection and documents sent to us both pre and post the inspection, plus our observations of staff practice.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We carried out an unannounced inspection on the 05 August 2015.

Summary of findings

What people who use the trust's services say

The Friends and Family score for Quarter One 2015/16 was 97.3%. The patient survey undertaken by CQC found the trust overall score as 8/10 which was about the same as other trusts in England.

This inspection was a follow up and as such we did not conduct listening events. However, we employed the services of an expert by experience and it was the responsibility of the team to get the views of patients and visitors whilst we were present. We received mostly positive feedback, even when people had some dissatisfaction with parts of the service; they felt it was still worth the shortcomings for other aspects, particularly the quality of care.

Facts and data about this trust

Population served

The trust treats patients from both Birmingham and the West Midlands as well as across the country, many of whom have been referred by other hospital consultants for second opinions or for treatment of complex or rare conditions.

Location

- 128 beds plus 20 day case beds
- 10 Operating theatres

Staff (WTE)

- 966 staff (862 WTE)

Intelligent Monitoring

Number of 'Risks' 1

Number of 'Elevated risks' 0

Overall Risk Score 1

Number of Applicable Indicators 54

Percentage Score 0.93%

Maximum Possible Risk Score 108

Activity summary Apr/14 to Mar/15

- 6,813 planned inpatients
- 301 emergency admissions
- 8,186 day cases
- 73,969 outpatients appointments
- Income: £77,998 million
- Surplus /deficit: -£464.000
- Full costs: £78,431 million

Summary of findings

Our judgements about each of our five key questions

	Rating

Are services at this trust safe?

Summary

Incident reporting by staff was well embedded in the service. However where they warranted further investigation such as a root cause analysis (RCA), we noted that not all of the points which may have contributed were considered as part of the RCA. This would impact negatively on the ability to learn from incidents.

The trust had undertaken to comply with the Duty of Candour regulations, demonstrating a willingness to comply with the essence of the regulations. We noted that although they were open and transparent with those involved when there were failings in patient safety, they were not able to demonstrate that they had met every part of the regulations in dispensing their duty.

The environment of pharmacy needed improvement in terms of the fabric and the space available. Medicines management (including those of controlled drugs) had received intensive focus and we found that they were being managed safely.

Within OPD not enough staff had undertaken safeguarding training to meet the trust target of 85%; this was for both adults and children.

HDU cared for children regularly but did not have enough paediatric nurses available to care for them throughout their stay. The trust informed us they would be taking further action to remedy this. However, in addition to this the medical cover arrangements for children were not sufficiently robust to act in the event of a child's condition deteriorating.

Incidents

- The trust had an electronic incident reporting tool that staff had access to. Staff completed the tool and we found that there was a good attitude and understanding regarding the process and access to learning opportunities from raising them.
- The HDU reported 45 incidents from 01 March 2015 to 30 June 2015 of which nine related to medication, and eight to staffing. There were no Never Events or incidents which required STEIS reporting (01 May 2014 to 30 April 2015).
- In OPD 43 incidents were reported from January to April 2015. 37 of these were graded green and the rest were amber; denoting low to moderate in severity.

- We found that there was an open and transparent culture of reporting medicine incidents which was recognised as safe practice. The appointed Medicine Safety Officer for the hospital worked closely with the pharmacy team. Learning from incidents was communicated to all staff through the Medicines Link Group. We observed how information about medicines was shared from the Medicine Link Nurses directly to nursing colleagues on the wards. The pharmacy team also undertook monitoring of any changes to ensure safe practice continued. The learning from these incidents helped to improve medicines safety and therefore patient safety.
- During the inspection we reviewed documents of Root Cause Analysis (RCA) which had been undertaken to understand if further learning was required from an incident. However, we noted that in some instances the full incident details were not all represented and investigated as part of the RCA. Within the trust presentation RCA's, incident feedback loop and learning from incidents were some of the areas identified for continuing improvement. This meant that not all learning opportunities had been fully utilised.

Duty of Candour

- Duty of candour regulations came into place for NHS trust November 2014. At this time all NHS trust needed to ensure compliance against this regulation.
- The trust needed to improve on the processes of compliance with this part of the regulation. We noted that there were a number of policies in place to encourage openness and transparency. These policies, with the exception of the "Incident reporting, event investigation, analysis and improvement and being open policy" did give a brief summary of staff responsibilities, but did not cover all of them. The above policy was not due for endorsement until September 2015, which meant staff could not access it at the time of our inspection. However, we did see that this contained comprehensive information regarding staff and trust responsibilities.
- Staff received information at induction via a staff handbook and during a presentation. Both did not contain the detail staff required to meet the regulations.
- In OPD staff confirmed that the duty of candour policy and procedures were imbedded in the Trust's 'openness' policies. However, staff could not find these within the very large 'risk management strategy' document available on the intranet. Staff undertook searches for the following terms; duty of candour and openness. So this was not helpful to staff.

- We identified 14 incidents which trust staff had raised and graded as medium to severe harm. At the first review four of the incidents the trust offered no detail to demonstrate duty of candour had been undertaken of the remaining 10, one incident took place prior to the regulations so did not apply. Two more were considered to be no harm. One incident more information was required but there was evidence of delay in reporting. The remaining six duty of candour was applied. We reviewed the remaining documents the trust supplied to demonstrate how they were meeting the regulations. However, not all of the parts of the regulation had been met consistently to demonstrate full compliance with the regulation.

Infection control

- There were no incidence of MRSA reported for the whole trust between May 2014 and May 2015.
- Within both HDU and OPD we saw that hand sanitising gel was readily available but obscured in some places. Prominent reminders to use hand hygiene and hand gel were evident and we saw that staff were complying with them.
- MRSA infection screening for patients admitted for planned surgery was undertaken.

Environment and equipment

- The OPD was situated in a purpose built part of the hospital, which had been opened in 2011 with enough space to meet the needs of the people and staff using it.
- The HDU was well equipped with all the equipment required in each patient space and side rooms. Two patient bed spaces were used for storing equipment.
- We found the pharmacy department building was not fit for purpose and was on the trust risk register. The fabric of the building was deteriorating with potential security issues for controlled drugs. We were shown a storage room used for the delivery and storage of boxes. The room was small with little room to store the amount of boxed fluids required for the hospital. Following the inspection the trust informed us of the work they had undertaken and were planning to improve the pharmacy building.

Medicines

- We found that medicines were managed safely by the pharmacy team. The hospital had an on-site pharmacy and clinical pharmacists. Despite reliance on locum pharmacists, the pharmacy team were actively involved in all aspects of patients' individual medicine requirements, from the point of

admission through to discharge. Nursing staff we spoke with also told us that the pharmacy service was essential for medicine safety and if they had any medicine queries they had access to pharmacist advice at all times. Following the inspection the trust made us aware that the chief pharmacist was now a substantive post.

- The trust became aware of controlled drug issues at the end of 2014 which required investigation. The trust informed us at the time and kept us updated of the actions they were undertaking. We noted stocks of controlled drugs were audited every three months by the pharmacy team as well as random spot checks. One pharmacist had been utilised to support theatres predominantly in response to the controlled drug issues previously identified. We found comprehensive checking procedures were well developed and embedded across the hospital. Stock levels were checked twice a day and suitable quantities were available for individual theatre or ward requirements.
- Medicine storage room temperatures were not recorded across the hospital site. Medicines should not be stored above temperatures of 25 degrees centigrade because it could affect the stability of the medicine. We were therefore not able to determine if medicines were stored within the recommended safe temperature range.
- The hospital had completed a medication storage audit in May 2015 which had assessed whether all intravenous (IV) fluids were stored appropriately and securely. IV fluids on HDU were not secured or stored safely. We were told that the storage of IV fluids on HDU had been risk assessed on 28 January 2015. This assessment determined that because staff required immediate access to the IV fluids the storage arrangements were acceptable. However, we found that the access to the IV fluids was not secure and therefore there was a potential risk to safety.

Safeguarding

- 87% of the HDU staff had undertaken level 2 safeguarding vulnerable adults training. They were also required to undertake level 2 children's safeguarding, which 100% of staff had achieved.
- Within OPD documents supplied at the time of the inspection by the trust demonstrated that adult safeguarding rates were; awareness 100%, level one 73% and level two 18%. Child safeguarding training levels were, awareness 100%, level one 9% and level two 27%. The trust identified three staff to

undertake level three child safeguarding which they had completed. The trust minimum requirement was 85%, this demonstrated that within level two for both adults and children more compliance was required.
- Within OPD, staff adhered to the trust requirements regarding non- attendance of appointments, which required staff to contact the patient or parent/ guardian to rearrange. This is recognised as good practice with regard to children and could be an indicator for raising a safeguard in the event of repeated non-attendance.

Mandatory training

- The trust target for mandatory training was 85% according to the provider information request we received. Within the KPI documents in both the core services the target was more than 90%. For the two core services they had a completion rate of 88%. However, the trust 2014/15 full year position was only 79%.

Assessing and responding to patient risk

- The trust had an outreach team which supported the wards with their deteriorating patients. In addition to this, patients discharged from HDU were all followed up by the team.
- The trust had a service level agreement in place with the another provider which allowed them to use the Magnetic Resonance Imaging facilities at their premises for children who needed to be anaesthetised to undertake the diagnostic test. This policy ensured the safety of children who required anaesthetised MRI.

Staffing

- The trust whole time establishment was 898.4 staff. At December 2014 the trust had in post 847.4 staff. Medical staff fill rate was 88%; nursing staff was 91.5% and allied healthcare professionals was 97.2%.
- The staff attrition rate for both core services for April to December 2014 was 8%. Notably for nursing staff in OPD for the same timescale it was 11%, and for medical and dental staff it was 29%, which was extremely high although this did include junior doctor rotation.
- Locum use was 17% in OPD for April to December 2014.
- Safer staffing results for HDU Q1 2015/16 qualified day staff averaged 98%, qualified night staff averaged 100%. We saw board papers that reported that HDU used 5% agency and 5%

Bank for May 2015; this was a significant reduction from the previous two board reports where bank and agency use was around 10% each. However a report June 2015 demonstrated that the trust had overspent against target of £84K.

- The trust had undertaken recruitment overseas to reduce the reliance on locum staff. They were recruiting to the position of Physician Associates. It was envisaged that they would take up posts summer 2015.
- The outpatients used bank and agency nursing staff to supplement the staffing. From April to December 2014 agency nurse use averaged 6% of the staff. HDU agency use for the same period was 2.3%.
- In HDU at our last inspection we found that there was not always a supernumerary nurse or 'shift coordinator' on duty. During this inspection we found that a supernumerary nurse was on duty 24 hours a day and seven days a week.
- The HDU did not have enough paediatric nurses available to care for the children in the unit. Following the inspection we received a whistleblowing allegation which we shared with the trust per our policy. Within their response were details regarding numbers of shifts which had a paediatric nurse present in HDU. For an eight week period from 20 July to 13 September 2015, of this 56 day period, on 49 of these days there was at least one child present on the unit. The shift patterns are broken into three - early, late and night shifts. We noted that 53% of the early shifts, 65% of late shifts and 82% of night shifts did not have a paediatric trained nurse on duty. The trust in mitigation had increased recruitment activity and booked two additional agency staff on long term bookings. However, this still did not cover all of the shifts in which children were present on the unit. For the week commencing 14 September 2015 for which the trust knew that children had been booked on the unit 40% of the 15 shifts did not have a paediatric trained nurse present.
- Medical paediatric cover was not sufficiently robust. The arrangement at the time of the inspection involved twice a week paediatrician visits to the hospital, but did not include HDU unless requested by staff. 24/7 telephone support when required was also offered as a service level agreement with a local provider. This was not adequate to meet the needs of children within the HDU in the event of a deteriorating child or young person.

- Medical staff previously identified as being responsible on the rota for HDU was also expected to work in another department in the hospital. That practice has now stopped and the medical staff when identified on the rota only have responsibility for the HDU.

Are services at this trust effective?

Audit activity was well embedded in the trust; we saw an audit plan for 2015/16 was in place. Audits completed showed that in antibiotic prescribing and use of central venous catheters good practice was demonstrated.

The appraisal completion rate for HDU and OPD was 100%, well above the Trust target.

Multidisciplinary working within the two core services we inspected improved services for patients.

HDU had done most of the work to have their outcomes present in Intensive Care National Audit and Research Centre, but were not able to upload due to an IT issue, although the Trust was confident this would be resolved soon. This would allow them to compare their patient outcomes with other Trusts.

We observed that within HDU, there was one toilet available for staff, visitors and patients.

Patient outcomes

- We noted that there was an audit plan in place which had identified areas of audit for 2015/16 and both core services were included.
- The HDU had not completed the process to have their audit and patient outcomes represented in Intensive Care National Audit and Research Centre (ICNARC). Much of the work had been undertaken but the ability to upload the information electronically was not available to staff. The Trust confirmed that work was on-going to address this. This meant we were still unable to compare the outcomes for patients against other Trusts. However, Critical Care speciality orthopaedics does not have a clear benchmarking criteria dataset in order to assess effectively the treatment received by patients.
- We noted that audits carried out regarding infection control; antibiotic prescribing and central venous catheters all demonstrated good practices within HDU.
- There had been an improvement (reduction) in the number of patients transferred out from HDU to other Trusts. There had been 19 patients transferred between 01 April 2014 to 28

February 2015, of which 13 patients required level three care. Between 01 March 2015 and 12 July 2015 seven patients had been transferred of which four patients required level three care.

Competent staff

- Both services were achieving high rates of completion for appraisals with both demonstrating 100% for March to June 2015. However, the Trust 2014/15 full year position was 79%.
- 56% of HDU staff had undertaken the post registration qualification in critical care. The requirement is for at least 50% of staff.
- There was an agreement in place for another specialist provider to support the 4.6 WTE paediatric nurses with competencies. The other adult nurses were not able to access this. There was a practice development nurse to support nursing and auxiliary staff learning needs.
- Doctors who worked in HDU had arrangements with another partnership NHS provider to enable them to be exposed to different complex cases within their critical care.

Multidisciplinary working

- Within both core services inspected, MDT working was well established. Physiotherapy staff were well embedded in the services. OPD demonstrated that oncology services took part in weekly MDT meetings
- A pharmacist attended the weekly microbiology consultant led ward round on the bone infection unit. We were told that this specialist role helped to support the decision making process for antibiotic prescribing.

Seven-day services

- Magnetic Resonance Imaging (MRI scan) was available seven days a week. OPD clinics ran Monday to Fridays and in core hours only.
- There was an intensive care consultant present in the high dependency unit five days a week 8am – 6pm. Consultant cover outside this time was provided by the consultant on call. In addition to this, at the weekend the named consultants on call did undertake ward rounds on the unit both days.
- The Outreach team was at risk as the business case to provide seven day services had been rejected. This meant the team would be unable to offer the full service including resuscitation training, audit activity and supporting the wards and medical staff. The Trust had identified some mitigation which included a rota of staff between HDU and outreach.

Summary of findings

Are services at this trust caring?

Summary

Both core services we inspected were rated good for care. The friends and family results for July were 98% for the trust overall, with OPD scoring 97% and HDU 96.8% (01 January - 31 March 2015). Between 06 May 2015 and 16 July 2015 100% of patients who completed the HDU patient survey said they were satisfied with the care provided by staff.

The CQC national patient survey which was conducted between September 2014 and January 2015 (for which we received 525 responses) found that for “Patients' views during their hospital stay, being asked to give their views about the quality of care” and “Better Information about complaints” was better than the England average.

We observed staff that treated patients and family with dignity and respect. The level of compassion was good too. We saw that patients were involved in their care and supported emotionally.

Within OPD we saw that chaperones were used when patients requested it.

Are services at this trust responsive?

Summary

We saw that a higher proportion of people waited over six weeks for an appointment than at other orthopaedic trusts, but this was still lower than the England average. Some consultant job plans had a detrimental impact on this, but was being addressed by the trust.

Cancer 62 day waits for Q1 2015/16 was worse than the England target. The trust was as risk of 52 week breaches in paediatric spinal surgery due to theatre space availability at another provider.

OPD did not have management reports of clinic waiting times, but had undertaken a snapshot audit, which identified reasons for delays.

Complaint response rates had risen in Q1 2015/16.

The HDU had an occupancy rate of 53%; therefore there was the ability to meet the needs of patients requiring that additional support.

Service planning and delivery to meet the needs of local people

- Both the HDU and OPD were able to meet the needs of those using the services. Within OPD we saw that there was additional capacity to enable short notice or emergency appointments.

- Within the HDU the occupancy rate was 53.7% for Q1 2015/16 which meant there were sufficient beds to meet the needs of the patients'.

Access and Flow

- Within OPD this trust had a higher proportion of people waiting over six weeks than the other Orthopaedic trusts from June 2014 to May 2015; however this was lower than the England average.
- Local leaders told us not all consultants adhered to the six week target and this was escalated within the directorate. In discussion with a member of the executive team they told us that they too were aware of this issue and had taken action to address this. This included changing retirement working arrangements for some consultants.
- Local initiative had resulted in an improved service within OPD at one Friday morning clinic resulting in a significant reduction in waiting times, as perceived by staff running it.
- The trust results for 18-Week Non-admitted was 94.8% and 18-Week Admitted was 91.3%, all covering the period of April 2014 to March 2015. Cancer two week waits for the same period was 97.2% of patients seen in that time. The national target was 95%. 18-Week Incomplete was 94.6% with the national target being 92%.
- The cancer 62 day waits for first treatment (from urgent GP referral) for Q1 2015/16 was 64%. The national target was 95%.
- 52 week breaches for paediatric spinal surgery was an issue, as there were capacity issues at another provider facilities which the trust used since December 2014. There was a risk that the children's condition could deteriorate. The trust had gone out to other NHS providers to access theatre sessions but none was available until autumn 2015.
- The hospital accepted patients outside of the area due to its specialist status. During the trust presentation we were told of the arrangements put in place to support patients who travelled long distances to attend OPD. During the inspection we spoke to a patient who was very pleased with the service as they had come from out of the area to attend a clinic appointment.
- The number of operations cancelled on the day or the day before for Q1 2015/16 had been 46 for April and May, but in June it had risen to 79. This was a slight reduction from the previous quarter but a large improvement on Q3 2014/15 which had reached a peak of 216.

- A snapshot audit of clinic running times was undertaken in May 2015. 20% of the clinics finished over 60 minutes late. It was believed this was due to X-ray requests not being made in advance, so patients had to wait until an available slot in X-ray.
- There was a standard operating procedure in place to report clinic delays - it was a newly implemented document and required some bedding in. We noted some discrepancy in when staff thought they were required to raise an incident form.
- The 'one stop cancer appointment' for scans and appointment was responsive, having the results also available same day for review during the appointment. Patients told us they thought this was a very good service.

Meeting people's individual needs

- The HDU only had one toilet to be used by both male and female adult and children patients, staff and visitors. We judged this practice to be unacceptable. When we gave feedback to the Trust they expressed their commitment to add additional toilet and wash facilities.
- Imaging took place in another part of the hospital. It was used by both in-patients and out-patients. We observed that when patients were waiting both in- and out-patients waited in the same area, some of whom were in beds. To maintain the dignity of the patients in beds we did see that screens were used to shield them from each other. However the space was limited if more than two patients in beds were waiting.
- The HDU met the needs of patients; we noted that patients with learning disabilities were identified and arrangements were put in place with the support of the person's family.
- Within OPD patients living with dementia were identified so additional support could be offered at their appointment.
- We noted that the trust offered training to staff regarding both learning disabilities and dementia.

Learning from complaints and concerns

- No formal complaints had been received in either core service from January to June 2015. HDU had no complaints since June 2014 and OPD since November 2014.
- Both services said they would direct patients to Patient Advise and Liaison.
- The complaints process was publicised to increase awareness.

Are services at this trust well-led?

Summary

Summary of findings

The trust governance arrangements needed strengthening. There had been changes in key personnel and this had resulted in people occupying interim posts. An independent review of governance arrangements had identified areas for improvement. Although the trust was sighted on its challenges they were not fully resolved at the time of the inspection.

The culture within the organisation needed further improvement as some of the improvements met resistance from the consultant body. We noted that the some of the executive had to adopt a more bullish approach to challenge long held beliefs.

Transformation work was taking place within the trust and staff were involved and had opportunities to add their views.

Vision and strategy

- The published vision for the trust was;
  - Delivering exceptional patient experience and world class outcomes
  - Developing services to meet changing needs, through partnerships where appropriate
  - Being at the cutting edge of knowledge, education and research
  - With safe, efficient processes that are patient centred
  - All delivered by highly motivated, skilled and inspiring colleagues.
- The trust had an associated strategy in place to achieve the vision. The trust had an improvement director who was responsible for identifying a five year strategy. There had been consultations with the whole staff group to ensure they were involved and continued to be involved in shaping the future of the service. Both core services staff demonstrated their understanding and the vision for their own department.
- There was a Transformation Team who supported units with effecting change. The OPD was working with this team regarding the project to improve the informatics available.

Governance, risk management and quality measurement

- The trust had a Board Assurance Framework and associated risks documented which we reviewed as part of this inspection. The risk documents clearly identified the risks and who was responsible for mitigation actions.
- The trust had a committee and subcommittee structure that ensured that the board was ultimately sighted on the issues within the trust and external impact factors. A governance review had been commissioned and completed by an

independent external body. One of the areas it had identified for improvement was the subcommittee structure and how it fed into the Clinical Governance Committee (CGC). We noted from the minutes of this committee and in discussion with an executive team member that the strengthening of the subcommittees had commenced. As part of this work it was noted that some subcommittees had not met. The improvement programme included updating terms of references and appointing new chairs where there was a potential for conflict of interests.

- An audit in May 2015 of the timeliness of reports to the CGC found that only 57% of data for reports were completed in time for them to be scrutinised in preparation for the board.
- As part of the assurance process at ward level senior staff met regularly. A senior sister meeting took place weekly, and at the time of the inspection it had been agreed that it needed to be minuted.
- We also spoke with other staff within governance and complaints and found that although staff were undertaking their roles and felt ownership, there appeared to be a disconnect between the governance and complaints departments and the clinical areas. This could have accounted for the increase in the number of days it took to respond to complaints. This meant that closing the loop of activities was not always achieved. However, the trust recognised it and at the time of the inspection there had been changes in personnel within the governance at the beginning of the year. We interviewed the trust Governance Director who made it clear that in response to this they were undergoing a comprehensive governance strengthening programme. This included the recruitment of interim staff to strengthen the offering.
- We were aware of two incidents that constituted “Never Events” for the period of 2014/2015. Both relate to wrong site surgery (Spinal). One of these incidents took place in 2013 and did come to light via the complaint process.
- As part of the process for undertaking inspections we expect to receive increased information regarding the service and this was also the case for this inspection. We had three whistle-blower allegations made, one of which was serious enough to warrant us recruiting an additional member of the team to review it in isolation. Of the allegations, one was found to be an issue, relating to the paediatric nurse cover in HDU, which we have reported on in the safe domain of this report and also in the HDU section of the location report.
- OPD did not have access to management reports to fully understand the number of clinics delayed. Staff, however, did

have a good understanding of the reasons. In discussion with leadership and documents supplied by the trust, transformation work was being undertaken. OPD was part of this and improved IT systems were due to be put in place winter 2015.
- The trust had undertaken a review in line with the Lampard report, demonstrating policies which identified actions to take to safeguard patients in the event of celebrities and volunteers being on the premises.

Leadership of the trust

- Most staff that we spoke with in all roles knew the name of the Chief Executive Officer and confirmed that senior leaders conducted 'walk arounds'. They were also aware of the CEO's monthly blog.
- The organisational structure supported the day-to-day running of the hospital.
- Within both core services the local leadership was good. The HDU had improved by the appointment of key personnel to manage the service and support staff effectively. The OPD had a modern matron in place. However at the time of the inspection there was an interim OPD improvement manager, this was in addition to the OPD clinical manager and the directorate lead. However there appeared to be a lack of clear lines of accountability within the unit. The trust informed us following the inspection that an offer had been made for the role of OPD improvement manager; the person would take up their post in September 2015. There also was a heavy reliance on the work of the Transformation Team to effect upcoming change in the department.

Fit and proper person

- The trust had adopted a process that ensured that they met the regulatory requirements with regards to senior appointments.

Culture within the trust

- The trust was undertaking revalidation for medical staff and information was being captured on a new electronic system. We noted in minutes of board papers that medical staff attitudinal behaviours were forming part of the process. Reviews of feedback mechanisms were being used, such as review of incidents and complaints where if an individual was mentioned, it would become part of their revalidation process.

Summary of findings

- We were told by staff of all levels that the medical culture was changing for the better, but some work still remained. We spoke with members of the leadership who gave examples of out dated modes of thinking and behaviours which they were challenging.
- During the inspection staff told us of changes they had made in services but also of the challenges they had faced with consultant staff resistance. OPD staff felt there had been a cultural change since the last inspection and that they had good professional working practices.

Staff engagement

- As part of the commitment of the trust to recognise and encourage staff contribution, some staff that had made suggestions which impacted on patient safety were recognised and taken to the HSJ "100 best places to work" awards dinner July 2015.
- During the inspection the trust was developing and communicating the strategic intentions. Staff were integral to this process, with 56% of the workforce taking part.

Innovation, improvement and sustainability

- The trust was involved in peer review with another NHS provider to share best practice.

Overview of ratings

Our ratings for The Royal Orthopaedic Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services						
Minor injuries unit						
Medical care						
Surgery						
Specialist burns and plastic services						
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology						
Neonatal services						
Services for children and young people						
End of life care						
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall						

Our ratings for The Royal Orthopaedic Hospital NHS Foundation Trust

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

Overview of ratings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident and emergency and Outpatients.

Outstanding practice and areas for improvement

Outstanding practice

- The unit manager had ensured that staff were both aware and understood the values of the trust. A post box had been put on the unit to enable staff to identify what the values meant to them in their work on HDU. Staff views on the values displayed on a noticeboard and had also been discussed during staff meetings.
- Within Outpatients we observed that some clinicians were dictating letters to GP's and other services onto an electronic system for same day delivery, in the presence of the patient before the patient left the clinic.

Areas for improvement

Action the trust MUST take to improve

HDU

Action the hospital MUST take to improve

- Medical and nursing cover must be improved on HDU when children are accommodated.
- Children must be cared for in an appropriate environment when requiring HDU care.

Action the hospital SHOULD take to improve

- The performance tool should be fully completed to ensure all risks are appropriately highlighted.
- The contribution of data to Intensive Care National Audit and Research Centre (ICNARC) or similar, to benchmarked the service against other similar hospitals should be commenced.
- There should be appropriate single sex toilet and wash facilities available for patients and separate toilet facilities should be available for patients (adults and children), staff and visitors.
- Multidisciplinary ward rounds and handovers should take place to ensure effective patient care.

OPD

Action the hospital MUST take to improve

- The trust must improve local leaders understanding of the processes involved in exercising the duty of candour in particular what they should expect beyond ward level and at a practical level including record keeping.
- The trust must ensure sufficient staff are trained in safeguarding adults and children in OPD.
- The trust must improve the flow through the OPD so patients are not kept waiting for appointments.
- The trust must embed management arrangements over and within the OPD to assume a firmer grip on the process of clinic booking and patient flow to improve waiting times for patients.

Action the hospital SHOULD take to improve

- The trust should review the location of hand cleansing stations within the OPD and further encourage patients to use them.
- The trust should review the car parking capacity for disabled drivers.

Trust wide

Action the hospital MUST take to improve

- The trust must ensure the security of controlled drugs and the space available for storage is appropriate for the activities within.
- The trust must ensure the process regarding duty of candour is more robust and ensure that all parts of the regulation are adhered to.

The trust must ensure that when conducting root cause analysis it must take into account all parts of the incident which has a bearing on the outcome. Also where more than one incident report is raised that the information within them forms part of the analysis.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good Governance **17**.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The trust was failing to meet this regulation in that; **OPD** The flow of patients through the OPD was not being effectively assessed and monitored to ensure patients were not kept waiting for appointments. There were not effective management arrangements in place over and within the OPD to assure a firm and consistent grip on the process of clinic booking and patient flow to improve waiting times and timely access to imaging services for patients. **Trust wide** The trust failed to have systems in place which ensured that all learning opportunities were identified due to root cause analysis process not being robust, leading to missed opportunities for learning.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **13**.— Safeguarding: (1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. The trust was failing to meet this regulation in that; Within OPD inadequate numbers of staff had undertaken appropriate safeguarding training for both adults and children including the correct levels dependant on the level of contacts.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **15.** —(1) All premises and equipment used by the service provider must be— (b) secure, (c) suitable for the purpose for which they are being used, (d) properly used The trust was failing to meet this regulation in that; Pharmacy building was not fit for purpose to ensure the storage of controlled medicines and adequate space for storage.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour

This section is primarily information for the provider

Requirement notices

20.— Duty of Candour (1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) The notification to be given under paragraph (2)(a) must—

(a) be given in person by one or more representatives of the registered person,

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c) the results of any further enquiries into the incident, and

(d) an apology.

(6) The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).

This section is primarily information for the provider

Requirement notices

(7) In this regulation—

"apology" means an expression of sorrow or regret in respect of a notifiable safety incident;

"moderate harm" means—

1. harm that requires a moderate increase in treatment, and

(b) significant, but not permanent, harm; "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

"notifiable safety incident" has the meaning given in paragraphs (8) and (9);

"prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

"prolonged pain" means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

"relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

(a) on the death of the service user,

(b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or

(c) where the service user is 16 or over and lacks capacity in relation to the matter;

"severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

(8) In relation to a health service body, "notifiable safety incident" means any unintended or unexpected incident

Requirement notices

that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

(b) severe harm, moderate harm or prolonged psychological harm to the service user.

(9) In relation to a registered person who is not a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—

(a) appears to have resulted in—

(i.) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

(ii.) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,

(iii.) changes to the structure of the service user's body,

(iv.) the service user experiencing prolonged pain or prolonged psychological harm, or

(v.) the shortening of the life expectancy of the service user; or

(b) requires treatment by a health care professional in order to prevent—

(i.) the death of the service user, or

(ii.) any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

The trust was failing to meet this regulation

in that;

The trust did not apply duty of candour where it was required. We also saw that when they did apply it not all the relevant parts of the regulation were followed.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15: Premises and equipment **15.** —(1) All premises and equipment used by the service provider must be— (c) suitable for the purpose for which they are being used, The trust was failing to meet this regulation in that; Children were being cared for on an adult HDU which did not have either the facilities or space required to meet their needs.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18: Staffing **18**.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. The trust was failing to meet this regulation in that; HDU required paediatric trained nurses to care for children for the full length of their stay. The arrangements in place were not adequate regarding the medical cover for the deteriorating child. By not having a paediatric doctor on the premises apart from twice a week and telephone support. This meant that visual assessment was by a suitably qualified doctor was limited.